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
Jan 31, 2019	2018_493652_0015 (A1)	004019-18, 024800-18	Resident Quality Inspection

Licensee/Titulaire de permis

Advent Health Care Corporation
541 Finch Avenue West NORTH YORK ON M2R 3Y3

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

Valleyview Residence
541 Finch Avenue West NORTH YORK ON M2R 3Y3

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

Amended by NATALIE MOLIN (652) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Ontario

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This report has been amended to reflect a new submission of the plan date February 1, 2019, for the following orders:
Order #003 s. 31 (3) Staffing Plan
Order #004 s. 33 (1) Bathing

Issued on this 31st day of January, 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

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

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Amended by NATALIE MOLIN (652) - (A1)

Amended Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 10, 11,12,13,14,17,18,19, 20, 21, 24, 25, 26, 28, and October 1, 2, 3, 4, 10, 11, Off Site Dates: 17, 18, and 19, 2018

The following critical incident System (CIS) inspections were conducted concurrently with the RQI:

Log #007678-18, CIS #2954-000004-18 related to missing/unaccounted controlled substance

Log #001679-18, CIS # related to outbreak trend,

Log # 022604-18, CIS #2954-000018-18 related to medication incidents involving 10 residents

The following complaint inspections were conducted concurrently with the RQI:

Log #0253336-18 related to medication management, housekeeping and sufficient staffing

Log #007543-18 related to re-assessment for secure unit and skin and wound care

Log #000141-18 related to staffing

Log #016847-18, #019421-18, #024330-18 related to staffing

Log #018851-18 related to staffing, bathing

Log #019422-18, related to bathing, transfers, plan of care, documentation

Follow-up inspections were conducted concurrently with the RQI:

Log #004019-18 related to staffing

During the course of the inspection, the inspector(s) spoke with the administrator, interim director of care (IDOC), food service manager (FSM), dietary aides, nurse managers (NM), registered nursing staff, personal support worker (PSWs), clinical service manager (CM), consultant pharmacist, chief executive officer (Pharmacy), director of sales (Cardinal Health) environmental services manager (ESM), housekeeping staff, physiotherapist (PT), activation staff, CSM/Restraint lead, Public Health Inspector (PHI), residents, substitute decision-makers (SDMs), Residents' Council president, Family Council representative and family members.

During the course of the inspection, the inspector(s) conducted a tour of the home; observed staff to resident interactions and the provision of care, resident to resident interactions; reviewed the home's complaints records, conducted records review, reviewed the home's policy for the Skin and Wound Program, Continence Care and Bowel Management Program, Restraints Program, home's staffing plan; observed infection control practices throughout the inspection process including the initial tour, and provision of personal care and services; observed the administration of medications and reviewed the licensee's medication incidents and adverse drug reactions processes.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the home's minimizing of restraint policy was complied with.

On September 10, 2018, during the Resident Quality Inspection (RQI) initial tour

of the home residents #002 and #003 were observed wearing an identified device while seated.

Resident #022 was included in order to expand the sample of residents using the identified device in the home.

Record review of the home's Restraints Policy #NMIIR008vv with an effective date September 1, 2017, indicated that staff was not complying with the home's policy, specifically related to the following concerns:

A. Alternative to restraint: Use the Alternatives to Restraint Form to determine the appropriate restraint for use.
B. Restraint: Restraint type and reason must be documented in the record and the plan of care. The following must be included in the plan of care:
-There is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained.
-Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to the above.
-The method of restraining is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable methods that would be effective to address the risk referred to above.
C. Physical Restraint: All physical restraints will be checked hourly by designated nursing staff (PSW) and the resident repositioned every two hours to promote circulation and maintain skin integrity. Times will be recorded to indicate application/removal of restraint. Hourly monitoring checked and every two hourly repositioning must be documented on the Restraint Monitoring Record.
D. Documentation: Registered staff will reassess the resident's condition and the effectiveness of the restraint every eight (Q8) hours and whenever necessary; and staff to complete documentation on MED e-care and resident's care plan regarding the prescriptive interventions for registered staff and PSWs. PSWs will complete documentation for hourly checks and two hourly repositioning on Restraint Flow Sheet.
Education: All staff must receive retraining/additional training on the policy to minimize the restraining of residents in accordance with the Act and its regulation as well as training in the application, use and potential dangers of restraints and personal assistive supportive devices (PASDs) annually.
E. Quality Improvement/program evaluation: Monthly restraint analysis will be conducted by the Falls Committee. Annual program evaluation will be conducted

by the Falls Committee to determine effectiveness of the policy. A written record will be kept and included monthly analysis result, date of the evaluation, names of the persons who participated in the evaluation and the date that the changes were implemented.

Record review, observations and staff interviews revealed the following information related to the use of an identified device for residents #002, #003 and #022:

Record review indicated resident #002, #003 and #022 were assessed using the home's Resident Assessment Instrument - Minimum Data Set (RAI-MDS) instrument. All MDS assessments indicated residents were secured by use of an identified device.

On multiple dates, during an identified time the inspector observed resident #002, #003 and #022 sitting in in the residents' lounge. At the time of each observation, the residents made no attempts to get up from their seats; however, they were secured by the use of an identified device.

During multiple interviews, registered staff #115, #118 and #150 verified that an order and consent were obtained for the use of the identified device for all residents. A review of residents' written plans of care included an identified focus with expected outcomes and interventions listed to minimize falls and injuries; and to have an identified device on when in the wheelchair. However, all residents' plans of care did not include the size of the identified device assigned; alternative to the identified device that was considered prior to implementation; and whether the physical or mental condition of all residents were taken into consideration.

A review of residents' #002, #003 and #022 personal support worker (PSW) identified monitoring sheets, which were to be completed when a resident was wearing the identified device, indicated during an identified month documentation was missing from each resident's monitoring sheet on multiple occasions.

A review of residents' #002 and #003 registered staff Q8 hourly MED e-care documentation related to monitoring of the resident while wearing the identified device during an identified month, indicated there was an absence of registered staff signatures on both residents' electronic treatment record (eTAR) which would indicate registered staff signed off during or at the end of their shift. Therefore, because of the misinformation entered by an identified technician, the

system prevented the identified order from populating the resident's eTAR as verified by the identified technician #147 from an identified pharmacy.

The inspector requested an identified analysis for review, and noted that resident #002, #003 and #022's identified device use was not analyzed by the home on a monthly basis as verified by the CSM/Restraint Lead #124.

Multiple residents were observed using the identified device in the home. Record review of the home's identified list indicated 18 residents were currently using the identified device as a form of security.

During separate interviews, registered staff RPN #115, #118, PT #121, PSW #100, #120 and #122 verified that they completed the identified training on Surge Learning; however, they did not receive training specific to the use of the identified device. In addition, RPN #115 and #118 verified that they do not have reference material on the units to support staff training if required related to the use of the identified device, specifically regarding contraindications and potential dangers of using the identified device.

A review of the home's Restraint training records indicated 97% of direct care staff completed the Minimizing of Restraint training using Surge Learning Modules which provided an overview of the home Restraint Policy; however, there was no information included on Surge Learning related to specific physical restraint devices used by the home, such as the identified device.

The inspector conducted interviews with the home's Clinical Service Manager/Restraint Lead RPN #124, Physiotherapist #121 and Interim Director of Care (I-DOC) #100 related to concerns identified with the use of the identified device; and to verify their expectation related to staff compliance with the home's Restraint policy. The following interview highlight their expectations:

During an interview, CSM/Restraint Lead #124 informed the inspector that the physiotherapist completes the training for direct care staff on the units.

During an interview with the PT, they informed the inspector that they do not conduct staff training; and in fact, did not receive any actual training related to the use of the identified device. The PT further stated that whenever they brought the identified device up to the unit for application, they would briefly explain how to apply the identified device to whomever staff was present and available at that

time. The PT further verified that there was no discussion related to contraindication and potential dangers of using the identified device.

During an interview on an identified date, PT #121 verified that they completed initial assessments for residents #002, #003 and #022; and documented their finding in each resident's progress notes. PT #121 verified that they have been working in the home for three years; however, they were not aware the home had an identified form to be used for assessing all residents prior to the use of an identified device. The PT verified that resident #002, #003 and #022 did not have an identified form completed by the interdisciplinary team, including the PT.

During an interview, CSM/Restraint Lead #124 verified that the physiotherapist was the most responsible person to ensure each resident receives an identified assessment by the interdisciplinary team and using the home's identified form prior to the use of any identified device. The CSM verified that they were not aware the PT was not using the identified form to assess and reassess resident's using an identified device; but verified the form should have been completed for resident #002, #003 and #022 and kept in all residents' paper chart for review by the team as needed.

During an interview, the I-DOC verified that resident #002, #003 and #022 who were currently using an identified device should have been assessed and reassessed quarterly by the interdisciplinary team including the PT, by completing the home's identified form prior to implementation of the identified device and with continued use.

During an interview, CSM/restraint lead #124, verified that it was their responsibility to assign each resident the correct identified device size which was based on the resident's weight at the time of the assessment; and also they were to document specific information related to an identified device in the resident's plan of care. The CSM verified that the identified device was available in sizes small, medium, and large which was also coordinated to specific colors for ease of identification. In addition, the CSM verified that the size information as well as the potential for risk of harm and alternatives used prior to the implementation of the identified device should have been documented in the resident's plan of care. After reviewing resident #002, #003 and #022's written care plans, the CSM verified that the information should have been documented in the care plan as required by the home's policy.

During separate interviews, CSM/Restraint Lead #124 and the I-DOC verified that the hourly PSW monitoring and documentation on the identified sheet during the times the resident was actually using the identified device, should have been completed. Also, the Q8 hourly registered staff documentation indicating reassessment of residents related to identified monitoring, evaluation and effectiveness of use, should have been completed by the scheduled registered staff in the Med e-care electronic system as required by the home's policy.

However, during separate interviews, registered staff RPN #118, CSM/Restraint Lead #124 and the I-DOC were not aware that an issue had occurred with the home's identified documentation system in Med e-care. They became aware when the concern was brought to their attention during the RQI.

During an interview, CSM/Restraint Lead #124 verified that a monthly identified analysis related to residents #002, #003 and #022 identified device use was not completed in 2017. A review of the home's annual identified evaluation indicated there was no monthly or quarterly identified analysis completed as per the home's policy.

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee has failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, is in compliance with and is implemented in accordance with applicable requirements under the Act.

Section 8 from The Long-Term Care Homes Act, 2007 and Regulation 79/10 states where the LTC Act and 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, is in compliance with and is implemented in accordance with applicable requirements under the Act;
According to O.Reg 79/10, r. 101. (1) every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with. As
per A Guide to LTC Act and regulation, a "Written" complaint include written notification in any format, including anything handwritten, such as letters, notes, correspondence, emails, facsimile documents and text messages.

A complaint was submitted to the MOHLTC on an identified date, regarding the SDM's concerns for resident #032. They felt the resident did not receive proper care because of the shortage of staff. In an interview, the SDM indicated they had sent about 12 emails to Nurse Manager (NM) #123, but never heard anything back from the NM. The SDM stated that they had emailed the Administrator as well, but the Administrator returned calls, always saying that the NM would reply back to them.

Review of the home's Policy and Procedure Manual title "Complaints" number DM-07-035 effective May 23, 2018, stated: A copy of all written complaints must be forwarded to the Administrator immediately. Email communication is not automatically considered a written complaint; the receiver of the email is to determine if it is a written complaint and act accordingly - page 2. Further review of the Policy, under the Procedures, point number 7 "about email communication" explains: not all email communications are considered a complaint. The receiver of the email needs to:
i. Carefully read the email - if the word complaint is used - then it is a complaint.
ii. If it is unclear if it is a complaint, then the receiver of the emails is to review the communication with the Administrator.
iii. If it is still unclear, the receiver of the email should contact the author of the email to further clarify what the concerns are - page 5.

An interview with the NM indicated that they have received emails from family members regarding concerns for residents' care due to shortage of staff, however the NM stated they do not recall how many emails they have received with this concern as they do not keep track of it. The NM also stated they tried to talk to some of the families but for others they were not able to explain when the issue will be solved as they are not the one directly involved in the operation of the home. Further the NM confirmed they do not document when they received the email, when they talk to the families, what was discussed with them or when the issue would be solved. The NM confirmed that if they did not consider the emails as a complaint and did not initiate complaining log, they would just forward the email to other departments if the issue was regarding their services.

In an interview, the Administrator indicated that the home had a Policy and Procedure regarding Complaints. As per the policy, not all emails are considered complaints until they are further clarified with the sender. The Administrator indicated they would expect the NM to clarify with the SDM which email was a complaint then forward the email to the Administrator to follow up. The Administrator also indicated that they had received emails from the SDM and they called the SDM back, as well as addressing the same concerns about short staffing to the Family and Residents' Councils meeting and what the home was doing regarding the issue. However the Administrator stated they did not consider those emails as complaints, and they had not received any emails from the NM identifying a complaint.

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

In accordance with O.Reg.79/10, s.114 (2), the licensee was required to ensure that written polices and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

1. Specifically, staff did not comply with the licensee's policy regarding "Quarterly Physician Medication Review - #6.02," last revised October 18, 2015, which is part of the Licensee's policies and procedures for medication management from their pharmacy service provider.

The quarterly physician medication review policy directed staff to the following:
a) Procedure number two - Reviews should be checked against the MAR/EMAR for accuracy before the physician's visit. The review should be signed and dated by two registered staff members prior to the physician's visit.
b) Procedure number five - Completed reviews must be checked, dated and signed by a second registered staff member.
c) Procedure number nine - Quarterly physician medication reviews should be fully processed, signed and returned to the resident's chart by the first day of the month at the beginning of the designated quarter.

A) During the mandatory medication inspection protocol (IP), record review of resident #043's quarterly medication review for an identified period, indicated the following:
1. Only one registered staff signed and dated the quarterly review on an identified date, prior to the physician's review four days later.
2. The quarterly medication review was completed 19 days after the start of the quarter.

The sample was expanded to residents #044 and #041. Resident #041 was identified through a complaint received by the Ministry of Health and Long-term Care (MOHLTC) on an identified date.

B) Record review of resident #044's quarterly medication review for an identified

period, indicated the following:
1. Only one registered staff signed and dated the quarterly review on an identified date, prior to the physician's review one day later.
2. The quarterly medication review was completed 21 days after the start of the quarter and was signed by one registered staff on identified date.

C) Record review of resident #041's quarterly medication reviews indicated the following:
1. Quarter of an identified period - The completed quarterly medication review was not signed and dated by a second registered staff and was completed 23 days after the beginning of the quarter.
2. Quarter of an identified period- The completed quarterly medication review was not signed by any registered staff and the physician reviewed and signed the review 88 days after the beginning of the quarter.
3. Quarter of an identified period - The quarterly medication review was completed 15 days after the beginning of the quarter.

In an interview, RN #135, indicated the home receives the quarterly medication reviews from the pharmacy before the new quarter begins. The RN stated that the night registered staff completes the first check and signs, a second check is completed by a registered staff with the physician and both signs the review. The quarterly is then faxed to the pharmacy and two registered staff will check the review and ensure that the orders are in the electronic medication record (EMAR) and sign the quarterly medication review. The RN indicated that the quarterly medication reviews are to be completed before the start of the next quarter.

In an interview, I-DOC #107 indicated it is the home's process for completed quarterly medication reviews to be reviewed and signed by two registered staff before and after the physician reviews the quarterlies. The I-DOC stated the quarterly medication reviews are to be completed before the start of or on the first day of the new quarter. The I-DOC acknowledged that staff did not follow the home's policy on quarterly medication reviews for residents #041, #043 and #044.

2. Staff did not comply with the licensee's policy regarding "Narcotic Prescriptions -#3.08", last revised September 1, 2015, which is part of the licensee's policies and procedures for medication management from their identified Pharmacy.

The narcotic prescriptions policy under procedure number seven, directed staff that the quantity of medication remaining must be reconciled at the end of each

shift and the incoming and outgoing registered staff members count or measure the remaining quantity. Procedure number eight indicated that if the incoming registered staff member is not available, or the outgoing registered staff member must leave before the registered staff member from the next shift arrives, another registered staff must be sought out to complete the reconciliation. If necessary, the Director of Care or Assistant Director of Care can be contacted to complete the process.

A) The MOHLTC received a critical incident system (CIS) report from the home on an identified date, for a missing and unaccounted controlled substance for resident #042 that occurred on an identified date, in an identified resident home area (RHA). The CIS report indicated that a half tablet of an identified medication was missing from resident #042's identified medication blister pack and that the narcotic and controlled substance count at the change of shift was only completed by the evening RPN #108 when the missing identified medication was discovered.

In interviews, RPNs #108 and #109 confirmed they had worked on the identified date, and the count was not completed together at the change of shift. RPN #109 indicated, they provided resident care and followed up with a family member and upon their return to the nursing station, RPN #108 had already counted the narcotics and controlled substances and discovered the missing medication. RPN #108 indicated that RPN #109 endorsed the medication cart keys to them at the change of shift just after an identified time and initiated the identified count without RPN #109, and discovered the missing identified medication. RPN #108 stated that they had initiated the count as there was trust amongst the registered staff. Both RPNs indicated it is the home's policy for narcotic counts to be completed by the incoming and outgoing nurses together, which was not followed on the identified date.

In an interview, NM #123 indicated that it is the home's policy for narcotic and controlled substance counts be completed by two registered staff together and acknowledged RPNs #108 and #109 did not follow policy.

B) The MOHLTC received a CIS report from the home regarding medication incidents that occurred on an identified date. The CIS report indicated that ten residents in an identified resident home area (RHA) did not receive their medications during an identified time when RPN #108 was unable to complete their shift due.

In an interview, RPN #161 indicated they had counted the narcotics and controlled substance on an identified date, on their own at the change of shift at an identified time as RPN #108 was unable to conduct the count. RPN #161 further indicated prior to counting the narcotics and controlled substances, both narcotic count books were already completed and signed by RPN #108. When asked the home's policy on narcotic and controlled substance counts, RPN #161 indicated that the count must be conducted and signed together by two registered staff and acknowledged they did not follow the policy.

Record review of the home's investigation notes indicated the narcotic and controlled substance count on an identified RHA was already completed and signed by RPN #108, when RPN #161 started their shift at an identified time.

C) On an identified date, at an identified time, RPN #109 informed the inspector that the home was short a registered staff on an identified resident home area for the identified shift. The RPN indicated that each registered staff working in the other five RHAs had been assigned identified resident home area residents to monitor and administer medications.

Record review of the identified home area RHA's narcotic book, indicated that narcotic and controlled substance counts on an identified date, were conducted at identified times. There were five registered staff from the other RHAs who had administered medications to residents in an identified resident home area on an identified date.

In interviews, RPNs #107, #109, #118, and #117 confirmed that narcotic and controlled substance counts were not conducted when an identified resident home area medication keys were endorsed to each other on an identified date. RPN #108 stated they had conducted a count with another RPN at an identified time, since a MOH inspector was on the unit. The RPNs indicated when the home is short a registered staff, it is the home's practice not to conduct narcotic and controlled substance counts when the medication keys are endorsed between them. RPN #108 stated whenever the home is short a registered staff, the registered staff's workload is increased and conducting narcotic counts whenever the medication keys are endorsed takes time and further increases their workload.

On an identified date, the home was able to schedule RN #119 to work on an identified resident home area. In an interview, RN #119 indicated they started their shift on an identified resident home area at an identified time. The RN

indicated that a narcotic and controlled substance count was not conducted at the start of their shift, as another registered staff was not available. RN #119 acknowledged that the narcotic and controlled substance count should have been completed at the start of their shift.

D) Observations conducted on an identified date, on an identified resident home area at an identified time, indicated RPN #141 endorsed the medication keys to RN #134. The RN was observed to unlock the medication room, unlocked the medication cart then the narcotic box. The RN proceeded to count the narcotics on their own, while RPN #141 was documenting in the nursing station. At an identified time, RPN #141 was observed to stand beside the medication cart and did not observe the RPN sign the narcotic count book at the completion of the count by RN #134.

In an interview, RPN #141 indicated they had already counted the narcotics and controlled substances and signed the narcotic count book prior to the change of shift. When asked if this was the home's policy for narcotic and controlled substance count, the RPN was unable to provide an answer to the inspector.

In an interview, RN #134 indicated that it is the home's policy for narcotic and controlled substance count to be completed by the incoming and outgoing nurses together and the narcotic book must be signed together. The RN acknowledged that the home's policy on narcotic and controlled substance count was not followed.

In an interview, I-DOC indicated it is the home's policy to conduct narcotic and controlled substance counts whenever the medication keys are endorsed to another registered staff. The I-DOC stated the counts are to be completed and signed together by the registered staff.

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

The licensee has failed to ensure that the staffing plan:
a) provide for a staffing mix that is consistent with residents' assessed care and safety needs;
c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident;
d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work.

The licensee has failed to comply with compliance order #001 from inspection

2017_631210_0021 served on January 16, 2018 with a compliance date of July 31, 2018.

The licensee was ordered to prepare, submit and implement a plan to ensure that the staffing plan provide for a staffing mix that was consistent with residents assessed care and safety needs and that met the requirements set out in the Act and this Regulation.

The plan was to include, at a minimum, the following elements:
1. A hiring plan that ensures the home has all vacant staff positions filled and a sufficient casual/part-time staffing pool in place in six months,
2. An alternate staffing plan that ensures the home is staffed appropriately while implementing their hiring plan and that the alternate staffing plan includes education in the home's practices related to resident care,
3. A documented monitoring system to ensure that all residents within the home receive at a minimum two baths/showers twice a week by method of his/her choice when short staffed and that also includes alternate baths/shower days when not provided as per their plan of care,
4. Collaboration methods of management staff and scheduling clerk in realization of the staffing plan,
5. Conduct an evaluation of the home's staffing plan and update at least annually in accordance with evidence based practices and, if there are none, in accordance with prevailing practices,
6. Maintain a record of the annual staffing plan review.

1. A review of the compliance order to prepare, submit and implement a hiring plan that ensures the home has all vacant staff positions filled and a sufficient casual/part-time staffing pool in place within six months, the home's action plan requiring the managers to analyze their department current staffing levels in light of resident care needs, and create a modified staffing plan. All managers will implement a revised staffing plan to ensure all departments have a sufficient staffing pool to meet resident care needs. Review of the Nursing staffing plan indicated that after compliance due date, July 31, 2018, the home had not filled one RN, three RPNs, and 11 PSWs vacancies on all three floors for all three shifts.

A review of the staffing plan for August 2018, indicated that there were still open vacancies with a total of two RNs, four RPNs and nine PSWs.

A review of a staffing plan and a summary submitted by the Administrator to Inspector #600, as of September 24, 2018, pointed out that the home still had open vacancies of one RN, two RPNs, and 11 PSWs.

A review of the staff master schedule by the end of the inspection in September 2018 confirmed that the above noted vacancies were still open.

2. Review of the home's compliance plan to develop and implement an alternate staffing plan that ensures the home is staffed appropriately while implementing their hiring plan and that the alternate staffing plan includes education in the home's practices related to resident care, indicated the home had arranged for an extra PSW staff for all shifts and provided orientation for new hires.

A review of the home's hiring records indicated that the home made multiple postings for various positions and shifts between February and July 2018.

A review of the hiring process from January 2018 to July 31, 2018, indicated that 8 PSWs and 1 RPN were hired.
- September 2018 - the home was still conducting interviews for registered staff and PSWs.

In an interview, the Administrator confirmed that not all vacant positions had been filled even after the compliance date. Further, the Administrator indicated that the home had been posting the open vacancies, reviewed applications, conducted interviews and had hired some staff but the process had been long and moving slowly and not all of the applicants had been successful through the interviews or the orientation process.

3. Review of the home's action plan regarding the order to implement a documented monitoring system to ensure that all residents within the home receive at a minimum two baths/showers twice a week by method of his/her choice when short staffed and that it also includes alternate baths/shower days when not provided as per their plan of care.
The home was directed to develop a process for systematically tracking residents who have not had a shower on their regularly scheduled shower day and ensuring that the shower is provided to compensate for the missed one, to ensure the residents receive at minimum of two baths /showers per week.

During the inspection, the records review indicated that there was a binder on

each unit titled "Daily log for missed shower or bath". A review of the four "missed shower/bath log" indicated that two of the reports were completed but the other two were not completed and did not indicate that anyone had followed up with the process.

A review of the record of the missed shower/bath log on an identified date on an identified resident home area (RHA) indicated that resident #039 had refused to be bathed. There was no rescheduled date or to-be-determined date for the missing bath/shower. The PSW flow sheet for an identified record indicated that the resident had a bath/shower on three identified dates.

A review of the record "missed bath/shower log" on an identified date, on an identified RHA and on an identified shift record indicated that resident #040 did not receive a bath or shower and there was no rescheduled date. A review of the PSWs flow sheet indicated that the resident was bathed on four identified dates in the identified month. There were no further “missed bath/ shower log” for this resident to indicate that the resident had missed any bath or shower and if it was rescheduled.

A review of the staff schedule record for the previous month, indicated that the home worked short 9 RPN shifts, and 14 PSW shifts. For an identified date, the home worked short 10.5 RPN shifts and 4 PSW shifts. All identified shifts were not replaced.

A review of the use of an agency staff record indicated that in an identified month, the home used 10 RNs, 65 RPNs, and 183 PSWs, in another identified month, 15 RNs, 65 RPNs, and 176 PSWs.

From an interview with RPN #109, they indicated that when the unit is short of staff, the staff does not provide a bath or shower, but that those residents who missed their bath or shower were listed in a separate form titled "missed shower/bath log". It is expected that when the managers do their rounds, they will collect the logs and call an extra PSW to provide a bath or shower to residents that had missed their bath or shower. However, the managers would not call an extra staff if there is only one or two residents on the list. At the time when more residents are written on the list, the resident is due for the next shower.

An interview with the NM #123 indicated the home had a plan in place when the home was short of staff. The resident who did not receive a bath/shower is to be

marked on the missing bath/shower log, so when the managers do rounds, they would identify which resident did not receive a bath/shower and would either call an extra PSW to provide the missed bath/shower or talk to an identified shift to provide the bath/shower. However, the NM confirmed that they did not follow up if all the residents who missed their original bath/shower had been provided with the second bath/shower. They indicated it may happen that residents may have missed their second bath/shower.

Review of residents #032, #033, and #036's daily documentation record for an identified period, indicated the residents were not bathed at a minimum twice a week.

In an interview the Administrator acknowledged that the home did not comply with the order to implement a documented monitoring system to ensure that all residents within the home received at a minimum two baths/showers twice a week by method of his/her choice when short staffed and that also includes alternate baths/shower days when not provided as per their plan of care.

4. A review of the home's action plan regarding the order to implement a collaboration method of management staff and scheduling clerk in realization of the staffing plan, indicated that the home's plan was that the scheduling clerks will be included in the planning and implementation of the revised staffing plan by revising the staffing roster and availability list to reflect the new plan and to schedule staff.

An observation on an identified date on an identified unit discovered the following: The unit was short of a registered staff. Five registered staff from other care units came to the identified floor to assist with medication administration. Each of the RPNs administered medication to six assigned residents.

As per the home's policy titled "Short staffing", number NMIIS036vv, effective from September 5, 2017, when the home is short of a registered staff, the nurse in charge should reallocate the medication administration and treatments between the remaining five registered staff from the other units. Those five units will be short of registered staff for some period of time until they finish the administering of medication on the unit that is short of registered staff.

An observation during the course of this inspection and interviews with RN #107 and RPN #108 identified the following concerns with this process:

-Each of the registered staff was taking the key from the medication room, medication cart and the box with controlled substances, and handed to the next nurse, or would leave with the nurse on an identified resident home area as a base for keeping the keys. None of the nurses were checking the narcotic box and did not count the controlled substances (Except RPN #108 who was approached by Inspector #600 who questioned the process).
-The medications were administered within an extended period of time and the residents who were to receive their medication at 0800H did not receive their medications on time or as prescribed by the physician. The inspector observed 0800Hmed-pass being completed at 1130H.
-There was no prioritizing considering those residents who had medication to be given only three or four times a day. The window between the two dosages was not as ordered by the physician.
-Consistency/collaboration. While RPN #108 was administering medication around 1130H, there was a warning light coming from the electronic medication administration screen, indicating
medication or treatment had not been given to the residents within the time frame for administering or had not been signed off. The RPN indicated that the treatment was to be given at 0800H but they were not sure if the nurse that was assigned to give medication to these residents had provided the treatment or not, so they were not sure whether or not they should sign off the treatments.
- A review of the e-MAR for an identified date for three residents on an identified resident home area indicated that the prescribed medications or treatment to be administered at 0800H, 1000H, 1200H, and 1400H were administered by nine different registered staff. During further review of the e-MAR it was noted that the treatments prescribed to residents to be given at 1000H were not signed off, indicating the treatments were not applied.

Review of the home's staffing plan and attendance for registered staff, indicated that besides the five registered nurses working on each unit, there were other registered staff working in the home with different roles as a nurse manager, acting nurse manager, two registered staff in MDS role, one registered staff in restorative role, and an extra RN assisting all units while the NM was acting as the I-DOC. NM #123 confirmed the number of registered staff present in the building at that time. An interview with acting scheduling clerk confirmed that besides the five registered staff working on the units, there were five registered staff working in roles as specified above and none of the registered staff were directed to go to the identified resident home area as a replacement for shortage of a nurse.

In an interview, the scheduling clerk confirmed that they were not involved in staffing plan review and not involved in the development of the compliance plan regarding staffing plan. The scheduling clerk further stated on the identified date, that they were not aware that an identified resident home area worked short of a registered staff because the nurse in charge had not communicated the sick call to them. After questioning by the inspector whether or not the scheduling clerk had made calls to fill the shortage on the identified resident home area, an agency nurse came around 1230H to the end of the shift.

An interview with I-DOC confirmed that when the home is short of registered staff, the staff is to follow the "short staffing policy" however the I-DOC acknowledged to the inspector that there was no process for prioritizing the administration of the medications for the units but the staff is to follow the pre- assigned schedule based on the residents' rooms.
The I-DOC also acknowledged that there was no collaboration between the night and day nurse with the scheduling clerk to replace the short shift on an identified unit.

A review of the home's policy titled "Short Staffing" number NMIIS036vv, effective September 5, 2017, indicated in the event when a PSW is not available to work on any given shift the nurse on unit will liaise with the nurse in charge to reallocate a PSW staff and the duties the staff are to provide to residents care and services that are essential to residents' well-being.
During the interview with PSWs #103, #139, #142, #100, and #149, the PSWs indicated when they are short of a third PSW on the resident home area, they "split" the assignments between both of them and provide the residents' care and services essential to residents' wellbeing. Further the PSWs stated the practice in the home is that when they were short of a third PSW, they sought assistance from the nurse on the resident home area to assist the PSW with providing morning care to the residents; the residents who required transfer using the mechanical lift by two staff are left in bed and have their meals in the bed; they did not provide baths to the residents on that shift; and they did not document in the Point of Care (POC) for the residents that they are not assigned.

Observations during the course of this inspection and interviews with RN #107 and RPN #110 identified the following concerns with this process:
-The residents' care and safety needs were not met. The residents had not received meals on time as they were left in the rooms and were served after the

residents in the dining room had finished their meal. The staff was not always available to monitor the residents having their meal in their rooms.

On an identified date, the inspector observed resident #038 and resident #039 were not in the dining room for breakfast. During the interview, PSW #156 indicated when they were short of a third PSW, they were behind with providing care to the residents and had to leave residents who needed two staff assistance with care and transfer in bed until the PSW finished assisting the residents with meals in the dining room. Interview with RPN #154 confirmed when the unit was short of a PSW, the RPN assists the two PSWs to provide care and to transfer the residents to the dining room, and leave those residents who needed two staff assistance with the mechanical lift in bed. In an interview, RPN #110 stated the unit they were working not all residents are provided with morning care and taken to the dining room for breakfast. The residents were left in their rooms and provided with a tray, after the breakfast in the dining room was completed.
-Risk for lack of care. An interview with resident #036 indicated, the staff who provided care to the resident when they are short of a PSW, was in a rush and the resident felt discomfort when assisted with transferring.
Further the resident stated when the staff was short of a PSW and the resident required an identified ADL, the staff would refer to the resident to use an identified product. The interview with above mentioned PSWs #103, #139, #142, #100, and #149 and #156 indicated the staff was supposed to provide care for an extra number of residents than they had routinely every day, so they had to rush as each of the residents had their own needs that needed to be met.
-Residents #032, #033 and #036 did not have baths/showers for two identified months.
-Inappropriate transfer - when the unit worked short of staff the practice in the home was the PSWs would ask a private caregiver to assist as a second person during transferring a resident using a mechanical lift, or one staff transferred a resident manually as the second staff was not around and resident could not wait.
Expressed concerns of the staff included not being able to provide care to the resident according to their needs, the work overload due to increased sick calls, increased their frustration and does not promote consistency in care to the residents.

An interview with I-DOC indicated they were aware of the problem of short staffing and the home and was working on solving the issues. Further, the I-DOC stated at this time the policy gives guidelines to the registered staff and to the PSW how to deal in situations when they are short of PSWs. The I-DOC confirmed that the

PSWs were to provide the essential care to the residents (which does not include baths) divided among the two PSWs.

Review of the staff schedule record for August 2018, indicated that the home worked short of 9 RPN and 14 PSW shifts. For September 2018, the home worked short of 10.5 RPN and 4 PSW shifts. All identified shifts from above were not replaced.

Review of the tool titled "Staff call in sheet - Nursing department" for August and September, indicated that the fields to be completed on the sheet included date, time, staff who called in sick, shift to be replaced, reason for calls, and person who received the call. The scheduling clerk confirmed that they do not have a tool to document when, who, how often and why they call the staff. They just go by the "Seniority list" and given availability by the staff and mark when someone accepted the shift. The clerk stated they cannot provide a record of every sick call or shortage of staff that was attempted to be replaced.
- A review of the nursing schedule record and an interview with the scheduling clerk confirmed that for the month of August 2018, the home failed to promote continuity of care by minimizing the number of different staff who provided nursing and personal service to each resident. Instead the short shift on every unit were replaced by staff from an agency.

The I-DOC acknowledged that the nurse in charge on an identified date, had not communicated to the scheduling clerk to look for a replacement when the clerk started their work, as the staff was expected to follow the short staffing policy.

In an interview with the Administrator, they indicated that the home had revised the staffing plan and had identified problems with sick calls as a reason for the short staffing.
The home had reactivated the "Attending Management" policy and another action taken by the home to make sure the home is staffed appropriately while implementing their hiring plan included contracting four staffing agencies. The Administrator reviewed the master schedule with the inspector and confirmed that the home had not complied with the order to ensure the home had all vacant staff positions filled.

In an interview, the Administrator and the I-DOC acknowledged that the home had failed to promote the continuity of care to the residents and failed to minimize the number of different staff members who provide nursing and personal care to the

residents.

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. 33. Bathing
Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

This IP was open to inspect a complaint submitted to the MOHLTC on an identified date, with concerns regarding staff shortage affecting resident #032's care.

An interview with a complainant indicated on an identified date, when the home was short of PSW on the unit where resident #032 resided, the resident did not receive a bath or shower. Further the complainant stated that whenever the home was short of staff, the residents do not receive a bath shower, or medication.

Review of resident #032's MDS assessment record on an identified date and a written plan of care on an identified date, indicated the resident needed an identified level of assistance for bathing by one staff twice a week, on identified days and times.

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A review of PSW's daily flow sheet indicated on an identified date resident #032 did not receive a bath or shower.

An interview with RPN #109 indicated when the resident home area is short of staff, the practice in the home was the staff do not provide baths or showers to the residents as per management approval.

An interview with RN #116 confirmed that it had been approved by management when the resident home area was short of PSW, no baths or showers are to be provided to the residents.
Those residents who missed their bath or shower were listed in a separate "missed bath log" and the manager would collect the log on their rounds. They would call an extra PSW to provide a bath or shower for those residents who had missed it. The RN further stated, however, the managers would not call an extra staff if there was only one or two residents on the list. The RN also elaborated at the time when more residents are listed on the "missed bath log", the resident is due for the next identified bath or shower.

An interview with I-DOC confirmed that when the home is short of staff, the staff used the "short staff" plan where the registered nurse on the floor direct the PSWs to prioritize the care of all residents, and make sure they provide basic care to each resident. The I- DOC acknowledged that providing bath or shower when the unit was short of PSW, was not considered priority, so the bath or showers were not given to the residents. The resident's name would be written down on the "missed bath log" and the management would try to find staff to provide a bath or shower to the resident. The I-DOC acknowledged that not every resident was bathed a minimum twice a week by the method of their choice as determined by the resident's requirements.

2. MOHLTC received a complaint on an identified date, regarding concerns of shortage of staff affecting resident #033's and other residents' care.
Review of resident #033's MDS assessment for an identified period, specified the resident needed an identified level of assistance for self-performance indicating the resident needed physical help in part with their bathing. The assessment did not indicate how many staff were required to assist the resident.

A review of the resident's written plan of care revised on an identified date, indicated there was no bathing schedule for resident #033. Further review of the plan showed no focus, no goals, and no intervention set for the PSW to follow the directions as when and how to provide the identified ADL to the resident.

A review of the PSW documentation Flow Sheet and Observation/Flow sheet Monitoring Form for an identified period indicated a discrepancy in documentation so it was not possible to identify if the resident had been bathed twice weekly for the two identified months.

In an interview, the MDS Coordinator was not able to explain why there was a discrepancy in two documents which were to produce same data, entered by the PSWs after they document in their POC.

Interview with resident #033 indicated that before, when the unit was short of staff, they would have only one bath or shower per week, but lately, as they have their private caregiver employed by the family, the caregiver ensured they had a bath or shower twice per week.

Interview with PSW #139, indicated that the resident may have missed a bath or shower when the unit was short of staff. If the caregiver insisted they would give the bath/shower, the PSW would assist the caregiver by transferring the resident. The caregiver would provide the bath/shower and the PSW would transfer the resident back again.

The I-DOC acknowledged that the process in the home to provide alternate shower/bath to those residents that had missed the shower/bath, was not followed, as the logs were left empty, no alternate date for the shower/bath were arranged, and no registered staff on the floor, nor management had followed up if the residents had received their second shower/bath.

3. MOHLTC received a complaint on an identified date, indicating shortage of staff

affecting resident #036's care in the home, specifically bathing and toileting.

A review of the resident's MDS assessment on an identified date, indicated resident needed total assistance by two staff for all activities of daily living including bathing.

A review of the resident's written plan of care on an identified date, indicated that resident #036 did not have a plan for a bath, no bathing preferences were identified and no scheduled bathing or showering day was marked.

A review of PSW's flow sheet displayed in an identified months, indicated resident #036 did not receive at least two baths/showers weekly.

An interview with the SDM indicated they had to hire a private caregiver to make sure the resident received baths/showers and the resident was looked after, because the practice in the home was not to provide baths/showers when the home was short of staff. Since they had a private caregiver, the resident was having a bath/shower twice a week.

Interviews with the PSW #155 and the RN #116 confirmed that the practice in the home was when they work short of PSW, the baths/showers were not provided.

Interview with the NM #123 indicated the home had a process implemented in the home after receiving the compliance order in January 2018. When the home was short of staff, the residents who did not receive a bath had their name marked on the missed bath/shower list, so when the managers do rounds, they would check if there was a resident who did not receive a bath/shower they would either call an extra PSW to provide the missed bath/shower or talk to another shift to provide the bath/shower. However the NM confirmed that they did not follow up if all the residents who missed the bath/shower had been provided with the second bath/shower.

4. The MOHLTC received a complaint through the Action-line on an identified date, regarding care concerns related to resident #041.

In an interview, the complainant indicated resident #041 was not groomed properly. The complainant indicated this occurred when an identified home area was short staffed.

Record review of the resident's written plan of care and the RHA weekly bath/shower schedule indicated that the resident's scheduled baths/showers were on identified days. Further review of the PSW flow-sheet documentation in MED e-care indicated on an identified date, resident #041 received partial care on all shifts and received their scheduled bath/shower on an identified date.

The PSW flow-sheet did not indicate that the scheduled bath/shower on an identified date,was rescheduled.

In an interview, PSW #158 indicated resident #041 was assigned to them on an identified date. The PSW stated they arrived on an identified RHA one hour after the shift started, as the home called them to come to work as the unit was short staffed. The PSW stated that it is the home's process, when the unit is short staffed, scheduled bath/showers are not given to the residents.

In an interview, the I-DOC indicated scheduled bath/showers are to be provided to residents and if not provided, the bath/shower is to be rescheduled. The I-DOC reviewed the PSW flow-sheet and acknowledged that resident #041's shower was not rescheduled and they did not receive the minimum twice a week shower.

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended: CO# 004

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

**s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).**

**s. 51. (2) Every licensee of a long-term care home shall ensure that,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence; O. Reg. 79/10, s. 51 (2).**

**s. 51. (2) Every licensee of a long-term care home shall ensure that,
(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes; O. Reg. 79/10, s. 51 (2).**

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who was incontinent received an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

MOHLTC received a complaint on an identified date, regarding SDM's concern of shortage of staff affecting resident #035's care.

An interview with SDM indicated that resident #035 had a cognitive deficit and was unable to make care decisions, and required the assistance of staff. Further, the SDM shared that the resident was not aware of using a call bell to seek assistance by staff.

Review of the home policy titled "Continence Care-Bowel and Bladder" revised November 2017, number NRS-03-091, page one indicated for each resident the

RN/RPN will determine the resident's bladder and bowel function and elimination pattern, taking into consideration possible reversible causes or conditions by completing the on line Continence assessment tool located on the facility's resident documentation software. The RN/RPN will review a three day voiding/bowel patterns and continence assessment completed by the PSW to determine resident's needs, and document in resident's written plan of care: Goals of care, toileting routine as appropriate, continence products to be utilized, resident's specific needs and interventions. Reassess the resident's continence status/needs annually at minimum and PRN.

Review of resident #035's assessment record, indicated the staff had not conducted an identified assessment to determine the resident's health function. Review of the resident's clinical record indicated an identified monitoring assessment had not been completed for resident #035.

Review of the resident's MDS record on an identified date, indicated resident had a cognitive deficit, identified diagnosis and a frequent health condition and was not involved in a restorative program. An identified plan was not in place for resident #035 and they did not wear certain products.

A review of a written plan of care on an identified date, indicated the resident was an active participant with their identified tasks, but required the assistance of staff due to health care deficit. This written plan of care identified specific goals and interventions for resident #035.

An interview with PSW #139 indicated that actually the PSW does not assist resident #035 with an identified task as whenever the PSW asked resident #035 if they required assistance resident #035 will say no they are okay.

Further the PSW stated they do not know the resident's pattern as the resident performed the task them-self.

In an interview, RPN #022 indicated they were not working on the RHA when the resident was admitted, but they confirmed resident #035's record indicated that the resident had not been monitored for an identified care needs assessment on admission. The RPN stated resident #035 had not been assessed by registered staff to determine the resident's care needs using a clinically appropriate assessment instrument.

In an interview, the I-DOC stated the home had a policy for continence assessment and the staff is expected to assess every resident admitted to the home for continence care following the policy guidance.

2.Resident #001's care needs was triggered during stage 1 of the RQI.

Record review resident #001's admission care plan and assessment summary on an identified date, did not have a focus note that addressed their care needs.

Record review of resident #001's assessments records in MED e-care are indicated they had not received an identified assessment when they experience a change in their health condition.

Record review of resident #001's personal support workers' flow sheet for an identified period, indicated resident #001 experience periods of an identified health condition.

Record review of resident #001's Kardex indicated there was no focus note that addressed their care needs related to this health condition.

Record review of resident #001's written plan of care dated for an identified period, indicated there was no focus note that addressed their care needs related this health condition.

Record review of the home's policy #NRS-03-091 Continence Care -Bladder and Bowel dated November 2017, indicated the registered nurses to determine the resident's bladder and bowel function and elimination pattern, taking into consideration possible reversible causes or conditions by completing the on-line continence assessment. This policy also indicated the following:
registered staff to conduct a 3 day voiding /bowel patterns and continence assessment to determine the resident's needs, and document in the resident's plan of care; goals of care, toileting routine as appropriate, continence products(s) to be utilized, resident specific needs and interventions and to reassess the resident's continence status/needs annually at a minimum and PRN.

Interview with RPN #125 acknowledged resident #001 experience an identified health condition and wore identified protective products. RPN #125 also acknowledged an identified assessment had not been completed for resident #001 since admission or mentioned in their written plan of care since there a

change in their health condition was noted.

Interview with I-DOC #107 acknowledged resident #001's care needs should have been on their written plan of care and an identified assessment should have been completed when there was a changed in resident #001's health condition and they required staff assistance.

3. During the resident quality inspection (RQI), resident #007 triggered for MDS assessment related to change in an identified health condition.

Record review indicated resident #007 was admitted to the home on an identified date; and was assessed using the home's Resident Assessment Instrument - Minimum Data Set (RAI-MDS) on an identified date. An identified assessment indicated resident #007 experienced an identified health condition.

A review of the home electronic documentation records indicated the resident did not receive an admission continence assessment using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

During separate interviews, registered staff RPN #116 and Clinical Manager (CM) #124 both verified that the resident did not receive an admission assessment using a clinically appropriate assessment instrument. RPN #116 further stated they were not working at the time of the resident's admission; but that in retrospect, they should have followed up and completed the admission assessment upon return to work.

During interviews, CM #124 and NM #123 both verified that continence assessment should be completed for all residents at admission, annually and with change in condition.

4. MOHLTC received a complaint on an identified date, indicating shortage of staff affecting resident #036's care in the home especially bathing and toileting.

Review of the resident's MDS record on an identified date, indicated resident #036 needed total as well as extensive assistance by two staff for identified tasks. Resident #036 was not able to attempt an identified task as they required physical support. Resident was incontinent and they were on identified medications.

A review of the resident's written plan of care on an identified date, indicated that resident #036 was identified to need assistance for an identified task. This written plan of care had identified goals and interventions for resident #036.

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A review of the resident's assessment record indicated resident #036 did not have an assessment for an identified health condition.

An interview with primary PSW #155 indicate that they were providing care to resident #036 and they stated that the resident was aware when they required an identified task but the PSW do not assist the resident with the identified task and there is no specific directions.

An interview with the RN #116 indicated that the nurse in charge is to assess the resident on admission, quarterly and when the resident's condition change. When they assess the resident they also assess the resident's potential to restorative and identified function. The RN confirmed there was no indication that resident #036 had been assessed.

An interview with I-DOC indicated resident #036 identified task was to be provided as per resident's needs. They also indicated the resident was not considered for participation in the restorative program as the resident had identified behavioural symptoms, however they acknowledged that the resident was to be assessed for continence care and possible participation in restorative program.

5. The licensee has failed to ensure that the resident who was unable to toilet independently some or all of the time received assistance from staff to manage and maintain continence.

MOHLTC received a complaint on an identified date, indicating shortage of staff affecting resident #036's care in the home especially bathing and toileting.

Review of the resident's MDS record on an identified date, indicated resident #036 needed total as well as extensive assistance by two staff for identified tasks. Resident #036 was not able to attempt an identified task as they required physical support.

Review of the resident's continence assessment record indicated the resident was not assessed for an identified health condition.

A review of the resident's written plan of care on an identified date, indicated that resident #036 was identified to need assistance for an identified task. This written plan of care had identified goals and interventions for resident #036.

An interview with primary PSW #155 indicated that they were providing care to resident #036 and they stated that the resident was aware when they required an identified task
but, they do not provide this task for the resident, because the resident needed to be attended throughout the process of the identified task which required more time, and they work short most of the time. PSW stated that when the resident was in bed and required this task, they do not use any receptacle.

In an interview, the I-DOC confirmed the resident who was unable to toilet independently receive assistance from staff to manage and maintain continence. The I-DOC elaborated resident #036 has identified behavioural symptoms however, the PSW should have assisted the resident with care as set in the plan of care.

6. The licensee has failed to ensure a range of continence care products are available and accessible to residents and staff at times, and in sufficient quantities for all required changes.

During the resident quality inspection, resident #008 triggered for MDS assessment related to change in continence status.

A review of the Prevail Resident Worksheet that listed all residents' continence status and incontinent product(s) indicated there were 17 residents who currently used family provided product; and 10 residents who currently used an alternate product including resident #008.

In an interview, RPN #109 verified that resident #008's identified diagnosis was progressing which caused an overall decline in the resident's health status, which affected the resident's continence status. The RPN stated the resident went from wearing one identified product to another during an identified time.
RPN #109 informed the inspector that the home does not have an identified product available in the range of continence care products offered to residents. The RPN further stated residents who were considered independent for an identified task; and assessed to wear the identified product were offered an alternate product in order to maintain independence.

During an interview, NM #123 verified all residents listed on the Prevail Resident Worksheet who wore an identified product were assessed as appropriately. Since the home does not provide the identified product, if the resident or family does not like what is provided by the home they will purchase the identified product in the community.

During an interview, the Prevail Continence Product representative verified the company does carry the identified product in their range of product; however for unknown reasons, the home decided not to include this product in their range of product offered to residents.

During an interview, the I-DOC verified that the home does not offer residents a full range of continence care products. The Interim DOC stated they were not sure of the reason why the
product was not offered; and verified that the home used an alternative product instead. Therefore, the home failed to ensure a range of continence care products are available and accessible to residents and staff at times, and in sufficient quantities for all required changes.

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 109. Policy to minimize restraining of residents, etc.
Every licensee of a long-term care home shall ensure that the home's written policy under section 29 of the Act deals with,
(a) use of physical devices; O. Reg. 79/10, s. 109.
(b) duties and responsibilities of staff, including,
(i) who has the authority to apply a physical device to restrain a resident or release a resident from a physical device,
(ii) ensuring that all appropriate staff are aware at all times of when a resident is being restrained by use of a physical device; O. Reg. 79/10, s. 109.
(c) restraining under the common law duty pursuant to subsection 36 (1) of the Act when immediate action is necessary to prevent serious bodily harm to the person or others; O. Reg. 79/10, s. 109.
(d) types of physical devices permitted to be used; O. Reg. 79/10, s. 109.
(e) how consent to the use of physical devices as set out in section 31 of the Act and the use of PASDs as set out in section 33 of the Act is to be obtained and documented; O. Reg. 79/10, s. 109.
(f) alternatives to the use of physical devices, including how these alternatives are planned, developed and implemented, using an interdisciplinary approach; and O. Reg. 79/10, s. 109.
(g) how the use of restraining in the home will be evaluated to ensure minimizing of restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation. O. Reg. 79/10, s. 109.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's policy address types of physical devices permitted to be used.

A review of the home's Restraint and PASD Policy #NMIIR008vv, with effective date September 1, 2017, listed physical restraints on the Restraint Consent form as follows: seat belt, lap tray and tilt chair.

Record review of the Resident Restraint List indicated 18 residents were using an identified device as a form of physical restraint; however the identified device was not included on the list of physical devices permitted to be used.

During an interview, PT #121 and CDM #124 both verified that the identified device have been in use for approximately three years. Therefore, the home failed to ensure that the policy address all types of physical devices permitted to be used.

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A) The MOHLTC received a complaint through the Action-line on an identified date, regarding care concerns related to resident #041. The complainant had concerns regarding the home's medication management of resident #041's identified medical condition.

In an interview, the complainant indicated on an identified date, resident #041 experienced a change in health status. The nurse on the unit tried to give the resident a beverage while in an identified state. The complainant indicated that the nurse could not find an
identified medication in the unit to administer to resident #041 and they were transferred to hospital. In addition, the complainant was also concerned that the registered staff were not administering an identified medication when the resident's condition warranted, as directed by the physician.

Record review of the clinical records of resident #041 indicated the resident had an identified diagnosis and a history of identified clinical symptoms. Review of resident #041's physician orders indicated an order for an identified medication to be administered if the resident presented with specific symptoms.
The order was located in the quarterly medication review for an identified period. The identified medication order was also in the resident's EMAR.

A review of resident #041's progress notes in MED e-care s indicated that at an identified time, RPN #136 found resident in an identified location drowsy but responded to verbal stimuli. The RPN checked resident #041's status. The RPN called RN #135 and was instructed to give a beverage to the resident and to check their status after a predetermined amount of time. The progress notes indicated that the resident was symptomatic and the RPN called RN #134 informing them of the resident and was instructed to give a beverage. The resident's substitute decision maker (SDM) was informed. The resident's status was rechecked.

RN #134 arrived in the unit, 911 was called and an identified medication was administered at an identified time to the resident. Status was improved after an identified medication was administered. Paramedics arrived at an identified time and transferred resident #041 to hospital. The resident returned to the home the same evening at an identified time.

Another progress note in MED e-care documented by RN #134 on an identified date and time indicated they observed resident #041 non responsive to verbal stimulation and symptomatic on an identified date.

In an interview, RPN #136 indicated they were not aware that resident #041 had a physician's order for an identified medication when the resident's status changes. The RPN stated they did not follow the order for the identified medication in accordance with the directions for use. The RPN indicated that the resident was transferred to hospital for assessment as the resident became unresponsive prior to the identified medication being administered.

B) Review of the physician's orders for resident #041 indicated they had an identified order at specific times.
Resident #041 had a physician's order since an identified date for the administration of an identified dosage of medication for an identified status. On an identified date, the physician changed the dosage of the identified medication for an identified status and also if the resident had eaten their meal prior to administration.

Further review of resident #041's EMARs for an identified period indicated the resident had an identified status on two occasions in two identified months and times.

Review of the progress notes in MED e-care and physician orders did not indicate documentation whether the identified dosage of the identified medication was administered with an identified status.

Review of the staffing schedules indicated the registered staff that worked at the time the status was checked during the identified months as times mentioned above were all agency nurses.

In an interview, RPN #141 who worked on identified dates, indicated that resident #041's status fluctuated and it was important to follow the orders to manage the resident's health condition. The RPN indicated that they would have documented in the EMAR and in the progress notes if they had administered the identified dosage of the identified medication for an identified status.

In interviews, NM #123 and I-DOC #107 indicated the registered staff are to follow

physician's orders. The NM and I-DOC acknowledged that resident #041's physician's orders to manage the resident's health condition were not followed as prescribed.

C) The MOHLTC received a CIS report from the home regarding medication incidents that occurred on an identified date. The CIS report indicated that ten residents in an identified RHA did not receive their 1200H medications when RPN #108 was unable to complete their shift due to an identified issue.

Record review of the home's medication incident reports indicated the ten residents involved were residents #045, #046, #047, #048, #049, #050, #051, #052, #053 and #054. The reports also indicated there were no adverse effects on the 10 residents as a result of the medication incidents.

Review of the EMARs for the 10 ten residents noted above indicated the following medications and treatments were not administered as follows:
-Resident #046, #047, #048, #049, #050, #051, #052, #053, #054 were not administered their 1200H medications.
-Resident #045 did not have their 1400H medication administered.

In an interview, RPN #110 indicated there were no adverse effects on the residents as a result of the medications and treatment not administered as prescribed.

In an interview, RPN #108 indicated they were not able to complete the 1200H medication pass and was unable to complete the rest of their shift in an identified RHA due to an identified issue. The RPN indicated they had communicated the same information to the in-charge RN and to the on call manager on an identified date.

Attempts to contact the in-charge RN who worked day shift on an unidentified date were unsuccessful.

In an interview, RPN #161 indicated they worked on an identified shift on an identified date. RPN #161 indicated RPN #108 was dealing with an identified issue, and did not receive a change of shift report from RPN #108. At 1700H during medication
administration, RPN #161 indicated they found 1200H medications in the medication cart for 10 residents and stored the medications in the discontinued

medications bucket in the
RHA's medication room. RPN #161 indicated they did not notify the in-charge RN of their discovery as the RPN believed the day in-charge RN had followed up with the situation.

In an interview, NM #123 was made aware of the medication incidents on an identified date, by RPN #108. The NM indicated the home conducted an investigation and had disciplined RPNs #108 and #161 related to the medication incidents.

In interviews, NM #123 and I-DOC #107 acknowledged that the staff failed to ensure that drugs were administered to residents #045, #046, #047, #048, #049, #050, #051, #052, #053 and #054 in accordance with the directions for use specified by the prescriber.

Additional Required Actions:

CO # - 007 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was, reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.
A) During the mandatory medication IP for the RQI, the home??s medication incidents were reviewed for the quarter of an identified period, for residents #043 and #044.

Record review of the medication incident reports for resident #043 on an identified date and resident #044 on an identified date, did not have documentation whether the Medical Director was notified of the medication incidents.
B) The MOHLTC received a CIS report from the home on an identified date, for a missing and unaccounted controlled substance for resident #042 that occurred on

an identified date, in an identified RHA.

A record review of resident #042's medication incident report completed on an identified date, indicated that a half tablet of an identified medication was missing from the resident's blister pack which was discovered at shift change at an identified time and date.
Further review of the medication incident report indicated that the physician and family were not notified and did not have documentation whether the Medical Director was notified of the medication incident.

In interviews, RPNs #108, #109 and #110 indicated it is the home's policy to notify the physician, the resident and or the SDM when a medication incident had occurred.

C) The MOHLTC received a CIS report from the home regarding medication incidents that occurred on an identified date. The CIS report indicated that ten residents in an identified RHA did not receive their 1200H medications when RPN #108 was unable to complete their shift.

Review of the medication incident reports for residents #045, #046, #047, #048, #049, #050, #051, #052, #053 and #054 did not have documentation whether the Medical Director was notified of the medication incidents.

In an interview, I-DOC #107 indicated it is the home's policy to notify the physician, resident and or SDM when a medication incident had occurred. The I-DOC acknowledged that the staff failed to notify the physician and substitute decision maker of the medication incident for resident #042. When asked whether the Medical Director had been notified of the medication incidents involving residents mentioned above, the I-DOC stated that the home only notifies the resident's attending physician, not the Medical Director.

2. The licensee failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions.

During the mandatory medication review of the home's medication incidents, the inspector requested documentation of the home's quarterly review of all medication incidents and adverse drug reactions that had occurred since their last

review. The home was unable to provide any documentation that quarterly reviews of all medication incidents and adverse drug reactions were conducted.

In an interview, I-DOC #107 indicated they have worked in the home as a nurse manager for years and had recently become the I-DOC. The I-DOC stated that the home does not conduct quarterly reviews of their medication incidents. The I-DOC further indicated that the home reviews the medication management system of the home in the quarterly Medical Advisory committee (MAC) meetings; however, medication incidents were not reviewed in the meetings as well. When asked why the home's medication incidents were not reviewed quarterly, the I-DOC, was unable to provide an answer to the inspector.

In interviews, an identified Pharmacist #113 and Pharmacist Owner #114 indicated that medication incidents are not reviewed during the quarterly MAC meetings. The identified Pharmacist #114 indicated that the pharmacy had been the home's pharmacy provider since an identified date, and stated it was unusual for the medication incidents not to be reviewed in the MAC meetings, but did not intervene with the home's process, as they thought that the home had their own system of reviewing the medication incidents quarterly.

In an interview, Administrator #101 who has been in the home since an identified time, indicated that the home's medication incidents have not been reviewed by the home on a quarterly and annual basis. The Administrator acknowledged that the home has failed to ensure that quarterly reviews of medication incidents were conducted.

Additional Required Actions:

CO # - 008, 009 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(e) that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 229 (2).

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

s. 229. (6) The licensee shall ensure that the information gathered under subsection (5) is analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks. O. Reg. 79/10, s. 229 (6).

Findings/Faits saillants :

1. The licensee has failed to ensure there was a written record of the annual Infection Prevention and Control (IPAC) program evaluation kept that includes a summary of the changes made, and the date those changes were implemented.

Record review of the home's IPAC program annual evaluation dated May 22, 2018, did not capture a summary of the changes made, and the date those changes were implemented. The annual evaluation identified changes to be made such as re-education of staff related to documentation of the tuberculosis (TB) skin test results under the immunization section in the electronic documentation system called MED e-care, with a target date of June 2018; and conducting infection control audits twice per year with a target date of September 2018.

During an interview, IPAC Lead #123 verified that the annual evaluation should have included an analysis of both outbreaks which occurred within the annual evaluation period; and verified that re-education of the staff and infection control audits were not completed as of October 4, 2018.

2. The licensee failed to ensure that all staff participated in the implementation of

the program.

A) During observations conducted identified dates at times, resident #041's shared washroom had two unlabeled clear urine collection hats on the floor.

In interviews, PSW #112 and RPN #111 indicated that the urine collection hats should have been discarded after use for infection prevention and control.
B) During the mandatory medication administration observation on an identified date and time, RPN #108 did not perform hand hygiene in between residents during medication administration to residents #043, #044 and #045. Additionally, the RPN administered an identified medication to resident #045 without performing hand hygiene.

In an interview, RPN #108 indicated they routinely do not perform hand hygiene in between residents during medication administration. The RPN indicated that hand hygiene is to be performed prior to administering eye drops for infection control and acknowledged they did not follow the home's infection prevention and control program.

In an interview, IPAC Lead #123 indicated that staff did not participate in the implementation of the infection control and prevention program as urine collections hats are to be discarded when used and hand hygiene is to be performed in between residents during medication administration.

C) The MOHLTC received a complaint through the Action-line on an identified date regarding care concerns related to resident #041. Record review of the written plan of care for resident #041 during an identified period, indicated that resident #041 had an identified diagnosis according to the discharge notes from an identified hospital at an identified time.

Observations conducted during identified dates and times did not observe any infection prevention and control precautions for resident #041.

In an interview, RPN #109 indicated that it is the home's infection prevention and control practice for residents who have an identified diagnosis to be on contact precautions with the appropriate personal protective equipment (PPE) in the room and signage at the resident's door informing staff and visitors of the precautions. The RPN #109 indicated
they were aware that resident #041 had the identified diagnosis and had included

the information in the written plan of care. When asked if the resident was put on any precautions since an identified time, the RPN said that resident #041 was not.

In an interview, IPAC Lead #123 indicated that it is the home's infection prevention and control practice to put residents with the identified diagnosis on contact precautions. The IPAC Lead indicated that resident #041 should have been placed on contact precautions since an identified date, and the staff did not participate in the infection prevention and control program.
D) 2East-Shower room contained the following unlabelled personal items -one bottle of used body lotion -left uncapped; one bottle of used white petroleum jelly; one used tube of Poli-grip; one used bottle of Infa-zinc 15% cream. Registered staff RPN #109 verified that the above personal items should not have been left in the shower room; and that they should have been labelled and stored in the resident's room.

4West - Shower room contained the following unlabelled personal items -three used bottles of white petroleum jelly, one used bottle of solid deodorant, registered staff #150 verified that these personal items should not have been left in the shower room; and that they should have been labelled and stored in the resident's room.

During an interview, Nurse Manager #123 who was also the home's IPAC lead verified that that personal items should not be kept in the shower rooms; and that they should be labelled and stored in the resident's room. Therefore, the licensee failed to ensure staff members participated in the implementation of the infection prevention and control program.

4. The licensee has failed to ensure the information that was gathered on every shift about the residents' infections, analyzed daily to detect the presence of infection and reviewed at least monthly to detect trends for the purpose of reducing the incidence of infections and outbreaks.

MOHLTC received critical incident system (CIS) on an identified date, related to outbreak notification.

On and identified date in January, 2018, Public Health Inspector (PHI) #146 declared the home in respiratory outbreak after receiving a call from IPAC Lead #123. During an interview, the IPAC Lead verified that they became aware of a possible outbreak occurring within the home after registered staff working the day

shift on two identified RHAs both received telephone calls from the local acute care hospital. The hospital called to report two residents who were transferred to hospital with respiratory symptoms were confirmed cases of an identified illness.

The inspector reviewed the critical incident report and the home's Public Health (PH) line list; and it was identified that the outbreak protocol should have been initiated two days prior, as verified during an interview with Public Health Inspector (PHI) #146.

According to PHI #146, the definition of an outbreak comes with a foot note above and beyond a normal level of burden for the unit to handle. PHI #146 reviewed their outbreak documentation related to the home's, declared outbreak, and confirmed that the first case was documented on three days prior to public health being informed; followed by three residents and two staff showing respiratory symptoms the next day. The PHI also stated on that date, the home should have been looking at initiating their outbreak protocol and contacting Public Health to discuss a possible outbreak..

During an interview, Nurse Manager and IPAC Lead #123 stated the home's definition of a suspected outbreak included two units with at least three residents experiencing respiratory symptoms. The NM verified that there were three residents experiencing respiratory symptoms; and on there were another four residents experiencing symptoms for a total of seven residents on multiple units; and therefore, the charge nurse in the building should have suspected an outbreak; and contacted the Manager on call to report their concern, which would have initiated the outbreak protocol and prompted a call to public health to discuss a possible outbreak. NM #123 acknowledged during the interview, that a gap was identified in the Outbreak Protocol process since registered staff working day shifts and evening shifts does not have direct communication with each other to discuss challenges or opportunities occurring on their units; and verified that the night nurse in charge was expected to make rounds on all units to identify concerns and safety issues.

NM #123 also verified that the home does not review the information gathered about residents' infections at least monthly to detect trends for the purpose of reducing the incidence of infections and outbreaks; however the IPAC committee meets quarterly to review infection statistics.

During an interview, the nurse manager on call/current I-DOC, was scheduled the

weekend of the outbreak; and verified they did not receive a call from the charge nurse related to concerns of residents and staff experiencing respiratory infection.

During an interview, the I- DOC stated that the home's practice was never to declare an outbreak over the week-end. However, if the charge nurse in the building noticed a trend of two or more residents experiencing one or more respiratory symptoms they should have alerted the manager on call to discuss a possible outbreak. The I-DOC further stated that it was the night charge nurses' responsibility to make rounds by visiting all units; overseeing the facility for all safety issues; and identify and analyze the information gathered for possible trends. However, management does not hold charge nurses accountable related to this practice. These rounds were not completed on a regular basis.

Therefore, the home did not use the information gathered on every shift about the residents' infections, and analyzed the information to detect the presence of infection and trends for the purpose of reducing the incidence of infections and outbreaks.

Additional Required Actions:

CO # - 010, 011 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #10: 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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

s. 6. (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 the plan of care set out clear directions to staff and other who provide direct care to the resident.

During the resident quality inspection, resident #007's MDS assessment care needs triggered in relation to change in an identified health status.

Record review indicated resident #007 was admitted to the home on an identified date; and was assessed using the home's Resident Assessment Instrument-Minimum Data Set three months later. The MDS Full Assessment indicated the resident had an identified diagnosis and required cues/supervision. The MDS assessment indicated the resident had an occasional health condition.

A review of the resident's written plan of care indicated the following expected outcomes and interventions related to this health condition and associated ADL.

An identified ADL: to be provided routinely by staff; identified products to be used; two staff to provide the identified ADL task at times.

During an interview, PSW #153 reviewed the plan and verified that an identified ADL instructions were not clear since there were no identified ADL times, and the identified product listed was not used for the resident.

During an interview, CM #124 verified that the missing information should have been included in the resident's plan of care to ensure clear directions to staff.

2. The licensee has failed to ensure the plan of care set out clear directions to staff and others who provided direct care to the resident.

During the resident quality inspection, resident #008's MDS assessment care needs triggered in relation to change in an identified health status.

Record review indicated resident #008 was admitted to the home on an identified date.

The resident was last assessed using the home's Resident Assessment Instrument-Minimum Data Set on an identified date. The MDS Full Assessment indicated the resident had an identified diagnosis. The MDS indicated the resident had an identified health condition.

A review of the resident's written plan of care included the following:
Identified focus area: Resident will continue to perform an identified task them-self safely and maintain the next three months; required an identified level of assistance; staff to ensure that resident performed the identified task safely; please ensure that staff stay with resident but provide privacy; one person physical assist when necessary; staff to ensure resident is using an identified item.

During an interview, RPN #109 reviewed the information in the resident's written care plan and verified that the information would not be clear to an agency staff or newly hired PSW because the written plan of care included four different identified products for use by the resident and the written plan of care listed conflicting information related to the resident's identified ADL status - independently and an identified level of assistance with staff ensuring resident task is carried out safely. RPN #116 stated they would adjust the resident's written plan of care following the interview with the inspector.

3. The licensee has failed to ensure the plan of care set out clear directions to staff and others who provide direct care to the resident.

A complaint received to the MOHLTC on an identified date, indicating shortage of staff affecting resident #036's care in the home, especially two identified ADLs.

Review of the resident's MDS assessment on an identified date, indicated the resident needed an identified level of assistance by two staff for an identified task, an identified level of assistance by two staff for three identified task. Resident had an identified health condition and they were on an identified medication daily.

Review of the resident's written plan of care effective by an identified date, indicated that resident #036 was identified to need assistance and identified ADL task due to an identified physical deficit. The intervention indicated two staff to provide an identified task for the resident at all times. One staff to support resident while the other staff provided an identified task. The written plan did not give clear direction as to when the identified task was to be provided to the resident.

During an interview, primary PSW #155 indicated that they were providing care to resident #036 and the resident was aware when they needed to perform an identified task, and could not perform the identified task them-self.
Further the PSW indicated that they assist the resident whenever they are

available, as the plan of care does not specify when the resident required the identified task. When asked if the resident had an identified ADL plan, the PSW reviewed the resident's written plan of care with inspector and stated that the plan of care guided the staff to provide the identified ADL task to the resident all the time, which was not possible. The PSW clarified that the plan was not giving directions as when to provide the identified ADL task for the resident; the direction given in the plan of care were not clear.

An interview with the RN #116 indicated resident #036 was to be provided the identified ADL task by the staff as per plan of care, but when the plan of care was reviewed with Inspector #600, the RN stated the directions given to the staff were not clear and they will adjust the plan with more specific directions.

An interview with the I-DOC confirmed the registered staff on the floor is to update the resident's written plan of care every quarter and as needed and when planning interventions for PSW to perform, the direction should be clear, specific and timed. The IDOC acknowledged the direction given to the staff regarding the identified ADL task for resident #036, was not clear.

4. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complement each other.

During the Resident Quality Inspection (RQI), the use of an identified device triggered in stage 2 for multiple residents observed to be using this device.

A review of the home's identified Policy #NMIIR008vv, with effective date September 1, 2017, indicated to use an identified form to assess residents in order to determine the appropriate device.

Record review indicated and staff interviews verified residents #002, #003 and #022 did not receive an interdisciplinary assessment of this identified device as indicated.

During an interview, Physiotherapist #121 verified that they were not aware the home had an identified form to be used for the assessment of a resident prior to the use of any of the identified device; and therefore, residents #002, #003 and #022 did not receive an interdisciplinary assessment since they conducted the

assessment independently and documented their assessment in each residents' progress notes.

During separate interviews, the CSM and restraint lead #124 and the I-DOC both verified that all residents currently using identified device in the home should be assessed by the interdisciplinary team lead by the physiotherapist, using the home's identified form prior to the device use.

5. Ministry of Health (MOH) received (CIS) report, on an identified date, related to an outbreak notification. PHI #146 declared the home in respiratory outbreak after receiving a call from IPAC Lead #123. During an interview, the IPAC Lead verified that they became aware of a possible outbreak occurring within the home after registered staff working the day shift on two identified RHAs both received telephone calls from the local acute care hospital. The hospital called to report two residents who were transferred to hospital with respiratory symptoms were confirmed cases of an identified illness.

The inspector reviewed the critical incident system report and the home's Public Health(PH) line list; and it was identified that the outbreak protocol should have been initiated on two days prior to the CIS notification, as verified during an interview with Public Health Inspector #146.

During an interview, Nurse Manager verified that on an identified date, there were three residents experiencing respiratory symptoms; and the following day, there were another four residents experiencing symptoms, for a total of seven residents on multiple units. NM #123 stated the charge nurse in the building should have suspected an outbreak; and contacted the manager on call (MOC) to report the concern, which would have initiated the outbreak protocol and prompted a call to public health to discuss a possible outbreak. NM #123 stated there was a gap in communication and registered staff did not collaborate with each other during this outbreak incident.

Staff working over the week-end did not collaborate with each other in the assessment of the residents so that their assessments were integrated, consistent with and complement each other in order to identify trends for the purpose of reducing the incidence of infections and outbreaks.

6. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, in the development

and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complement each other.

The MOHLTC received a complaint through the Action-line on an identified date, regarding care concerns related to resident #041. The complainant had concerns regarding the home's management of resident #041's identified medical diagnosis.
A) During a record review of the written plan of care for resident #041 on an identified date, it indicated that resident #041 experienced identified symptoms according to the discharge notes from the hospital on an identified date. Further review of the written plan of care with an effective identified date, indicated the same information for the identified diagnosis.

A review of the home's laboratory reports indicated identified cultures on two identified dates, were positive for an identified bacteria.

In an interview, RPN #109 indicated they had included the information in the written plan of care when the resident returned from hospital on an identified date.

In an interview, PSW #139, who was the full time PSW assigned to resident #041 indicated they were not aware that the resident had the identified diagnosis and just found out about the identified status of the resident on an identified date after asking RPN #109. The PSW stated that the home did not communicate this information about the resident prior to an identified date.

In an interview on an identified date and time, IPAC Lead #123 indicated they were not aware that resident #041 had the identified diagnosis and that it was not documented in the written plan of care until it was brought to their attention by the inspector on an identified date. The IPAC Lead stated they would put resident #041 on contact precautions as per their infection prevention and control practices.

Observations conducted on an identified date and time indicated that resident #041 did not have signage on their bedroom door and PPE supplies to indicate they were on contact precautions.

In an interview, RPN #109 indicated it was their understanding that the resident was put on contact precautions by the evening nurse on an identified time and was not aware that contact precautions had not been implemented, until it was

brought to their attention by the inspector.

In an interview, I-DOC #107 indicated it is important for all staff to be aware if a resident has an identified diagnosis for infection prevention. The I-DOC acknowledged the staff did not collaborate with each other in the development and implementation of the plan of care for resident #041.

B) A record review of resident #041's clinical records indicated the resident had an identified diagnosis. A review of the progress notes in MED e-care from the registered dietitian (RD) during an identified period, indicated that the resident had dietary interventions in place for an identified health condition and to maintain their weight and hydration status. The RD indicated that the resident was at a high nutritional risk due to their disease status.

Record review of the written plan of care on an identified date, indicated the nutrition intervention to provide an identified assistive device had been in the plan of care since an identified date.

Observations conducted on an identified date, during the lunch meal service at 1220H in the RHA's dining room, resident #041's table setting did not include the identified assistive device.
In another observation conducted on an identified date, during the lunch meal at 1240H in the RHA's dining room, resident table setting did include the identified assistive device.

Record review of the diet list on an identified date, located in the severy indicated the identified assistive device under the heading assist aides for resident #041.

In an interview, Dietary Aide (DA) #138 indicated it is the home's process for the dietary aides to follow the diet list. The DA stated they did not provide resident #041 with the identified assistive device during lunch on an identified date.

In an interview, DA #140, who worked on an identified date, indicated the dietary aides follow the diet list and set the table with the appropriate assistive device.

In interviews, RPN #109 and PSW #139 stated on an identified date, was the first day they had observed resident #041 to have the identified
assistive device during meals and were not aware that it had been in the written plan of care prior to an identified date. Both staff indicated that the resident was

able to consume easier with the assistive device. The RPN stated the resident had a history of poor intake and the assistive device assisted the resident to manage the resident's medical diagnosis. The RPN and PSW indicated that communication and collaboration did not occur with the nursing and dietary departments as to resident #041's use of the assistive device.

In an interview, Food Services Manager (FSM) #137 indicated when a resident has been assessed for an assistive device for meals, the assistive device is documented in the written plan of care, the diet list is updated and communication occurs between the dietary and nursing departments regarding the assistive device. The FSM stated the assistive device for resident #041 had been in place for a while and acknowledged the nursing and dietary departments did not collaborate with each other in the implementation in the plan of care for resident #041.

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

This IP was inspector initiated during a follow up order inspection, order issued January 16, 2018, inspection 2017_631210_0021, regarding sufficient staffing.

On an identified date, during an observation on an identified resident home area (RHA), Inspector #600 conducted an interview with PSW #142, regular full time staff assigned to resident #037. The PSW stated that that morning they performed an identified task for resident #037 using an identified level of assistance by one staff only and that is how they have been assisting the resident with the identified task. The PSW also stated that they were not aware of the resident's written plan of care and said they were not able to review the resident's plan because there is no time to go into the files. The PSW further stated they look at the logo posted in the resident's identified location and respected that. When PSW reviewed the logo in the identified location indicating two person identified level of assistance or the use of an identified equipment, the PSW confirmed that they performed the identified task for the resident alone as in their opinion the resident was able to carry out the identified task.

Review of the resident's physiotherapist's assessment, MDS and the written plan of care indicated that resident #037 needed two staff assistance for performing an identified task. Interventions were set to assist this resident with an identified ADL and one of them was two person total assist/identified equipment x two person

assist/if resident could not perform an identified task.

In an interview, RPN #118 review the resident's MDS assessment and the written plan of care and acknowledged that PSW #142 did not provide care to resident #037 as specified in the plan of care.

During an interview, the I-DOC acknowledged the PSW may have put the resident at risk by performing the identified task for the resident alone and not seeking assistance from the other staff or the RPN on the floor. The I-DOC further stated the home expect the staff to provide care to the residents as specified in the residents' plan of care.

8. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #033 as specified in the plan.

MOHLTC received a complaint on an identified date, regarding concerns of shortage of staff affecting resident's care.

Review of resident #033's MDS assessment on an identified date, indicated the resident needed an identified level assistance by two staff for performing two identified tasks. Resident had an identified health condition.

Review of resident #033's written plan of care on an identified date, indicated the resident required assistance by two staff for two identified tasks by the use of an identified equipment. Among other interventions an identified task was to be provided for the resident at, five specified times of the day and PRN or when resident required.

A review of PSW daily documentation flow sheet for an identified period, under an identified focus, indicated resident #033 was not provided an identified ADL task routinely as set in the plan of care. The review of the flow sheet indicated that the resident was provided this identified task once per shift, and the record did not indicate if the resident received this ADL task.

During an interview, PSW #139 stated sometimes they provided an identified ADL task for the resident in the morning and when the resident called usually around an identified time, if they are available they would provide the identified ADL task for them. After the PSW looked at the identified ADL task routine in the resident's

written plan of care, they confirmed they did not provide the identified care to the resident as set in the plan.

In an interview, resident #033 stated that they would prefer to have the identified task every day at the same time as they do not have to wait for the PSW after they called them, or experience discomfort.

An interview with RPN #109 indicated that the PSWs try to provide the identified ADL task for the residents whenever they can, but is not possible when they are short of staff to follow the routine. The RPN also stated that resident #033 has an identified condition and the PSW should follow the identified ADL routine set in the resident's written plan of care.

In an interview with I-DOC, the I-DOC indicated that when the unit is working short of staff, the registered staff must prioritize the care to the residents. An identified ADL task is one priority in caring for the residents and the PSW had to follow the resident's identified ADL routine as specified in the plan.

9. Record review of resident #023's external consultation record on an identified date, indicated the resident had an identified appliance. The external consultant had made identified recommendations.

Record review of resident #023's Treatment Administration Record (TAR) for an identified period indicated the external consultant's recommendations on an identified date, was not on the TAR and implemented for an identified month. Record review of resident #023's physician's records indicated there was no physician's order or nurse practitioner's orders for this recommendation on an identified date. A physician's order on an identified date, indicated for registered staff to please note and follow the recommendations made by the external consultant.

Record review of resident #023's physician's order form indicated a treatment order on an identified date.

Record review of resident #023's external consultation record on an identified date, indicated the appliance that was recommended in an identified month was not in use and the identified accessories were very loose and not really assisting in keeping the identified appliance secure. The external consultant recommended a change to the type of appliance to another identified appliance.

Record review of resident #023's physician's order forms indicated an order on an identified date, which was transcribed six days after the external consultant's recommendations.

Record review of resident #023's Treatment Administration Record for an identified period, indicated resident #023 received the recommended treatment on an identified date, late. The first date the order was written on the physician's orders on an identified date six days after the external consultant's recommendations and the resident did not start the treatment until an identified date, three days after the order was transcribed.

Record review of resident #023's assessments in MED e-care indicated an identified care assessment was not completed for resident #023 to address their altered skin integrity at an identified site.

Interview with RN #135 acknowledged the external consultant's recommendations on an identified date, had not been transcribed to the physician's orders, and resident #023 did not receive their treatment in an identified month. RN #135 also acknowledged the external consultant's recommendations on an identified date, was transcribed on an identified date, six days after the external consultant's recommendations and the resident did not receive the treatment until an identified date, three days after the order was transcribed. RN #135 also acknowledged an identified assessment should have been completed for resident #023 when they experienced altered skin integrity at an identified site.

Interview with I-DOC #107 acknowledged resident #023 did not receive the recommended treatment in an identified month the external consultant recommended treatment on an identified date, could have been transcribed sooner and resident #023 could have received the treatment at least the next day. I-DOC #107 also acknowledged the registered staff should have completed the identified assessment for resident #023 when they experienced altered skin integrity at the identified site.

10. The licensee has failed to ensure that staff and others who provide direct care to a resident were kept aware of the contents of the plan of care.

This IP was inspector initiated while conducting a follow up order inspection, order issued January 16, 2018, inspection #2017_631210_0021, regarding sufficient

staffing.

On an identified date, during the observation of agency staff working on an identified residents' home area, Inspector #600 conducted an interview with PSW #106 regarding resident #037. The PSW stated that they provided care to resident #037 that morning and provided identified tasks for resident alone using extensive assistance. The PSW stated they were not aware of what the written plan of care guides the staff to do regarding this resident's care.

Interview with RPN #105 indicated that they briefed the staff that morning about resident's needs and care but they had not reviewed the resident's plan of care with the agency PSW.

In an interview with PSW #142, on an identified date, a regular full time PSW assigned for resident #037, the PSW stated that they provided care to resident #037 that morning and performed an identified task for the resident using extensive assistance by one person. The PSW confirmed they have not reviewed the resident's written plan of care as they did not have time to review every single residents' plan of care.

During an interview, RPN #118 indicated that resident #037 needed one person extensive assistance for an identified task. However the RPN was not aware of the resident's written plan of care as to how it guides the PSWs, how to perform the identified task for the resident. Further the
RPN stated that the ability of the resident is assessed by the physiotherapist and they are the one completing the MDS assessment as well as updating the care plans. When asked how that is communicated to the rest of the team, the RPN acknowledged the staff is expected to review the resident's plan of care, but they were not able to do, as the resident's condition had been fluctuating and care plan had been changing often.

A review of the resident's written plan of care effective on an identified date, which corresponded with MDS assessment on an identified, indicated resident #037 needed assistance for transferring. Interventions set for accomplishing these goals were:
* Encourage client to request assistance of staff with all tasks identified
* Report any change to client's ability to perform the identified task safely;
* Assess client's ability to perform the identified task safely prior to being carried out;

* Two person total assist via an identified equipment x two person assist/if resident has an identified physical deficit.
* staff requested to perform the identified task for the client towards an identified side where resident will be able to help with the task.

During the interview, the I-DOC stated that all staff is expected to be familiar with the content of the resident's written plan of care as they have access at any time. The plan of care was to be reviewed and revised every quarter and staff is to be aware of it prior to providing care to the resident.

11. The MOHLTC received a complaint through the Action-line on an identified date, regarding care concerns related to resident #041. The complainant had concerns regarding the home's medication management of resident #041's identified medical diagnosis.

In an interview, the complainant indicated on an identified date, resident #041 experienced a change in health status. The nurse on the unit tried to give the resident a beverage while experiencing a change in health status.

Record review of resident #041's clinical records indicated they had an identified diagnosis. The written plans of care with effective identified dates, also indicated that resident #041 has a history of an identified medical symptom.

Record review of resident #041's physician orders indicated an order for an identified medication if the resident experienced identified symptoms. The order was located in the quarterly medication review for an identified period. Further review of the resident's EMAR for an identified month indicated the order for the identified medication.

Record review of resident #041's progress notes in MED e-care indicated on an identified date, the resident had an identified symptom at an identified time. Further review of the progress notes indicated resident #041's change in health status deteriorated. The resident received the identified medication over an hour later at an identified time by RN #134.
In an interview, RPN #136 indicated they were not aware that resident #041's plan of care had a physician's order for an identified medication, as it was their first day working on their own as a new hire in the home.

In an interview, I-DOC indicated it is the expectation for staff to be aware of the

contents in the plan of care and acknowledged that RPN #136 who provided direct care to resident #041 was not aware of the contents of the resident's plan of care.

12. The licensee failed to ensure that the following are documented: 1) the provision of the care set out in the plan of care.

1) The Ministry of Health and Long Term Care (MOHLTC) received a complaint through the Action-line on an identified date, regarding care concerns related to resident #041.

In an interview, the complainant indicated that the registered staff were not documenting resident #041's symptoms and were not administering an identified medication as ordered.

Record review of the clinical records of resident #041 indicated the resident had an identified diagnosis. Review of the physician's orders indicated since an identified time and assessment had been ordered.

Review of the physician's orders for resident #041 indicated they had an identified order at specific times.
Resident #041 had a physician's order since an identified date for the administration of an identified dosage of medication for an identified status. On an identified date, the physician changed the the dosage of the identified medication for an identified status and also if the resident had eaten their meal prior to administration.

Record review of resident #041's EMARs for an identified period, indicated identified checks were completed by the registered staff. Review of the resident's identified reports for an identified period, did not have corresponding documentation of those checks for an identified period.
Further review of the identified report for an identified date, indicated readings of over an identified amount, without documentation in the EMAR.

In interviews, RPNs #111 and #141 indicated it is the home's expectation for the registered staff to document the care that has been provided. Both RPNs indicated that the readings are to be entered in the EMAR. The RPNs stated that resident #041's readings fluctuates and was important that their readings are documented and if additional medication was administered to manage the

resident's medical diagnosis.

RPN #111 stated that they had forgotten to document the resident's readings on an identified date, and did not sign off on the EMAR after they had administered an identified dosage of an identified medication.

In an interview, the I-DOC indicated that the registered staff are to document the care they provide to the residents. The I-DOC stated that the registered staff are to enter the readings in the EMAR and to sign off on the EMAR when medication orders have been administered. The I-DOC reviewed the reports and EMARs for resident #041 and acknowledged that staff did not document the care provided.

13. The MOHLTC received a CIS report from the home regarding medication incidents that occurred on an identified date. The CIS report indicated that ten residents in an identified RHA did not receive their 1200H medications when RPN #108 was unable to complete their shift due to an identified issue.

One of the residents involved in the medication incidents was resident #053. Review of resident #053's EMAR indicated a treatment order for an identified treatment to be applied to an identified affected areas of the resident's body at identified times. The EMAR did not have a registered staff signature that the treatment was provided at an identified time.

In an interview, RPN #108 indicated it is the home's expectation for the registered staff to document the care that is provided. The RPN stated that the treatment for resident #053 was delegated to the PSW assigned and confirmed they did not document the care provided in the EMAR as per home's expectation.

In an interview, the I-DOC #107 indicated it is the home's expectation for registered staff to document the care that was provided. The I-DOC acknowledged that RPN #108 did not document the treatment provided for resident #053.

14. The licensee has failed to ensure that the provision of care set out in the plan of care for the residents was documented.

A follow up inspection was conducted for a compliance order issued on January 16, 2018, regarding non-compliance with sufficient staffing affecting resident's care specifically activities of daily living.

A review of the home action plan indicated the home had put a plan in place regarding how to provide a bath/shower to those residents who would miss a bath/shower due to shortage of staff. "Missing Bath Log" was a tool the staff was to use any time a resident missed a bath/shower.
The process involved the registered staff to check if every resident assigned to have a bath/shower, had received the bath/shower, the nurse would mark in a box provided confirming all residents assigned had received a bath/shower on that shift. If not, the PSW would write the name of the resident who did not receive a bath/shower in the designated box and next to the name another box the staff needed to enter a rescheduled date when the resident would receive the second bath/shower. The Manager would do rounds and if there are residents that had not received a bath/shower the manager will book an extra PSW to provide a bath/shower.

A review of four missing bath log records from randomly chosen units for an identified date, indicated that two out of the four did not have a re-scheduled date. Review of the two residents' PSW daily record showed no documentation if the baths/showers were provided.

An interview with NM #123 indicated that the NM does not document when they booked a PSW to provide a compensated bath/shower. The NM stated the staff was to document in the log the date when a PSW would provide missing bath/shower. When the NM was asked if the PSW who provided the compensated bath/shower document in the daily record, the NM
acknowledged that the PSWs providing baths/showers were not assigned to the residents in the electronic documentation so they are not able to document there.

Further review of the PSW daily records for residents #032, #033, #034, #035, #036, and #037 demonstrated provision of care as set in the plan of care had not been documented every shift. There were multiple empty areas for identified ADL task that were not documented.

Interview with PSWs #139, #142, and #155, indicated that when they work short, they split the residents so that two PSWs provide care to all residents. The PSW stated that they don't have a lot of time to document so they document for those residents that were assigned to them, but do not document the resident that were assigned to a third PSW.

Interview with the NM confirmed when the staff work short the documentation was not completed.

15. The MOHLTC received a complaint through the Action-line on an identified date, regarding care concerns related to resident #041.

In an interview, the complainant indicated that the registered staff were not documenting resident #041's identified readings and were not administering an identified medication as ordered when the resident's reading was over an identified level.

Record review of the clinical records of resident #041 indicated the resident had an identified medical diagnosis. Review of the physician's orders indicated since an identified date there was an order for an assessment and administration of an identified medication.

Record review of resident #041's EMARs for an identified period, indicated the assessments were completed by the registered staff. Review of the resident's reports for an identified period, did not have corresponding documentation of the readings on identified dates.

Further review of the report for an identified period, indicated readings over an identified value, without documentation in the EMAR if the order for an identified dosage of medication if readings were greater than an identified level was administered to resident #041. The readings were documented by RPN #111 on occasions in an identified month.

In interviews, RPNs #111 and #141 indicated it is the home's expectation for the registered staff to document the care that has been provided. Both RPNs indicated that reading levels are to be entered into the EMAR. The RPNs stated that resident #041's reading levels fluctuates and was important that their reading levels are documented and if additional identified medication was administered to manage the resident's medical condition.

RPN #111 stated that they had forgotten to document the resident's reading levels on an identified date, and did not sign off on the EMAR
after they had administered an identified dosage of an identified medication.

In an interview, the I-DOC indicated that the registered staff are to document the care they provide to the residents. The I-DOC stated that the registered staff are to enter the reading levels in the EMAR and to sign off on the EMAR when medication orders have been administered.

The I-DOC reviewed identified reports and EMARs for resident #041 and acknowledged that staff did not document the care provided.

16. MOHLTC received a critical incident system (CIS) report from the home regarding medication incidents that occurred on an identified date. The CIS report indicated that 10 residents in an identified RHA did not receive their 1200H medications when RPN #108 was unable to complete their shift.
One of the residents involved in the medication incidents was resident #053.

Record review of resident #053's EMAR indicated a treatment order for an identified medication to be applied to the affected areas on the resident's body twice a day (BID) at identified times. The EMAR did not have a registered staff signature that indicated the treatment was provided to resident #053 at an identified time and date.

In an interview, RPN #108 indicated it is the home's expectation for the registered staff to document the care that is provided. RPN #108 stated that the treatment for resident #053 was delegated to the PSW assigned and confirmed they did not document the care provided in the EMAR as per home's expectation.

In an interview, the I-DOC #107 indicated that it is the home's expectation for the registered staff to document the care that was provided. The I-DOC acknowledged that RPN #108 did not document the treatment provided for resident #053.

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

A complaint was submitted to the MOHLTC on an identified date, regarding concerns of shortage of staff affecting resident #035's identified ADL care.

Review of the resident's MDS record on an identified date, indicated the resident

had an identified diagnosis and had a fall in an identified period prior to the assessment. Resident frequently experienced an identified condition. The resident was not involved in any restorative program, did not have any scheduled ADL plan, and did not use an identified product.

A review of a written plan of care revised on an identified date, under focus for an identified ADL indicated the resident was an active participant with the identified ADL tasks going to the identified location on their own, but required assistance by staff.. The goal set for this problem was to maintain ability to perform the identified task them- self safely. Some of the interventions to reach
that goal were:
- No changes, resident performed the identified task at identified times and as needed (PRN). Further review of the resident's plan of care in the identified ADL care section indicated that the resident experienced an identified condition and the goal set for identified condition care was to monitor the resident for any decline in status.

An interview with SDM indicated that resident #035 exhibited an identified behavioural symptom who was not able to make proper decisions if and when they needed assistance with some of the daily activities; however they still had a sense of when they needed to perform an identified task. The SDM stated that the resident needed assistance from staff for this identified task as the resident was not safe to perform the task them-self. Further, the SDM shared that the resident was not aware of using a call bell to seek assistance by staff, when they required assistance. The resident often tried to perform this identified task them-self and put self at risk for fall.

An interview with PSW #139 indicated that the PSW had not provided the identified task for the resident because whenever they would go and ask the resident to help them, the resident would always say no, they were okay.

In an interview, RPN #022 indicated that the resident was not able to use an identified equipment without staff assistance for some time and the care plan does not reflect that. Further they stated the written plan of care should be reviewed and revised when the resident's condition changed or on the quarterly assessment by the registered staff and the PSW who was looking after the resident. In regards to the discrepancy in the plan of
care, the RPN stated it may be a casual or agency staff working on the day when resident #035's plan of care was to be reviewed so they did not update the

resident's written plan of care.

An interview with I-DOC indicated all registered staff, regardless of position they hold are responsible to make sure they review and revise the residents' plan of care each time when there is change in the residents' condition, especially after quarterly assessment.

18. During the resident quality inspection, resident #008's MDS assessment has a triggered care area related to change in an identified ADL status.

Record review of the MDS Full Assessment on an identified date, indicated the resident required cues/supervision. The MDS identified assessment indicated the resident usually demonstrated an identified health condition.

Record review indicated resident #008 received an identified annual assessment using a clinically appropriate instrument on an identified date however, there was no annual assessment completed on an identified date, as verified by RPN #109 and Clinical Manager #124.

During an interview, RPN #109 verified that although resident #008's identified ADL status did not change, their identified diagnosis had progressed and caused the resident to decline in other ways; therefore, the resident was changed from using one identified product to another. RPN #109 also verified that the resident was not reassessed when there was a change in their health status.

During an interview, NM #123 and the I-DOC verified that the annual assessment and a change in status assessment should have been completed by the staff on an identified date and at the time resident #008's ADL product was changed.

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 the plan of care set out clear directions to staff and other who provide direct care to the resident, ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other, ensure that the care set out in the plan of care was provided to resident #033 as specified in the plan, ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it, to ensure that the provision of care set out in the plan of care for the residents was documented and to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan was no longer necessary, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential were are equipped with locks to restrict unsupervised access to those areas by residents, and locked when they are not being supervised by staff.

On September 10, 2018, during the initial tour of the home, the inspector observed the following unsupervised internal doors to be unlocked:
2 West-Electrical Room (multiple electrical wires and telephone wires) was unlocked when the handle was turned. PSW #126 verified that the door was unsupervised and unlocked, when it should have been locked after use by maintenance. The Linen Cart Storage room was unlocked when the handle was turned. There was a sign posted on the door which read "Please lock this door at all times." PSW #126 verified that the door
should have been locked with the key after use.
3 West-Shower room door was unlocked when the handle was turned; and the Linen Cart Storage room door was unlocked when the handle was turned. PSW #149 verified both unsupervised doors should have been locked with the key after use.
4 West-Nursing Supply Storage room door was unlocked when the handle was turned. PSW #150 verified that the unsupervised door should have been locked with a key after use.

On September 19, 2018, while conducting an observation on the unit, the inspector observed the following unsupervised doors to be unlocked:
2 East - Linen Cart Storage room and Nursing Supply Storage room door with a sign posted which read "Attention all staff please keep door locked" were both unlocked when the handles were turned. PSW #151 verified both doors should have been locked with a key after use; and proceeded to lock both doors.

During an interview, Nursing Manager #123 verified that all internal doors leading to non-residential areas of the home should be locked when they are unsupervised by staff.

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 all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

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

This IP was inspector initiated during a follow up order inspection, order issued January 16, 2018, inspection 2017_631210_0021.

On an identified date, during an observation of agency staff working on an identified residents' home area, Inspector #600 conducted an interview with PSW #106 regarding resident #037. The PSW stated that they provided care to resident #037 that morning and performed an identified task for the resident. The identified task was executed manually by one person only. After the PSW assisted the resident with their identified ADL, they then performed the identified task for the resident. After assisting the resident with an identified ADL, the PSW performed the identified task for the resident alone. The PSW stated that they were familiar with the resident and the resident needed one staff extensive assistance for the identified task. In description how they performed the identified task the resident, they stated that they just helped the resident to get off an identified location and using an identified assistance they performed the identified task the resident from one destination to another. The PSW also stated that there was a logo sticker in the resident's identified location that guide them how to perform the identified task

for the resident. However, when the inspector and the PSW went in the identified location, there were three logos placed on the mirror. One logo directed staff to use extensive assistance, second logo indicated an identified method of performing the task with two staff, and the third logo indicated the use of an identified equipment. The PSW reviewed the logos and stated that they had not reviewed the resident's plan of care as of what level of assistance the resident needed for the identified task.

Interview with RPN #105 stated that resident #037 needed extensive assistance by two staff for the identified task. The RPN indicated that they provided a light briefing to the agency PSW as of what level of care the resident needed, and reminded the PSW to seek assistance for second person assistance either from other PSWs or from the RPN.
The agency PSW confirmed that the RPN had told them the highlights of each resident's needs and level of care, but they did not see any available PSW at the time so they performed the identified task for the resident alone.

Review of the resident's physiotherapist's assessment, MDS and the written plan of care indicated that resident #037 needed assistance for the identified task. Interventions set to assist this resident with identified task was two person total assistance with an identified equipment.

During an interview, the I-DOC stated the agency PSW had put the resident at risk by performing the identified task for the resident alone and not seeking assistance from the other staff or the RPN on the floor. The I-DOC further stated the agency PSW's action was not acceptable, and the home expect of all staff regardless if they are agency staff or employee, to use safe techniques when assisting resident with the identified task.

2. The licensee has failed to ensure that staff used safe techniques for an identified task when assisting resident #033.

MOHLTC received a complaint on an identified date, regarding concerns of shortage of staff affecting resident #033's care.

Review of resident #033's MDS assessment indicated the resident needed extensive assistance by two staff for performing two identified tasks.

Resident's written plan of care indicated the resident needed extensive assistance

by two staff for the identified task by using an identified equipment.

In an interview, PSW #139 stated that because they are busy the resident's private caregiver set up the resident for the identified task with an identified equipment. The private caregiver applied the identified accessory and called the PSW. The PSW went in the identified area with the identified equipment, put the resident's accessory on the identified equipment and perform the identified task. Same process of carrying out the identified task had happened in another identified location. The PSW had used the private caregiver as a second person for conducting the identified task with an identified equipment.

During an interview, the private caregiver confirmed they set up resident #033 in an identified area for the identified task, applied the identified accessory and called the PSW.
The PSW came in with an identified equipment then two of them put the identified accessory onto the identified equipment and the PSW managed the equipment while performing the identified task for the resident in presence of the private caregiver only, considering the private caregiver as a second person.

In an interview, the I-DOC, they indicated that the home does not consider private caregivers as staff and their work in the home is strictly between the SDM and the private caregivers. The staff of the home is to look after the residents as if there is no private caregiver present. The I-DOC acknowledged that using private caregiver as a second person during the identified task is not acceptable and it put the resident at risk.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #13: 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,
(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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who is dependent on staff for repositioning had been repositioned: every two hours or more frequently as required depending on the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated.

Resident #005 was observed during this inspection lying supine on an identified surface. They expired two days after the inspector's last observation.

Record review of resident #005's identified assessments in MED e-care for an identified period, indicated the resident had altered skin integrity during a period of time and staff was directed to turn and reposition the resident every two hours.

Record review of resident #005's external consultation record on an identified date, recommended that they should have been placed on a repositioning and turning schedule.

Record review of resident #005's physician order form on an identified date indicated the resident has altered skin integrity and required staff to turn and reposition the resident and inform medical doctor/nurse practitioner (MD/NP) of any deterioration.

Record review of resident #005's Treatment Administration Record (TAR) for an identified period, indicated for an identified skin integrity administer an identified treatment and staff to turn and reposition the resident as per the external consultant's recommendations on an identified date.

Record review of resident #005's external consultation record on an identified date directed staff to put the resident on a repositioning and turning schedule.

Record review of resident #005's physician order form on an identified date, indicated a telephone order that had been transcribed by the nurse directed staff to put the resident on a repositioning and turning scheduled and monitor for sign and symptoms of infection.

Record review of resident #005's TAR for an identified period indicated; for an identified altered skin integrity staff to administer treatment. This TAR did not include the repositioning and turning schedule as per the external consultation record on an identified date. This TAR indicated the treatment was initiated during an identified period.

Record review of resident #005's TAR for an identified period, indicated the following order; For an identified altered skin integrity administer an identified treatment and put the resident on a reposition and turning schedule.

Record review of resident #005's external consultation record on an identified date, provided identified treatment recommendations and to put the resident on a turning and repositioning schedule.

Record review of resident #005's physician order form on an identified date, indicated a telephone order; to discontinue current treatment and a new treatment order was provided.

Record review of resident #005's identified care assessments for an identified period, indicated resident #005 had altered skin integrity on an identified body part. The external consultation records for an identified period, indicated staff to put resident #005 on a repositioning and turning schedule. The physician order forms for an identified period, indicated staff to turn and reposition resident #005. There were no documented evidence in resident #005's chart, or in the resident's turning and position binder to support that resident #005 were turned and

reposition during any of these periods.

Record review of resident #005's written plan of care on an identified date, indicated staff to frequently reposition resident #005 using the turning clock for skin integrity and wound.

Record review of the home's Skin and Wound Care Program policy #NRS-15-10 dated January 2017, indicated residents with identified altered skin integrity; registered staff to ensure that the resident is on a turning and repositioning schedule. This policy also indicated the personal support worker to reposition any resident who is dependent on staff for
repositioning every 2 hours and document the same. It also provided a resident repositioning guideline on how to use the turn clock poster and the resident repositioning form to be utilized.

Interview with RN #116 acknowledged resident #005 required to be turned and repositioned and the staff would inform them, when RN #116 reviewed resident #005's healthcare records and the residents' turning and repositioning documentation binder in the presence of the inspector there was no documented evidence to support resident #005 has been put on a turning and repositioning schedule and it was implemented.

Interview with I-DOC #107 acknowledged resident #005 required to be put on a turning and repositioning schedule.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident who is dependent on staff for repositioning had been repositioned: every two hours or more frequently as required depending on the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that as part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures were developed and implemented for addressing incidents of lingering offensive odours.

The MOHLTC received a complaint through the Action-line on an identified date, regarding care concerns related to resident #041. The complainant indicated that resident #041's room was not cleaned.

In an interview, the complainant indicated resident #041's room had an odour which had worsened over the last six months. The complainant indicated that on an identified date, the odour in the room was offensive and had informed the staff and Administrator #101.

During observations that were conducted on September 26, 2018, at 1230H, Housekeeper #133 was observed removing a fan out of resident #041's room. Housekeeper #133 said to the inspector that staff were complaining of odour in the room after the carpet was shampooed in the morning. The Housekeeper

further indicated that there was an odour coming from the resident's washroom. Observations conducted on September 26, 2018, at 1440H indicated a lingering offensive odour in resident #041's room.

In interviews, Housekeepers #131, #132 and #133, and Personal Support Worker (PSW) #139 indicated that they were aware that resident #041's room had an offensive odour for a long time and the complainant had approached them regarding the odour.

In an interview, Environmental Services Manager (ESM) #130 indicated that resident 041's room was identified as having an offensive odour since an identified date, and the complainant raised the concern of the identified odour in the room on an identified date, to one of their housekeeping staff. When asked if the home had procedures and policy on addressing incidents of lingering offensive odours, the ESM indicated they did not find a policy on managing lingering odours.

In an interview, Administrator #101 said that the home's organized housekeeping program did not have procedures developed to address incidents of lingering offensive odour for resident #041's room.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that as part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for addressing incidents of lingering offensive odours, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the physical device was applied in accordance with the manufacturer's instructions.

During the resident quality inspection, potential restraint was triggered related to multiple observations of residents using a physical device.

On identified dates the inspector observed resident #022 sitting in an identified location; with an identified device applied and secured at the back of the wheelchair.

During these observations the resident did not appear to be sliding.

Record review of the identified device information found inside the package indicated to monitor resident to ensure resident cannot slide down; and to 'stop use at once' if the resident has a tendency to slide forward or down in the device.

During separate interviews, RPN #150, PT #121 and CSM and restraint lead #124 verified that resident #022 tends to slide down while sitting in the wheelchair with the identified device in place.

During an interview, PT #121 and CSM and restraint lead #124 verified they were both unaware of the manufacturer's instructions related to the use of the identified device for a resident who tends to slide down while seated in the wheelchair. PT #121 further stated that a resident who slides forward in the wheelchair while secured with the identified device could result in strangulation of the groin muscles; and issues related to skin breakdown. Both staff verified that resident #022 will be reassessed immediately since the use of the identified device was contraindicated for use by the manufacturer if a resident slides down while seated in the wheelchair. The inspector confirmed an occupational therapist referral was sent to recommend a device to prevent sliding. Therefore, the home failed to ensure the physical device was applied in accordance with the manufacturer's instructions.

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 the physical device is applied in accordance with the manufacturer's instructions, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that drugs are stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies.

During the mandatory drug storage observation on September 21, 2018, at 1025H in an RHA, with RPN #110, the narcotic box located in the medication cart had two envelopes and a plastic bag which contained currency. The sample was expanded to two other RHAs.

Observations conducted in an identified resident home area on September 21, 2018, indicated the following:
1) On an identified RHA at an identified time, with RPN #115, the narcotic box in the medication cart had a plastic case with digital pen refills.
2) On another identified RHA at an identified time, with RN #116, the narcotic box in the medication cart had a plastic bag with currency.

In interviews, RPNs #110 and #115 and RN #116 indicated it is the home's process that the narcotic box is only to contain narcotics and controlled substances and the items found should not have been stored in the narcotic box. In an interview, NM #123 indicated that the currency and digital pen refills should not have been stored in the narcotic box and acknowledged that only drugs and drug related supplies are to be stored in the narcotic box.

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 drugs are stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee failed to ensure that there is, at least quarterly, a documented reassessment of each resident's drug regime.
The MOHLTC received a complaint through the Action-line on an identified date, regarding care concerns related to resident #041. The complainant had concerns regarding the home's medication management of resident #041's identified medical diagnosis.

Record review of resident #041's quarterly drug regime reassessment indicated the quarter for an identified period, was completed on an identified period, was signed by the physician on an identified date.

There was 144 days between the reassessments which exceeded the minimum quarterly requirement of 90 days.

The sample was expanded to residents #043 and #044.

Record review of resident #044's quarterly drug regime reassessment indicated the quarter for an identified period was signed by the physician on an identified date; and for an identified period, was signed by the physician on an identified date. There was 105 days between the reassessments which exceeded the minimum quarterly requirement.

The home uses an identified pharmacy's policies and procedures and policy #6.02 titled, Quarterly Physician Medication Review with a revised identified date, indicated that quarterly physician medication reviews should be fully processed, signed and returned to the resident's chart by the first day of the month at the beginning of the designated quarter.

In an interview, RN #135, indicated the home receives the quarterly medication reviews from the pharmacy before the new quarter begins. The RN stated it is the home's process for the quarterly medication reviews to be completed before the start of the next quarter.

In an interview, I-DOC #107 indicated it is the home's process for the quarterly medication reviews to be completed before the start of the new quarter or on the first day of the new quarter. The I-DOC acknowledged that at least quarterly, a documented reassessment of each resident's drug regime was not completed for residents #041 and #044.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is, at least quarterly, a documented reassessment of each resident's drug regime, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any written complaints that have been received concerning the care of a resident or the operation of the home has immediately been forwarded to the Director.

A complaint submitted to the MOHLTC on an identified date, indicated SDM's concerns that resident #032 would not receive a proper care because of the shortage of staff.
In an interview, the SDM indicated they have sent about 12 emails to NM #123, but never heard anything back from NM. The SDM stated that they had emailed the Administrator as well, but the Administrator would return calls always saying that the NM would reply back to them.

An interview with the NM indicated that they had received emails from family members regarding concerns for residents' care due to shortage of staff, however the NM stated they did not recall how many as they tried to talk to the family whenever they can and it is not their responsibility to forward complaints to the Director.

In an interview the Administrator indicated that not all emails had been complaints and the NM should have clarified with the SDM which email was a complaint, then forward to the Administrator to follow the process. The Administrator also indicated that they had received emails from the SDM and they called the SDM back, as well as addressing the concerns to the Family and Residents' Councils meeting and what the home was doing regarding the issue. However the Administrator stated they did not consider those emails as complaints, and they had not received email clarification by the NM to be a complaint, so they have not forwarded any complaint to the Director.

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A complaint submitted to the MOHLTC on an identified date, indicated SDM's concerns resident #032 would not receive proper care because of the shortage of staff. In an interview, the SDM indicated they have sent about 12 emails to NM #123, but never heard anything back from NM. The SDM stated that they had emailed the Administrator as well, but the Administrator would return calls always saying that the NM would reply back to them.

An interview with the NM indicated that they had received emails from family members regarding concerns for residents' care due to shortage of staff, however the NM stated they did not recall how many emails they had received with this

concern as they did not keep track of it. The NM also stated they tried to talk to some of the family but for others they were not able to explain when the issue would be solved as they were not responsible for hiring staff. Further the NM confirmed they did not document when they received the email, when they talked to the families, what was discussed with them or when the issue would be solved. The NM confirmed they did not initiate a complaining log, they would just forward the email to other departments if the issue was regarding their services.

In an interview the Administrator indicated that not all emails had been complaints and they would expect the NM to clarify with the SDM which email was a complaint then forward to the Administrator to follow up. The Administrator also indicated that they had received emails from the SDM and they called the SDM back, as well as addressing the concerns to the Family and Residents' Councils meeting and what the home is doing regarding the issue. However the Administrator stated they did not consider those emails as a complaints, and they had not received email clarification by the NM to be a complaint, so they did not have an official record with complaining logs.

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):

1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).

2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).

3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).

4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).
6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure an outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act, was reported to the Director immediately, in as much detail as is possible.

MOHLTC received a critical incident system report on an identified date, related to an outbreak in the home.

A review of the critical incident system report indicated that Public Health declared an outbreak in the home in January 2018; however the home reported the outbreak to the Director on the following day.

As a result of the non-compliance identified above, the inspector reviewed two previous outbreaks to expand the sample.

A review of critical incident system report indicated that in December, 2017, Public Health declared an outbreak in the home; however the home reported the outbreak to the Director four days later.

A review of critical incident system report indicated that in August , 2017, Public Health declared an outbreak in the home; however the home reported the outbreak to the Director the following day.

During separate interviews, NM, IPAC Lead #123 and the I-DOC both reviewed the three critical incidents; and verified late reporting to the Director.

2. The licensee has failed to ensure that the Director is informed of the following incident in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): A medication incident or adverse drug reaction in respect of which a resident is taken to hospital.

The MOHLTC received a complaint through the Action-line on an identified date, regarding care concerns related to resident #041. The complainant had concerns regarding the home's medication management of resident #041's identified medical diagnosis.

In an interview, the complainant indicated on an identified date, resident #041

experienced an identified change in health status and was transferred to hospital.

Record review of the clinical records of resident #041 indicated the resident had an identified medical diagnosis with a history of identified symptoms related to the identified diagnosis.

Record review of resident #041's physician orders indicated an order for an identified medication, if the resident's reading is less than an identified reading. The order was located in the quarterly medication review for an identified period.

A review of resident #041's progress notes in MED e-care indicated on an identified date, the resident experienced an identified medical symptom at an identified time. Further review of the progress notes indicated resident #041 experienced an identified change in health status which deteriorated. The resident received an identified medication over an hour later at an identified time by RN #134. The unit called 911 and the resident was transferred to hospital.

In an interview, RPN #136 indicated they were not aware that resident #041 had a physician's order for an identified medication and the resident was transferred to hospital for assessment as the resident became unresponsive.

In interviews, RNs #134 and #135 indicated they were not aware that resident #041 had a physician's order for an identified medication.

Both RNs indicated that the identified medication should have been administered right away by RPN #136 instead of waiting an hour for it to be administered. RN #134 indicated 911 was called as the resident became unresponsive during the identified event. The RNs indicated they considered this event to be a medication incident.

In interviews, NM #123 and I-DOC #107 considered the incident with resident #041 a medication incident as the identified medication should have been administered right away. The NM and the I-DOC indicated there was a change in the resident's identified health status and was taken to hospital.

The NM and I-DOC confirmed that a CIS was not submitted to the MOHLTC. The NM acknowledged that a CIS should have been submitted as the medication incident resulted in resident #041's transfer to hospital.

3. The licensee has failed to ensure to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident: 3. Actions taken in response to the incident, including, iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons.

The MOHLTC received a CIS report from the home on an identified date, for a missing and unaccounted controlled substance for resident #042 that occurred on an identified date, on an identified RHA. The CIS report indicated that an identified medication was missing from resident #042's medication blister pack and that the narcotic and controlled substance
count at the change of shift was only completed by the evening RPN #108 when the missing medication was discovered.

Record review of the CIS report indicated that a family member was not notified of the incident, but the home called the family member to call the home.

Record review of the home's medication incident report for the critical incident indicated that family was not notified.

In an interview, NM #123 indicated it is the home's process whenever a critical incident occurs related to a resident, the resident and or the SDM are notified of the incident. The NM stated they left a message for resident #042's SDM but did not receive a call back.

The NM indicated they did not speak to the SDM of the critical incident, as per the home's process.

4. The licensee has failed to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident: 4. Analysis and follow-up action, including, i. the immediate actions that have been taken to prevent recurrence, and ii. the long-term actions planned to correct the situation and prevent recurrence.

The MOHLTC received a CIS report from the home on an identified date, for a missing and unaccounted controlled substance for resident #042 that occurred on

an identified date, on an identified RHA.

The CIS report indicated that an identified medication was missing from resident #042's medication blister pack and that the narcotic and controlled substance count at the change of shift was only completed by an identified shift RPN #108 when the missing medication was discovered.

A record review of the CIS report indicated that the MOHLTC requested the home on an identified date, to amend the CIS report as to the outcome of the home's investigation.

The CIS report submitted to the MOHLTC on an identified date, indicated under the analysis and follow-up section that the investigation was in progress. An amendment to the CIS report was not submitted at the time of the inspection.

In an interview, NM #123, confirmed that they had submitted the CIS report and was responsible for amending the report. The NM reviewed the CIS report and stated that they had forgotten to amend the CIS report after the home completed their investigation and when requested by the MOHLTC on an identified date.

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that written policies and protocols are

developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and the destruction and disposal of all drugs used in the home.

MOHLTC received a CIS report from the home regarding medication incidents that occurred on an identified date. The CIS report indicated that ten residents in an identified RHA did not receive their 1200H medications when RPN #108 was unable to complete their shift due to a personal issue.

One of the residents involved in the CIS was resident #053.

Review of resident #053's EMAR indicated on an identified date and time, the identified treatment order to be applied to the resident's identified affected areas to an identified body part was not signed by RPN #108. Further review of the EMAR indicated at an identified time, RPN #161, documented that the identified order was administered by the PSW.

In an interview, RPN #108 indicated that the identified treatment for resident #053 was administered by the PSW on an identified date.

In an interview, PSW #160 indicated that RPN #110 permitted them to apply the identified treatment order noted above to resident #053 on an identified date. Further interviews with PSWs #159 and #160 indicated that the registered staff would allow them to administer the identified treatment to residents after training was provided by the registered staff. PSW #160 indicated they work on all units and have administered the identified treatment to residents throughout the home.

In interviews, RPNs #110 and #161 indicated that it has been a practice for many years that they have allowed PSWs to administer the identified treatment to residents. Both RPNs indicated they provided instructions to the PSWs prior to providing them the identified treatment for application.

The RPNs indicated that they sign the EMAR that the PSW had administered the identified treatment.

In an interview, the NM #123 indicated they were aware that the registered staff allowed the PSWs to apply the identified treatment to residents and stated that the PSWs were able to if the registered staff was present during the application. The NM indicated they were not aware if the home had a policy on the application

of the identified treatments by the PSWs.

In an interview, the I-DOC indicated that PSWs are not allowed to apply identified treatment to residents. The I-DOC stated the home does not have a policy on the application of identified treatment by the PSWs.

Issued on this 31st day of January, 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 NATALIE MOLIN (652) - (A1)
Inspection No. / No de l'inspection :	2018_493652_0015 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	004019-18, 024800-18 (A1)
Type of Inspection / Genre d'inspection :	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jan 31, 2019(A1)
Licensee / Titulaire de permis :	Advent Health Care Corporation 541 Finch Avenue West, NORTH YORK, ON, M2R-3Y3
LTC Home / Foyer de SLD :	Valleyview Residence 541 Finch Avenue West, NORTH YORK, ON, M2R-3Y3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Elizabeth Bryce

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 Advent Health Care Corporation, 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)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 29. (1) Every licensee of a long-term care home,

(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and

(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Order / Ordre :

The licensee must be compliant with s. 29 (1) of the LTCHA. Specifically, the licensee must ensure:
1. All staff are trained:
(a) on minimizing restraints including specific physical restraint devices used by the home,
(b) on the home's policy on minimizing restraints including use of the Alternative to Restraint Form,
2. That the home maintain a documentation record of the education and training material content provided, the dates of when the education was provided, who provided the education and signed staff attendance records,
3. That residents #002, #003 and #022, and all other residents who use restraints are assessed and reassessed quarterly by the interdisciplinary team including the PT, by completing the home's Alternative to Restraint Form prior to implementation of the restraint and with continued use of the restraint.
4. That the plan of care for residents #002, #003 and #022, and all other residents who use restraints, include: the alternatives to restraining that were considered and tried, but have not been effective in addressing the risk. It should also include the type and the size of the restraint of the device that the resident is using where applicable.
5. That resident #002, #003 and #022, and all other residents who use restraints are monitored by a member of the registered nursing staff, or by another member of the staff as authorized by the registered nursing staff, at least every hour while restrained.
6. That resident #002, #003 and #022, and all other residents who use restraints are reassessed and the effectiveness of the restraint is evaluated at least every eight hours.
7. That resident #002, #003 and #022, and all other residents who use restraints are reassessed, and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.
8. That all interventions provided to resident #002, #003 and #022, and all other residents who use restraints are documented.
9. That the home's minimizing of restraint policy is complied with.

Grounds / Motifs :

1. The licensee has failed to ensure that the home's minimizing of restraint policy

was complied with.

On September 10, 2018, during the Resident Quality Inspection (RQI) initial tour of the home residents #002 and #003 were observed wearing an identified device while seated.

Resident #022 was included in order to expand the sample of residents using the identified device in the home.

Record review of the home's Restraints Policy #NMIIR008vv with an effective date September 1, 2017, indicated that staff was not complying with the home's policy, specifically related to the following concerns:

A. Alternative to restraint: Use the Alternatives to Restraint Form to determine the appropriate restraint for use.
B. Restraint: Restraint type and reason must be documented in the record and the plan of care. The following must be included in the plan of care:
-There is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained.
-Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to the above.
-The method of restraining is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable methods that would be effective to address the risk referred to above.
C. Physical Restraint: All physical restraints will be checked hourly by designated nursing staff (PSW) and the resident repositioned every two hours to promote circulation and maintain skin integrity. Times will be recorded to indicate application/removal of restraint. Hourly monitoring checked and every two hourly repositioning must be documented on the Restraint Monitoring Record.
D. Documentation: Registered staff will reassess the resident's condition and the effectiveness of the restraint every eight (Q8) hours and whenever necessary; and staff to complete documentation on MED e-care and resident's care plan regarding the prescriptive interventions for registered staff and PSWs. PSWs will complete documentation for hourly checks and two hourly repositioning on Restraint Flow Sheet.
Education: All staff must receive retraining/additional training on the policy to

minimize the restraining of residents in accordance with the Act and its regulation as well as training in the application, use and potential dangers of restraints and personal assistive supportive devices (PASDs) annually.
E. Quality Improvement/program evaluation: Monthly restraint analysis will be conducted by the Falls Committee. Annual program evaluation will be conducted by the Falls Committee to determine effectiveness of the policy. A written record will be kept and included monthly analysis result, date of the evaluation, names of the persons who participated in the evaluation and the date that the changes were implemented.

Record review, observations and staff interviews revealed the following information related to the use of an identified device for residents #002, #003 and #022:

Record review indicated resident #002, #003 and #022 were assessed using the home's Resident Assessment Instrument - Minimum Data Set (RAI-MDS) instrument. All MDS assessments indicated residents were secured by use of an identified device.

On multiple dates, during an identified time the inspector observed resident #002, #003 and #022 sitting in in the residents' lounge. At the time of each observation, the residents made no attempts to get up from their seats; however, they were secured by the use of an identified device.

During multiple interviews, registered staff #115, #118 and #150 verified that an order and consent were obtained for the use of the identified device for all residents. A review of residents' written plans of care included an identified focus with expected outcomes and interventions listed to minimize falls and injuries; and to have an identified device on when in the wheelchair. However, all residents' plans of care did not include the size of the identified device assigned; alternative to the identified device that was considered prior to implementation; and whether the physical or mental condition of all residents were taken into consideration.

A review of residents' #002, #003 and #022 personal support worker (PSW) identified monitoring sheets, which were to be completed when a resident was wearing the identified device, indicated during an identified month documentation was missing from each resident's monitoring sheet on multiple occasions.

A review of residents' #002 and #003 registered staff Q8 hourly MED e-care documentation related to monitoring of the resident while wearing the identified device during an identified month, indicated there was an absence of registered staff signatures on both residents' electronic treatment record (eTAR) which would indicate registered staff signed off during or at the end of their shift. Therefore, because of the misinformation entered by an identified technician, the system prevented the identified order from populating the resident's eTAR as verified by the identified technician #147 from an identified pharmacy.

The inspector requested an identified analysis for review, and noted that resident #002, #003 and #022's identified device use was not analyzed by the home on a monthly basis as verified by the CSM/Restraint Lead #124.

Multiple residents were observed using the identified device in the home. Record review of the home's identified list indicated 18 residents were currently using the identified device as a form of security.

During separate interviews, registered staff RPN #115, #118, PT #121, PSW #100, #120 and #122 verified that they completed the identified training on Surge Learning; however, they did not receive training specific to the use of the identified device. In addition, RPN #115 and #118 verified that they do not have reference material on the units to support staff training if required related to the use of the identified device, specifically regarding contraindications and potential dangers of using the identified device.

A review of the home's Restraint training records indicated 97% of direct care staff completed the Minimizing of Restraint training using Surge Learning Modules which provided an overview of the home Restraint Policy; however, there was no information included on Surge Learning related to specific physical restraint devices used by the home, such as the identified device.

The inspector conducted interviews with the home's Clinical Service Manager/Restraint Lead RPN #124, Physiotherapist #121 and Interim Director of Care (I-DOC) #100 related to concerns identified with the use of the identified device; and to verify their expectation related to staff compliance with the home's Restraint policy. The following interview highlight their expectations:

During an interview, CSM/Restraint Lead #124 informed the inspector that the physiotherapist completes the training for direct care staff on the units.

During an interview with the PT, they informed the inspector that they do not conduct staff training; and in fact, did not receive any actual training related to the use of the identified device. The PT further stated that whenever they brought the identified device up to the unit for application, they would briefly explain how to apply the identified device to whomever staff was present and available at that time. The PT further verified that there was no discussion related to contraindication and potential dangers of using the identified device.

During an interview on an identified date, PT #121 verified that they completed initial assessments for residents #002, #003 and #022; and documented their finding in each resident's progress notes. PT #121 verified that they have been working in the home for three years; however, they were not aware the home had an identified form to be used for assessing all residents prior to the use of an identified device. The PT verified that resident #002, #003 and #022 did not have an identified form completed by the interdisciplinary team, including the PT.

During an interview, CSM/Restraint Lead #124 verified that the physiotherapist was the most responsible person to ensure each resident receives an identified assessment by the interdisciplinary team and using the home's identified form prior to the use of any identified device. The CSM verified that they were not aware the PT was not using the identified form to assess and reassess resident's using an identified device; but verified the form should have been completed for resident #002, #003 and #022 and kept in all residents' paper chart for review by the team as needed.

During an interview, the I-DOC verified that resident #002, #003 and #022 who were currently using an identified device should have been assessed and reassessed quarterly by the interdisciplinary team including the PT, by completing the home's identified form prior to implementation of the identified device and with continued use.

During an interview, CSM/restraint lead #124, verified that it was their responsibility to assign each resident the correct identified device size which was based on the resident's weight at the time of the assessment; and also they were to document

specific information related to an identified device in the resident's plan of care. The CSM verified that the identified device was available in sizes small, medium, and large which was also coordinated to specific colors for ease of identification. In addition, the CSM verified that the size information as well as the potential for risk of harm and alternatives used prior to the implementation of the identified device should have been documented in the resident's plan of care. After reviewing resident #002, #003 and #022's written care plans, the CSM verified that the information should have been documented in the care plan as required by the home's policy.

During separate interviews, CSM/Restraint Lead #124 and the I-DOC verified that the hourly PSW monitoring and documentation on the identified sheet during the times the resident was actually using the identified device, should have been completed. Also, the Q8 hourly registered staff documentation indicating reassessment of residents related to identified monitoring, evaluation and effectiveness of use, should have been completed by the scheduled registered staff in the Med e-care electronic system as required by the home's policy.

However, during separate interviews, registered staff RPN #118, CSM/Restraint Lead #124 and the I-DOC were not aware that an issue had occurred with the home's identified documentation system in Med e-care. They became aware when the concern was brought to their attention during the RQI.

During an interview, CSM/Restraint Lead #124 verified that a monthly identified analysis related to residents #002, #003 and #022 identified device use was not completed in 2017. A review of the home's annual identified evaluation indicated there was no monthly or quarterly identified analysis completed as per the home's policy.

The severity of this issue was determined to be a level 2 as there was potential for actual harm to residents being restrained. The scope of the issue was a level 3 as it was widespread and affected three residents. The home had a level 2 history as they had previous written notification (unrelated) of the LTCHA, O. Reg. 79/10.

(535)

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

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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 : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 8. (1) of the O. Reg. 79/10. Specifically the licensee must:

1a) Ensure that Complaints Policy #ADM-07-035 is in compliance with the requirements under the Act and that the policy is implemented and complied with, including:
i) Revision of the policy to clarify the definition of what constitutes a complaint.
ii) All received complaints are recorded, investigated, action taken for resolution, and written report(s) documenting all responses made to the complainant(s) with the appropriate timelines.
iii) All written complaints to the Director are recorded and kept.
1b) Ensure the written complaint procedures are in place, implemented, and consistent with reporting requirements as outlined in the LTCHA.
1c) Ensure the licensee has provided training with clear directions to home staff on the complaints reporting procedures, how reporting practices are monitored, evaluated, and analyzed for improvement.
2a) Ensure that the Quarterly Physician Medication Review Policy #6.02 is complied with, for residents #041, #043, #044 and all other residents in the home.
2b) Ensure the quarterly physician medication reviews for residents #041, #043,
#044 and all other residents in the home have two registered staff signatures before and after it is reviewed by the physician.
2c) Ensure that the quarterly physician medication reviews for residents #041,
#043, #044 and all other residents in the home are completed and in the resident's chart by the first day of the month at the beginning of the designated quarter.
2d) Ensure that the Narcotic Prescriptions Policy #3.08 is complied with, by all registered staff.
2e) Ensure that RPNs #108, #109, #141 and #161 and RN #134 and all other registered staff conduct narcotic and controlled substance counts together.
2f) The home to review their process when the home is short a registered staff to ensure that narcotic and controlled substance counts are conducted when the medication keys are endorsed amongst the registered staff.

Grounds / Motifs :

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

Section 8 from The Long-Term Care Homes Act, 2007 and Regulation 79/10 states where the LTC Act and 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, is in compliance with and is implemented in accordance with applicable requirements under the Act; According to O.Reg 79/10, r. 101. (1) every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with. As per A Guide to LTC Act and regulation, a "Written" complaint include written notification in any format, including anything handwritten, such as letters, notes, correspondence, emails, facsimile documents and text messages.

A complaint was submitted to the MOHLTC on an identified date, regarding the SDM's concerns for resident #032. They felt the resident did not receive proper care because of the shortage of staff. In an interview, the SDM indicated they had sent about 12 emails to Nurse Manager (NM) #123, but never heard anything back from the NM. The SDM stated that they had emailed the Administrator as well, but the Administrator returned calls, always saying that the NM would reply back to them.

Review of the home's Policy and Procedure Manual title "Complaints" number DM-07 -035 effective May 23, 2018, stated: A copy of all written complaints must be forwarded to the Administrator immediately. Email communication is not automatically considered a written complaint; the receiver of the email is to determine if it is a written complaint and act accordingly - page 2. Further review of the Policy, under the Procedures, point number 7 “about email communication” explains: not all email communications are considered a complaint. The receiver of the email needs to:
i. Carefully read the email - if the word complaint is used - then it is a complaint.
ii. If it is unclear if it is a complaint, then the receiver of the emails is to review the communication with the Administrator.

iii. If it is still unclear, the receiver of the email should contact the author of the email to further clarify what the concerns are - page 5.

An interview with the NM indicated that they have received emails from family members regarding concerns for residents' care due to shortage of staff, however the NM stated they do not recall how many emails they have received with this concern as they do not keep track of it. The NM also stated they tried to talk to some of the families but for others they were not able to explain when the issue will be solved as they are not the one directly involved in the operation of the home. Further the NM confirmed they do not document when they received the email, when they talk to the families, what was discussed with them or when the issue would be solved. The NM confirmed that if they did not consider the emails as a complaint and did not initiate complaining log, they would just forward the email to other departments if the issue was regarding their services.

In an interview, the Administrator indicated that the home had a Policy and Procedure regarding Complaints. As per the policy, not all emails are considered complaints until they are further clarified with the sender. The Administrator indicated they would expect the NM to clarify with the SDM which email was a complaint then forward the email to the Administrator to follow up. The Administrator also indicated that they had received emails from the SDM and they called the SDM back, as well as addressing the same concerns about short staffing to the Family and Residents' Councils meeting and what the home was doing regarding the issue. However the Administrator stated they did not consider those emails as complaints, and they had not received any emails from the NM identifying a complaint.

(600)

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

In accordance with O.Reg.79/10, s.114 (2), the licensee was required to ensure that written polices and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

1. Specifically, staff did not comply with the licensee's policy regarding "Quarterly Physician Medication Review - #6.02," last revised October 18, 2015, which is part of the Licensee's policies and procedures for medication management from their pharmacy service provider.

The quarterly physician medication review policy directed staff to the following:
a) Procedure number two - Reviews should be checked against the MAR/EMAR for accuracy before the physician's visit. The review should be signed and dated by two registered staff members prior to the physician's visit.
b) Procedure number five - Completed reviews must be checked, dated and signed by a second registered staff member.
c) Procedure number nine - Quarterly physician medication reviews should be fully processed, signed and returned to the resident's chart by the first day of the month at the beginning of the designated quarter.

A) During the mandatory medication inspection protocol (IP), record review of resident #043's quarterly medication review for an identified period, indicated the following:
1. Only one registered staff signed and dated the quarterly review on an identified date, prior to the physician's review four days later.
2. The quarterly medication review was completed 19 days after the start of the quarter.

The sample was expanded to residents #044 and #041. Resident #041 was identified through a complaint received by the Ministry of Health and Long-term Care (MOHLTC) on an identified date.

B) Record review of resident #044's quarterly medication review for an identified period, indicated the following:
1. Only one registered staff signed and dated the quarterly review on an identified date, prior to the physician's review one day later.

2. The quarterly medication review was completed 21 days after the start of the quarter and was signed by one registered staff on identified date.
C) Record review of resident #041's quarterly medication reviews indicated the following:

1. Quarter of an identified period - The completed quarterly medication review was not signed and dated by a second registered staff and was completed 23 days after the beginning of the quarter.
2. Quarter of an identified period- The completed quarterly medication review was not signed by any registered staff and the physician reviewed and signed the review 88 days after the beginning of the quarter.
3. Quarter of an identified period - The quarterly medication review was completed 15 days after the beginning of the quarter.

In an interview, RN #135, indicated the home receives the quarterly medication reviews from the pharmacy before the new quarter begins. The RN stated that the night registered staff completes the first check and signs, a second check is completed by a registered staff with the physician and both signs the review. The quarterly is then faxed to the pharmacy and two registered staff will check the review and ensure that the orders are in the electronic medication record (EMAR) and sign the quarterly medication review. The RN indicated that the quarterly medication reviews are to be completed before the start of the next quarter.

In an interview, I-DOC #107 indicated it is the home's process for completed quarterly medication reviews to be reviewed and signed by two registered staff before and after the physician reviews the quarterlies.The I-DOC stated the quarterly medication reviews are to be completed before the start of or on the first day of the new quarter. The I-DOC acknowledged that staff did not follow the home's policy on quarterly medication reviews for residents #041, #043 and #044.
2. Staff did not comply with the licensee's policy regarding "Narcotic Prescriptions -#3.08", last revised September 1, 2015, which is part of the licensee's policies and procedures for medication management from their identified Pharmacy.

The narcotic prescriptions policy under procedure number seven, directed staff that the quantity of medication remaining must be reconciled at the end of each shift and the incoming and outgoing registered staff members count or measure the remaining quantity. Procedure number eight indicated that if the incoming registered staff member is not available, or the outgoing registered staff member must leave before the registered staff member from the next shift arrives, another registered staff must be sought out to complete the reconciliation. If necessary, the Director of Care or Assistant Director of Care can be contacted to complete the process.

A) The MOHLTC received a critical incident system (CIS) report from the home on an identified date, for a missing and unaccounted controlled substance for resident #042 that occurred on an identified date, in an identified resident home area (RHA). The CIS report indicated that a half tablet of an identified medication was missing from resident #042's identified medication blister pack and that the narcotic and controlled substance count at the change of shift was only completed by the evening RPN #108 when the missing identified medication was discovered.

In interviews, RPNs #108 and #109 confirmed they had worked on the identified date, and the count was not completed together at the change of shift. RPN #109 indicated, they provided resident care and followed up with a family member and upon their return to the nursing station, RPN #108 had already counted the narcotics and controlled substances and discovered the missing medication. RPN #108 indicated that RPN #109 endorsed the medication cart keys to them at the change of shift just after an identified time and initiated the identified count without RPN #109, and discovered the missing identified medication. RPN #108 stated that they had initiated the count as there was trust amongst the registered staff. Both RPNs indicated it is the home's policy for narcotic counts to be completed by the incoming and outgoing nurses together, which was not followed on the identified date.

In an interview, NM #123 indicated that it is the home's policy for narcotic and controlled substance counts be completed by two registered staff together and acknowledged RPNs #108 and #109 did not follow policy.

B) The MOHLTC received a CIS report from the home regarding medication incidents that occurred on an identified date. The CIS report indicated that ten residents in an identified resident home area (RHA) did not receive their medications during an identified time when RPN #108 was unable to complete their shift due.

In an interview, RPN #161 indicated they had counted the narcotics and controlled substance on an identified date, on their own at the change of shift at an identified time as RPN #108 was unable to conduct the count. RPN #161 further indicated prior to counting the narcotics and controlled substances, both narcotic count books were already completed and signed by RPN #108. When asked the home's policy on narcotic and controlled substance counts, RPN #161 indicated that the count must be conducted and signed together by two registered staff and acknowledged they did not follow the policy.

Record review of the home's investigation notes indicated the narcotic and controlled substance count on an identified RHA was already completed and signed by RPN #108, when RPN #161 started their shift at an identified time.

C) On an identified date, at an identified time, RPN #109 informed the inspector that the home was short a registered staff on an identified resident home area for the identified shift. The RPN indicated that each registered staff working in the other five RHAs had been assigned identified resident home area residents to monitor and administer medications.

Record review of the identified home area RHA's narcotic book, indicated that narcotic and controlled substance counts on an identified date, were conducted at identified times. There were five registered staff from the other RHAs who had administered medications to residents in an identified resident home area on an identified date.

In interviews, RPNs #107, #109, #118, and #117 confirmed that narcotic and controlled substance counts were not conducted when an identified resident home area medication keys were endorsed to each other on an identified date. RPN #108 stated they had conducted a count with another RPN at an identified time, since a MOH inspector was on the unit. The RPNs indicated when the home is short a registered staff, it is the home's practice not to conduct narcotic and controlled substance counts when the medication keys are endorsed between them. RPN #108 stated whenever the home is short a registered staff, the registered staff's workload is increased and conducting narcotic counts whenever the medication keys are endorsed takes time and further increases their workload.

On an identified date, the home was able to schedule RN #119 to work on an identified resident home area. In an interview, RN #119 indicated they started their shift on an identified resident home area at an identified time. The RN indicated that a narcotic and controlled substance count was not conducted at the start of their shift, as another registered staff was not available. RN #119 acknowledged that the narcotic and controlled substance count should have been completed at the start of their shift.

D) Observations conducted on an identified date, on an identified resident home area

at an identified time, indicated RPN #141 endorsed the medication keys to RN #134. The RN was observed to unlock the medication room, unlocked the medication cart then the narcotic box. The RN proceeded to count the narcotics on their own, while RPN #141 was documenting in the nursing station. At an identified time, RPN #141 was observed to stand beside the medication cart and did not observe the RPN sign the narcotic count book at the completion of the count by RN #134.

In an interview, RPN #141 indicated they had already counted the narcotics and controlled substances and signed the narcotic count book prior to the change of shift. When asked if this was the home's policy for narcotic and controlled substance count, the RPN was unable to provide an answer to the inspector.

In an interview, RN #134 indicated that it is the home's policy for narcotic and controlled substance count to be completed by the incoming and outgoing nurses together and the narcotic book must be signed together. The RN acknowledged that the home's policy on narcotic and controlled substance count was not followed.

In an interview, I-DOC indicated it is the home's policy to conduct narcotic and controlled substance counts whenever the medication keys are endorsed to another registered staff. The I-DOC stated the counts are to be completed and signed together by the registered staff.

The severity of this issue was determined to be a level 2 as there was potential for actual harm to residents. The scope of the issue was a level 2 as it was a pattern. The home had a level 3 history as they had previous written notification (similar area) of the LTCHA, O. Reg. 79/10, that included:
1)Written notification (WN) issued April 15, 2016 (2016_263524_0013); 2) WN issued October 31, 2016 (2016_378116_0012);
3) WN issued January 16, 2018 (2017_631210_002).

(665)

Apr 30, 2019

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 :

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) (b)

Linked to Existing Order / Lien vers ordre existant: 2017_631210_0021, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation;
(b) set out the organization and scheduling of staff shifts;
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident;
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Order / Ordre :

(A1)
The licensee must be compliant with O.Reg 79/10, s. 31. of the LTCHA.

The licensee shall prepare, submit and implement a plan to ensure that the staffing plan provides for a staffing mix that is consistent with residents' assessed care and safety needs and that it meets the requirements set out in the Act and this Regulation.

The plan must have the following elements in place:

1. The development of the plan and implementation schedule of the plan to ensure that all vacancies on each fixed or prearranged intervals shifts are

filled.

2. An alternate staffing plan that ensures the home is staffed appropriately while implementing their hiring plan, and that the alternate staffing plan includes education in the home's practices related to resident care.

3. A process to ensure all new hired staff are introduced, participate in, complete and provide feedback on the orientation.

4. A process to ensure:
a. all residents within the home receive at a minimum two baths/showers twice a week by method of his/her choice when short staffed and that also includes alternate baths/shower days when not provided as per their plan of care,
b. all resident who need physical assistance for toileting or need assistance to attend the dining room for meals are cared for as per residents' plan of care,
c. every transfer of resident who need mechanical lift be conducted by two staff who are trained for using mechanical lift.

5. The implementation of a monthly auditing process to ensure compliance with all of the above.

6. The maintenance of a written record of audits conducted. The written record must include the date, the resident's name, staff member's name, the name of the person completing the audit and the action taken from the outcome of the audit.

7. The maintaining of documented records of the orientation, education and training material content provided to new staff, including the dates of when the education was provided, who provided the education and signed staff attendance records

For all the above, as well as for any other elements included in the plan, please include who will be responsible for implementing, as well as a timeline for achieving compliance, for each part of the plan.

Please submit the written plan for achieving compliance for inspection 2018_493652_0015
to Gordana Krstevska, LTC Homes Inspector, MOHLTC, by email to: TorontoSAO.generalemail@ontario.ca by February 1, 2019, .
Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

1. The licensee has failed to ensure that the staffing plan:
a) provide for a staffing mix that is consistent with residents' assessed care and safety needs;
c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident;
d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work.

The licensee has failed to comply with compliance order #001 from inspection 2017_631210_0021 served on January 16, 2018 with a compliance date of July 31, 2018.

The licensee was ordered to prepare, submit and implement a plan to ensure that the staffing plan provide for a staffing mix that was consistent with residents assessed care and safety needs and that met the requirements set out in the Act and this Regulation.

The plan was to include, at a minimum, the following elements:
1. A hiring plan that ensures the home has all vacant staff positions filled and a sufficient casual/part-time staffing pool in place in six months,
2. An alternate staffing plan that ensures the home is staffed appropriately while implementing their hiring plan and that the alternate staffing plan includes education in the home's practices related to resident care,
3. A documented monitoring system to ensure that all residents within the home receive at a minimum two baths/showers twice a week by method of his/her choice when short staffed and that also includes alternate baths/shower days when not provided as per their plan of care,
4. Collaboration methods of management staff and scheduling clerk in realization of the staffing plan,

5. Conduct an evaluation of the home's staffing plan and update at least annually in accordance with evidence based practices and, if there are none, in accordance with prevailing practices,
6. Maintain a record of the annual staffing plan review.

1. A review of the compliance order to prepare, submit and implement a hiring plan that ensures the home has all vacant staff positions filled and a sufficient casual/part-time staffing pool in place within six months, the home's action plan requiring the managers to analyze their department current staffing levels in light of resident care needs, and create a modified staffing plan. All managers will implement a revised staffing plan to ensure all departments have a sufficient staffing pool to meet resident care needs. Review of the Nursing staffing plan indicated that after compliance due date, July 31, 2018, the home had not filled one RNs, three RPNs, and 11 PSWs vacancies on all three floors for all three shifts.

A review of the staffing plan for August 2018, indicated that there were still open vacancies with a total of two RNs, four RPNs and nine PSWs.

A review of a staffing plan and a summary submitted by the Administrator to Inspector #600, as of September 24, 2018, pointed out that the home still had open vacancies of one RN, two RPNs, and 11 PSWs.

A review of the staff master schedule by the end of the inspection in September 2018 confirmed that the above noted vacancies were still open.

2. Review of the home's compliance plan to develop and implement an alternate staffing plan that ensures the home is staffed appropriately while implementing their hiring plan and that the alternate staffing plan includes education in the home's practices related to resident care, indicated the home had arranged for an extra PSW staff for all shifts and provided orientation for new hires.

A review of the home's hiring records indicated that the home made multiple postings for various positions and shifts between February and July 2018.

A review of the hiring process from January 2018 to July 31, 2018, indicated that 8 PSWs and 1 RPN were hired.
- September 2018 - the home was still conducting interviews for registered staff and

PSWs.

In an interview, the Administrator confirmed that not all vacant positions had been filled even after the compliance date. Further, the Administrator indicated that the home had been posting the open vacancies, reviewed applications, conducted interviews and had hired some staff but the process had been long and moving slowly and not all of the applicants had been successful through the interviews or the orientation process.

3. Review of the home's action plan regarding the order to implement a documented monitoring system to ensure that all residents within the home receive at a minimum two baths/showers twice a week by method of his/her choice when short staffed and that it also includes alternate baths/shower days when not provided as per their plan of care.
The home was directed to develop a process for systematically tracking residents who have not had a shower on their regularly scheduled shower day and ensuring that the shower is provided to compensate for the missed one, to ensure the residents receive at minimum of two baths /showers per week.

During the inspection, the records review indicated that there was a binder on each unit titled "Daily log for missed shower or bath". A review of the four "missed shower/bath log" indicated that two of the reports were completed but the other two were not completed and did not indicate that anyone had followed up with the process.

A review of the record of the missed shower/bath log on an identified date on an identified resident home area indicated (RHA) that resident #039 had refused to be bathed. There was no rescheduled date or to-be-determined date for the missing bath/shower. The PSW flow sheet for an identified record indicated that the resident had a bath/shower on three identified dates.

A review of the record "missed bath/shower log" on an identified date, on an identified RHA and on an identified shift record indicated that resident #040 did not receive a bath or shower and there was no rescheduled date. A review of the PSWs flow sheet indicated that the resident was bathed on four identified dates in the identified month. There were no further “missed bath/ shower log” for this resident to indicate that the resident had missed any bath or shower and if it was rescheduled.

A review of the staff schedule record for the previous month, indicated that the home worked short 9 RPN shifts, and 14 PSW shifts. For an identified date, the home worked short 10.5 RPN shifts and 4 PSW shifts. All identified shifts were not replaced.

A review of the use of an agency staff record indicated that in an identified month, the home used 10 RNs, 65 RPNs, and 183 PSWs, in another identified month,15 RNs, 65 RPNs, and 176 PSWs.

From an interview with RPN #109, they indicated that when the unit is short of staff, the staff does not provide a bath or shower, but that those residents who missed their bath or shower were listed in a separate form titled "missed shower/bath log". It is expected that when the managers do their rounds, they will collect the logs and call an extra PSW to provide a bath or shower to residents that had missed their bath or shower. However, the managers would not call an extra staff if there is only one or two residents on the list. At the time when more residents are written on the list, the resident is due for the next shower.

An interview with the NM #123 indicated the home had a plan in place when the home was short of staff. The resident who did not receive a bath/shower is to be marked on the missing bath/shower log, so when the managers do rounds, they would identify which resident did not receive a bath/shower and would either call an extra PSW to provide the missed bath/shower or talk to an identified shift to provide the bath/shower. However, the NM confirmed that they did not follow up if all the residents who missed their original bath/shower had been provided with the second bath/shower. They indicated it may happen that residents may have missed their second bath/shower.

Review of residents #032, #033, and #036's daily documentation record for an identified period, indicated the residents were not bathed at a minimum twice a week.

In an interview the Administrator acknowledged that the home did not comply with the order to implement a documented monitoring system to ensure that all residents within the home received at a minimum two baths/showers twice a week by method of his/her choice when short staffed and that also includes alternate baths/shower days when not provided as per their plan of care.

4. A review of the home's action plan regarding the order to implement a collaboration method of management staff and scheduling clerk in realization of the staffing plan, indicated that the home's plan was that the scheduling clerks will be included in the planning and implementation of the revised staffing plan by revising the staffing roster and availability list to reflect the new plan and to schedule staff.

An observation on an identified date on an identified unit discovered the following: The unit was short of a registered staff. Five registered staff from other care units came to the identified floor to assist with medication administration. Each of the RPNs administered medication to six assigned residents.

As per the home's policy titled "Short staffing", number NMIIS036vv, effective from September 5, 2017, when the home is short of a registered staff, the nurse in charge should reallocate the medication administration and treatments between the remaining five registered staff from the other units. Those five units will be short of registered staff for some period of time until they finish the administering of medication on the unit that is short of registered staff.

An observation during the course of this inspection and interviews with RN #107 and RPN #108 identified the following concerns with this process:
-Each of the registered staff was taking the key from the medication room, medication cart and the box with controlled substances, and handed to the next nurse, or would leave with the nurse on an identified resident home area as a base for keeping the keys. None of the nurses were checking the narcotic box and did not count the controlled substances (Except RPN #108 who was approached by Inspector #600 who questioned the process).
-The medications were administered within an extended period of time and the residents who were to receive their medication at 0800H did not receive their medications on time or as prescribed by the physician. The inspector observed 0800H med-pass being completed at 1130H.
-There was no prioritizing considering those residents who had medication to be given only three or four times a day. The window between the two dosages was not as ordered by the physician.
-Consistency/collaboration. While RPN #108 was administering medication around 1130H, there was a warning light coming from the electronic medication administration screen, indicating

medication or treatment had not been given to the residents within the time frame for administering or had not been signed off. The RPN indicated that the treatment was to be given at 0800H but they were not sure if the nurse that was assigned to give medication to these residents had provided the treatment or not, so they were not sure whether or not they should sign off the treatments.
- A review of the e-MAR for an identified date for three residents on an identified resident home area indicated that the prescribed medications or treatment to be administered at 0800H, 1000H, 1200H, and 1400H were administered by nine different registered staff. During further review of the e-MAR it was noted that the treatments prescribed to residents to be given at 1000H were not signed off, indicating the treatments were not applied.

Review of the home's staffing plan and attendance for registered staff, indicated that besides the five registered nurses working on each unit, there were other registered staff working in the home with different roles as a nurse manager, acting nurse manager, two registered staff in MDS role, one registered staff in restorative role, and an extra RN assisting all units while the NM was acting as the I-DOC. NM #123 confirmed the number of registered staff present in the building at that time. An interview with acting scheduling clerk confirmed that besides the five registered staff working on the units, there were five registered staff working in roles as specified above and none of the registered staff were directed to go to the identified resident home area as a replacement for shortage of a nurse.

In an interview, the scheduling clerk confirmed that they were not involved in staffing plan review and not involved in the development of the compliance plan regarding staffing plan. The scheduling clerk further stated on the identified date, that they were not aware that an identified resident home area worked short of a registered staff because the nurse in charge had not communicated the sick call to them. After questioning by the inspector whether or not the scheduling clerk had made calls to fill the shortage on the identified resident home area, an agency nurse came around 1230H to the end of the shift.

An interview with I-DOC confirmed that when the home is short of registered staff, the staff is to follow the "short staffing policy" however the I-DOC acknowledged to the inspector that there was no process for prioritizing the administration of the medications for the units but the staff is to follow the pre- assigned schedule based on the residents' rooms.

The I-DOC also acknowledged that there was no collaboration between the night and day nurse with the scheduling clerk to replace the short shift on an identified unit.

A review of the home's policy titled "Short Staffing" number NMIIS036vv, effective September 5, 2017, indicated in the event when a PSW is not available to work on any given shift the nurse on unit will liaise with the nurse in charge to reallocate a PSW staff and the duties the staff are to provide to residents care and services that are essential to residents' well-being.
During the interview with PSWs #103, #139, #142, #100, and #149, the PSWs indicated when they are short of a third PSW on the resident home area, they "split" the assignments between both of them and provide the residents' care and services essential to residents' wellbeing. Further the PSWs stated the practice in the home is that when they were short of a third PSW, they sought assistance from the nurse on the resident home area to assist the PSW with providing morning care to the residents; the residents who required transfer using the mechanical lift by two staff are left in bed and have their meals in the bed; they did not provide baths to the residents on that shift; and they did not document in the Point of Care (POC) for the residents that they are not assigned.

Observations during the course of this inspection and interviews with RN #107 and RPN #110 identified the following concerns with this process:
-The residents' care and safety needs were not met. The residents had not received meals on time as they were left in the rooms and were served after the residents in the dining room had finished their meal. The staff was not always available to monitor the residents having their meal in their rooms.

On an identified date, the inspector observed resident #038 and resident #039 were not in the dining room for breakfast. During the interview, PSW #156 indicated when they were short of a third PSW, they were behind with providing care to the residents and had to leave residents who needed two staff assistance with care and transfer in bed until the PSW finished assisting the residents with meals in the dining room. Interview with RPN #154 confirmed when the unit was short of a PSW, the RPN assists the two PSWs to provide care and to transfer the residents to the dining room, and leave those residents who needed two staff assistance with the mechanical lift in bed. In an interview, RPN #110 stated the unit they were working not all residents are provided with morning care and taken to the dining room for breakfast. The residents were left in their rooms and provided with a tray, after the

breakfast in the dining room was completed.
-Risk for lack of care. An interview with resident #036 indicated, the staff who provided care to the resident when they are short of a PSW, was in a rush and the resident felt discomfort when assisted with transferring.
Further the resident stated when the staff was short of a PSW and the resident required an identified ADL, the staff would refer to the resident to use an identified product. The interview with above mentioned PSWs #103, #139, #142, #100, and #149 and #156 indicated the staff was supposed to provide care for an extra number of residents than they had routinely every day, so they had to rush as each of the residents had their own needs that needed to be met.
-Residents #032, #033 and #036 did not have baths/showers for two identified months.
-Inappropriate transfer - when the unit worked short of staff the practice in the home was the PSWs would ask a private caregiver to assist as a second person during transferring a resident using a mechanical lift, or one staff transferred a resident manually as the second staff was not around and resident could not wait. Expressed concerns of the staff included not being able to provide care to the resident according to their needs, the work overload due to increased sick calls, increased their frustration and does not promote consistency in care to the residents.

An interview with I-DOC indicated they were aware of the problem of short staffing and the home and was working on solving the issues. Further, the I-DOC stated at this time the policy gives guidelines to the registered staff and to the PSW how to deal in situations when they are short of PSWs. The I-DOC confirmed that the PSWs were to provide the essential care to the residents (which does not include baths) divided among the two PSWs.

Review of the staff schedule record for August 2018, indicated that the home worked short of 9 RPN and 14 PSW shifts. For September 2018, the home worked short of 10.5 RPN and 4 PSW shifts. All identified shifts from above were not replaced.

Review of the tool titled "Staff call in sheet - Nursing department" for August and September, indicated that the fields to be completed on the sheet included date, time, staff who called in sick, shift to be replaced, reason for calls, and person who received the call. The scheduling clerk confirmed that they do not have a tool to document when, who, how often and why they call the staff. They just go by the "Seniority list" and given availability by the staff and mark when someone accepted

the shift. The clerk stated they cannot provide a record of every sick call or shortage of staff that was attempted to be replaced.
- A review of the nursing schedule record and an interview with the scheduling clerk confirmed that for the month of August 2018, the home failed to promote continuity of care by minimizing the number of different staff who provided nursing and personal service to each resident. Instead the short shift on every unit were replaced by staff from an agency.

The I-DOC acknowledged that the nurse in charge on an identified date, had not communicated to the scheduling clerk to look for a replacement when the clerk started their work, as the staff was expected to follow the short staffing policy.

In an interview with the Administrator, they indicated that the home had revised the staffing plan and had identified problems with sick calls as a reason for the short staffing.
The home had reactivated the "Attending Management" policy and another action taken by the home to make sure the home is staffed appropriately while implementing their hiring plan included contracting four staffing agencies. The Administrator reviewed the master schedule with the inspector and confirmed that the home had not complied with the order to ensure the home had all vacant staff positions filled.

In an interview, the Administrator and the I-DOC acknowledged that the home had failed to promote the continuity of care to the residents and failed to minimize the number of different staff members who provide nursing and personal care to the residents.

Based upon the outcomes and failure to provide for staffing mix that is consistent with residents' assessed care and safety needs, failure to promote continuity of care by minimizing the number of different staff members who provide care to the residents and failure to provide care to residents as per plan of care. The severity of this issue was determined to be a level 2 as there was potential for for actual harm to the residents. The scope of this issue was a level 3 as this issue was widespread. The home had a level 4 history of on-going non-compliance with this section of the Act that included:
-Compliance order (CO) issued January 16, 2018, 2017_631210_0021)

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

(600)

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

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 : 004

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

Pursuant to / Aux termes de :

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

Order / Ordre :

(A1)
The licensee must be compliant with O. Reg 79/10, s. 33. (1).

The licensee shall prepare, submit and implement a plan to ensure that residents #032, #033, #036, and #041 and all other residents within the home receive at a minimum two baths/showers twice a week by method of his/her choice.

The plan must include, but is not limited, to the following:
a. Develop and implement a process to ensure that all residents within the home receive at a minimum two baths/showers twice a week by method of his/her choice when short staffed including reason why the bath/shower was not given, name of the person assigned to the resident who was to receive a bath/shower, and dates when the resident had alternate baths/shower,
b. Implement a weekly auditing process to ensure that residents within the home received at a minimum two (scheduled or alternate) baths/showers twice a week,
c. Maintain a written record of audits conducted. The written record must include the date, the resident's name, staff member's name, the name of the person completing the audit and the action taken from the outcome of the audit.

Please submit the written plan, inspection # 2018_462600_0015 and inspector Gordana Krstevska by email to TSAO@ontario.ca by February 1, 2019

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

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

This IP was open to inspect a complaint submitted to the MOHLTC on an identified date, with concerns regarding staff shortage affecting resident #032's care.

An interview with a complainant indicated on an identified date, when the home was short of PSW on the unit where resident #032 resided, the resident did not receive a bath or shower. Further the complainant stated that whenever the home was short of staff, the residents do not receive a bath/shower, or medication.

Review of resident #032's MDS assessment record on an identified date and a written plan of care on an identified date, indicated the resident needed an identified level of assistance for bathing by one staff twice a week, on identified days and times.

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A review of PSW's daily flow sheet indicated on an identified date resident #032 did not receive a bath or shower.

An interview with RPN #109 indicated when the resident home area is short of staff, the practice in the home was the staff do not provide baths or showers to the residents as per management approval.

An interview with RN #116 confirmed that it had been approved by management when the resident home area was short of PSW, no baths or showers are to be provided to the residents.
Those residents who missed their bath or shower were listed in a separate "missed bath log" and the manager would collect the log on their rounds. They would call an extra PSW to provide a bath or shower for those residents who had missed it. The RN further stated, however, the managers would not call an extra staff if there was only one or two residents on the list. The RN also elaborated at the time when more residents are listed on the "missed bath log", the resident is due for the next identified bath or shower.

An interview with I-DOC confirmed that when the home is short of staff, the staff used the "short staff" plan where the registered nurse on the floor direct the PSWs to prioritize the care of all residents, and make sure they provide basic care to each resident. The I- DOC acknowledged that providing bath or shower when the unit was short of PSW, was not considered priority, so the bath or showers were not given to the residents. The resident's name would be written down on the "missed bath log" and the management would try to find staff to provide a bath or shower to the resident. The I-DOC acknowledged that not every resident was bathed a minimum twice a week by the method of their choice as determined by the resident's

requirements.
(600)

2. MOHLTC received a complaint on an identified date, regarding concerns of shortage of staff affecting resident #033's and other residents' care.
Review of resident #033's MDS assessment for an identified period, specified the resident needed an identified level of assistance for self-performance indicating the resident needed physical help in part with their bathing. The assessment did not indicate how many staff were required to assist the resident.

A review of the resident's written plan of care revised on an identified date, indicated there was no bathing schedule for resident #033. Further review of the plan showed no focus, no goals, and no intervention set for the PSW to follow the directions as when and how to provide the identified ADL to the resident.

A review of the PSW documentation Flow Sheet and Observation/Flow sheet Monitoring Form for an identified period indicated a discrepancy in documentation so it was not possible to identify if the resident had been bathed twice weekly for the two identified months.

In an interview, the MDS Coordinator was not able to explain why there was a discrepancy in two documents which were to produce same data, entered by the PSWs after they document in their POC.

Interview with resident #033 indicated that before, when the unit was short of staff, they would have only one bath or shower per week, but lately, as they have their private caregiver employed by the family, the caregiver ensured they had a bath or shower twice per week.

Interview with PSW #139, indicated that the resident may have missed a bath or shower when the unit was short of staff. If the caregiver insisted they would give the bath/shower, the PSW would assist the caregiver by transferring the resident. The caregiver would provide the bath/shower and the PSW would transfer the resident back again.

The I-DOC acknowledged that the process in the home to provide alternate shower/bath to those residents that had missed the shower/bath, was not followed, as the logs were left empty, no alternate date for the shower/bath were arranged, and no registered staff on the floor, nor management had followed up if the residents had received their second shower/bath. (600)

3. MOHLTC received a complaint on an identified date, indicating shortage of staff affecting resident #036's care in the home, specifically bathing and toileting.

A review of the resident's MDS assessment on an identified date, indicated resident needed total assistance by two staff for all activities of daily living including bathing.

A review of the resident's written plan of care on an identified date, indicated that resident #036 did not have a plan for a bath, no bathing preferences were identified and no scheduled bathing or showering day was marked.

A review of PSW's flow sheet displayed in an identified months, indicated resident #036 did not receive at least two baths/showers weekly.

An interview with the SDM indicated they had to hire a private caregiver to make sure the resident received baths/showers and the resident was looked after, because the practice in the home was not to provide baths/showers when the home was short of staff. Since they had a private caregiver, the resident was having a bath/shower twice a week.

Interviews with the PSW #155 and the RN #116 confirmed that the practice in the home was when they work short of PSW, the baths/showers were not provided.

Interview with the NM #123 indicated the home had a process implemented in the home after receiving the compliance order in January 2018. When the home was short of staff, the residents who did not receive a bath had their name marked on the missed bath/shower list, so when the managers do rounds, they would check if there was a resident who did not receive a bath/shower they would either call an extra PSW to provide the missed bath/shower or talk to another shift to provide the bath/shower. However the NM confirmed that they did not follow up if all the residents who missed the bath/shower had been provided with the second bath/shower.

(665)

4. The MOHLTC received a complaint through the Action-line on an identified date, regarding care concerns related to resident #041.

In an interview, the complainant indicated resident #041 was not groomed properly. The complainant indicated this occurred when an identified home area was short staffed.

Record review of the resident's written plan of care and the RHA weekly bath/shower schedule indicated that the resident's scheduled baths/showers were on identified days. Further review of the PSW flow-sheet documentation in MED e-care indicated on an identified date, resident #041 received partial care on all shifts and received their scheduled bath/shower on an identified date.

The PSW flow-sheet did not indicate that the scheduled bath/shower on an identified date,was rescheduled.

In an interview, PSW #158 indicated resident #041 was assigned to them on an identified date. The PSW stated they arrived on an identified RHA one hour after the shift started, as the home called them to come to work as the unit was short staffed. The PSW stated that it is the home's process, when the unit is short staffed, scheduled bath/sshowers are not given to the residents.

In an interview, the I-DOC indicated scheduled bath/showers are to be provided to residents and if not provided, the bath/shower is to be rescheduled. The I-DOC reviewed the PSW flow-sheet and acknowledged that resident #041's shower was not rescheduled and they did not receive the minimum twice a week shower.

The severity of this issue was determined to be a level 2 as there was potential for actual harm to residents. The scope of the issue was a level 2 as it was a pattern. The home had a level 4 history of on-going non -compliance with this section of the Act that included:
-Voluntary plan of correction (VPC) issued December 5, 2017, (2017_631210_0021)

(600)

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

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

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

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 : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 51. (2) Every licensee of a long-term care home shall ensure that,

(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;

(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;

(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time;

(e) continence care products are not used as an alternative to providing assistance to a person to toilet;

(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes;

(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

(h) residents are provided with a range of continence care products that,

(i) are based on their individual assessed needs,

(ii) properly fit the residents,

(iii) promote resident comfort, ease of use, dignity and good skin integrity,

(iv) promote continued independence wherever possible, and

(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Order / Ordre :

The licensee must be compliant with s. 51. (2) of the LTCHA.
Specifically the licensee must:

1. ensure that residents #001, #007 and #036 and all residents who are incontinent receive an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;
2. Ensure that residents #035, #036 and all residents who are unable to toilet independently some or all of the time receive assistance from staff to manage and maintain continence;
3. Ensure resident #008 and all other residents are assessed and offered a full range of continence products and that there is availability to residents and staff at all times, and in sufficient quantities for all required changes.

Grounds / Motifs :

1. The licensee has failed to ensure that the resident who was incontinent received an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

MOHLTC received a complaint on an identified date, regarding SDM's concern of shortage of staff affecting resident #035's care.

An interview with SDM indicated that resident #035 had a cognitive deficit and was unable to make care decisions, and required the assistance of staff.
Further, the SDM shared that the resident was not aware of using a call bell to seek assistance by staff.

Review of the home policy titled "Continence Care-Bowel and Bladder" revised November 2017, number NRS-03-091, page one indicated for each resident the

RN/RPN will determine the resident's bladder and bowel function and elimination pattern, taking into consideration possible reversible causes or conditions by completing the on line Continence assessment tool located on the facility's resident documentation software. The RN/RPN will review a three day voiding/bowel patterns and continence assessment completed by the PSW to determine resident's needs, and document in resident's written plan of care: Goals of care, toileting routine as appropriate, continence products to be utilized, resident's specific needs and interventions. Reassess the resident's continence status/needs annually at minimum and PRN.

Review of resident #035's assessment record, indicated the staff had not conducted an identified assessment to determine the resident's health function. Review of the resident's clinical record indicated an identified monitoring assessment had not been completed for resident #035.

Review of the resident's MDS record on an identified date, indicated resident had a cognitive deficit, identified diagnosis and a frequent health condition and was not involved in a restorative program. An identified plan was not in place for resident #035 and they did not wear certain products.

A review of a written plan of care on an identified date, indicated the resident was an active participant with their identified tasks, but required the assistance of staff due to health care deficit. This written plan of care identified specific goals and interventions for resident #035.

An interview with PSW #139 indicated that actually the PSW does not assist resident #035 with an identified task as whenever the PSW asked resident #035 if they required assistance resident #035 will say no they are okay.

Further the PSW stated they do not know the resident's pattern as the resident performed the task them-self.

In an interview, RPN #022 indicated they were not working on the RHA when the resident was admitted, but they confirmed resident #035's record indicated that the resident had not been monitored for an identified care needs assessment on admission. The RPN stated resident #035 had not been assessed by registered staff to determine the resident's care needs using a clinically appropriate assessment

instrument.

In an interview, the I-DOC stated the home had a policy for continence assessment and the staff is expected to assess every resident admitted to the home for continence care following the policy guidance.

Based upon the outcomes and failure to provide continence assessments to the residents, failure to promote continence independence where possible and failure to ensure a full range of continence products are available to residents and staff at all times. The severity of this issue was determined to be a level 2 as there was minimal harm or potential for actual harm to the resident. The scope of the issue was a level 2 as there was a pattern. The home had a level 4 history of on-going non-compliance with this section of the Act that included:
-Written notification (WN) issued December 5, 2017, (2017_631210_0021)
-Voluntary plan of correction (VPC) issued June 23, 2016, (2016_378116_0012)

(600)

2. Resident #001's care needs was triggered during stage 1 of the RQI.

Record review resident #001's admission care plan and assessment summary on an identified date, did not have a focus note that addressed their care needs.

Record review of resident #001's assessments records in MED e-care are indicated they had not received an identified assessment when they experience a change in their health condition.

Record review of resident #001's personal support workers' flow sheet for an identified period, indicated resident #001 experience periods of an identified health condition.

Record review of resident #001's Kardex indicated there was no focus note that addressing their care needs related to this health condition.

Record review of resident #001's written plan of care dated for an identified period, indicated there was no focus note that addressed their care needs related this health

condition.

Record review of the home's policy #NRS-03-091 Continence Care -Bladder and Bowel dated November 2017, indicated the registered nurses to determine the resident's bladder and bowel function and elimination pattern, taking into consideration possible reversible causes or conditions by completing the on-line continence assessment. This policy also indicated the following:
registered staff to conduct a 3 day voiding /bowel patterns and continence assessment to determine the resident's needs, and document in the resident's plan of care; goals of care, toileting routine as appropriate, continence products(s) to be utilized, resident specific needs and interventions and to reassess the resident's continence status/needs annually at a minimum and PRN.

Interview with RPN #125 acknowledged resident #001 experience an identified health condition and wore identified protective products. RPN #125 also acknowledged an identified assessment had not been completed for resident #001 since admission or mentioned in their written plan of care since there a change in their health condition was noted.

Interview with I-DOC #107 acknowledged resident #001's care needs should have been on their written plan of care and an identified assessment should have been completed when there was a changed in resident #001's health condition and they required staff assistance.

(652)

3. During the resident quality inspection (RQI), resident #007 triggered for MDS assessment related to change in an identified health condition.

Record review indicated resident #007 was admitted to the home on an identified date; and was assessed using the home's Resident Assessment Instrument - Minimum Data Set (RAI-MDS) on an identified date. An identified assessment indicated resident #007 experienced an identified health condition.

A review of the home electronic documentation records indicated the resident did not receive an admission continence assessment using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

During separate interviews, registered staff RPN #116 and Clinical Manager (CM) #124 both verified that the resident did not receive an admission assessment using a clinically appropriate assessment instrument. RPN #116 further stated they were not working at the time of the resident's admission; but that in retrospect, they should have followed up and completed the admission assessment upon return to work.

During interviews, CM #124 and NM #123 both verified that continence assessment should be completed for all residents at admission, annually and with change in condition.

(535)

4. MOHLTC received a complaint on an identified date, indicating shortage of staff affecting resident #036's care in the home, especially an identified task.

Review of the resident's MDS record on an identified date, indicated resident #036 needed total as well as extensive assistance by two staff for identified tasks. Resident #036 was not able to attempt an identified task as they required physical support. Resident was incontinent and they were on identified medications.

A review of the resident's written plan of care on an identified date, indicated that resident #036 was identified to need assistance for an identified task. This written plan of care had identified goals and interventions for resident #036.

A review of the resident's assessment record indicated resident #036 did not have an assessment for an identified health condition.

An interview with primary PSW #155 indicate that they were providing care to resident #036 and they stated that the resident was aware when they required an identified task but the PSW do not assist the resident with the identified task and there is no specific directions.

An interview with the RN #116 indicated that the nurse in charge is to assess the resident on admission, quarterly and when the resident's condition change. When they assess the resident they also assess the resident's potential to restorative and identified function. The RN confirmed there was no indication that resident #036 had been assessed.

An interview with I-DOC indicated resident #036 identified task was to be provided as per resident's needs. They also indicated the resident was not considered for participation in the restorative program as the resident had identified behavioural symptoms, however they acknowledged that the resident was to be assessed for continence care and possible participation in restorative program.
(600)

5. The licensee has failed to ensure that the resident who was unable to toilet independently some or all of the time received assistance from staff to manage and maintain continence.

MOHLTC received a complaint on an identified date, indicating shortage of staff affecting resident #036's care in the home especially bathing and toileting.

Review of the resident's MDS record on an identified date, indicated resident #036 needed total as well as extensive assistance by two staff for identified tasks. Resident #036 was not able to attempt an identified task as they required physical support.

Review of the resident's continence assessment record indicated the resident was not assessed for an identified health condition.

A review of the resident's written plan of care on an identified date, indicated that resident #036 was identified to need assistance for an identified task. This written plan of care had identified goals and interventions for resident #036.

An interview with primary PSW #155 indicated that they were providing care to resident #036 and they stated that the resident was aware when they required an identified task
but, they do not provide this task for the resident, because the resident needed to be attended throughout the process of the identified task which required more time, and they work short most of the time. PSW stated that when the resident was in bed and required this task, they do not use any receptacle.

In an interview, the I-DOC confirmed the resident who was unable to toilet independently receive assistance from staff to manage and maintain continence. The I-DOC elaborated resident #036 has identified behavioural symptoms however, the PSW should have assisted the resident with care as set in the plan of care.
(600)

6. The licensee has failed to ensure a range of continence care products are available and accessible to residents and staff at times, and in sufficient quantities for all required changes.

During the resident quality inspection, resident #008 triggered for MDS assessment

related to change in continence status.

A review of the Prevail Resident Worksheet that listed all residents' continence status and incontinent product(s) indicated there were 17 residents who currently used family provided product; and 10 residents who currently used an alternate product including resident #008.

In an interview, RPN #109 verified that resident #008's identified diagnosis was progressing which caused an overall decline in the resident's health status, which affected the resident's continence status. The RPN stated the resident went from wearing one identified product to another during an identified time.
RPN #109 informed the inspector that the home does not have an identified product available in the range of continence care products offered to residents. The RPN further stated residents who were considered independent for an identified task; and assessed to wear the identified product were offered an alternate product in order to maintain independence.

During an interview, NM #123 verified all residents listed on the Prevail Resident Worksheet who wore an identified product were assessed as appropriately. Since the home does not provide the identified product, if the resident or family does not like what is provided by the home they will purchase the identified product in the community.

During an interview, the Prevail Continence Product representative verified the company does carry the identified product in their range of product; however for unknown reasons, the home decided not to include this product in their range of product offered to residents.

During an interview, the I-DOC verified that the home does not offer residents a full range of continence care products. The Interim DOC stated they were not sure of the reason why the
product was not offered; and verified that the home used an alternative product instead. Therefore, the home failed to ensure a range of continence care products are available and accessible to residents and staff at times, and in sufficient quantities for all required changes.

The severity of this issue was determined to be a level 2 as there was potential for

actual harm to residents.The scope of the issue was a level 2 as there was a pattern. The home had a level 4 history of on-going non-compliance with this section of the Act that included:
-Written notification (WN) issued December 5, 2017, 2017_631210_0021
-Voluntary plan of correction (VPC) issued June 23, 2016, 2016_378116_0012
(535)

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

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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 : 006

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 109. Every licensee of a long-term care home shall ensure that the home's written policy under section 29 of the Act deals with,
(a) use of physical devices;
O. Reg. 79/10, s. 109.

Order / Ordre :

The licensee must be compliant with s. 109. of the LTCHA.

Specifically the licensee must ensure:
1. That the policy to minimize the restraining of residents and that any restraining that is necessary and is done in accordance with this Act and the regulation, is complied with,
2. That the home's policy addresses types of physical devices permitted to be used.

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

Grounds / Motifs :

1. The licensee has failed to ensure that the home's policy address types of physical devices permitted to be used.

A review of the home's Restraint and PASD Policy #NMIIR008vv, with effective date September 1, 2017, listed physical restraints on the Restraint Consent form as follows: seat belt, lap tray and tilt chair.

Record review of the Resident Restraint List indicated 18 residents were using an identified device as a form of physical restraint; however the identified device was not included on the list of physical devices permitted to be used.

During an interview, PT #121 and CDM #124 both verified that the identified device have been in use for approximately three years. Therefore, the home failed to ensure that the policy address all types of physical devices permitted to be used.

The severity of this issue was determined to be level 2 as there was potential for actual harm to the residents. The scope of the issue was level 3 as it was widespread to the residents that were reviewed. The home had a level 2 compliance history as they had a previous unrelated non-compliance. (535)

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

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 : 007

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

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 O. Reg. 79/10, s. 131 (2) . The licensee must:
1) Ensure that drugs are administered to residents #041, #045, #046, #047, #048, #049, #050, #051, #052, #053 and #054 and all other residents in accordance with the directions for use specified by the prescriber.

2) Ensure that resident #041's prescribed drugs are reviewed with all registered staff including agency staff who provides direct care to the resident.

3) Develop an on-going auditing process to ensure that resident #041 receives their drugs in accordance with the directions for use specified by the prescriber. The home is required to maintain a documentation record of the audits. The audit should include the dates the audits were conducted, who performed the audits and an evaluation of the results along with action(s) taken.

4) Ensure that all registered staff including agency staff are educated on the home's process of medication administration in the electronic medication and treatment records. The home is required to maintain a record of the education, including the dates education was provided, who provided the education and the content of the education session(s) and who attended.

Grounds / Motifs :

1. The licensee has failed to ensure that drugs were administered to residents in

accordance with the directions for use specified by the prescriber.

A) The MOHLTC received a complaint through the Action-line on an identified date, regarding care concerns related to resident #041. The complainant had concerns regarding the home's medication management of resident #041's identified medical condition.

In an interview, the complainant indicated on an identified date, resident #041 experienced a change in health status. The nurse on the unit tried to give the resident a beverage while in an identified state. The complainant indicated that the nurse could not find an identified medication in the unit to administer to resident #041 and they were transferred to hospital. In addition, the complainant was also concerned that the registered staff were not administering an identified medication when the resident's condition warranted, as directed by the physician.

Record review of the clinical records of resident #041 indicated the resident had an identified diagnosis and a history of identified clinical symptoms. Review of resident #041's physician orders indicated an order for an identified medication to be administered if the resident presented with specific symptoms.
The order was located in the quarterly medication review for an identified period. The identified medication order was also in the resident's EMAR.

A review of resident #041's progress notes in MED e-care s indicated that at an identified time, RPN #136 found resident in an identified location drowsy but responded to verbal stimuli. The RPN checked resident #041's status. The RPN called RN #135 and was instructed to give a beverage to the resident and to check their status after a predetermined amount of time. The progress notes indicated that the resident was symptomatic and the RPN called RN #134 informing them of the resident and was instructed to give a beverage. The resident's substitute decision maker (SDM) was informed. The resident's status was rechecked.

RN #134 arrived in the unit, 911 was called and an identified medication was administered at an identified time to the resident. Status was improved after an identified medication was administered. Paramedics arrived at an identified time and transferred resident #041 to hospital. The resident returned to the home the same evening at an identified time.

Another progress note in MED e-care documented by RN #134 on an identified date and time indicated they observed resident #041 non responsive to verbal stimulation and symptomatic on an identified date.

In an interview, RPN #136 indicated they were not aware that resident #041 had a physician's order for an identified medication when the resident's status changes. The RPN stated they did not follow the order for the identified medication in accordance with the directions for use. The RPN indicated that the resident was transferred to hospital for assessment as the resident became unresponsive prior to the identified medication being administered.

B) Review of the physician's orders for resident #041 indicated they had an identified order at specific times.
Resident #041 had a physician's order since an identified date for the administration of an identified dosage of medication for an identified status. On an identified date, the physician changed the dosage of the identified medication for an identified status and also if the resident had eaten their meal prior to administration.

Further review of resident #041's EMARs for an identified period indicated the resident had an identified status on two occasions in two identified months and times.

Review of the progress notes in MED e-care and physician orders did not indicate documentation whether the identified dosage of the identified medication was administered with an identified status.

Review of the staffing schedules indicated the registered staff that worked at the time the status was checked during the identified months as times mentioned above were all agency nurses.

In an interview, RPN #141 who worked on identified dates, indicated that resident #041's status fluctuated and it was important to follow the orders to manage the resident's health condition. The RPN indicated that they would have documented in the EMAR and in the progress notes if they had administered the identified dosage of the identified medication for an identified status.

In interviews, NM #123 and I-DOC #107 indicated the registered staff are to follow

physician's orders. The NM and I-DOC acknowledged that resident #041's physician's orders to manage the resident's health condition were not followed as prescribed.

C) The MOHLTC received a CIS report from the home regarding medication incidents that occurred on an identified date. The CIS report indicated that ten residents in an identified RHA did not receive their 1200H medications when RPN #108 was unable to complete their shift due to an identified issue.

Record review of the home's medication incident reports indicated the ten residents involved were residents #045, #046, #047, #048, #049, #050, #051, #052, #053 and #054. The reports also indicated there were no adverse effects on the 10 residents as a result of the medication incidents.

Review of the EMARs for the 10 ten residents noted above indicated the following medications and treatments were not administered as follows:
-Resident #046, #047, #048, #049, #050, #051, #052, #053, #054 were not administered their 1200H medications.
-Resident #045 did not have their 1400H medication administered.

In an interview, RPN #110 indicated there were no adverse effects on the residents as a result of the medications and treatment not administered as prescribed.

In an interview, RPN #108 indicated they were not able to complete the 1200H medication pass and was unable to complete the rest of their shift in an identified RHA due to an identified issue. The RPN indicated they had communicated the same information to the in-charge RN and to the on call manager on an identified date.

Attempts to contact the in-charge RN who worked day shift on an unidentified date were unsuccessful.

In an interview, RPN #161 indicated they worked on an identified shift on an identified date. RPN #161 indicated RPN #108 was dealing with an identified issue, and did not receive a change of shift report from RPN #108. At 1700H during medication
administration, RPN #161 indicated they found 1200H medications in the medication cart for 10 residents and stored the medications in the discontinued medications

bucket in the
RHA's medication room. RPN #161 indicated they did not notify the in-charge RN of their discovery as the RPN believed the day in-charge RN had followed up with the situation.

In an interview, NM #123 was made aware of the medication incidents on an identified date, by RPN #108. The NM indicated the home conducted an investigation and had disciplined RPNs #108 and #161 related to the medication incidents.

In interviews, NM #123 and I-DOC #107 acknowledged that the staff failed to ensure that drugs were administered to residents #045, #046, #047, #048, #049, #050, #051, #052, #053 and #054 in accordance with the directions for use specified by the prescriber.

The severity of this issue was determined to be a level 3 as there was actual harm to resident #041. The scope of the issue was a level 1 as it was isolated to resident #041. The home had a level 3 history as they had previous written notification (similar area) of the LTCHA, O. Reg. 79/10, that included:
1) Written notification (WN) issued January 16, 2018 (2017_631210_0021);
2) Voluntary plan of correction (VPC) issued April 15, 2016 (2016_263524_0013) .

(665)

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

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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 : 008

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(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).

Order / Ordre :

The licensee must be compliant with O.Reg 79/10, s. 135. (1).
Specifically the licensee must:
1) Ensure that every medication incident involving a resident is reported to the:
A) Medical Director;
B) resident's physician;
C) substitute decision-maker (SDM).

Grounds / Motifs :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was, reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

A) During the mandatory medication IP for the RQI, the home's medication incidents

were reviewed for the quarter of an identified period, for residents #043 and #044.

Record review of the medication incident reports for resident #043 on an identified date and resident #044 on an identified date, did not have documentation whether the Medical Director was notified of the medication incidents.
B) The MOHLTC received a CIS report from the home on an identified date, for a missing and unaccounted controlled substance for resident #042 that occurred on an identified date, in an identified RHA.

A record review of resident #042's medication incident report completed on an identified date, indicated that a half tablet of an identified medication was missing from the resident's blister pack which was discovered at shift change at an identified time and date.
Further review of the medication incident report indicated that the physician and family were not notified and did not have documentation whether the Medical Director was notified of the medication incident.

In interviews, RPNs #108, #109 and #110 indicated it is the home's policy to notify the physician, the resident and or the SDM when a medication incident had occurred.

C) The MOHLTC received a CIS report from the home regarding medication incidents that occurred on an identified date. The CIS report indicated that ten residents in an identified RHA did not receive their 1200H medications when RPN #108 was unable to complete their shift.

Review of the medication incident reports for residents #045, #046, #047, #048, #049, #050, #051, #052, #053 and #054 did not have documentation whether the Medical Director was notified of the medication incidents.

In an interview, I-DOC #107 indicated it is the home's policy to notify the physician, resident and or SDM when a medication incident had occurred. The I-DOC acknowledged that the staff failed to notify the physician and substitute decision maker of the medication incident for resident #042. When asked whether the Medical Director had been notified of the medication incidents involving residents mentioned above, the I-DOC stated that the home only notifies the resident's attending physician, not the Medical Director.

2. The licensee failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions.

During the mandatory medication review of the home's medication incidents, the inspector requested documentation of the home's quarterly review of all medication incidents and adverse drug reactions that had occurred since their last review. The home was unable to provide any documentation that quarterly reviews of all medication incidents and adverse drug reactions were conducted.

In an interview, I-DOC #107 indicated they have worked in the home as a nurse manager for years and had recently become the I-DOC. The I-DOC stated that the home does not conduct quarterly reviews of their medication incidents. The I-DOC further indicated that the home reviews the medication management system of the home in the quarterly Medical Advisory committee (MAC) meetings; however, medication incidents were not reviewed in the meetings as well. When asked why the home's medication incidents were not reviewed quarterly, the I-DOC, was unable to provide an answer to the inspector.

In interviews, an identified Pharmacist #113 and Pharmacist Owner #114 indicated that medication incidents are not reviewed during the quarterly MAC meetings. The identified Pharmacist #114 indicated that the pharmacy had been the home's pharmacy provider since an identified date, and stated it was unusual for the medication incidents not to be reviewed in the MAC meetings, but did not intervene with the home's process, as they thought that the home had their own system of reviewing the medication incidents quarterly.

In an interview, Administrator #101 who has been in the home since an identified time, indicated that the home's medication incidents have not been reviewed by the home on a quarterly and annual basis. The Administrator acknowledged that the home has failed to ensure that quarterly reviews of medication incidents were conducted.

The severity of this issue was determined to be a level 1 as there was minimum risk to the residents. The scope of the issue was a level 3 widespread as it related to the residents that were reviewed. The home had a level 2 history as they had previous

non-compliance unrelated of the LTCHA, O. Reg. 79/10.
(665)

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

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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 : 009

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s.135 (1) of the O.Reg 79/10, s. 135. (3).
Specifically the licensee must:
1) Ensure that a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home.

2) Ensure that medication incidents and adverse drug reactions are reviewed in the licensee's quarterly Medical Advisory committee (MAC) meetings.

Grounds / Motifs :

1. The licensee failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions.

During the mandatory medication review of the home's medication incidents, the inspector requested documentation of the home's quarterly review of all medication incidents and adverse drug reactions that had occurred since their last review. The

home was unable to provide any documentation that quarterly reviews of all medication incidents and adverse drug reactions were conducted.

In an interview, I-DOC #107 indicated they have worked in the home as a nurse manager for 14 years and had been the I-DOC since July 2018. The I-DOC stated that the home does not conduct quarterly reviews of their medication incidents. The I-DOC further indicated that the home reviews the medication management system of the home in the quarterly Medical Advisory committee (MAC) meetings; however, medication incidents were not reviewed in the meetings as well. When asked why the home's medication incidents were not reviewed quarterly, the I-DOC, was unable to provide an answer to the inspector.

In interviews, an identified Pharmacists #113 and Pharmacist Owner #114 indicated that medication incidents are not reviewed during the quarterly MAC meetings. The identified Pharmacist #114 indicated that the pharmacy had been the home's pharmacy provider since an identified date, and stated it was unusual for the medication incidents not to be reviewed in the MAC meetings, but did not intervene with the home's process, as they thought that the home had their own system of reviewing the medication incidents quarterly.

In an interview, Administrator #101 who has been in the home since an identified time, indicated that the home's medication incidents have not been reviewed by the home on a quarterly and annual basis. The Administrator acknowledged that the home has failed to ensure that quarterly reviews of medication incidents were conducted.

The severity of this issue was determined to be a level 1 as there was minimum risk to the residents. The scope of the issue was a level 3 as it related to the residents that were reviewed. The home had a level 2 history as they had previous non-compliance unrelated of the LTCHA, O. Reg. 79/10.

(665)

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

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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 : 010

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (6) The licensee shall ensure that the information gathered under subsection (5) is analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks. O. Reg. 79/10, s. 229 (6).

Order / Ordre :

The licensee must be compliant with O.Reg 79/10, s. 229. (6). Specifically the licensee must:
1) Ensure that IPAC Lead #123 reviews the information that is gathered on every shift about the residents' infections, analyze daily samples to detect the presence of infection and reviews information at least monthly to detect trends to reduce the incidence of infections and outbreaks.

2) Develop an on-going auditing process to ensure the information that is gathered on every shift about residents' infections, is analyzed daily and reviewed at least monthly. The home is required to maintain records of the audits, the dates the audits were conducted, who performed the audits and an evaluation of the results.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

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

Grounds / Motifs :

1. 1. The licensee has failed to ensure there was a written record of the annual Infection Prevention and Control (IPAC) program evaluation kept that includes a summary of the changes made, and the date those changes were implemented.

Record review of the home's IPAC program annual evaluation dated May 22, 2018, did not capture a summary of the changes made, and the date those changes were implemented. The annual evaluation identified changes to be made such as re-education of staff related to documentation of the tuberculosis (TB) skin test results under the immunization section in the electronic documentation system called MED e-care, with a target date of June 2018; and conducting infection control audits twice per year with a target date of September 2018.

During an interview, IPAC Lead #123 verified that the annual evaluation should have included an analysis of both outbreaks which occurred within the annual evaluation period; and verified that re-education of the staff and infection control audits were not completed as of October 4, 2018.

The severity of this issue was determined to be a level 2 as there was potential for actual harm to the residents. The scope of the issue was a level 2 as it was a pattern to the residents that were reviewed. The home had a level 3 compliance history as they had previous WN (similar area) that included:
1) VPC issued October 31, 2016 (2016_378116_0012).

(535)

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

Order # / Ordre no : 011

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with O.Reg 79/10, s. 229. (4). Specifically the licensee must:
1) Ensure that urine collection hats and personal items of residents are:
a) labelled and stored appropriately in shared resident washrooms;
b) labelled and stored appropriately in residents' rooms, not in the unit shower room.

2) Ensure that RPN #108 and all registered staff who provide direct care receive education regarding hand hygiene during medication administration and the four moments of hand hygiene. The licensee is required to maintain a documentation record of the education, including the dates education was provided, who provided the education and the content of the education session(s) and who attended.

3) Ensure that resident #041 and other residents who are symptomatic for an identified diagnosis have infection prevention and control precautions implemented.

Grounds / Motifs :

1. The licensee failed to ensure that all staff participated in the implementation of the program.

A) During observations conducted identified dates at times, resident #041's shared washroom had two unlabeled clear urine collection hats on the floor.

In interviews, PSW #112 and RPN #111 indicated that the urine collection hats

should have been discarded after use for infection prevention and control.
B) During the mandatory medication administration observation on an identified date and time, RPN #108 did not perform hand hygiene in between residents during medication administration to residents #043, #044 and #045. Additionally, the RPN administered an identified medication to resident #045 without performing hand hygiene.

In an interview, RPN #108 indicated they routinely do not perform hand hygiene in between residents during medication administration. The RPN indicated that hand hygiene is to be performed prior to administering eye drops for infection control and acknowledged they did not follow the home's infection prevention and control program.

In an interview, IPAC Lead #123 indicated that staff did not participate in the implementation of the infection control and prevention program as urine collections hats are to be discarded when used and hand hygiene is to be performed in between residents during medication administration.

C) The MOHLTC received a complaint through the Action-line on an identified date regarding care concerns related to resident #041. Record review of the written plan of care for resident #041 during an identified period, indicated that resident #041 had an identified diagnosis according to the discharge notes from an identified hospital at an identified time.

Observations conducted during identified dates and times did not observe any infection prevention and control precautions for resident #041.

In an interview, RPN #109 indicated that it is the home's infection prevention and control practice for residents who have an identified diagnosis to be on contact precautions with the appropriate personal protective equipment (PPE) in the room and signage at the resident's door informing staff and visitors of the precautions. The RPN #109 indicated
they were aware that resident #041 had the identified diagnosis and had included the information in the written plan of care. When asked if the resident was put on any precautions since an identified time, the RPN said that resident #041 was not.

In an interview, IPAC Lead #123 indicated that it is the home's infection prevention

and control practice to put residents with the identified diagnosis on contact precautions. The IPAC Lead indicated that resident #041 should have been placed on contact precautions since an identified date, and the staff did not participate in the infection prevention and control program.
D) 2East-Shower room contained the following unlabelled personal items -one bottle of used body lotion -left uncapped; one bottle of used white petroleum jelly; one used tube of Poli-grip; one used bottle of Infa-zinc 15% cream. Registered staff RPN #109 verified that the above personal items should not have been left in the shower room; and that they should have been labelled and stored in the resident's room.

4West - Shower room contained the following unlabelled personal items -three used bottles of white petroleum jelly, one used bottle of solid deodorant, registered staff #150 verified that these personal items should not have been left in the shower room; and that they should have been labelled and stored in the resident's room.

During an interview, Nurse Manager #123 who was also the home's IPAC lead verified that that personal items should not be kept in the shower rooms; and that they should be labelled and stored in the resident's room. Therefore, the licensee failed to ensure staff members participated in the implementation of the infection prevention and control program.

4. The licensee has failed to ensure the information that was gathered on every shift about the residents' infections, analyzed daily to detect the presence of infection and reviewed at least monthly to detect trends for the purpose of reducing the incidence of infections and outbreaks.

MOHLTC received critical incident system (CIS) on an identified date, related to outbreak notification.

On an identified date in January, 2018, Public Health Inspector (PHI) #146 declared the home in respiratory outbreak after receiving a call from IPAC Lead #123. During an interview, the IPAC Lead verified that they became aware of a possible outbreak occurring within the home after registered staff working the day shift on two identified RHAs both received telephone calls from the local acute care hospital. The hospital called to report two residents who were transferred to hospital with respiratory symptoms were confirmed cases of an identified illness.

The inspector reviewed the critical incident report and the home's Public Health (PH) line list; and it was identified that the outbreak protocol should have been initiated two days prior, as verified during an interview with Public Health Inspector (PHI) #146.

According to PHI #146, the definition of an outbreak comes with a foot note above and beyond a normal level of burden for the unit to handle. PHI #146 reviewed their outbreak documentation related to the home's, declared outbreak, and confirmed that the first case was documented on three days prior to public health being informed; followed by three residents and two staff showing respiratory symptoms the next day. The PHI also stated on that date, the home should have been looking at initiating their outbreak protocol and contacting Public Health to discuss a possible outbreak..

During an interview, Nurse Manager and IPAC Lead #123 stated the home's definition of a suspected outbreak included two units with at least three residents experiencing respiratory symptoms. The NM verified that there were three residents experiencing respiratory symptoms; and there were another four residents experiencing symptoms for a total of seven residents on multiple units; and therefore, the charge nurse in the building should have suspected an outbreak; and contacted the Manager on call to report their concern, which would have initiated the outbreak protocol and prompted a call to public health to discuss a possible outbreak. NM #123 acknowledged during the interview, that a gap was identified in the Outbreak Protocol process since registered staff working day shifts and evening shifts does not have direct communication with each other to discuss challenges or opportunities occurring on their units; and verified that the night nurse in charge was expected to make rounds on all units to identify concerns and safety issues.

NM #123 also verified that the home does not review the information gathered about residents' infections at least monthly to detect trends for the purpose of reducing the incidence of infections and outbreaks; however the IPAC committee meets quarterly to review infection statistics.

During an interview, the nurse manager on call/current I-DOC, was scheduled the weekend of the outbreak; and verified they did not receive a call from the charge nurse related to concerns of residents and staff experiencing respiratory infection.

During an interview, the I- DOC stated that the home's practice was never to declare an outbreak over the week-end. However, if the charge nurse in the building noticed a trend of two or more residents experiencing one or more respiratory symptoms they should have alerted the manager on call to discuss a possible outbreak. The I-DOC further stated that it was the night charge nurses' responsibility to make rounds by visiting all units; overseeing the facility for all safety issues; and identify and analyze the information gathered for possible trends. However, management does not hold charge nurses accountable related to this practice. These rounds were not completed on a regular basis.

Therefore, the home did not use the information gathered on every shift about the residents' infections, and analyzed the information to detect the presence of infection and trends for the purpose of reducing the incidence of infections and outbreaks.

The severity of this issue was determined to be a level 2 as there was potential for actual harm to the residents. The scope of the issue was a level 2 as it was a pattern to the residents that were reviewed. The home had a level 4 compliance history as they had ongoing non-compliance with a voluntary plan of correction (VPC) that included:
1) VPC issued October 31, 2016 (2016_378116_0012).

(665)

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

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:

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

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

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

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 31st day of January, 2019 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by NATALIE MOLIN (652) - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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