Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 17, 2019	2019_703625_0016	002695-19, 002696-19	Follow up

Licensee/Titulaire de permis

CVH (No. 9) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)
766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

Southbridge Pinewood
2625 Walsh Street East THUNDER BAY ON P7E 2E5

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

KATHERINE BARCA (625)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): July 22 to 26, July 29 to 31, 2019; August 1, 7, 8, 12 and 14, 2019.

The following intakes were inspected during this Follow-up inspection:
- log #002695-19, related to compliance order (CO) #001 from inspection #2018_703625_0026 issued pursuant to the Long-Term Care Homes Act (LTCHA), 2007, c.8, s. 6. (1) (c); and
- log #002696-10, related to CO #002 from inspection #2018_703625_0026 issued pursuant to the LTCHA, 2007, c.8, s. 19. (1).

Non-compliance identified in concurrent Critical Incident System (CIS) inspection #2019_703625_0015 has been issued in this Follow-up inspection report #2019_703625_0016:
- a Written Notification (WN) and CO related to the LTCHA, 2007, c.8, s. 6. (1) (c);
- a WN and CO related to Ontario Regulation (O. Reg.) 79/10, s. 8. (1) (b); and
- a WN and Voluntary Plan of Correction (VPC) related to O. Reg. 79/10, s. 131. (2).

During the course of the inspection, the inspector(s) spoke with residents, residents' family members, Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), a Physiotherapy Assistant (PTA), Physiotherapists (PTs), the Dietary Manager, an Associate Director of Care (ADOC), the Director of Nursing (DOC) and the Executive Director (ED).

The Inspector also conducted daily tours of the home, observed the care and services provided to residents, and observed interactions between and among staff and residents. The Inspector reviewed records including, but not limited to, residents' health care records; home's programs, policies, protocols and guides related to falls prevention and management, skin and wound care and pain management; staff schedules; CIS reports; and an internal incident report.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Pain
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

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

- **4 WN(s)**
- **2 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #002	2018_703625_0026	625

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for resident #003 that set out clear directions to staff and others who provided direct care to the resident, with respect to the administration of analgesic medication prn (pro re nata, or as required).

CO #001 was issued in inspection report #2018_703625_0026, with an amended compliance due date of May 31, 2019. The order was issued pursuant to s. 6. (1) (c) of the LTCHA, 2007, and required the licensee to review and update, as required, resident #003's written plan of care to ensure the written plan set out clear directions to staff and others who provided direct care to the resident.

Inspector #625 reviewed resident #003's health care record including Digital Prescriber's Orders entries dated:
- a date in the spring of 2019, to change the analgesic to a specific dose range by mouth, administered at a specific frequency, as needed. The corresponding Clinical Indicator section included a note dated four days later referring to a resolved illness; and
- a second date in the spring of 2019, to change the analgesic to a specific dose by mouth, administered at a specific frequency, as needed. The corresponding Clinical Indicator identified the specific cause of the illness.

The Inspector reviewed the electronic Medication Administration Record (eMAR) entries for a month in 2019, which corresponded to the orders and noted that the entries for the prn analgesic identified two pain assessments were to be completed when the medication was administered, but did not identify the indication for administration, instead directing administration "as needed for indicated diagnosis". The prn analgesic administration was documented on a date in the spring of 2019, when the analgesic was administered at a specific time and was noted to be ineffective.

Corresponding eMAR administration notes identified the analgesic was administered on a date in the spring of 2019, at a specific time, for a particular reason and was ineffective as the resident continued to exhibit a specific characteristic.

The Inspector reviewed the format of medical directives ordered in the home with a focus on the analgesic and noted the Admission and Yearly Medical Directives listed the name of the analgesic, the dose, the route of administration and for what indication it could be administered. The Inspector noted the medical directive indicated the reason or criteria

for which the prn administration would occur.

During an interview with RPN #120, they identified that the first order for the analgesic on a date in the spring of 2019, was ordered for a specific reason, that the eMAR listed the analgesic as ineffective, the progress notes indicated it was administered for a particular reason, and the eMAR entry referred to the required completion of a pain assessment. The RPN stated that, if writing the order, it needed to be written with the indication for use as the home's medical directive orders were. The RPN stated the medical directives listed the analgesic for two different reasons, it was listed for either and when it was administered by staff, they were required to write what it was given for. The RPN stated the order was not clear if it was ordered for one indication, or if it was ordered for another indication, if it listed "as needed for indicated diagnosis".

During an interview with the DOC, they stated that, although the entry on the eMAR listed a pain assessment was required for the prn analgesic administration, it had been administered for another reason on a date in the spring of 2019. The DOC identified that it was not clear from the most recent order if the analgesic was to be used for one indication, for another indication, or for both. [s. 6. (1) (c)]

2. The licensee has failed to ensure there was a written plan of care for resident #001 that set out clear directions to staff and others who provided direct care to the resident, with respect to a specific topical drug to be administered to the resident, and the indication for use for administration of a second topical drug to the resident.

CO #001 was issued in inspection report #2018_703625_0026, with an amended compliance due date of May 31, 2019. The order was issued pursuant to s. 6. (1) (c) of the LTCHA, 2007, and required the licensee to review and update, as required, resident #001's written plan of care to ensure the written plan set out clear direction to staff and others who provided direct care to the resident.

(a) Inspector #625 reviewed the home's policy titled "Skin and Wound Program: Wound Care Management – RC-23-01-02", last updated February 2017, that defined plan of care as a clinician driven plan that focused on a specific health concern or closely related concerns. The policy detailed that the plan of care consisted of a series of documents developed collaboratively that provided information to the care team regarding the assessed needs, delivered care and outcomes of care.

Inspector #625 reviewed the home's policy titled "Management of Skin Rashes, Lesion

and Irritations – Appendix 9", last updated February 2017, which identified that nurses were to obtain orders for topical applications, such as treatment creams, and enter treatment orders on the Treatment Administration Record (TAR).

Inspector #625 reviewed resident #001's health care record, including their electronic Treatment Administration Records (eTARs) for two months in 2019, which listed a "COMPOUNDED TOPICAL PREPARATION" was to be applied to an area of the resident's body at a specific frequency, at specific times, for an "indicated diagnosis", until a condition resolved. The eTARs did not list what the compounded topical preparation was.

The Inspector reviewed resident #001's prescriber's orders for the "compounded topical preparation" and noted the orders were for specific compounded topical drugs, of specific strengths, to be applied to an area of the resident's body until a condition was resolved.

During an interview with PSW #121, at 1101 hours, they stated that they had provided care to resident #001 that morning but had not applied the topical drug to any area of the resident's body, as they didn't know that it had to be put on. The PSW stated they hadn't provided care to the resident recently, didn't know about the topical drug, and the RPN didn't say that it had to be put on.

During an interview with PSW #122, they stated that new staff coming on would need to look on the care carts to see what topical drugs they were to apply that day as they were not written down anywhere for the PSWs to apply. The PSW stated that some RPNs verbally delegated their application.

During an interview with PSW #123, they stated that they knew resident #001 had a topical drug to be applied because they were familiar with the resident as they worked on that home area. The PSW stated that PSWs would know a topical drug was to be applied because they would find it on the care cart and the RPNs may tell them. The PSW stated that the RPN on that day worked at a specific frequency and wouldn't know, but that it would be nice if the topical drugs were written somewhere for people to know, for casual people especially, so they knew what they were supposed to put on.

During an interview with RPN #124, they checked the eTAR for resident #001 and stated it was not clear what was to be applied as it listed a compound and they couldn't tell what the topical was from the eTAR. The RPN stated they would not have enough time in the morning to go through the eTARs for 32 residents to find out what they had to delegate to

each PSW. They stated that they thought the PSWs would know the residents better than the RPN would, so the PSWs would know if something had to be applied.

During an interview with RPN #120, they stated that it was not safe for resident #001 to have the topical drug for a specific area of their body listed as a "compound" and not specifically named.

During an interview with ADOC #102, they stated that staff wouldn't know what was to be applied other than a compounded topical drug and, if pharmacy had sent the incorrect topical drug, staff would not know if was incorrect based on the eTARs' directions. The ADOC stated PSWs would know they were to apply topical drugs as RPNs were expected to go through the eTAR and delegate verbally to the PSWs. They stated that the plan of care was not clear as to which topical drug was to be applied to resident #001.

During an interview with the DOC, they identified that staff should have addressed the entry by pharmacy for the "COMPOUNDED TOPICAL PREPARATION" on the eTAR by contacting the pharmacy to update the entry to the specific topical drug to be applied.

(b) Inspector #625 reviewed the home's policy titled "Management of Skin Rashes, Lesion and Irritations – Appendix 9", last updated February 2017, which identified nurses were to initiate/update the resident care plan to reflect altered skin integrity, including the characteristic of the rash/lesion/irritation, current goals and interventions.

Inspector #625 reviewed resident #001's health care record including the eTARs for two months in 2019, which listed entries for a specific type and strength of topical drug "Apply to [a particular part of the body] topically as needed for indicated diagnosis [at a specific frequency]" started on a date in the summer of 2019. The Inspector noted the specific topical had been documented as administered during those months, on a specific date in the summer of 2019.

The corresponding eTAR medication administration note identified the topical drug was applied for particular characteristics, by RPN #120, and was effective as the body part it had been applied to exhibited less of one characteristic for which it had been applied.

The Inspector reviewed resident #001's current care plan and was not able to locate a focus related to altered skin integrity or the potential for altered skin integrity.

The Inspector reviewed orders related to the eTAR entries to determine what the "indicated diagnosis" for the topical drug application was. On a date in the summer of 2018, and a date in the summer of 2019, the orders for the topical drug listed in the Physician Medication Reviews were to "Apply to [a particular part of the body at a specific frequency] as needed", and did not identify what the topical drug was to be applied for. On another date in the summer of 2018, a Digital Prescriber's Orders entry listed the topical drug to applied to an affected area of the resident's body at a specific frequency until clear, and the Clinical Indicator section identified specific characteristics and a specific condition.

During an interview with RPN #120 in the summer of 2019, they were not able to identify what the "indicated diagnosis" was for which the eTAR directed staff to apply the topical drug, although they had applied the topical to a particular part of the resident's body on a date in the summer of 2019. The RPN reviewed the resident's chart and identified the resident's physical, dated the spring of 2018, listed "There are [areas of altered skin integrity of specific characteristics to a particular part of the resident's body] consistent with [a specific condition]"; and an order dated the spring of 2019, which noted that the specific condition was clear and the topical drug was changed to an as needed basis. [s. 6. (1) (c)]

3. The licensee has failed to ensure there was a written plan of care for resident #001 that set out clear directions to staff and others who provided direct care to the resident, with respect to their individualized toileting schedule.

CO #001 was issued in inspection report #2018_703625_0026, with an amended compliance due date of May 31, 2019. The order was issued pursuant to s. 6. (1) (c) of the LTCHA, 2007, and required the licensee to review and update, as required, resident #001's written plan of care to ensure the written plan set out clear directions to staff and others who provided direct care to the resident.

During an observation of resident #001, Inspector #625 observed a sign of incontinence.

Inspector #625 reviewed resident #001's current care plan that listed the resident was incontinent at a specific frequency and was to be toileted according to the "resident's individualized schedule ([resident] will usually show non verbal signs that [they require] toileting [and identified the signs the resident would exhibit])". The care plan did not list an individualized schedule for toileting the resident.

The Inspector also reviewed the resident's most recent Continence Assessment dated the spring of 2019, which did not identify the resident's particular elimination pattern as incontinent, which was a listed option. The assessment did include two comments listed elsewhere which identified the resident was incontinent at a particular frequency, as well as identified the resident was incontinent in another location. The assessment also identified the resident was toileted at distinct times and when a particular sign was exhibited.

During an interview with PSW #122, they stated that they toileted resident #001 when they started to act in a certain way, and the resident usually engaged in elimination at specific times. During a subsequent interview, the PSW stated that, with respect to a particular type of elimination, the resident was toileted at additional distinct times. The PSW identified that, in addition to the times the resident was toileted, they were also toileted when they exhibited certain signs.

During an interview with PSW #124, they acknowledged that resident #001's care plan listed the resident had an individualized toileting schedule related to a particular type of incontinence. The PSW stated that resident #001 was not toileted on a schedule, but when they started to act in a certain way the staff would know the resident had to engage in elimination. The PSW stated that the resident usually engaged in a particular type of elimination at distinct times, but there was no set schedule to toilet the resident, toileting was just based on how the resident acted. During a subsequent interview, the PSW stated the resident was toileted for a particular type of incontinence at additional distinct times. The PSW acknowledged the resident's care plan did not identify the individualized toileting schedule the resident was on. The PSW stated they would tell new staff working with the resident about the times the resident had to be toileted, as the documents the PSWs referred to did not identify the individualized schedule for toileting resident #001 for a particular type of elimination.

During an interview with ADOC #102, they stated that, when they read the care plan, they interpreted it to mean the resident was toileted when they exhibited certain signs, but not at specific times although "individualized schedule" was referenced in the care plan. The ADOC reviewed the Continence Assessment completed in the spring of 2019, that identified the resident was toileted daily at distinct times and when a specific sign was exhibited. The ADOC identified that toileting the resident at the distinct times for a particular elimination need was not identified in the care plan, and that the care plan and the Continence Assessment should have been consistent. [s. 6. (1) (c)]

4. The licensee has failed to ensure that there was a written plan of care for resident #002 that set out clear directions to staff and others who provided direct care to the resident, with respect to antibiotic use.

CO #002 was issued in inspection report #2018_703625_0026, with an amended compliance due date of May 31, 2019. The order was issued pursuant to s. 19. (1) of the LTCHA, 2007, and required the licensee to ensure that all residents who required treatment, care, services and assistance for health, safety or well-being, were provided with the treatment, care, services and assistance required, with a focus on skin and wound care.

Inspector #625 reviewed resident #002's care plan, with a focus on skin and wound care, with a review date in the winter of 2019, and a review date in the spring of 2019. The Inspector also reviewed the resident's current care plan. The Inspector noted that each care plan contained a focus related to a skin disease diagnosis, a goal related to the diagnosis to "Improve skin integrity optimally (antibiotic for [a specific period of time])". The corresponding interventions in the first two care plans directed staff to refer to the eMAR for antibiotic orders. The corresponding interventions in the current care plan directed staff to refer to the eMAR for orders.

Inspector #625 reviewed the eMARs in place from dates in the winter to summer of 2019, and was not able to locate an antibiotic ordered for the specific period of time related to resident #002's skin disease diagnosis, or any other current medication ordered related to the skin disease diagnosis.

During an interview with the DOC, they stated that resident #002's care plan which listed "antibiotic for [a specific period of time]" had not been revised to correspond to their eMAR for a month in the summer of 2019, which did not list the resident on an antibiotic for the specific period of time. The DOC identified the order [for an antibiotic for a specific period of time related to the skin disease diagnosis] had been entered in a month in 2018. The DOC also indicated that the current care plan's reference to the eMAR for orders related to the skin disease diagnosis had not been revised to correspond to the current eMAR, which did not list a current medication ordered to which the care plan would refer. [s. 6. (1) (c)]

5. The licensee has failed to ensure that there was a written plan of care for resident #004 that set out clear directions to staff and others who provided direct care to the resident, with respect to their use of a continence device, the position of their bed rails,

their transfer status, and their use of mobility aids.

A CIS report was submitted for a fall experienced by resident #004 in the spring of 2019, where the resident was taken to hospital and which resulted in a significant change in the resident's health condition. The report identified the resident had returned to the home on a date later in the spring of 2019, and the resident's care plan would continue to be revised as the resident recuperated.

(a) The CIS report identified that, upon return from hospital, the resident had a temporary continence device in place.

Inspector #625 reviewed resident #004's health care record including:
- the current care plan in place on a date in the summer of 2019, which identified that the resident had "returned home from hospital with a [particular continence device]. No date set for removal at this time". In the specific incontinence focus, the care plan listed "Check resident [at a specific frequency for a sign of incontinence] or need to use the toilet" as well as "Resident…has a [particular continence device]";
- a Digital Prescriber's Orders entry dated the summer of 2019, to discontinue use of the continence device; and
- a progress note dated the same date as the order, that identified "POA aware of [the continence device] being removed".

During observations of resident #004 throughout the inspection, Inspector #625 did not observe the particular continence device in use, but observed staff assist the resident to use the bathroom when the resident stated they had to be toileted.

During an interview with PSW #125, they stated that resident #004 had previously used the continence device but currently used the toilet.

During an interview with the DOC, they acknowledged that resident #004's health care record included an order to discontinue the use of the continence device on a specific date in the summer of 2019, a progress note identified the continence device was removed on that date, and a care plan which continued to identify that the resident used the continence device.

(b) The CIS report identified that, upon return from hospital, the resident required assistance with bed mobility.

Inspector #625 observed resident #004 laying in bed, sitting in bed, changing positions in bed, sitting on the edge of the bed and transferring out of bed. During each of the activities, one of the resident's bed rails was in one position and another was in a different position.

During one occasion, the Inspector observed the resident laying in bed, grab on to a family member's arms and pull themselves to a sitting position. On a second occasion the Inspector observed resident #004 attempt to stand with assistance after laying down in bed. The resident rocked back to a seated position, then stood on the second attempt, without using the bed rail or their mobility aid to assist with the transfer.

During an interview with PSW #126, they stated that they had helped resident #004 get up from bed that date. The PSW stated they put the resident's mobility aid in front of them, supported the resident and then the resident stood up by themself.

During an interview with PSW #125, they stated that resident #004's two bed rails had both been in the same position after they returned from hospital as the resident needed to use the bed rails more in bed, and required staff assistance for care and transfers. The PSW stated that the one bed rail was then moved to another position when the resident started transferring out of bed more, such as to use the bathroom. The PSW stated the resident used that bed rail, the bed rail closest to the bathroom, to grab on to when they transferred out of bed, but the other bed rail had always been in the same position because the resident did not exit that side of the bed.

Inspector #625 reviewed a current "Bedrail and Entrapment Risk Assessment" dated the summer of 2019, and a "Least Restraint - Personal Assistance Service Device (PASD) Assessment" also dated the summer of 2019. Neither assessment identified the position of the bed rails or that the resident used a bed rail to assist with transferring out of bed.

Inspector #625 reviewed resident #004's current care plan which identified, under the personal assistance services devices (PASDs) focus, that the resident used bed rails to assist with positioning and to offer comfort. The intervention for bed rail use identified the resident used the bed rails for bed mobility and positioning, and had been initiated, created and revised on a date in the spring of 2018, more than one year prior to the date of the fall that resulted in injuries to the resident, in the spring of 2019. The transfer and the bed mobility foci sections of the care plan did not list the use of bed rails as interventions.

In March 2019, a LTCHomes.net Memo to the Sector from the Long-Term Care Homes Division related to bed rail use identified documents to be used to determine compliance with bed rails, including the document titled "Clinical Guidance For the Assessment and Implementation of Bed Rails In Hospitals, Long Term Care Facilities, and Home Care Settings, April 2003". The document indicates:
- The intended purpose of bed rails includes assisting patients with movement (moving within the bed; getting in and out of bed), to provide a feeling of comfort and security, etc.
- Decisions to use or to discontinue the use of a bed rail should be made in the context of an individualized patient assessment using an interdisciplinary team approach.
- Regardless of the purpose for which bed rails are being used or considered, a decision to utilize or remove those in current use should occur within the framework of an individual patient assessment.
- The individualized patient assessment provides ongoing information necessary to develop a care plan, to provide the appropriate care and services for each patient, and to modify the care plan and care/services based on the patient's status. Assessment considerations include the appropriateness of the bed such as support for turning and strategy for safe egress.
- Use of bed rails should be based on a patient's assessed medical needs and should be documented clearly and approved by the interdisciplinary team. Bed rail use for treatment of a medical symptom or condition should be accompanied by a care plan designed for that symptom or condition. Bed rail use for a patient's mobility and/or transferring, for example turning and positioning within the bed and providing a hand-hold for getting into or out of bed, should be accompanied by a care plan.
- Care plan considerations include diagnoses, symptoms, conditions, and/or behavioral symptoms for which the use of a bed rail is being considered.
- The team should review the care plan and determine its effects on the patient through an ongoing cycle of evaluation that includes assessment of outcomes.

During an interview with ADOC #102, they confirmed one of resident #004's bed rails was in one position and another bed rail was in another position. The ADOC identified that, if the positioning of the resident's bed rails had changed, none of the home's care plans were that specific and, as bedrails were a personal assistance services device (PASD), their use was not meant to be that specific. The ADOC stated the bed rails were used for positioning and comfort, staff used them whatever way they needed to as appropriate for care for the resident that day. The ADOC indicated that staff had the discretion to place the bed rails in whatever position they felt was appropriate based on the resident's need.

(c) The CIS report identified that, upon return from hospital, resident #004 required the assistance of more than one person to transfer using an assistive device.

On multiple occasions throughout the inspection, Inspector #625 observed resident #004 transfer without using the assistive device, with the assistance of one person.

A review of resident #004's current care plan as of a date in the summer of 2019, identified, under the transfer focus, the resident required a particular level of assistance from staff, who were to provide physical assistance (specific physical assistance, or use of a specific device as needed when the resident exhibited a specific characteristic). The falls risk focus identified the resident's transfer/lift status had been reviewed and changed as required, including their transfer logo which had been updated to a specific device.

Following interviews with staff regarding resident #004's care plan, the Inspector noted that the current care plan identified, under the transfer focus, that the resident required a particular range of assistance of one staff member and their assistive device was to be used in a particular manner. The falls risk focus continued to indicate that the resident's transfer/lift status had been reviewed and changed as required, including their transfer logo updated to a specific device.

During an interview with PSW #126, they stated that, to transfer resident #004, they assisted the resident to get up from bed, supported the resident, used the resident's mobility aid in a particular manner and the resident then stood up by themself. The PSW identified that they had asked other staff how resident #004 transferred because the transfer logo on the resident's wall identified the resident used a specific device, however when the PSW asked other staff about the resident's transfer status, the staff informed them that the resident no longer used the device, they could transfer by themself.

During an interview with PSW #114, they stated that resident #004 was independent with transfers as long as staff watched the resident, even from a few feet away.

During an interview with the DOC, they acknowledged that the plan of care was not clear regarding resident #004's transfer status.

(d) The CIS report identified that, upon return from hospital, resident #004 mobilized using a mobility aid but had previously used a different mobility aid.

On multiple occasions during the inspection, Inspector #625 observed resident #004

mobilize using one mobility aid. The Inspector did not observe the resident use the second mobility aid at any time during the inspection, although one was located in the resident's room.

The Inspector reviewed resident #004's health care record including a progress note dated the summer of 2019, which identified the resident utilized one mobility aid for mobility that evening; a PT progress note dated two days later, which identified the resident had been mobilizing [in a manner which corresponded to the use of one mobility aid] to all meals with supervision; and Pain Assessment generated notes which indicated the resident was mobilizing in a manner that corresponded to the use of one mobility aid and/or using that one aid on multiple dates in the summer of 2019.

A review of resident #004's current care plan, under the locomotion on/off unit and in room focus, identified the goal that the resident would be able to mobilize in a particular manner on/off the unit safely using one mobility aid within the next quarter. The associated interventions identified the resident used a second mobility aid for mobility due to a injury and would mobilize in a particular manner using the second mobility aid at times, as well as would move with assistance. The interventions did not identify the resident used the first mobility aid to mobilize in a particular manner, although the corresponding goal was related to the use of the first mobility aid.

During an interview with PSW #126, they stated that the resident used the first mobility aid to transfer and to mobilize and did not know if the resident used the second mobility aid that was present in their room.

During an interview with PSW #125, they stated resident #004 used the first mobility aid to mobilize in a particular manner on the unit, as well as had mobilized in that manner outside with the first mobility aid at the time of the interview, to engage in an activity with a family member. The PSW stated they did not know what the resident used the second mobility aid for.

During an interview with PSW #114, they stated that resident #004 used the first mobility aid, including to mobilize in a particular manner to specific activities, had been mobilizing well, and the second mobility aid was going to be returned as they no longer needed it. The PSW stated the resident was independent with mobility in a particular manner, as long as staff watched, even from a few feet away. The PSW stated that resident #004 had been using the first mobility aid for weeks before the interview, including to mobilize in a particular manner to supper the last few days, and acknowledged the care plan in

place during that time did not identify the resident used the first mobility aid and no longer used the second mobility aid.

During an interview with PT #115, they identified that resident #004 had been mobilizing in a particular manner with the first mobility aid at the time resident #004's care plan identified they used a second mobility aid for mobility. The PT stated the resident may have used the second mobility aid if they were tired in the evening or complained of pain. The PT stated they had contacted the resident's family and told them the resident should use the second mobility aid for certain distances, if they take the resident out, but they could return the second mobility aid they had obtained for the resident.

During an interview with the DOC, they acknowledged that resident #004's care plan identified they used the second mobility aid for mobility and did not identify the resident used the first mobility aid [although the goal corresponding to use of the second mobility aid referred to safe use of the first mobility aid]. [s. 6. (1) (c)]

6. The licensee has failed to ensure that there was a written plan of care for resident #004 that set out clear directions to staff and others who provided direct care to the resident, with respect to the frequency of administration of one analgesic drug, the frequency of administration of another analgesic drug, and the frequency of completion of pain assessments.

A CIS report was submitted for a fall experienced by resident #004, in the spring of 2019, where the resident was taken to hospital and which resulted in a significant change in the resident's health condition. The report identified the resident sustained injuries and returned to the home on a date later in the spring of 2019.

(a) Inspector #625 reviewed resident #004's health care record including a Digital Prescriber's Orders entry dated the spring of 2019, which ordered a change in the dose of an analgesic to a specific dose, administered by a specific route, at a specific frequency, in a particular circumstance; and to start the analgesic of a specific dose, administered by a specific route, at a specific frequency, as needed.

A review of the 2019 eMAR for one month identified two corresponding entries for the analgesic with start dates identified as the date after the orders were written:
- one entry identified the analgesic was to be given at specific times between certain hours, and directed staff to use the as needed medication at night; and
- the other entry identified administration of the analgesic of a specific dose, by a specific

route, at a specific frequency, as needed, for an "indicated diagnosis [also has reg dose]".

The Inspector noted the frequency of the analgesic administration ordered was not the same as the frequency of analgesic administration listed on the eMAR.

During an interview with the DOC, they stated that the Physician's order for the analgesic, and the corresponding eMAR entry, were not clear as they did not provide staff with the same directions for administration. The DOC indicated they expected to see the analgesic listed on the eMAR for administration at the ordered frequency, with staff documentation if the analgesic was not administered at those times due to the resident sleeping.

(b) Inspector #625 reviewed resident #004's health care record including Digital Prescriber's Orders entries dated the spring of 2019, which ordered another analgesic, of a specific dose, administered by a specific route, at a specific frequency, in a specific circumstance, as well as that analgesic of a specific dose, administered by a specific route, at a specific frequency, as needed.

A review of the eMARs identified two entries that corresponded with the start date of the analgesic orders listed as:
- give a specific dose, by a specific route, at a specific frequency for indicated diagnosis in a specific circumstance "[also has prn]" scheduled between certain hours; and
- give a specific dose, by a specific route, at a specific frequency, "as needed for indicated diagnosis ... [also has regular dose]"

The Inspector noted the frequency of analgesic administration ordered was not the same as the frequency of analgesic administration listed on the eMAR.

During an interview with the DOC, they stated that the Physician's order for the analgesic and the corresponding eMAR entry for the order were not clear as to whether the analgesic was ordered for scheduled administration at the specific frequency listed in the order, or if it was to be administered for the number of times listed on the eMAR.

(c) Inspector #625 reviewed resident #004's health care record including orders in place at the time of the resident's return from hospital listed on an Order Summary Report signed by the Physician in the spring of 2019. The report included an entry for staff to "Complete Pain Flow Record 'Pain/Palliation-Pain Flow (LPQRSTU)(SPN)' x 72 hours as

per pain management policy [at a specified frequency] for 3 Days until finished". The order was identified as an active order which was ordered and started on a date in the winter of 2019, ended three days later in the winter of 2019, and was renewed by the Physician on a date in the spring of 2019.

Inspector #625 reviewed components of the home's pain management program including a policy titled "Pain Identification and Management-RC-19-01-01", last updated November 2018, and a protocol titled "Pain Management-RC-19-01-01", revised June 5, 2019. Both documents identified that staff were to complete pain assessments for specific indications for 72 hours on the day and evening shifts only. The documents did not indicate pain assessments were required at the frequency identified in the Order Summary Report for the 72 hour period.

During an interview with RPN #127, they stated that the direction to complete pain assessments at the frequency specified in the Order Summary Report for 72 hours differed from the policy, which directed staff to complete the pain assessments for 72 hours on the day and evening shifts.

During an interview with ADOC #102, they stated that multiple components of the home's pain management program identified that pain assessments were to be completed for 72 hours on the day and evening shifts when specific criteria were met. The ADOC stated staff would only complete a pain assessment on the night shift if a resident was awake or prn pain medication was administered on the night shift. During a subsequent interview with the ADOC, they stated that the order entered in the winter of 2019, had been entered incorrectly as it was supposed to be in place for three days and then "drop off", but that it was still active under the orders tab.

During an interview with the DOC, they stated that staff were required to complete pain assessments for 72 hours on the day and evening shifts. The DOC stated staff only completed pain assessment at night if a resident was awake. The DOC stated they would look into whether the staff were required to complete the pain assessments at the frequency specified in the Order Summary Report for 72 hours after the Physician renewed the order, which had been originally initiated in the winter of 2019, to end three days later in the winter of 2019, as it was not clear. During a subsequent meeting with the DOC, they stated that the Order Summary Report would not have been clear to either RN #128 or RN #129, who had processed the order, if they were to complete the pain assessment at the frequency specified in the Order Summary Report for 72 hours as it was renewed as an order, or if it was completed on a date in the winter of 2019, as the

end date listed. [s. 6. (1) (c)]

7. The licensee has failed to ensure that there was a written plan of care for resident #005 that set out clear directions to staff and others who provided direct care to the resident, with respect to the use of a medical device, the use of a second medical device and the resident's mobility.

A CIS report was submitted for a fall experienced by resident #005, in the summer of 2019, where the resident was taken to hospital and which resulted in a significant change in the resident's health condition.

(a) The CIS report identified that the resident had sustained an injury and required the use of a medical device.

Inspector #625 observed resident #005 with the medical device in use in the summer of 2019.

During an interview with resident #005, in the summer of 2019, they stated they had a medical appointment the following date, when the Physician would see if their injury was resolved and the medical device could be removed.

Two days after the interview with the resident, the Inspector observed the medical device was no longer in place, but a temporary treatment was in use. Later that date, the Inspector observed the resident with a second medical device in use.

During an interview with resident #005 and their family member #119, on the same date as the Inspector's observation of the second medical device, the family member stated they had just returned from attending an appointment for the second medical device with resident #005.

Inspector #625 reviewed resident #005's health care record including an eMAR entry directing staff to monitor and document specific criteria every shift while the resident had the first medical device in place. The Inspector noted the entry had been discontinued six days after the first medical device had been removed. The Inspector noted that, although resident #005's first medical device had been removed six days earlier, staff had documented that they had monitored specific criteria while the resident had the first medical device in use six times on one type of shift; once on another type of shift, and twice on a third type of shift. The Inspector further noted that staff had documented "9"

for "other/see progress note" five times on one type of shift and three times on another type of shift related to the monitoring of the first device [which was no longer in use].

The Inspector reviewed eMARs progress notes entered following the removal of the first medical device. The Inspector noted that one progress note identified the device was no longer in place, but that monitoring would remain [without updating the entry to reflect the device had been removed] as a temporary treatment was applied; six progress notes documented monitoring of the medical device and did not identify that the device was no longer in place; and three progress notes identified the author spoke to the resident about monitoring the first medical device [which was no longer in place].

During an interview with ADOC #102, they stated that, if staff wanted to continue with the monitoring a specific characteristic of resident #005, their care plan should have been updated to reflect that the resident used a second medical device.

During an interview with the DOC, they identified that resident #005's plan of care was not clear to staff that the resident no longer used one medical device but used a second medical device.

(b) Inspector #625 reviewed resident #005's care plan in place in the summer of 2019. The care plan identified resident #005 had one medical device in place, as well as identified the resident had a second medical device in place, in the same location as the first. The care plan identified staff were to apply the second medical device at a certain time of day and perform an action related to the second medical device at another time of day, as well as that staff were to perform a different action related to the first medical device during a certain activity.

During an interview with the DOC, they acknowledged that the care plan in place in the summer of 2019, listed that the resident had in use both the first medical device and the second medical device and stated that it did not provide clear direction to staff.

(c) The CIS report identified that interventions put in place post-fall for resident #005 included that the resident may use a mobility aid in a particular situation. The report also identified that, when walking in the room, corridor, on and off the unit, the resident needed specific assistance, as well as identified the resident was not to use the mobility aid at that time due to an injury. The report also identified that, to address their risk for falls/risk for fractures, the resident would use second mobility aid for mobility for safety.

Inspector #625 observed resident #005 using the second mobility aid for mobility in their room and on their home area on multiple dates in the summer of 2019. On one date in the summer of 2019, the Inspector also observed the resident use the mobility aid in a different manner than observed on other occasions, with no staff present. On another date in the summer of 2019, the Inspector observed the resident mobilize using a different mobility aid, on another floor of the home.

Inspector #625 reviewed the resident's current care plan which identified the following interventions:
- under the focus related to toileting, the resident would use one mobility aid in a particular situation with the assistance of staff, created by RPN #104 on a date in the summer of 2019;
- under the focus related to walking in room/corridor/on and off unit, the resident required assistance while mobilizing in a particular manner, revised by RPN #104 two days prior to the identified toileting intervention date; was not able to use the mobility aid referred to in the toileting focus at that time, revised by RPN #104 two days prior to the identified toileting intervention date; and would be assisted to use a second mobility aid in particular situations for their safety, revised by RPN #104 on the same date as the toileting intervention date; and
- under the focus risk for falls/risk for fractures, the resident was not able to use the mobility aid referred to in the toileting focus at that time, revised by RPN #104 two days prior to the identified toileting intervention date; and would use a second mobility aid for mobility for safety, created by RPN #104 on the same date as the toileting intervention date.

A progress note entered by RPN #104 on the date of the referenced toileting intervention, identified that mobility in the resident's room, in a particular situation could be done with one mobility aid, with the assistance of staff, while mobility outside of their room in particular situations would be completed with a second mobility aid for safety.

During an interview with RPN #104, they stated that they reviewed the resident's current care plan and confirmed that it listed the resident was not to use one mobility aid, as well contrarily identified that the resident could use that mobility aid in a particular situation. The RPN acknowledged that resident #005's care plan did not provide clear direction to staff on the resident's use of the first and second mobility aids.

During an interview with ADOC #102, they indicated that resident #005's care plan was not clear as, under the same focus for walking, it directed staff to provide specific

assistance with a particular manner of mobilizing, as well as directed staff not to use the first mobility aid.

During an interview with the DOC, they indicated that resident #005's care plan was not clear with respect to whether the resident used the first or the second mobility aid. The DOC acknowledged that the report submitted to the Director also listed different information about the use of the first mobility aid, whether it was used with staff assistance, or not used at all. [s. 6. (1) (c)]

8. The licensee has failed to ensure that there was a written plan of care for resident #002 that set out clear directions to staff and others who provided direct care to the resident, with respect to their transfer status.

A CIS report was submitted for a fall experienced by resident #002, in the winter of 2019, where the resident was taken to hospital and which resulted in a significant change in the resident's health condition.

Inspector #625 reviewed resident #002's health care record, including their current care plan which identified, under the risk for falls focus, that the resident transferred with one staff using a particular piece of transfer equipment for all transfers, or multiple staff as needed, revised in the spring of 2019. The care plan also identified, under the transfers focus, that the resident required the assistance of multiple staff to transfer using a specific device, revised later in the spring of 2019.

On a date in the summer of 2019, the Inspector observed a logo in resident #002's room identifying they used a specific device.

Two days later, the Inspector observed staff use a specific device when assisting the resident.

During an interview with PSW #130, they stated that resident #002 had required the assistance of a staff person to transfer prior to their fall.

During an interview with RPN #112, they stated that resident #002 currently transferred with the assistance of two staff using a specific device.

During an interview with PT #115, they identified that resident #002's transfer status had been changed to a specific device for safety reasons. [s. 6. (1) (c)]

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 :

1. The licensee has failed to ensure that where the LTCHA, 2007, or O. Reg. 79/10 required the licensee of a long-term care home to have, institute or otherwise put in place any policy, protocol or procedure, that the policy, protocol or procedure was complied with, with respect to resident #003 and compliance with the falls prevention and management program.

In accordance with O. Reg. 79/10, s. 48. (1) 1., the licensee was required to ensure that an interdisciplinary falls prevention and management program was developed and implemented in the home.

In accordance with O. Reg. 79/10, s. 30. (1) 1., the licensee was required to ensure that there was a written description of the falls prevention and management program that included relevant policies, procedures and protocols.

Specifically, staff did not comply with the licensee's policy titled "Falls Prevention and Management Program RC-15-01-01", last updated February 2017, which directed staff to assess, at each shift for 72 hours post fall, pain, bruising, change in functional status, change in cognitive status and changes in range of motion. The policy directed staff to

document the fall and results of all assessments and actions taken during the 72 hour post fall follow-up.

CO #002 was issued in inspection report #2018_703625_0026, with an amended compliance due date of May 31, 2019. The order was issued pursuant to s. 19. (1) of the LTCHA, 2007, and required the licensee to ensure that resident #003 was provided with the treatment, care, services and assistance required for health, safety or well-being, with a focus on falls prevention and management.

The findings supporting CO #002 identified that registered nursing staff failed to provide resident #003 with appropriate clinical monitoring post-fall, as required by the licensee.

Inspector #625 reviewed resident #003's health care record including a progress note dated the spring of 2019, which identified the resident fell at a specific time. A review of the progress notes for the 72 hour period post-fall identified that staff had not documented assessment of resident #003 post-fall on the evening shifts for two required shifts. The Inspector noted that the various components of the criteria required to be assessed, as listed in the home's policy, had not been documented in the progress notes on the night shifts for three required shifts; or on the day shift for one required shift.

During an interview with RPN #120, they stated that staff had been educated on the criteria to be documented for 72 hours post-fall. The RPN stated they placed a note identifying the criteria to be documented according to the home's program on each computer in the home's meeting and medication rooms. The RPN identified that the required progress notes had not been completed on the two specific evening shifts, and that other progress note contained documentation which did not include all of the required assessment information.

During an interview with ADOC #102, they reviewed resident #003's progress notes and acknowledged that there was no documentation on two specific evening shifts, and three or four other entries were missing components of the 72 hour documentation required as indicated in the home's policy. [s. 8. (1) (b)]

2. The licensee has failed to ensure that where the LTCHA, 2007, or O. Reg. 79/10 required the licensee of a long-term care home to have, institute or otherwise put in place any policy, protocol or procedure, that the policy, protocol or procedure was complied with, with respect to resident #003 and compliance with the pain management program.

In accordance with O. Reg. 79/10, s. 48. (1) 4., the licensee was required to ensure that an interdisciplinary pain management program was developed and implemented in the home.

In accordance with O. Reg. 79/10, s. 30. (1) 1., the licensee was required to ensure that there was a written description of the pain management program that included relevant policies, procedures and protocols.

Specifically, staff did not comply with the licensee's policy titled "Pain Identification and Management – RC-19-01-01", last updated November 2018, or with the protocol titled "Pain Management – RC-19-01-01", revised June 5, 2019, which were part of the licensee's pain management program.

The policy titled "Pain Identification and Management – RC-19-01-01", last updated November 2018, identified that nurses were required to complete a pain assessment for an indication of the presence of pain; to complete specific sections of the pain assessment post-analgesia; and to complete pain assessments for 72 hours, on the day and evening shifts, when a new pain medication was started.

The protocol titled "Pain Management – RC-19-01-01", revised June 5, 2019, identified that one pain assessment was to be completed for new pain, or for an indication of pain (not a new report of pain); two pain assessments were to be completed if a medication was administered on an as needed basis, one detailing the reason for the assessment and one upon follow-up; and pain assessments were to be completed for 72 hours, on the day and evening shifts, when new pain medication was started.

CO #002 was issued in inspection report #2018_703625_0026, with an amended compliance due date of May 31, 2019. The order was issued pursuant to s. 19. (1) of the LTCHA, 2007, and required the licensee to ensure that resident #003 was provided with the treatment, care, services and assistance required for health, safety or well-being, with a focus on pain management.

The findings supporting CO #002 identified that registered nursing staff failed to provide resident #003 with appropriate pain monitoring, as required by the licensee.

Inspector #625 reviewed resident #003's health care record including progress notes which identified, on a date in the spring of 2019, the resident had pain during particular activities, a prn analgesic was ordered to help with pain; the analgesic was administered

and was effective.

The Inspector also reviewed resident #003's eMAR for a month in 2019, which identified the resident was administered the analgesic by a specific route, at a specific time, for pain of a specific quantifiable level, which was effective.

Inspector #625 reviewed resident #003's Digital Prescriber's Orders entry dated the spring of 2019, for a specific dose of the analgesic, administered by a specific route, at a specific frequency, as needed.

The Inspector reviewed pain assessments and was not able to locate pain assessments for the new pain medication started and administered prn, on a specific date in the spring of 2019.

During an interview with the DOC, they stated that resident #003 should have had pain assessments completed for the administration of the analgesic on a specific date in the spring of 2019. The DOC reviewed the completed assessments in PCC and stated that the pain assessments had not been completed. [s. 8. (1) (b)]

3. The licensee has failed to ensure that where the LTCHA, 2007, or O. Reg. 79/10 required the licensee of a long-term care home to have, institute or otherwise put in place any policy, protocol or procedure, that the policy, protocol or procedure was complied with, with respect to resident #001 and compliance with the skin and wound care program.

In accordance with O. Reg. 79/10, s. 48. (1) 2., the licensee was required to ensure that an interdisciplinary skin and wound care program was developed and implemented in the home.

In accordance with O. Reg. 79/10, s. 30. (1) 1., the licensee was required to ensure that there was a written description of the skin and wound care program that included relevant policies, procedures and protocols.

Specifically, staff did not comply with the licensee's policy titled "Skin and Wound Program: Wound Care Management – RC-23-01-02", last updated February 2017, the policy titled "Management of Skin Rashes, Lesions and Irritations – Appendix 9 - RC-23-01-02", last updated February 2017, or with the "Impaired Skin Integrity Guide – RC-23-01-02", updated June 5, 2019, which were part of the home's skin and wound care

program.

CO #002 was issued in inspection report #2018_703625_0026, with an amended compliance due date of May 31, 2019. The order was issued pursuant to s. 19. (1) of the LTCHA, 2007, and required the licensee to ensure that all residents who required treatment, care, services and assistance for health, safety or well-being, were provided with the treatment, care, services and assistance required, with a focus on skin and wound care.

The findings supporting CO #002 identified that registered nursing staff failed to provide a resident with appropriate skin and wound care, as required by the licensee.

(a) The policy titled "Skin and Wound Program: Wound Care Management – RC-23-01-02", last updated February 2017, identified that interdisciplinary staff were to reassess and update the care plan as needed and communicate to care staff and other relevant persons.

The policy titled "Management of Skin Rashes, Lesions and Irritations – Appendix 9 - RC-23-01-02", last updated February 2017, identified that staff were to initiate/update a resident's care plan to reflect an altered skin integrity focus, including characteristics of a rash/lesion/irritation, current goals and interventions.

The protocol titled "Impaired Skin Integrity Guide – RC-23-01-02", updated June 5, 2019, identified that staff were to update the care plan with a focus of "Impaired Skin Integrity".

Inspector #625 reviewed resident #001's health care record, including their electronic eTARs for two months in 2019, which identified a topical drug was to be applied to an area of the resident's body, until specific altered skin integrity resolved; as well as identified a second topical drug was to be applied as required to another part of the resident's body.

Inspector #625 also reviewed a progress note dated the summer of 2019, which identified resident #001 performed an action to multiple parts of their body, had several indications of altered skin integrity present on multiple body parts, and had a topical treatment for the issues which had been applied to the body parts with relief. A progress note dated the following date, identified resident #001 had altered skin integrity exhibiting specific characteristics on a part of the their body.

Inspector #625 reviewed resident #001's current care plan which did not contain a focus related to impaired skin integrity, did not refer staff to the eTAR and did not list any topical drug to be applied to two of the resident's body parts.

During an interview with the DOC, they acknowledged that the resident's care plan had not been reassessed and updated in accordance with the skin and wound program with respect to the resident's altered skin integrity on one of the parts of their body, corresponding treatment ordered on a date in the summer of 2019, or the altered skin integrity on two other parts of resident #001's body.

(b) The licensee's policy titled "Skin and Wound Program: Wound Care Management – RC-23-01-02", last updated February 2017, identified that staff were to promptly assess all residents exhibiting altered skin integrity on initial discovery and use the Impaired Skin Integrity Assessment for skin impairments such as rashes or reddened areas.

The policy titled "Management of Skin Rashes, Lesions and Irritations – Appendix 9 - RC-23-01-02", last updated February 2017, identified that staff were to document in the progress notes an assessment of rashes, lesions, and irritations (including location, size and characteristics).

The protocol titled "Impaired Skin Integrity Guide – RC-23-01-02", updated June 5, 2019, identified that staff were to complete a wound assessment in Point Click Care (PCC).

The home failed to complete initial assessments of resident #001's altered skin integrity on multiple parts of the resident's body.

See WN #3, finding #1 for details.

(c) The licensee's policy titled "Skin and Wound Program: Wound Care Management – RC-23-01-02", last updated February 2017, identified that staff were to re-assess at a minimum weekly, and that re-evaluation and documentation of treatment with creams or other medicated preparations was to occur at minimum weekly.

The policy titled "Management of Skin Rashes, Lesions and Irritations – Appendix 9 - RC-23-01-02", last updated February 2017, identified that staff were to complete an assessment a minimum of every seven days until resolved, which was to include the need to continue treatment and any signs of improvement or worsening condition.

The protocol titled "Impaired Skin Integrity Guide – RC-23-01-02", updated June 5, 2019, identified that staff were to complete a weekly assessment and enter a reminder to complete the weekly assessment on the eTAR by creating a separate order for it.

Resident #001's eTARs for two months in 2019, did not contain any entries related to completion of weekly skin assessments, and no weekly wound assessments had been completed for the altered skin integrity on a specific part of resident #001's body.

During an interview with the DOC, they indicated that staff had not entered a reminder to complete the weekly assessments as the guide required.

See WN # 3, finding #3 for details related to the lack of completion of weekly assessments.

(d) The licensee's policy titled "Skin and Wound Program: Wound Care Management – RC-23-01-02", last updated February 2017, identified that staff were to complete a referral to the Registered Dietitian (RD) for all residents exhibiting altered skin integrity.

The policy titled "Management of Skin Rashes, Lesions and Irritations – Appendix 9 - RC-23-01-02", last updated February 2017, identified that staff were to complete a dietary referral as required and forward to the Nutritional Care Team for the RD to assess.

The home failed to submit referrals to the RD for the areas of altered skin integrity on multiple parts of resident #001's body.

See WN #3, finding #2 for details.

(e) The policy titled "Skin and Wound Program: Wound Care Management – RC-23-01-02", last updated February 2017, identified that staff were to "Document resident/POA/SDM/family communication in the interdisciplinary progress notes". The policy listed specific criteria staff were to document related to the communication including involvement in the development and awareness of the plan of care related to skin/wound, how long the resident had the skin breakdown, how the skin had been treated in the past, prevention interventions attempted, interventions reflecting choices and preferences, and any relevant skin education provided.

The policy titled "Management of Skin Rashes, Lesions and Irritations – Appendix 9 -

RC-23-01-02", last updated February 2017, identified that staff were to document in the interdisciplinary progress notes "Communication to POA/SDM/family".

The protocol titled "Impaired Skin Integrity Guide – RC-23-01-02", updated June 5, 2019, identified that staff were to "Notify the POA of the wound (new, worsening or recurring) and document in the progress notes in PCC". It was also identified that all skin impairments required notification regardless of the situation.

Inspector #625 was not able to locate documentation in the progress notes that identified communication with the resident's Attorney for Personal Care, substitute decision-maker (SDM) or family had occurred related to resident #001's altered skin integrity on multiple parts of their body.

During an interview with the DOC, they indicated that communication with the resident's Attorney for Personal Care, SDM or family had not been documented in the progress notes as required, including any involvement in the development and awareness of the plan of care related to skin integrity.

(f) The protocol titled "Impaired Skin Integrity Guide – RC-23-01-02", updated June 5, 2019, identified that staff were to send a referral to the Wound Care Champion using PCC for all skin impairments.

Inspector #625 was not able to locate a referral to the Wound Care Champion for the altered skin integrity on multiple parts of resident #001's body.

During an interview with the DOC, they stated that staff had not submitted referrals to the Wound Care Champion for resident #001's areas of altered skin integrity on multiple parts of resident #001's body. [s. 8. (1) (b)]

4. The licensee has failed to ensure that where the LTCHA, 2007, or O. Reg. 79/10 required the licensee of a long-term care home to have, institute or otherwise put in place any policy, protocol or procedure, that the policy, protocol or procedure was complied with, with respect to resident #002 and compliance with the pain management program.

In accordance with O. Reg. 79/10, s. 48. (1) 4., the licensee was required to ensure that an interdisciplinary pain management program was developed and implemented in the home.

In accordance with O. Reg. 79/10, s. 30. (1) 1., the licensee was required to ensure that there was a written description of the pain management program that included relevant policies, procedures and protocols.

Specifically, staff did not comply with the licensee's policy titled "Pain Identification and Management – RC-19-01-01", last updated November 2018, or with the protocol titled "Pain Management – RC-19-01-01", revised June 5, 2019, which were part of the licensee's pain management program.

The policy titled "Pain Identification and Management – RC-19-01-01", last updated November 2018, identified that nurses would complete a pain assessment for residents for a new pain and when there was an indication of the presence of pain (including reported pain). The policy indicated that nurses were to complete the pain assessment for 72 hours, on the day and evening shifts, when a new pain medication was started.

The protocol titled "Pain Management – RC-19-01-01", revised June 5, 2019, identified that one pain assessment was to be completed for new pain, or when an indication of pain was present (not a report of new pain). The protocol also identified that two pain assessments were required, one to detail the reason for the assessment and one upon follow-up if prn medication was administered. The protocol also indicated that pain assessments were to be completed for 72 hours, on the day and evening shifts, when new pain medication was started and when existing pain medication was increased or decreased.

(a) Inspector #625 reviewed resident #002's eMAR for a month in 2019, which identified the resident had received a prn analgesic for pain on multiple dates in the spring of 2019, including dates where the analgesic had been administered multiple times.

The Inspector reviewed pain assessments completed in that month in 2019 and identified that 12 out of 22, or 55 per cent, of the individual pain assessments had not been completed.

During an interview with the DOC, they stated that resident #002 should have had two pain assessments completed for each administration of the medication administered on an as needed basis, one on complaint of pain before the administration [presence of pain/complaints of pain assessment] and one after the pain medication was administered [post analgesia/follow up assessment]. The DOC identified pain assessments for the following dates were absent:

- on one date in the spring of 2019, the follow up pain assessment was missing;
- on another date in the spring of 2019, a follow up pain assessment was missing;
- on another date in the spring of 2019, both pain assessments were missing;
- on another date in the spring of 2019, both pain assessments were documented in the presence of pain assessment;
- on another date in the spring of 2019, both pain assessments were missing; and
- on another date in the spring of 2019, both pain assessments were documented in the presence of pain assessment.

(b) Inspector #625 reviewed resident #002's eMAR for another month in 2019, which identified the resident had received prn analgesic for pain on a date in the spring of 2019.

The Inspector reviewed pain assessments completed in that month in 2019 and was not able to locate either required pain assessment for the date in the spring of 2019.

During an interview with the DOC, they identified that both required pain assessments for the date in the spring of 2019, were missing.

(c) Inspector #625 reviewed Digital Prescriber's Orders entries, after the resident's return from hospital on a date in the spring of 2019, with a focus on pain medication. On another date in the spring of 2019, a specific analgesic drug, of a specific dose, administered by a specific route, at a specific time of day, was ordered.

Inspector #625 reviewed resident #002's eMAR for a month in 2019 which identified the medication was to start on a specific date, at a specific time.

Inspector #625 reviewed pain assessments completed for the corresponding order and identified that pain assessments had not been completed on one shift on a date in the spring of 2019.

During interviews with the DOC, they identified pain assessments were required on the day and evening shifts for 72 hours. The DOC indicated that pain assessment for one shift on a date in the spring of 2019, was absent.

(d) Inspector #625 further reviewed Digital Prescriber's Orders entries, with a focus on pain medication. On a date in the spring of 2019, the dose of one scheduled analgesic drug was changed, and the frequency of administration of a second analgesic drug was changed.

Inspector #625 reviewed resident #002's eMAR for a month in 2019, which identified the administered first analgesic dose was changed on a specific date and time in the spring of 2019, and the second analgesic drug order was changed on the same date and time.

Inspector #625 reviewed pain assessments completed for that date, and identified that pain assessments had not been completed as required on one shift on the first date, on two shifts on the second date, on one shift on the third date, or on one shift on the fourth date. The Inspector noted that five out of six of the required pain assessments, or 83 per cent of the assessments, had not been completed. Further, the pain assessment completed on the third date, did not indicate the assessment was related to, or considered the changes to, the resident's analgesic in the assessment.

During an interview with the DOC, they stated that pain assessments had not been completed as required on three separate dates. The DOC also stated that none of the assessments completed on the second date, had been completed for the new analgesic orders.

(e) Further review of the Digital Prescriber's Orders entries, with a focus on pain medication, identified an order dated the spring of 2019, to change resident #002's analgesic to a specific dose, administered by a specific route, at a specific frequency.

The resident's eMAR for a month in 2019 indicated the change in administered analgesic for resident #002 occurred on a specific shift, on the date after the order was written.

Inspector #625 searched for pain assessments completed for the date the dose change occurred and identified that none of the pain assessments had been completed as required. The resident had no pain assessments completed between a date in the spring of 2019, to a date in the summer of 2019, a period of 44 days.

During an interview with the DOC, they stated that none of the six required pain assessments had been completed as required for 72 hours post medication change. [s. 8. (1) (b)]

5. The licensee has failed to ensure that where the LTCHA, 2007, or O. Reg. 79/10 required the licensee of a long-term care home to have, institute or otherwise put in place any policy, protocol or procedure, that the policy, protocol or procedure was complied with, with respect to resident #004 and compliance with the pain management program.

In accordance with O. Reg. 79/10, s. 48. (1) 4., the licensee was required to ensure that an interdisciplinary pain management program was developed and implemented in the home.

In accordance with O. Reg. 79/10, s. 30. (1) 1., the licensee was required to ensure that there was a written description of the pain management program that included relevant policies, procedures and protocols.

Specifically, staff did not comply with the licensee's policy titled "Pain Identification and Management – RC-19-01-01", last updated November 2018, or with the protocol titled "Pain Management – RC-19-01-01", revised June 5, 2019, which were part of the licensee's pain management program.

The policy titled "Pain Identification and Management – RC-19-01-01", last updated November 2018, indicated that nurses were to complete the pain assessment for 72 hours, on the day and evening shifts, when a new pain medication was started.

The protocol titled "Pain Management – RC-19-01-01", revised June 5, 2019, identified that pain assessments were to be completed for 72 hours, on the day and evening shifts, when new pain medication was started and when existing pain medication was increased or decreased.

A CIS report was submitted for a fall experienced by resident #004, in the spring of 2019, where the resident was taken to hospital and which resulted in a significant change in the resident's health condition. The report identified the resident sustained injuries and returned to the home on a date later in the spring of 2019.

(a) Inspector #625 reviewed Digital Prescriber's Orders entries, after the resident's return from hospital in the spring of 2019, with a focus on pain medication. On the date following the resident's return from hospital, a change in an analgesic to a specific dose, administered at a specific frequency, in a specific circumstance, was ordered.

Inspector #625 reviewed resident #004's eMAR for a month in 2019 which identified the change in frequency of the analgesic began two days after their return from hospital, at a specific time.

Inspector #625 reviewed pain assessments completed for the change in the analgesic

which began two days after the resident returned from hospital, and identified that pain assessments had not been completed as required. The resident had no pain assessments completed from over nine dates, beginning on the date two days after they had returned from hospital.

During interviews with the DOC, they identified pain assessments were required on the day and evening shifts for 72 hours. The DOC indicated that one pain assessment had been completed on the day after the resident returned from hospital, [prior to the change in the analgesic that occurred two days after their return from hospital, at a specific time] and no other pain assessments had been completed corresponding to the order dated the day after the resident returned from hospital.

(b) Inspector #625 further reviewed Digital Prescriber's Orders entries, with a focus on pain medication. On a date in the spring of 2019, one analgesic drug was discontinued and a second analgesic drug was ordered at a specific frequency, in a specific circumstance.

Inspector #625 reviewed resident #004's eMAR for a month in 2019 which identified the second analgesic drug was first administered on the date it was ordered, at a specific time.

Inspector #625 reviewed pain assessments completed for the orders and identified that pain assessments had not been completed as required on one shift on a date in the spring of 2019, on two shifts on a second date in the spring of 2019, and on one shift on a third date in the spring of 2019. The Inspector noted that four out of six of the required pain assessments, or 67 per cent of the assessments, had not been completed.

During an interview with the DOC, they stated that pain assessments had not been completed as required on one shift on a date in the spring of 2019, on two shifts on a second date in the spring of 2019, and on one shift on a third date in the spring of 2019.

(c) Further review of the Digital Prescriber's Orders entries, with a focus on pain medication, identified an order dated the summer of 2019, to change the frequency of administration of a scheduled analgesic starting on the following date.

The resident's eMAR for a month in 2019 indicated that the change in administered analgesic for resident #004 occurred on a particular shift on the same date the order was written. The resident's previous analgesic order was discontinued on the eMARs on the

same date the new order was written, at a specific time, after the resident had been administered multiple doses at specific times.

Inspector #625 searched for pain assessments completed for the frequency change that occurred on a date in the summer of 2019, and identified that none of the pain assessments had been completed as required. The resident had no pain assessments completed from a date in the spring of 2019 to a date in the summer of 2019, over 28 days.

During an interview with the DOC, they stated that none of the six required pain assessments had been completed as required for 72 hours post medication change. [s. 8. (1) (b)]

6. The licensee has failed to ensure that where the LTHCA, 2007 or O. Reg. 79/10 required the licensee of a long-term care home to have, institute or otherwise put in place any policy, protocol or procedure, that the policy, protocol or procedure was complied with, with respect to resident #005 and compliance with the pain management program.

In accordance with O. Reg. 79/10, s. 48. (1) 4., the licensee was required to ensure that an interdisciplinary pain management program was developed and implemented in the home.

In accordance with O. Reg. 79/10, s. 30. (1) 1., the licensee was required to ensure that there was a written description of the pain management program that included relevant policies, procedures and protocols.

Specifically, staff did not comply with the licensee's policy titled "Pain Identification and Management – RC-19-01-01", last updated November 2018, or with the protocol titled "Pain Management – RC-19-01-01", revised June 5, 2019, which were part of the licensee's pain management program.

The policy titled "Pain Identification and Management – RC-19-01-01", last updated November 2018, identified that nurses would complete a pain assessment for residents when there was an indication of the presence of pain (including reported pain).

The protocol titled "Pain Management – RC-19-01-01", revised June 5, 2019, identified that one pain assessment was to be completed when an indication of pain was present (not a report of new pain).

A CIS report was submitted for a fall experienced by resident #005, in the summer of 2019, where the resident was taken to hospital and which resulted in a significant change in the resident's health condition. The report identified that the resident had sustained an injury.

Inspector #625 reviewed resident #005's health care record post-fall and identified PCC progress notes detailing pain experienced by the resident entered on multiple specific dates and times in the summer of 2019.

Inspector #625 reviewed pain assessments completed and was not able to locate assessments completed for the complaints of pain made by the resident on any of the dates.

During interviews with the DOC, they identified that pain assessments were required for resident #005's complaints of pain documented on four dates in the summer of 2019. The DOC reviewed completed pain assessments and stated that no pain assessments had been completed for resident #005's complaints of pain on those dates. [s. 8. (1) (b)]

7. The licensee has failed to ensure that where the LTCHA, 2007, or O. Reg. 79/10 required the licensee of a long-term care home to have, institute or otherwise put in place any policy, protocol or procedure, that the policy, protocol or procedure was complied with, with respect to resident #005 and compliance with the falls prevention and management program.

In accordance with O. Reg. 79/10, s. 48. (1) 1., the licensee was required to ensure that an interdisciplinary falls prevention and management program was developed and implemented in the home.

In accordance with O. Reg. 79/10, s. 30. (1) 1., the licensee was required to ensure that there was a written description of the falls prevention and management program that included relevant policies, procedures and protocols.

(a) Specifically, staff did not comply with the licensee's policy titled "Falls Prevention and Management Program RC-15-01-01", last updated February 2017, which identified that staff were to complete a Clinical Monitoring Record if a resident hit their head or was suspected of hitting their head, such as if they had an unwitnessed fall.

A CIS report was submitted for a fall experienced by resident #005, in the summer of 2019, where the resident was taken to hospital and which resulted in a significant change in the resident's health condition. The CIS report identified that the fall was not witnessed as a PSW heard the resident fall, entered the room, and found the resident on a particular surface.

Inspector #625 reviewed resident #005's health care record, including a Clinical Monitoring Record initiated on the date of the fall, at a specific time. The Inspector noted that the third entry did not list a date or time and did not contain all of the required assessment information. The third to 11th entries did not list the dates of the entries.

During an interview with the DOC, they indicated that the Clinical Monitoring Record for the fall which occurred in the summer of 2019, was incomplete, did not list the dates of the entries for 11 out of 13 entries and did not list the time of the third entry.

(b) Specifically, staff did not comply with the licensee's policy titled "Falls Prevention and Management Program RC-15-01-01", last updated February 2017, which directed staff to asses pain, bruising, change in functional status, change in cognitive status and changes in range of motion, on each shift for 72 hours post fall. The policy directed staff to document the fall and results of all assessments and actions taken during the 72 hour post fall follow-up.

Inspector #625 reviewed progress notes for the 72 hours post-fall for each shift, from the evening shift on three dates in the summer of 2019, and was not able to locate an entry for any shift which included all of the required components of the assessment documentation. On one shift in the summer of 2019, the shift following the resident's return from hospital, the Inspector was not able to locate any documentation in the progress notes of the resident's status that shift.

During an interview with the DOC, they confirmed that the required documentation had not been completed as there was no progress note entered on the shift following the resident's return from hospital, and none of the progress notes that were entered for the 72 hours after the fall contained all of the criteria the home's policy identified was to be assessed and documented.

(c) Specifically, staff did not comply with the licensee's policy titled "Falls Prevention and Management Program RC-15-01-01", last updated February 2017, which identified that the program would "engage the resident, family/SDM and the interdisciplinary team to

proactively identify and address individual and environmental risk factors and causes of falls" and "ensure falls and fall injuries are promptly investigated…and root causes identified and addressed to prevent recurrence". The policy indicated that interdisciplinary staff were to create an individualized plan addressing identified fall causes and risk factors such as a history of falls and or/fractures.

Inspector #625 noted that the CIS report submitted for resident #005's fall in the summer of 2019, did not identify the events leading up to the incident, or the cause of the fall.

During an interview with resident #005 and their family member #119, the resident's family member stated the resident fell when reaching for an item. The resident elaborated that they had been in contact with an entity regarding financial information and had been required to provide them information they had been reaching for. The resident said their mobility aid had not been close by when they fell, they had been standing, leaned over to reach for the information and then fell.

Inspector #625 reviewed resident #005's health care record, including progress notes and a Post Fall Assessment, and was not able to locate documentation as to the cause of the fall, or factors contributing to the fall, that occurred in the summer of 2019. Although the resident's Post Fall Assessment did not identify the cause of the fall, it indicated that staff were to "Continue with current plan of care and fall interventions."

During an interview with the DOC, they acknowledged the cause of resident #005's fall in the summer of 2019, had not been documented in their health care record, including the Post Fall Assessment and progress notes, and since it was not documented, the cause was not communicated to other staff through the record. The DOC reviewed an internal incident report for the known circumstances of the fall and stated that the internal incident report had identified the resident was performing a specific activity and fell over, using parts of their body to break the fall. The DOC stated the home's falls prevention and management program had not been followed as the home had been aware of aspects of the resident's fall which had not been entered into their medical record. [s. 8. (1) (b)]

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. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that, when resident #001 exhibited altered skin integrity on multiple distinct parts of their body, they received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

CO #001 was issued in inspection report #2018_703625_0026, with an amended compliance due date of May 31, 2019. The order was issued pursuant to s. 6. (1) (c) of the LTCHA, 2007, and required the licensee to review and update, as required, resident #001's written plan of care to ensure the written plan set out clear direction to staff and others who provided direct care to the resident. The findings supporting CO #001 included a finding related to resident #001's skin and wound care.

The licensee's policy titled "Skin and Wound Program: Wound Care Management – RC-23-01-02", last updated February 2017, identified that staff were to promptly assess all residents exhibiting altered skin integrity on initial discovery and use the Impaired Skin Integrity Assessment for skin impairments such as rashes or reddened areas.

Inspector #625 reviewed resident #001's health care record including progress notes dated:
- a date in the summer of 2019, that identified the resident performed an action to multiple parts of their body, had several indications of altered skin integrity present on multiple body parts, and had a topical treatment for the issues which had been applied to the body parts with relief; and
- the following date in the summer of 2019, that identified the resident had altered skin integrity exhibiting specific characteristics on a part of their body, a topical drug was applied, the resident's body part exhibited less of one characteristic and the administration was determined to have been effective.

Inspector #625 reviewed resident #001's health care record including a Digital Prescriber's Order entry dated a date in the summer of 2019, which identified the resident had altered skin integrity on one part of their body and ordered a topical drug for the altered skin integrity until it resolved.

The Inspector also reviewed the resident's eTARs for two specific months in 2019, which identified that the resident had a topical drug to be applied to a part of their body, at a specific frequency, until the altered skin integrity was resolved, started on a date in the summer of 2019; as well as a second topical drug to be applied to another area of their body, as needed, at a specific frequency, for an indicated diagnosis, started on a date in the summer of 2018, and documented as applied once during the two months, on a date in the summer of 2019.

The Inspector was not able to locate corresponding initial wound assessments completed for resident #001's altered skin integrity on the any of the the multiple documented areas of altered skin integrity.

During an interview with RPN #120, they stated that initial skin assessments had not been completed for the altered skin integrity on multiple distinct areas on resident #001's body. The RPN stated they had entered a progress note which identified the resident had altered skin integrity on multiple distinct areas of their body, but had not completed an initial skin assessment, although they should have.

During an interview with the DOC, they indicated that initial impaired skin integrity assessments had not been completed for the impaired skin integrity on multiple distinct areas of resident #001's body. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that, when resident #001 exhibited altered skin integrity on multiple areas of their body, they were assessed by a registered dietitian who was a member of the staff of the home.

CO #001 was issued in inspection report #2018_703625_0026, with an amended compliance due date of May 31, 2019. The order was issued pursuant to s. 6. (1) (c) of the LTCHA, 2007, and required the licensee to review and update, as required, resident #001's written plan of care to ensure the written plan set out clear direction to staff and others who provided direct care to the resident. The findings supporting CO #001 included a finding related to resident #001's skin and wound care.

The licensee's policy titled "Skin and Wound Program: Wound Care Management – RC-23-01-02", last updated February 2017, identified that staff were to complete a referral to the RD for all residents exhibiting altered skin integrity.

Inspector #625 reviewed resident #001's health care record which identified the resident had altered skin integrity on multiple areas of their body, documented on dates in the summer of 2019.

The Inspector was not able to locate referrals to the RD submitted for the altered skin integrity on multiple areas of the resident's body.

During an interview with the DOC, they indicated that referrals to the RD had not been submitted for the altered skin integrity on multiple specific areas of resident #001's body. The DOC then provided the Inspector, upon request, the Assessment History Report Setup from a date in the spring of 2019 to a date in the summer of 2019, which identified that no referral to the RD had occurred during that time. [s. 50. (2) (b) (iii)]

3. The licensee has failed to ensure that, when resident #001 exhibited altered skin integrity on a particular area of their body, they were reassessed at least weekly by a member of the registered nursing staff.

CO #001 was issued in inspection report #2018_703625_0026, with an amended compliance due date of May 31, 2019. The order was issued pursuant to s. 6. (1) (c) of the LTCHA, 2007, and required the licensee to review and update, as required, resident #001's written plan of care to ensure the written plan set out clear direction to staff and others who provided direct care to the resident. The findings supporting CO #001 included a finding related to resident #001's skin and wound care.

The licensee's policy titled "Skin and Wound Program: Wound Care Management – RC-23-01-02", last updated February 2017, identified that staff were to re-assess altered skin integrity at a minimum weekly. The policy also indicated that re-evaluation and documentation of treatment with creams or other medicated preparations was to occur at minimum weekly.

Inspector #625 reviewed resident #001's health care record including a Digital Prescriber's Orders entry dated the summer of 2019, which identified the resident had altered skin integrity on an area of their body and ordered a topical drug for the altered skin integrity until it resolved.

The Inspector also reviewed the resident's eTARs for two specific months in 2019, which identified that the resident had a topical drug applied to the area on their body at a specific frequency started on a date in the summer of 2019.

The Inspector was not able to locate corresponding weekly assessments completed for the altered skin integrity on the specific area of the resident's body.

During an interview with RPN #120, they stated that weekly assessments had not been completed for the altered skin integrity to resident #001's specific body part from the time of the order in the summer of 2019, to the current date in the summer of 2019, a period of 32 days.

During an interview with the DOC, they indicated that weekly impaired skin integrity assessments had not been completed for the impaired skin integrity on the resident's specific body part. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds:
- receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment;
- is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented; and
- is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #4: 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 a topical drug was administered to resident #001 in accordance with the directions for use specified by the prescriber.

CO #001 was issued in inspection report #2018_703625_0026, with an amended compliance due date of May 31, 2019. The order was issued pursuant to s. 6. (1) (c) of the LTCHA, 2007, and required the licensee to review and update, as required, resident #001's written plan of care to ensure the written plan set out clear direction to staff and others who provided direct care to the resident. The findings supporting CO #001 included a finding related to resident #001's skin and wound care.

Inspector #625 reviewed resident #001's health care record including progress notes

dated the summer of 2019, which identified the resident performed an action to multiple parts of their body, had several indications of altered skin integrity present on multiple parts of their body, and had a topical drug treatment for the issues which had been applied to the body parts with relief.

Inspector #625 reviewed resident #001's health care record including a Digital Prescriber's Orders entry dated the summer of 2019, which identified the resident had altered skin integrity on one area of their body and ordered a topical drug for the area of altered skin integrity until it resolved. The Inspector was unable to identify directions that identified the topical drug was to be applied to locations other than the resident's one body part, such as the additional body parts it had been applied to as identified in the progress notes.

The Inspector also reviewed the resident's eTARs for two months in 2019, which identified that the resident had a topical drug to be applied to one area of their body, at a specific frequency, until the altered skin integrity was resolved, started on on a date in the summer of 2019. The Inspector was unable to locate directions that identified the topical drug was to be applied to locations other than the area of the resident's body identified on the eTARs.

During an interview with the DOC, they reviewed the progress note dated a specific date in the summer of 2019, which identified the topical drug had been applied to multiple areas of resident #001's body. The DOC indicated that the prescriber's directions had not been followed if staff applied the topical drug to areas other than those for which it had been ordered. [s. 131. (2)]

2. The licensee has failed to ensure that an analgesic drug was administered to resident #004 in accordance with the directions for use specified by the prescriber.

A CIS report was submitted for a fall experienced by resident #004 in the spring of 2019, where the resident was taken to hospital and which resulted in a significant change in the resident's health condition. The report identified the resident sustained injuries and returned to the home later in the spring of 2019.

Inspector #625 reviewed resident #004's health care record including a Digital Prescriber's Orders entry dated the spring of 2019, for an analgesic medication of a specific dose, administered by a specific route, at a specific frequency, in a specific circumstance; and a second entry, dated 14 days after the first, to change the frequency

of the analgesic starting the following date.

A review of the corresponding eMARs identified an entry for the analgesic scheduled at specific times, started on a date in the spring of 2019, and discontinued on a date in the summer of 2019, at a specific time. A second entry for the analgesic, to be administered at a different frequency, started on the date after the first entry was discontinued, and indicated that staff had administered the analgesic at specific times that date. The Inspector noted that resident #004 had not received the analgesic between the discontinuation of the first entry and inititation of the second entry, an 18 hour period.

During an interview with the DOC, they indicated that staff had not followed the directions for use specified in the order when they had prematurely discontinued the analgesic on the date the second order was written. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 31st day of October, 2019

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	KATHERINE BARCA (625)
Inspection No. / No de l’inspection :	2019_703625_0016
Log No. / No de registre :	002695-19, 002696-19
Type of Inspection / Genre d’inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Oct 17, 2019
Licensee / Titulaire de permis :	CVH (No. 9) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.) 766 Hespeler Road, Suite 301, CAMBRIDGE, ON, N3H-5L8
LTC Home / Foyer de SLD :	Southbridge Pinewood 2625 Walsh Street East, THUNDER BAY, ON, P7E-2E5
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Jonathon Riabov

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 CVH (No. 9) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.), you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2018_703625_0026, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident.
2007, c. 8, s. 6 (1).

Order / Ordre :

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

The licensee must be compliance with s. 6 (1) of the Long-Term Care Homes Act (LTCHA), 2007.

Specifically, the licensee must:
(a) Ensure resident #001's plan of care provides clear directions to staff and others who provide direct care to the resident, with a focus on topical drug application, prn (pro re nata, or as required) medication indications for use and continence care (including toileting routines).
(b) Ensure resident #002's plan of care provides clear directions to staff and others who provide direct care to the resident, with a focus on interventions related to altered skin integrity and transfer ability.
(c) Ensure resident #003's plan of care provides clear directions to staff and others who provide direct care to the resident, with a focus on medication administration (including indications for use of prn drugs).
(d) Ensure resident #004's plan of care provides clear directions to staff and others who provide direct care to the resident, with a focus on urinary continence, bed rail use, transfer ability, use of assistive devices to mobilize/ambulate, medication administration, and the completion of pain assessments.
(e) Ensure resident #005's plan of care provides clear directions to staff and others who provide direct care to the resident, with a focus on interventions related to the injury they sustained post-fall, and use of assistive devices to mobilize/ambulate.

Grounds / Motifs :

1. The licensee has failed to ensure that there was a written plan of care for resident #003 that set out clear directions to staff and others who provided direct care to the resident, with respect to the administration of analgesic medication prn (pro re nata, or as required).

CO #001 was issued in inspection report #2018_703625_0026, with an amended compliance due date of May 31, 2019. The order was issued pursuant to s. 6. (1) (c) of the LTCHA, 2007, and required the licensee to review and update, as required, resident #003's written plan of care to ensure the written plan set out clear directions to staff and others who provided direct care to the resident.

Inspector #625 reviewed resident #003's health care record including Digital Prescriber's Orders entries dated:
- a date in the spring of 2019, to change the analgesic to a specific dose range by mouth, administered at a specific frequency, as needed. The corresponding Clinical Indicator section included a note dated four days later referring to a resolved illness; and
- a second date in the spring of 2019, to change the analgesic to a specific dose by mouth, administered at a specific frequency, as needed. The corresponding Clinical Indicator identified the specific cause of the illness.

The Inspector reviewed the electronic Medication Administration Record (eMAR) entries for a month in 2019, which corresponded to the orders and noted that the entries for the prn analgesic identified two pain assessments were to be completed when the medication was administered, but did not identify the indication for administration, instead directing administration "as needed for indicated diagnosis". The prn analgesic administration was documented on a date in the spring of 2019, when the analgesic was administered at a specific time and was noted to be ineffective.

Corresponding eMAR administration notes identified the analgesic was administered on a date in the spring of 2019, at a specific time, for a particular reason and was ineffective as the resident continued to exhibit a specific characteristic.

The Inspector reviewed the format of medical directives ordered in the home with a focus on the analgesic and noted the Admission and Yearly Medical Directives listed the name of the analgesic, the dose, the route of administration and for what indication it could be administered. The Inspector noted the medical directive indicated the reason or criteria for which the prn administration would occur.

During an interview with RPN #120, they identified that the first order for the analgesic on a date in the spring of 2019, was ordered for a specific reason, that the eMAR listed the analgesic as ineffective, the progress notes indicated it was administered for a particular reason, and the eMAR entry referred to the required completion of a pain assessment. The RPN stated that, if writing the order, it needed to be written with the indication for use as the home's medical directive

orders were. The RPN stated the medical directives listed the analgesic for two different reasons, it was listed for either and when it was administered by staff, they were required to write what it was given for. The RPN stated the order was not clear if it was ordered for one indication, or if it was ordered for another indication, if it listed "as needed for indicated diagnosis".

During an interview with the DOC, they stated that, although the entry on the eMAR listed a pain assessment was required for the prn analgesic administration, it had been administered for another reason on a date in the spring of 2019. The DOC identified that it was not clear from the most recent order if the analgesic was to be used for one indication, for another indication, or for both. (625)

2. The licensee has failed to ensure there was a written plan of care for resident #001 that set out clear directions to staff and others who provided direct care to the resident, with respect to a specific topical drug to be administered to the resident, and the indication for use for administration of a second topical drug to the resident.

CO #001 was issued in inspection report #2018_703625_0026, with an amended compliance due date of May 31, 2019. The order was issued pursuant to s. 6. (1) (c) of the LTCHA, 2007, and required the licensee to review and update, as required, resident #001's written plan of care to ensure the written plan set out clear direction to staff and others who provided direct care to the resident.

(a) Inspector #625 reviewed the home's policy titled "Skin and Wound Program: Wound Care Management – RC-23-01-02", last updated February 2017, that defined plan of care as a clinician driven plan that focused on a specific health concern or closely related concerns. The policy detailed that the plan of care consisted of a series of documents developed collaboratively that provided information to the care team regarding the assessed needs, delivered care and outcomes of care.

Inspector #625 reviewed the home's policy titled "Management of Skin Rashes, Lesion and Irritations – Appendix 9", last updated February 2017, which identified that nurses were to obtain orders for topical applications, such as

treatment creams, and enter treatment orders on the Treatment Administration Record (TAR).

Inspector #625 reviewed resident #001's health care record, including their electronic Treatment Administration Records (eTARs) for two months in 2019, which listed a "COMPOUNDED TOPICAL PREPARATION" was to be applied to an area of the resident's body at a specific frequency, at specific times, for an "indicated diagnosis", until a condition resolved. The eTARs did not list what the compounded topical preparation was.

The Inspector reviewed resident #001's prescriber's orders for the "compounded topical preparation" and noted the orders were for specific compounded topical drugs, of specific strengths, to be applied to an area of the resident's body until a condition was resolved.

During an interview with PSW #121, at 1101 hours, they stated that they had provided care to resident #001 that morning but had not applied the topical drug to any area of the resident's body, as they didn't know that it had to be put on. The PSW stated they hadn't provided care to the resident recently, didn't know about the topical drug, and the RPN didn't say that it had to be put on.

During an interview with PSW #122, they stated that new staff coming on would need to look on the care carts to see what topical drugs they were to apply that day as they were not written down anywhere for the PSWs to apply. The PSW stated that some RPNs verbally delegated their application.

During an interview with PSW #123, they stated that they knew resident #001 had a topical drug to be applied because they were familiar with the resident as they worked on that home area. The PSW stated that PSWs would know a topical drug was to be applied because they would find it on the care cart and the RPNs may tell them. The PSW stated that the RPN on that day worked at a specific frequency and wouldn't know, but that it would be nice if the topical drugs were written somewhere for people to know, for casual people especially, so they knew what they were supposed to put on.

During an interview with RPN #124, they checked the eTAR for resident #001 and stated it was not clear what was to be applied as it listed a compound and

they couldn't tell what the topical was from the eTAR. The RPN stated they would not have enough time in the morning to go through the eTARs for 32 residents to find out what they had to delegate to each PSW. They stated that they thought the PSWs would know the residents better than the RPN would, so the PSWs would know if something had to be applied.

During an interview with RPN #120, they stated that it was not safe for resident #001 to have the topical drug for a specific area of their body listed as a "compound" and not specifically named.

During an interview with ADOC #102, they stated that staff wouldn't know what was to be applied other than a compounded topical drug and, if pharmacy had sent the incorrect topical drug, staff would not know if was incorrect based on the eTARs' directions. The ADOC stated PSWs would know they were to apply topical drugs as RPNs were expected to go through the eTAR and delegate verbally to the PSWs. They stated that the plan of care was not clear as to which topical drug was to be applied to resident #001.

During an interview with the DOC, they identified that staff should have addressed the entry by pharmacy for the "COMPOUNDED TOPICAL PREPARATION" on the eTAR by contacting the pharmacy to update the entry to the specific topical drug to be applied.

(b) Inspector #625 reviewed the home's policy titled "Management of Skin Rashes, Lesion and Irritations – Appendix 9", last updated February 2017, which identified nurses were to initiate/update the resident care plan to reflect altered skin integrity, including the characteristic of the rash/lesion/irritation, current goals and interventions.

Inspector #625 reviewed resident #001's health care record including the eTARs for two months in 2019, which listed entries for a specific type and strength of topical drug "Apply to [a particular part of the body] topically as needed for indicated diagnosis [at a specific frequency]" started on a date in the summer of 2019. The Inspector noted the specific topical had been documented as administered during those months, on a specific date in the summer of 2019.

The corresponding eTAR medication administration note identified the topical

drug was applied for particular characteristics, by RPN #120, and was effective as the body part it had been applied to exhibited less of one characteristic for which it had been applied.

The Inspector reviewed resident #001's current care plan and was not able to locate a focus related to altered skin integrity or the potential for altered skin integrity.

The Inspector reviewed orders related to the eTAR entries to determine what the "indicated diagnosis" for the topical drug application was. On a date in the summer of 2018, and a date in the summer of 2019, the orders for the topical drug listed in the Physician Medication Reviews were to "Apply to [a particular part of the body at a specific frequency] as needed", and did not identify what the topical drug was to be applied for. On another date in the summer of 2018, a Digital Prescriber's Orders entry listed the topical drug to applied to an affected area of the resident's body at a specific frequency until clear, and the Clinical Indicator section identified specific characteristics and a specific condition.

During an interview with RPN #120 in the summer of 2019, they were not able to identify what the "indicated diagnosis" was for which the eTAR directed staff to apply the topical drug, although they had applied the topical to a particular part of the resident's body on a date in the summer of 2019. The RPN reviewed the resident's chart and identified the resident's physical, dated the spring of 2018, listed "There are [areas of altered skin integrity of specific characteristics to a particular part of the resident's body] consistent with [a specific condition]"; and an order dated the spring of 2019, which noted that the specific condition was clear and the topical drug was changed to an as needed basis. (625)

3. The licensee has failed to ensure there was a written plan of care for resident #001 that set out clear directions to staff and others who provided direct care to the resident, with respect to their individualized toileting schedule.

CO #001 was issued in inspection report #2018_703625_0026, with an amended compliance due date of May 31, 2019. The order was issued pursuant to s. 6. (1) (c) of the LTCHA, 2007, and required the licensee to review and update, as required, resident #001's written plan of care to ensure the written plan set out clear directions to staff and others who provided direct care to the

resident.

During an observation of resident #001, Inspector #625 observed a sign of incontinence.

Inspector #625 reviewed resident #001's current care plan that listed the resident was incontinent at a specific frequency and was to be toileted according to the "resident's individualized schedule ([resident] will usually show non verbal signs that [they require] toileting [and identified the signs the resident would exhibit])". The care plan did not list an individualized schedule for toileting the resident.

The Inspector also reviewed the resident's most recent Continence Assessment dated the spring of 2019, which did not identify the resident's particular elimination pattern as incontinent, which was a listed option. The assessment did include two comments listed elsewhere which identified the resident was incontinent at a particular frequency, as well as identified the resident was incontinent in another location. The assessment also identified the resident was toileted at distinct times and when a particular sign was exhibited.

During an interview with PSW #122, they stated that they toileted resident #001 when they started to act in a certain way, and the resident usually engaged in elimination at specific times. During a subsequent interview, the PSW stated that, with respect to a particular type of elimination, the resident was toileted at additional distinct times. The PSW identified that, in addition to the times the resident was toileted, they were also toileted when they exhibited certain signs.

During an interview with PSW #124, they acknowledged that resident #001's care plan listed the resident had an individualized toileting schedule related to a particular type of incontinence. The PSW stated that resident #001 was not toileted on a schedule, but when they started to act in a certain way the staff would know the resident had to engage in elimination. The PSW stated that the resident usually engaged in a particular type of elimination at distinct times, but there was no set schedule to toilet the resident, toileting was just based on how the resident acted. During a subsequent interview, the PSW stated the resident was toileted for a particular type of incontinence at additional distinct times. The PSW acknowledged the resident's care plan did not identify the individualized

toileting schedule the resident was on. The PSW stated they would tell new staff working with the resident about the times the resident had to be toileted, as the documents the PSWs referred to did not identify the individualized schedule for toileting resident #001 for a particular type of elimination.

During an interview with ADOC #102, they stated that, when they read the care plan, they interpreted it to mean the resident was toileted when they exhibited certain signs, but not at specific times although "individualized schedule" was referenced in the care plan. The ADOC reviewed the Continence Assessment completed in the spring of 2019, that identified the resident was toileted daily at distinct times and when a specific sign was exhibited. The ADOC identified that toileting the resident at the distinct times for a particular elimination need was not identified in the care plan, and that the care plan and the Continence Assessment should have been consistent. (625)

4. The licensee has failed to ensure that there was a written plan of care for resident #002 that set out clear directions to staff and others who provided direct care to the resident, with respect to antibiotic use.

CO #002 was issued in inspection report #2018_703625_0026, with an amended compliance due date of May 31, 2019. The order was issued pursuant to s. 19. (1) of the LTCHA, 2007, and required the licensee to ensure that all residents who required treatment, care, services and assistance for health, safety or well-being, were provided with the treatment, care, services and assistance required, with a focus on skin and wound care.

Inspector #625 reviewed resident #002's care plan, with a focus on skin and wound care, with a review date in the winter of 2019, and a review date in the spring of 2019. The Inspector also reviewed the resident's current care plan. The Inspector noted that each care plan contained a focus related to a skin disease diagnosis, a goal related to the diagnosis to "Improve skin integrity optimally (antibiotic for [a specific period of time])". The corresponding interventions in the first two care plans directed staff to refer to the eMAR for antibiotic orders. The corresponding interventions in the current care plan directed staff to refer to the eMAR for orders.

Inspector #625 reviewed the eMARs in place from dates in the winter to summer

of 2019, and was not able to locate an antibiotic ordered for the specific period of time related to resident #002's skin disease diagnosis, or any other current medication ordered related to the skin disease diagnosis.

During an interview with the DOC, they stated that resident #002's care plan which listed "antibiotic for [a specific period of time]" had not been revised to correspond to their eMAR for a month in the summer of 2019, which did not list the resident on an antibiotic for the specific period of time. The DOC identified the order [for an antibiotic for a specific period of time related to the skin disease diagnosis] had been entered in a month in 2018. The DOC also indicated that the current care plan's reference to the eMAR for orders related to the skin disease diagnosis had not been revised to correspond to the current eMAR, which did not list a current medication ordered to which the care plan would refer. (625)

5. The licensee has failed to ensure that there was a written plan of care for resident #004 that set out clear directions to staff and others who provided direct care to the resident, with respect to their use of a continence device, the position of their bed rails, their transfer status, and their use of mobility aids.

A CIS report was submitted for a fall experienced by resident #004 in the spring of 2019, where the resident was taken to hospital and which resulted in a significant change in the resident's health condition. The report identified the resident had returned to the home on a date later in the spring of 2019, and the resident's care plan would continue to be revised as the resident recuperated.

(a) The CIS report identified that, upon return from hospital, the resident had a temporary continence device in place.

Inspector #625 reviewed resident #004's health care record including:
- the current care plan in place on a date in the summer of 2019, which identified that the resident had "returned home from hospital with a [particular continence device]. No date set for removal at this time". In the specific incontinence focus, the care plan listed "Check resident [at a specific frequency for a sign of incontinence] or need to use the toilet" as well as "Resident…has a [particular continence device]";
- a Digital Prescriber's Orders entry dated the summer of 2019, to discontinue

use of the continence device; and
- a progress note dated the same date as the order, that identified "POA aware of [the continence device] being removed".

During observations of resident #004 throughout the inspection, Inspector #625 did not observe the particular continence device in use, but observed staff assist the resident to use the bathroom when the resident stated they had to be toileted.

During an interview with PSW #125, they stated that resident #004 had previously used the continence device but currently used the toilet.

During an interview with the DOC, they acknowledged that resident #004's health care record included an order to discontinue the use of the continence device on a specific date in the summer of 2019, a progress note identified the continence device was removed on that date, and a care plan which continued to identify that the resident used the continence device.

(b) The CIS report identified that, upon return from hospital, the resident required assistance with bed mobility.

Inspector #625 observed resident #004 laying in bed, sitting in bed, changing positions in bed, sitting on the edge of the bed and transferring out of bed. During each of the activities, one of the resident's bed rails was in one position and another was in a different position.

During one occasion, the Inspector observed the resident laying in bed, grab on to a family member's arms and pull themselves to a sitting position. On a second occasion the Inspector observed resident #004 attempt to stand with assistance after laying down in bed. The resident rocked back to a seated position, then stood on the second attempt, without using the bed rail or their mobility aid to assist with the transfer.

During an interview with PSW #126, they stated that they had helped resident #004 get up from bed that date. The PSW stated they put the resident's mobility aid in front of them, supported the resident and then the resident stood up by themself.

During an interview with PSW #125, they stated that resident #004's two bed rails had both been in the same position after they returned from hospital as the resident needed to use the bed rails more in bed, and required staff assistance for care and transfers. The PSW stated that the one bed rail was then moved to another position when the resident started transferring out of bed more, such as to use the bathroom. The PSW stated the resident used that bed rail, the bed rail closest to the bathroom, to grab on to when they transferred out of bed, but the other bed rail had always been in the same position because the resident did not exit that side of the bed.

Inspector #625 reviewed a current "Bedrail and Entrapment Risk Assessment" dated the summer of 2019, and a "Least Restraint - Personal Assistance Service Device (PASD) Assessment" also dated the summer of 2019. Neither assessment identified the position of the bed rails or that the resident used a bed rail to assist with transferring out of bed.

Inspector #625 reviewed resident #004's current care plan which identified, under the personal assistance services devices (PASDs) focus, that the resident used bed rails to assist with positioning and to offer comfort. The intervention for bed rail use identified the resident used the bed rails for bed mobility and positioning, and had been initiated, created and revised on a date in the spring of 2018, more than one year prior to the date of the fall that resulted in injuries to the resident, in the spring of 2019. The transfer and the bed mobility foci sections of the care plan did not list the use of bed rails as interventions.

In March 2019, a LTCHomes.net Memo to the Sector from the Long-Term Care Homes Division related to bed rail use identified documents to be used to determine compliance with bed rails, including the document titled "Clinical Guidance For the Assessment and Implementation of Bed Rails In Hospitals, Long Term Care Facilities, and Home Care Settings, April 2003". The document indicates:
- The intended purpose of bed rails includes assisting patients with movement (moving within the bed; getting in and out of bed), to provide a feeling of comfort and security, etc.
- Decisions to use or to discontinue the use of a bed rail should be made in the context of an individualized patient assessment using an interdisciplinary team

approach.
- Regardless of the purpose for which bed rails are being used or considered, a decision to utilize or remove those in current use should occur within the framework of an individual patient assessment.
- The individualized patient assessment provides ongoing information necessary to develop a care plan, to provide the appropriate care and services for each patient, and to modify the care plan and care/services based on the patient's status. Assessment considerations include the appropriateness of the bed such as support for turning and strategy for safe egress.
- Use of bed rails should be based on a patient's assessed medical needs and should be documented clearly and approved by the interdisciplinary team. Bed rail use for treatment of a medical symptom or condition should be accompanied by a care plan designed for that symptom or condition. Bed rail use for a patient's mobility and/or transferring, for example turning and positioning within the bed and providing a hand-hold for getting into or out of bed, should be accompanied by a care plan.
- Care plan considerations include diagnoses, symptoms, conditions, and/or behavioral symptoms for which the use of a bed rail is being considered.
- The team should review the care plan and determine its effects on the patient through an ongoing cycle of evaluation that includes assessment of outcomes.

During an interview with ADOC #102, they confirmed one of resident #004's bed rails was in one position and another bed rail was in another position. The ADOC identified that, if the positioning of the resident's bed rails had changed, none of the home's care plans were that specific and, as bedrails were a personal assistance services device (PASD), their use was not meant to be that specific. The ADOC stated the bed rails were used for positioning and comfort, staff used them whatever way they needed to as appropriate for care for the resident that day. The ADOC indicated that staff had the discretion to place the bed rails in whatever position they felt was appropriate based on the resident's need.

(c) The CIS report identified that, upon return from hospital, resident #004 required the assistance of more than one person to transfer using an assistive device.

On multiple occasions throughout the inspection, Inspector #625 observed resident #004 transfer without using the assistive device, with the assistance of

one person.

A review of resident #004's current care plan as of a date in the summer of 2019, identified, under the transfer focus, the resident required a particular level of assistance from staff, who were to provide physical assistance (specific physical assistance, or use of a specific device as needed when the resident exhibited a specific characteristic). The falls risk focus identified the resident's transfer/lift status had been reviewed and changed as required, including their transfer logo which had been updated to a specific device.

Following interviews with staff regarding resident #004's care plan, the Inspector noted that the current care plan identified, under the transfer focus, that the resident required a particular range of assistance of one staff member and their assistive device was to be used in a particular manner. The falls risk focus continued to indicate that the resident's transfer/lift status had been reviewed and changed as required, including their transfer logo updated to a specific device.

During an interview with PSW #126, they stated that, to transfer resident #004, they assisted the resident to get up from bed, supported the resident, used the resident's mobility aid in a particular manner and the resident then stood up by themself. The PSW identified that they had asked other staff how resident #004 transferred because the transfer logo on the resident's wall identified the resident used a specific device, however when the PSW asked other staff about the resident's transfer status, the staff informed them that the resident no longer used the device, they could transfer by themself.

During an interview with PSW #114, they stated that resident #004 was independent with transfers as long as staff watched the resident, even from a few feet away.

During an interview with the DOC, they acknowledged that the plan of care was not clear regarding resident #004's transfer status.

(d) The CIS report identified that, upon return from hospital, resident #004 mobilized using a mobility aid but had previously used a different mobility aid.

On multiple occasions during the inspection, Inspector #625 observed resident #004 mobilize using one mobility aid. The Inspector did not observe the resident use the second mobility aid at any time during the inspection, although one was located in the resident's room.

The Inspector reviewed resident #004's health care record including a progress note dated the summer of 2019, which identified the resident utilized one mobility aid for mobility that evening; a PT progress note dated two days later, which identified the resident had been mobilizing [in a manner which corresponded to the use of one mobility aid] to all meals with supervision; and Pain Assessment generated notes which indicated the resident was mobilizing in a manner that corresponded to the use of one mobility aid and/or using that one aid on multiple dates in the summer of 2019.

A review of resident #004's current care plan, under the locomotion on/off unit and in room focus, identified the goal that the resident would be able to mobilize in a particular manner on/off the unit safely using one mobility aid within the next quarter. The associated interventions identified the resident used a second mobility aid for mobility due to a injury and would mobilize in a particular manner using the second mobility aid at times, as well as would move with assistance. The interventions did not identify the resident used the first mobility aid to mobilize in a particular manner, although the corresponding goal was related to the use of the first mobility aid.

During an interview with PSW #126, they stated that the resident used the first mobility aid to transfer and to mobilize and did not know if the resident used the second mobility aid that was present in their room.

During an interview with PSW #125, they stated resident #004 used the first mobility aid to mobilize in a particular manner on the unit, as well as had mobilized in that manner outside with the first mobility aid at the time of the interview, to engage in an activity with a family member. The PSW stated they did not know what the resident used the second mobility aid for.

During an interview with PSW #114, they stated that resident #004 used the first mobility aid, including to mobilize in a particular manner to specific activities, had been mobilizing well, and the second mobility aid was going to be returned as

they no longer needed it. The PSW stated the resident was independent with mobility in a particular manner, as long as staff watched, even from a few feet away. The PSW stated that resident #004 had been using the first mobility aid for weeks before the interview, including to mobilize in a particular manner to supper the last few days, and acknowledged the care plan in place during that time did not identify the resident used the first mobility aid and no longer used the second mobility aid.

During an interview with PT #115, they identified that resident #004 had been mobilizing in a particular manner with the first mobility aid at the time resident #004's care plan identified they used a second mobility aid for mobility. The PT stated the resident may have used the second mobility aid if they were tired in the evening or complained of pain. The PT stated they had contacted the resident's family and told them the resident should use the second mobility aid for certain distances, if they take the resident out, but they could return the second mobility aid they had obtained for the resident.

During an interview with the DOC, they acknowledged that resident #004's care plan identified they used the second mobility aid for mobility and did not identify the resident used the first mobility aid [although the goal corresponding to use of the second mobility aid referred to safe use of the first mobility aid]. (625)

6. The licensee has failed to ensure that there was a written plan of care for resident #004 that set out clear directions to staff and others who provided direct care to the resident, with respect to the frequency of administration of one analgesic drug, the frequency of administration of another analgesic drug, and the frequency of completion of pain assessments.

A CIS report was submitted for a fall experienced by resident #004, in the spring of 2019, where the resident was taken to hospital and which resulted in a significant change in the resident's health condition. The report identified the resident sustained injuries and returned to the home on a date later in the spring of 2019.

(a) Inspector #625 reviewed resident #004's health care record including a Digital Prescriber's Orders entry dated the spring of 2019, which ordered a change in the dose of an analgesic to a specific dose, administered by a specific

route, at a specific frequency, in a particular circumstance; and to start the analgesic of a specific dose, administered by a specific route, at a specific frequency, as needed.

A review of the 2019 eMAR for one month identified two corresponding entries for the analgesic with start dates identified as the date after the orders were written:
- one entry identified the analgesic was to be given at specific times between certain hours, and directed staff to use the as needed medication at night; and
- the other entry identified administration of the analgesic of a specific dose, by a specific route, at a specific frequency, as needed, for an "indicated diagnosis [also has reg dose]".

The Inspector noted the frequency of the analgesic administration ordered was not the same as the frequency of analgesic administration listed on the eMAR.

During an interview with the DOC, they stated that the Physician's order for the analgesic, and the corresponding eMAR entry, were not clear as they did not provide staff with the same directions for administration. The DOC indicated they expected to see the analgesic listed on the eMAR for administration at the ordered frequency, with staff documentation if the analgesic was not administered at those times due to the resident sleeping.

(b) Inspector #625 reviewed resident #004's health care record including Digital Prescriber's Orders entries dated the spring of 2019, which ordered another analgesic, of a specific dose, administered by a specific route, at a specific frequency, in a specific circumstance, as well as that analgesic of a specific dose, administered by a specific route, at a specific frequency, as needed.

A review of the eMARs identified two entries that corresponded with the start date of the analgesic orders listed as:
- give a specific dose, by a specific route, at a specific frequency for indicated diagnosis in a specific circumstance "[also has prn]" scheduled between certain hours; and
- give a specific dose, by a specific route, at a specific frequency, "as needed for indicated diagnosis ... [also has regular dose]"

The Inspector noted the frequency of analgesic administration ordered was not the same as the frequency of analgesic administration listed on the eMAR.

During an interview with the DOC, they stated that the Physician's order for the analgesic and the corresponding eMAR entry for the order were not clear as to whether the analgesic was ordered for scheduled administration at the specific frequency listed in the order, or if it was to be administered for the number of times listed on the eMAR.

(c) Inspector #625 reviewed resident #004's health care record including orders in place at the time of the resident's return from hospital listed on an Order Summary Report signed by the Physician in the spring of 2019. The report included an entry for staff to "Complete Pain Flow Record 'Pain/Palliation-Pain Flow (LPQRSTU)(SPN)' x 72 hours as per pain management policy [at a specified frequency] for 3 Days until finished". The order was identified as an active order which was ordered and started on a date in the winter of 2019, ended three days later in the winter of 2019, and was renewed by the Physician on a date in the spring of 2019.

Inspector #625 reviewed components of the home's pain management program including a policy titled "Pain Identification and Management-RC-19-01-01", last updated November 2018, and a protocol titled "Pain Management-RC-19-01-01", revised June 5, 2019. Both documents identified that staff were to complete pain assessments for specific indications for 72 hours on the day and evening shifts only. The documents did not indicate pain assessments were required at the frequency identified in the Order Summary Report for the 72 hour period.

During an interview with RPN #127, they stated that the direction to complete pain assessments at the frequency specified in the Order Summary Report for 72 hours differed from the policy, which directed staff to complete the pain assessments for 72 hours on the day and evening shifts.

During an interview with ADOC #102, they stated that multiple components of the home's pain management program identified that pain assessments were to be completed for 72 hours on the day and evening shifts when specific criteria were met. The ADOC stated staff would only complete a pain assessment on the night shift if a resident was awake or prn pain medication was administered

on the night shift. During a subsequent interview with the ADOC, they stated that the order entered in the winter of 2019, had been entered incorrectly as it was supposed to be in place for three days and then "drop off", but that it was still active under the orders tab.

During an interview with the DOC, they stated that staff were required to complete pain assessments for 72 hours on the day and evening shifts. The DOC stated staff only completed pain assessment at night if a resident was awake. The DOC stated they would look into whether the staff were required to complete the pain assessments at the frequency specified in the Order Summary Report for 72 hours after the Physician renewed the order, which had been originally initiated in the winter of 2019, to end three days later in the winter of 2019, as it was not clear. During a subsequent meeting with the DOC, they stated that the Order Summary Report would not have been clear to either RN #128 or RN #129, who had processed the order, if they were to complete the pain assessment at the frequency specified in the Order Summary Report for 72 hours as it was renewed as an order, or if it was completed on a date in the winter of 2019, as the end date listed. (625)

7. The licensee has failed to ensure that there was a written plan of care for resident #005 that set out clear directions to staff and others who provided direct care to the resident, with respect to the use of a medical device, the use of a second medical device and the resident's mobility.

A CIS report was submitted for a fall experienced by resident #005, in the summer of 2019, where the resident was taken to hospital and which resulted in a significant change in the resident's health condition.

(a) The CIS report identified that the resident had sustained an injury and required the use of a medical device.

Inspector #625 observed resident #005 with the medical device in use in the summer of 2019.

During an interview with resident #005, in the summer of 2019, they stated they had a medical appointment the following date, when the Physician would see if their injury was resolved and the medical device could be removed.

Two days after the interview with the resident, the Inspector observed the medical device was no longer in place, but a temporary treatment was in use. Later that date, the Inspector observed the resident with a second medical device in use.

During an interview with resident #005 and their family member #119, on the same date as the Inspector's observation of the second medical device, the family member stated they had just returned from attending an appointment for the second medical device with resident #005.

Inspector #625 reviewed resident #005's health care record including an eMAR entry directing staff to monitor and document specific criteria every shift while the resident had the first medical device in place. The Inspector noted the entry had been discontinued six days after the first medical device had been removed. The Inspector noted that, although resident #005's first medical device had been removed six days earlier, staff had documented that they had monitored specific criteria while the resident had the first medical device in use six times on one type of shift; once on another type of shift, and twice on a third type of shift. The Inspector further noted that staff had documented "9" for "other/see progress note" five times on one type of shift and three times on another type of shift related to the monitoring of the first device [which was no longer in use].

The Inspector reviewed eMARs progress notes entered following the removal of the first medical device. The Inspector noted that one progress note identified the device was no longer in place, but that monitoring would remain [without updating the entry to reflect the device had been removed] as a temporary treatment was applied; six progress notes documented monitoring of the medical device and did not identify that the device was no longer in place; and three progress notes identified the author spoke to the resident about monitoring the first medical device [which was no longer in place].

During an interview with ADOC #102, they stated that, if staff wanted to continue with the monitoring a specific characteristic of resident #005, their care plan should have been updated to reflect that the resident used a second medical device.

During an interview with the DOC, they identified that resident #005's plan of care was not clear to staff that the resident no longer used one medical device but used a second medical device.

(b) Inspector #625 reviewed resident #005's care plan in place in the summer of 2019. The care plan identified resident #005 had one medical device in place, as well as identified the resident had a second medical device in place, in the same location as the first. The care plan identified staff were to apply the second medical device at a certain time of day and perform an action related to the second medical device at another time of day, as well as that staff were to perform a different action related to the first medical device during a certain activity.

During an interview with the DOC, they acknowledged that the care plan in place in the summer of 2019, listed that the resident had in use both the first medical device and the second medical device and stated that it did not provide clear direction to staff.

(c) The CIS report identified that interventions put in place post-fall for resident #005 included that the resident may use a mobility aid in a particular situation. The report also identified that, when walking in the room, corridor, on and off the unit, the resident needed specific assistance, as well as identified the resident was not to use the mobility aid at that time due to an injury. The report also identified that, to address their risk for falls/risk for fractures, the resident would use second mobility aid for mobility for safety.

Inspector #625 observed resident #005 using the second mobility aid for mobility in their room and on their home area on multiple dates in the summer of 2019. On one date in the summer of 2019, the Inspector also observed the resident use the mobility aid in a different manner than observed on other occasions, with no staff present. On another date in the summer of 2019, the Inspector observed the resident mobilize using a different mobility aid, on another floor of the home.

Inspector #625 reviewed the resident's current care plan which identified the following interventions:
- under the focus related to toileting, the resident would use one mobility aid in a particular situation with the assistance of staff, created by RPN #104 on a date

in the summer of 2019;
- under the focus related to walking in room/corridor/on and off unit, the resident required assistance while mobilizing in a particular manner, revised by RPN #104 two days prior to the identified toileting intervention date; was not able to use the mobility aid referred to in the toileting focus at that time, revised by RPN #104 two days prior to the identified toileting intervention date; and would be assisted to use a second mobility aid in particular situations for their safety, revised by RPN #104 on the same date as the toileting intervention date; and
- under the focus risk for falls/risk for fractures, the resident was not able to use the mobility aid referred to in the toileting focus at that time, revised by RPN #104 two days prior to the identified toileting intervention date; and would use a second mobility aid for mobility for safety, created by RPN #104 on the same date as the toileting intervention date.

A progress note entered by RPN #104 on the date of the referenced toileting intervention, identified that mobility in the resident's room, in a particular situation could be done with one mobility aid, with the assistance of staff, while mobility outside of their room in particular situations would be completed with a second mobility aid for safety.

During an interview with RPN #104, they stated that they reviewed the resident's current care plan and confirmed that it listed the resident was not to use one mobility aid, as well contrarily identified that the resident could use that mobility aid in a particular situation. The RPN acknowledged that resident #005's care plan did not provide clear direction to staff on the resident's use of the first and second mobility aids.

During an interview with ADOC #102, they indicated that resident #005's care plan was not clear as, under the same focus for walking, it directed staff to provide specific assistance with a particular manner of mobilizing, as well as directed staff not to use the first mobility aid.

During an interview with the DOC, they indicated that resident #005's care plan was not clear with respect to whether the resident used the first or the second mobility aid. The DOC acknowledged that the report submitted to the Director also listed different information about the use of the first mobility aid, whether it was used with staff assistance, or not used at all. (625)

8. The licensee has failed to ensure that there was a written plan of care for resident #002 that set out clear directions to staff and others who provided direct care to the resident, with respect to their transfer status.

A CIS report was submitted for a fall experienced by resident #002, in the winter of 2019, where the resident was taken to hospital and which resulted in a significant change in the resident's health condition.

Inspector #625 reviewed resident #002's health care record, including their current care plan which identified, under the risk for falls focus, that the resident transferred with one staff using a particular piece of transfer equipment for all transfers, or multiple staff as needed, revised in the spring of 2019. The care plan also identified, under the transfers focus, that the resident required the assistance of multiple staff to transfer using a specific device, revised later in the spring of 2019.

On a date in the summer of 2019, the Inspector observed a logo in resident #002's room identifying they used a specific device.

Two days later, the Inspector observed staff use a specific device when assisting the resident.

During an interview with PSW #130, they stated that resident #002 had required the assistance of a staff person to transfer prior to their fall.

During an interview with RPN #112, they stated that resident #002 currently transferred with the assistance of two staff using a specific device.

During an interview with PT #115, they identified that resident #002's transfer status had been changed to a specific device for safety reasons.

The severity of the issue was determined to be a level 3, as there was actual risk of harm to residents. The scope of the issue was a level 2 as a pattern of occurrence was present. The home had a level 4 compliance history as it had on-going non-compliance pursuant to this subsection of the legislation, and three or fewer compliance orders, which included compliance order (CO) #001 issued

January 30, 2019, in inspection report #2018_703625_0026. (625)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 18, 2019

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

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 Ontario Regulation (O. Reg.) 79/10.

Specifically, the licensee must:
(a) Ensure residents #003 and #005, and any other resident, are provided with care in accordance with the home's falls prevention and management program.
(b) Ensure resident #001, and any other resident, are provided with care in accordance with the home's skin and wound care program.
(c) Ensure residents #002, #003, #004 and #005, and any other resident, are provided with care in accordance with the home's pain management program.

Grounds / Motifs :

1. The licensee has failed to ensure that where the LTCHA, 2007, or O. Reg. 79/10 required the licensee of a long-term care home to have, institute or otherwise put in place any policy, protocol or procedure, that the policy, protocol or procedure was complied with, with respect to resident #003 and compliance with the falls prevention and management program.

In accordance with O. Reg. 79/10, s. 48. (1) 1., the licensee was required to ensure that an interdisciplinary falls prevention and management program was developed and implemented in the home.

In accordance with O. Reg. 79/10, s. 30. (1) 1., the licensee was required to

ensure that there was a written description of the falls prevention and management program that included relevant policies, procedures and protocols.

Specifically, staff did not comply with the licensee's policy titled "Falls Prevention and Management Program RC-15-01-01", last updated February 2017, which directed staff to assess, at each shift for 72 hours post fall, pain, bruising, change in functional status, change in cognitive status and changes in range of motion. The policy directed staff to document the fall and results of all assessments and actions taken during the 72 hour post fall follow-up.

CO #002 was issued in inspection report #2018_703625_0026, with an amended compliance due date of May 31, 2019. The order was issued pursuant to s. 19. (1) of the LTCHA, 2007, and required the licensee to ensure that resident #003 was provided with the treatment, care, services and assistance required for health, safety or well-being, with a focus on falls prevention and management.

The findings supporting CO #002 identified that registered nursing staff failed to provide resident #003 with appropriate clinical monitoring post-fall, as required by the licensee.

Inspector #625 reviewed resident #003's health care record including a progress note dated the spring of 2019, which identified the resident fell at a specific time. A review of the progress notes for the 72 hour period post-fall identified that staff had not documented assessment of resident #003 post-fall on the evening shifts for two required shifts. The Inspector noted that the various components of the criteria required to be assessed, as listed in the home's policy, had not been documented in the progress notes on the night shifts for three required shifts; or on the day shift for one required shift.

During an interview with RPN #120, they stated that staff had been educated on the criteria to be documented for 72 hours post-fall. The RPN stated they placed a note identifying the criteria to be documented according to the home's program on each computer in the home's meeting and medication rooms. The RPN identified that the required progress notes had not been completed on the two specific evening shifts, and that other progress note contained documentation which did not include all of the required assessment information.

During an interview with ADOC #102, they reviewed resident #003's progress notes and acknowledged that there was no documentation on two specific evening shifts, and three or four other entries were missing components of the 72 hour documentation required as indicated in the home's policy. (625)

2. The licensee has failed to ensure that where the LTCHA, 2007, or O. Reg. 79/10 required the licensee of a long-term care home to have, institute or otherwise put in place any policy, protocol or procedure, that the policy, protocol or procedure was complied with, with respect to resident #003 and compliance with the pain management program.

In accordance with O. Reg. 79/10, s. 48. (1) 4., the licensee was required to ensure that an interdisciplinary pain management program was developed and implemented in the home.

In accordance with O. Reg. 79/10, s. 30. (1) 1., the licensee was required to ensure that there was a written description of the pain management program that included relevant policies, procedures and protocols.

Specifically, staff did not comply with the licensee's policy titled "Pain Identification and Management – RC-19-01-01", last updated November 2018, or with the protocol titled "Pain Management – RC-19-01-01", revised June 5, 2019, which were part of the licensee's pain management program.

The policy titled "Pain Identification and Management – RC-19-01-01", last updated November 2018, identified that nurses were required to complete a pain assessment for an indication of the presence of pain; to complete specific sections of the pain assessment post-analgesia; and to complete pain assessments for 72 hours, on the day and evening shifts, when a new pain medication was started.

The protocol titled "Pain Management – RC-19-01-01", revised June 5, 2019, identified that one pain assessment was to be completed for new pain, or for an indication of pain (not a new report of pain); two pain assessments were to be completed if a medication was administered on an as needed basis, one detailing the reason for the assessment and one upon follow-up; and pain

assessments were to be completed for 72 hours, on the day and evening shifts, when new pain medication was started.

CO #002 was issued in inspection report #2018_703625_0026, with an amended compliance due date of May 31, 2019. The order was issued pursuant to s. 19. (1) of the LTCHA, 2007, and required the licensee to ensure that resident #003 was provided with the treatment, care, services and assistance required for health, safety or well-being, with a focus on pain management.

The findings supporting CO #002 identified that registered nursing staff failed to provide resident #003 with appropriate pain monitoring, as required by the licensee.

Inspector #625 reviewed resident #003's health care record including progress notes which identified, on a date in the spring of 2019, the resident had pain during particular activities, a prn analgesic was ordered to help with pain; the analgesic was administered and was effective.

The Inspector also reviewed resident #003's eMAR for a month in 2019, which identified the resident was administered the analgesic by a specific route, at a specific time, for pain of a specific quantifiable level, which was effective.

Inspector #625 reviewed resident #003's Digital Prescriber's Orders entry dated the spring of 2019, for a specific dose of the analgesic, administered by a specific route, at a specific frequency, as needed.

The Inspector reviewed pain assessments and was not able to locate pain assessments for the new pain medication started and administered prn, on a specific date in the spring of 2019.

During an interview with the DOC, they stated that resident #003 should have had pain assessments completed for the administration of the analgesic on a specific date in the spring of 2019. The DOC reviewed the completed assessments in PCC and stated that the pain assessments had not been completed. (625)

3. The licensee has failed to ensure that where the LTCHA, 2007, or O. Reg.

79/10 required the licensee of a long-term care home to have, institute or otherwise put in place any policy, protocol or procedure, that the policy, protocol or procedure was complied with, with respect to resident #001 and compliance with the skin and wound care program.

In accordance with O. Reg. 79/10, s. 48. (1) 2., the licensee was required to ensure that an interdisciplinary skin and wound care program was developed and implemented in the home.

In accordance with O. Reg. 79/10, s. 30. (1) 1., the licensee was required to ensure that there was a written description of the skin and wound care program that included relevant policies, procedures and protocols.

Specifically, staff did not comply with the licensee's policy titled "Skin and Wound Program: Wound Care Management – RC-23-01-02", last updated February 2017, the policy titled "Management of Skin Rashes, Lesions and Irritations – Appendix 9 - RC-23-01-02", last updated February 2017, or with the "Impaired Skin Integrity Guide – RC-23-01-02", updated June 5, 2019, which were part of the home's skin and wound care program.

CO #002 was issued in inspection report #2018_703625_0026, with an amended compliance due date of May 31, 2019. The order was issued pursuant to s. 19. (1) of the LTCHA, 2007, and required the licensee to ensure that all residents who required treatment, care, services and assistance for health, safety or well-being, were provided with the treatment, care, services and assistance required, with a focus on skin and wound care.

The findings supporting CO #002 identified that registered nursing staff failed to provide a resident with appropriate skin and wound care, as required by the licensee.

(a) The policy titled "Skin and Wound Program: Wound Care Management – RC-23-01-02", last updated February 2017, identified that interdisciplinary staff were to reassess and update the care plan as needed and communicate to care staff and other relevant persons.

The policy titled "Management of Skin Rashes, Lesions and Irritations –

Appendix 9 - RC-23-01-02", last updated February 2017, identified that staff were to initiate/update a resident's care plan to reflect an altered skin integrity focus, including characteristics of a rash/lesion/irritation, current goals and interventions.

The protocol titled "Impaired Skin Integrity Guide – RC-23-01-02", updated June 5, 2019, identified that staff were to update the care plan with a focus of "Impaired Skin Integrity".

Inspector #625 reviewed resident #001's health care record, including their electronic eTARs for two months in 2019, which identified a topical drug was to be applied to an area of the resident's body, until specific altered skin integrity resolved; as well as identified a second topical drug was to be applied as required to another part of the resident's body.

Inspector #625 also reviewed a progress note dated the summer of 2019, which identified resident #001 performed an action to multiple parts of their body, had several indications of altered skin integrity present on multiple body parts, and had a topical treatment for the issues which had been applied to the body parts with relief. A progress note dated the following date, identified resident #001 had altered skin integrity exhibiting specific characteristics on a part of the their body.

Inspector #625 reviewed resident #001's current care plan which did not contain a focus related to impaired skin integrity, did not refer staff to the eTAR and did not list any topical drug to be applied to two of the resident's body parts.

During an interview with the DOC, they acknowledged that the resident's care plan had not been reassessed and updated in accordance with the skin and wound program with respect to the resident's altered skin integrity on one of the parts of their body, corresponding treatment ordered on a date in the summer of 2019, or the altered skin integrity on two other parts of resident #001's body.

(b) The licensee's policy titled "Skin and Wound Program: Wound Care Management – RC-23-01-02", last updated February 2017, identified that staff were to promptly assess all residents exhibiting altered skin integrity on initial discovery and use the Impaired Skin Integrity Assessment for skin impairments such as rashes or reddened areas.

The policy titled "Management of Skin Rashes, Lesions and Irritations – Appendix 9 - RC-23-01-02", last updated February 2017, identified that staff were to document in the progress notes an assessment of rashes, lesions, and irritations (including location, size and characteristics).

The protocol titled "Impaired Skin Integrity Guide – RC-23-01-02", updated June 5, 2019, identified that staff were to complete a wound assessment in Point Click Care (PCC).

The home failed to complete initial assessments of resident #001's altered skin integrity on multiple parts of the resident's body.

See WN #3, finding #1 for details.

(c) The licensee's policy titled "Skin and Wound Program: Wound Care Management – RC-23-01-02", last updated February 2017, identified that staff were to re-assess at a minimum weekly, and that re-evaluation and documentation of treatment with creams or other medicated preparations was to occur at minimum weekly.

The policy titled "Management of Skin Rashes, Lesions and Irritations – Appendix 9 - RC-23-01-02", last updated February 2017, identified that staff were to complete an assessment a minimum of every seven days until resolved, which was to include the need to continue treatment and any signs of improvement or worsening condition.

The protocol titled "Impaired Skin Integrity Guide – RC-23-01-02", updated June 5, 2019, identified that staff were to complete a weekly assessment and enter a reminder to complete the weekly assessment on the eTAR by creating a separate order for it.

Resident #001's eTARs for two months in 2019, did not contain any entries related to completion of weekly skin assessments, and no weekly wound assessments had been completed for the altered skin integrity on a specific part of resident #001's body.

During an interview with the DOC, they indicated that staff had not entered a reminder to complete the weekly assessments as the guide required.

See WN # 3, finding #3 for details related to the lack of completion of weekly assessments.

(d) The licensee's policy titled "Skin and Wound Program: Wound Care Management – RC-23-01-02", last updated February 2017, identified that staff were to complete a referral to the Registered Dietitian (RD) for all residents exhibiting altered skin integrity.

The policy titled "Management of Skin Rashes, Lesions and Irritations – Appendix 9 - RC-23-01-02", last updated February 2017, identified that staff were to complete a dietary referral as required and forward to the Nutritional Care Team for the RD to assess.

The home failed to submit referrals to the RD for the areas of altered skin integrity on multiple parts of resident #001's body.

See WN #3, finding #2 for details.

(e) The policy titled "Skin and Wound Program: Wound Care Management – RC-23-01-02", last updated February 2017, identified that staff were to "Document resident/POA/SDM/family communication in the interdisciplinary progress notes". The policy listed specific criteria staff were to document related to the communication including involvement in the development and awareness of the plan of care related to skin/wound, how long the resident had the skin breakdown, how the skin had been treated in the past, prevention interventions attempted, interventions reflecting choices and preferences, and any relevant skin education provided.

The policy titled "Management of Skin Rashes, Lesions and Irritations – Appendix 9 - RC-23-01-02", last updated February 2017, identified that staff were to document in the interdisciplinary progress notes "Communication to POA/SDM/family".

The protocol titled "Impaired Skin Integrity Guide – RC-23-01-02", updated June

5, 2019, identified that staff were to "Notify the POA of the wound (new, worsening or recurring) and document in the progress notes in PCC". It was also identified that all skin impairments required notification regardless of the situation.

Inspector #625 was not able to locate documentation in the progress notes that identified communication with the resident's Attorney for Personal Care, substitute decision-maker (SDM) or family had occurred related to resident #001's altered skin integrity on multiple parts of their body.

During an interview with the DOC, they indicated that communication with the resident's Attorney for Personal Care, SDM or family had not been documented in the progress notes as required, including any involvement in the development and awareness of the plan of care related to skin integrity.

(f) The protocol titled "Impaired Skin Integrity Guide – RC-23-01-02", updated June 5, 2019, identified that staff were to send a referral to the Wound Care Champion using PCC for all skin impairments.

Inspector #625 was not able to locate a referral to the Wound Care Champion for the altered skin integrity on multiple parts of resident #001's body.

During an interview with the DOC, they stated that staff had not submitted referrals to the Wound Care Champion for resident #001's areas of altered skin integrity on multiple parts of resident #001's body. (625)

4. The licensee has failed to ensure that where the LTCHA, 2007, or O. Reg. 79/10 required the licensee of a long-term care home to have, institute or otherwise put in place any policy, protocol or procedure, that the policy, protocol or procedure was complied with, with respect to resident #002 and compliance with the pain management program.

In accordance with O. Reg. 79/10, s. 48. (1) 4., the licensee was required to ensure that an interdisciplinary pain management program was developed and implemented in the home.

In accordance with O. Reg. 79/10, s. 30. (1) 1., the licensee was required to

ensure that there was a written description of the pain management program that included relevant policies, procedures and protocols.

Specifically, staff did not comply with the licensee's policy titled "Pain Identification and Management – RC-19-01-01", last updated November 2018, or with the protocol titled "Pain Management – RC-19-01-01", revised June 5, 2019, which were part of the licensee's pain management program.

The policy titled "Pain Identification and Management – RC-19-01-01", last updated November 2018, identified that nurses would complete a pain assessment for residents for a new pain and when there was an indication of the presence of pain (including reported pain). The policy indicated that nurses were to complete the pain assessment for 72 hours, on the day and evening shifts, when a new pain medication was started.

The protocol titled "Pain Management – RC-19-01-01", revised June 5, 2019, identified that one pain assessment was to be completed for new pain, or when an indication of pain was present (not a report of new pain). The protocol also identified that two pain assessments were required, one to detail the reason for the assessment and one upon follow-up if prn medication was administered. The protocol also indicated that pain assessments were to be completed for 72 hours, on the day and evening shifts, when new pain medication was started and when existing pain medication was increased or decreased.

(a) Inspector #625 reviewed resident #002's eMAR for a month in 2019, which identified the resident had received a prn analgesic for pain on multiple dates in the spring of 2019, including dates where the analgesic had been administered multiple times.

The Inspector reviewed pain assessments completed in that month in 2019 and identified that 12 out of 22, or 55 per cent, of the individual pain assessments had not been completed.

During an interview with the DOC, they stated that resident #002 should have had two pain assessments completed for each administration of the medication administered on an as needed basis, one on complaint of pain before the administration [presence of pain/complaints of pain assessment] and one after

the pain medication was administered [post analgesia/follow up assessment]. The DOC identified pain assessments for the following dates were absent:
- on one date in the spring of 2019, the follow up pain assessment was missing;
- on another date in the spring of 2019, a follow up pain assessment was missing;
- on another date in the spring of 2019, both pain assessments were missing;
- on another date in the spring of 2019, both pain assessments were documented in the presence of pain assessment;
- on another date in the spring of 2019, both pain assessments were missing; and
- on another date in the spring of 2019, both pain assessments were documented in the presence of pain assessment.

(b) Inspector #625 reviewed resident #002's eMAR for another month in 2019, which identified the resident had received prn analgesic for pain on a date in the spring of 2019.

The Inspector reviewed pain assessments completed in that month in 2019 and was not able to locate either required pain assessment for the date in the spring of 2019.

During an interview with the DOC, they identified that both required pain assessments for the date in the spring of 2019, were missing.

(c) Inspector #625 reviewed Digital Prescriber's Orders entries, after the resident's return from hospital on a date in the spring of 2019, with a focus on pain medication. On another date in the spring of 2019, a specific analgesic drug, of a specific dose, administered by a specific route, at a specific time of day, was ordered.

Inspector #625 reviewed resident #002's eMAR for a month in 2019 which identified the medication was to start on a specific date, at a specific time.

Inspector #625 reviewed pain assessments completed for the corresponding order and identified that pain assessments had not been completed on one shift on a date in the spring of 2019.

During interviews with the DOC, they identified pain assessments were required on the day and evening shifts for 72 hours. The DOC indicated that pain assessment for one shift on a date in the spring of 2019, was absent.

(d) Inspector #625 further reviewed Digital Prescriber's Orders entries, with a focus on pain medication. On a date in the spring of 2019, the dose of one scheduled analgesic drug was changed, and the frequency of administration of a second analgesic drug was changed.

Inspector #625 reviewed resident #002's eMAR for a month in 2019, which identified the administered first analgesic dose was changed on a specific date and time in the spring of 2019, and the second analgesic drug order was changed on the same date and time.

Inspector #625 reviewed pain assessments completed for that date, and identified that pain assessments had not been completed as required on one shift on the first date, on two shifts on the second date, on one shift on the third date, or on one shift on the fourth date. The Inspector noted that five out of six of the required pain assessments, or 83 per cent of the assessments, had not been completed. Further, the pain assessment completed on the third date, did not indicate the assessment was related to, or considered the changes to, the resident's analgesic in the assessment.

During an interview with the DOC, they stated that pain assessments had not been completed as required on three separate dates. The DOC also stated that none of the assessments completed on the second date, had been completed for the new analgesic orders.

(e) Further review of the Digital Prescriber's Orders entries, with a focus on pain medication, identified an order dated the spring of 2019, to change resident #002's analgesic to a specific dose, administered by a specific route, at a specific frequency.

The resident's eMAR for a month in 2019 indicated the change in administered analgesic for resident #002 occurred on a specific shift, on the date after the order was written.

Inspector #625 searched for pain assessments completed for the date the dose change occurred and identified that none of the pain assessments had been completed as required. The resident had no pain assessments completed between a date in the spring of 2019, to a date in the summer of 2019, a period of 44 days.

During an interview with the DOC, they stated that none of the six required pain assessments had been completed as required for 72 hours post medication change. (625)

5. The licensee has failed to ensure that where the LTCHA, 2007, or O. Reg. 79/10 required the licensee of a long-term care home to have, institute or otherwise put in place any policy, protocol or procedure, that the policy, protocol or procedure was complied with, with respect to resident #004 and compliance with the pain management program.

In accordance with O. Reg. 79/10, s. 48. (1) 4., the licensee was required to ensure that an interdisciplinary pain management program was developed and implemented in the home.

In accordance with O. Reg. 79/10, s. 30. (1) 1., the licensee was required to ensure that there was a written description of the pain management program that included relevant policies, procedures and protocols.

Specifically, staff did not comply with the licensee's policy titled "Pain Identification and Management – RC-19-01-01", last updated November 2018, or with the protocol titled "Pain Management – RC-19-01-01", revised June 5, 2019, which were part of the licensee's pain management program.

The policy titled "Pain Identification and Management – RC-19-01-01", last updated November 2018, indicated that nurses were to complete the pain assessment for 72 hours, on the day and evening shifts, when a new pain medication was started.

The protocol titled "Pain Management – RC-19-01-01", revised June 5, 2019, identified that pain assessments were to be completed for 72 hours, on the day and evening shifts, when new pain medication was started and when existing

pain medication was increased or decreased.

A CIS report was submitted for a fall experienced by resident #004, in the spring of 2019, where the resident was taken to hospital and which resulted in a significant change in the resident's health condition. The report identified the resident sustained injuries and returned to the home on a date later in the spring of 2019.

(a) Inspector #625 reviewed Digital Prescriber's Orders entries, after the resident's return from hospital in the spring of 2019, with a focus on pain medication. On the date following the resident's return from hospital, a change in an analgesic to a specific dose, administered at a specific frequency, in a specific circumstance, was ordered.

Inspector #625 reviewed resident #004's eMAR for a month in 2019 which identified the change in frequency of the analgesic began two days after their return from hospital, at a specific time.

Inspector #625 reviewed pain assessments completed for the change in the analgesic which began two days after the resident returned from hospital, and identified that pain assessments had not been completed as required. The resident had no pain assessments completed from over nine dates, beginning on the date two days after they had returned from hospital.

During interviews with the DOC, they identified pain assessments were required on the day and evening shifts for 72 hours. The DOC indicated that one pain assessment had been completed on the day after the resident returned from hospital, [prior to the change in the analgesic that occurred two days after their return from hospital, at a specific time] and no other pain assessments had been completed corresponding to the order dated the day after the resident returned from hospital.

(b) Inspector #625 further reviewed Digital Prescriber's Orders entries, with a focus on pain medication. On a date in the spring of 2019, one analgesic drug was discontinued and a second analgesic drug was ordered at a specific frequency, in a specific circumstance.

Inspector #625 reviewed resident #004's eMAR for a month in 2019 which identified the second analgesic drug was first administered on the date it was ordered, at a specific time.

Inspector #625 reviewed pain assessments completed for the orders and identified that pain assessments had not been completed as required on one shift on a date in the spring of 2019, on two shifts on a second date in the spring of 2019, and on one shift on a third date in the spring of 2019. The Inspector noted that four out of six of the required pain assessments, or 67 per cent of the assessments, had not been completed.

During an interview with the DOC, they stated that pain assessments had not been completed as required on one shift on a date in the spring of 2019, on two shifts on a second date in the spring of 2019, and on one shift on a third date in the spring of 2019.

(c) Further review of the Digital Prescriber's Orders entries, with a focus on pain medication, identified an order dated the summer of 2019, to change the frequency of administration of a scheduled analgesic starting on the following date.

The resident's eMAR for a month in 2019 indicated that the change in administered analgesic for resident #004 occurred on a particular shift on the same date the order was written. The resident's previous analgesic order was discontinued on the eMARs on the same date the new order was written, at a specific time, after the resident had been administered multiple doses at specific times.

Inspector #625 searched for pain assessments completed for the frequency change that occurred on a date in the summer of 2019, and identified that none of the pain assessments had been completed as required. The resident had no pain assessments completed from a date in the spring of 2019 to a date in the summer of 2019, over 28 days.

During an interview with the DOC, they stated that none of the six required pain assessments had been completed as required for 72 hours post medication change. (625)

6. The licensee has failed to ensure that where the LTHCA, 2007 or O. Reg. 79/10 required the licensee of a long-term care home to have, institute or otherwise put in place any policy, protocol or procedure, that the policy, protocol or procedure was complied with, with respect to resident #005 and compliance with the pain management program.

In accordance with O. Reg. 79/10, s. 48. (1) 4., the licensee was required to ensure that an interdisciplinary pain management program was developed and implemented in the home.

In accordance with O. Reg. 79/10, s. 30. (1) 1., the licensee was required to ensure that there was a written description of the pain management program that included relevant policies, procedures and protocols.

Specifically, staff did not comply with the licensee's policy titled "Pain Identification and Management – RC-19-01-01", last updated November 2018, or with the protocol titled "Pain Management – RC-19-01-01", revised June 5, 2019, which were part of the licensee's pain management program.

The policy titled "Pain Identification and Management – RC-19-01-01", last updated November 2018, identified that nurses would complete a pain assessment for residents when there was an indication of the presence of pain (including reported pain).

The protocol titled "Pain Management – RC-19-01-01", revised June 5, 2019, identified that one pain assessment was to be completed when an indication of pain was present (not a report of new pain).

A CIS report was submitted for a fall experienced by resident #005, in the summer of 2019, where the resident was taken to hospital and which resulted in a significant change in the resident's health condition. The report identified that the resident had sustained an injury.

Inspector #625 reviewed resident #005's health care record post-fall and identified PCC progress notes detailing pain experienced by the resident entered on multiple specific dates and times in the summer of 2019.

Inspector #625 reviewed pain assessments completed and was not able to locate assessments completed for the complaints of pain made by the resident on any of the dates.

During interviews with the DOC, they identified that pain assessments were required for resident #005's complaints of pain documented on four dates in the summer of 2019. The DOC reviewed completed pain assessments and stated that no pain assessments had been completed for resident #005's complaints of pain on those dates. (625)

7. The licensee has failed to ensure that where the LTCHA, 2007, or O. Reg. 79/10 required the licensee of a long-term care home to have, institute or otherwise put in place any policy, protocol or procedure, that the policy, protocol or procedure was complied with, with respect to resident #005 and compliance with the falls prevention and management program.

In accordance with O. Reg. 79/10, s. 48. (1) 1., the licensee was required to ensure that an interdisciplinary falls prevention and management program was developed and implemented in the home.

In accordance with O. Reg. 79/10, s. 30. (1) 1., the licensee was required to ensure that there was a written description of the falls prevention and management program that included relevant policies, procedures and protocols.

(a) Specifically, staff did not comply with the licensee's policy titled "Falls Prevention and Management Program RC-15-01-01", last updated February 2017, which identified that staff were to complete a Clinical Monitoring Record if a resident hit their head or was suspected of hitting their head, such as if they had an unwitnessed fall.

A CIS report was submitted for a fall experienced by resident #005, in the summer of 2019, where the resident was taken to hospital and which resulted in a significant change in the resident's health condition. The CIS report identified that the fall was not witnessed as a PSW heard the resident fall, entered the room, and found the resident on a particular surface.

Inspector #625 reviewed resident #005's health care record, including a Clinical Monitoring Record initiated on the date of the fall, at a specific time. The Inspector noted that the third entry did not list a date or time and did not contain all of the required assessment information. The third to 11th entries did not list the dates of the entries.

During an interview with the DOC, they indicated that the Clinical Monitoring Record for the fall which occurred in the summer of 2019, was incomplete, did not list the dates of the entries for 11 out of 13 entries and did not list the time of the third entry.

(b) Specifically, staff did not comply with the licensee's policy titled "Falls Prevention and Management Program RC-15-01-01", last updated February 2017, which directed staff to asses pain, bruising, change in functional status, change in cognitive status and changes in range of motion, on each shift for 72 hours post fall. The policy directed staff to document the fall and results of all assessments and actions taken during the 72 hour post fall follow-up.

Inspector #625 reviewed progress notes for the 72 hours post-fall for each shift, from the evening shift on three dates in the summer of 2019, and was not able to locate an entry for any shift which included all of the required components of the assessment documentation. On one shift in the summer of 2019, the shift following the resident's return from hospital, the Inspector was not able to locate any documentation in the progress notes of the resident's status that shift.

During an interview with the DOC, they confirmed that the required documentation had not been completed as there was no progress note entered on the shift following the resident's return from hospital, and none of the progress notes that were entered for the 72 hours after the fall contained all of the criteria the home's policy identified was to be assessed and documented.

(c) Specifically, staff did not comply with the licensee's policy titled "Falls Prevention and Management Program RC-15-01-01", last updated February 2017, which identified that the program would "engage the resident, family/SDM and the interdisciplinary team to proactively identify and address individual and environmental risk factors and causes of falls" and "ensure falls and fall injuries are promptly investigated…and root causes identified and addressed to prevent

recurrence". The policy indicated that interdisciplinary staff were to create an individualized plan addressing identified fall causes and risk factors such as a history of falls and or/fractures.

Inspector #625 noted that the CIS report submitted for resident #005's fall in the summer of 2019, did not identify the events leading up to the incident, or the cause of the fall.

During an interview with resident #005 and their family member #119, the resident's family member stated the resident fell when reaching for an item. The resident elaborated that they had been in contact with an entity regarding financial information and had been required to provide them information they had been reaching for. The resident said their mobility aid had not been close by when they fell, they had been standing, leaned over to reach for the information and then fell.

Inspector #625 reviewed resident #005's health care record, including progress notes and a Post Fall Assessment, and was not able to locate documentation as to the cause of the fall, or factors contributing to the fall, that occurred in the summer of 2019. Although the resident's Post Fall Assessment did not identify the cause of the fall, it indicated that staff were to "Continue with current plan of care and fall interventions."

During an interview with the DOC, they acknowledged the cause of resident #005's fall in the summer of 2019, had not been documented in their health care record, including the Post Fall Assessment and progress notes, and since it was not documented, the cause was not communicated to other staff through the record. The DOC reviewed an internal incident report for the known circumstances of the fall and stated that the internal incident report had identified the resident was performing a specific activity and fell over, using parts of their body to break the fall. The DOC stated the home's falls prevention and management program had not been followed as the home had been aware of aspects of the resident's fall which had not been entered into their medical record.

The severity of the issue was determined to be a level 3, as actual risk of harm to residents was present. The scope of the issue was a level 2 as a pattern of

occurrence was present. The home had a level 3 compliance history as it had previous non-compliance issued pursuant to the same subsection of the legislation that included a voluntary plan of correction (VPC) issued January 30, 2019, in inspection report #2019_703625_0026. (625)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 16, 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:

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

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

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

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

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

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

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

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

Issued on this 17th day of October, 2019

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : Katherine Barca

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