Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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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
Aug 1, 2019	2019_740621_0022	009558-19, 009800-19, 010629-19, 011900-19	Critical Incident System

Licensee/Titulaire de permis

Riverside Health Care Facilities Inc.
110 Victoria Avenue FORT FRANCES ON P9A 2B7

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

Rainycrest
550 Osborne Street FORT FRANCES ON P9A 3T2

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

JULIE KUORIKOSKI (621), MELISSA HAMILTON (693)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): July 22 - 25, 2019.

The following Critical Incident System (CIS) intakes were inspected during this CIS Inspection:

- Three intakes, related to prevention of abuse and neglect; and
- One intake, related to falls prevention and management.

Additionally, Follow Up Inspection #2019_740621_0021 was conducted concurrently with this CIS Inspection.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), the Nurse Practitioner (NP), the Physiotherapist (PT), the Registered Dietitian (RD), a Registered Nurse (RN), Registered Practical Nurses (RPN's), Personal Support Worker's (PSWs), residents and their families.

The Inspectors also observed the provision of care and services to residents, reviewed the home's supporting documentation, including relevant health care records, applicable assessments and auditing documentation, and specific licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation

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

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

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

Specifically failed to comply with the following:

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

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

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

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

A Critical Incident System (CIS) report was received by the Director on a day in May 2019, which identified that on an earlier date in May 2019, resident #004 had a specific incident which had resulted in injury. Results of an examination that was completed on a certain date after the incident, supported the presence of a certain type of injury, on a specific location of the body.

On review of resident #004's healthcare record, Inspector #621 identified documentation from a particular date in May 2019, identifying that the resident completed an

examination. There was no documentation however, to identify the outcome of the examination, but a progress note a day later, which identified that the resident was found wearing a particular medical device. On another date in May 2019, documentation from RN #113 identified that they followed up with physician #114, regarding resident #004's examination results, and orders were received including, the use of a particular medical device, over specific parts of the day, and during specified activities. On review of the physician orders documented from a specific date in May 2019, up to the time of inspection, the Inspector found no order to direct staff on the purpose and use of the identified medical device with the resident. Additionally, on review of resident #004's care plan, the Inspector found no documentation to indicate that use of the specified medical device was a required as part of their plan of care.

During a review of resident #004's healthcare record with RN Unit Coordinator #113, they confirmed that an examination report from a specific date in May 2019, identified a specific type of injury, on a particular location of the body. RN #113 confirmed with the Inspector that resident #004 returned from hospital on the same date in May 2019, following the examination, but was unable to locate documentation regarding the status of the resident at that time. RN #113 verified that a day after the examination, documentation in the resident's healthcare record identified that the resident was found wearing a specific type of medical device, on a particular location of the body. Additionally, on another date in May 2019, documentation identified that RN #113 had notified physician #114 of the resident's examination results, and had obtained orders for use of a specific medical device. RN #113 reviewed the resident's healthcare record, and found no written order after a certain day in May 2019, or after another later day in May 2019, when physician orders were received by RN #113, to direct staff on application and use of a particular medical device for this resident. RN #113 also reviewed the resident's care plan and confirmed that there was no update to the resident's care plan at any time, to provide clear directions for the use of the medical device.

During an interview with the DOC, they reported that it was their expectation that the when resident #004 returned to the home, after examination, on a specific date in May 2019, that registered staff ensured that there was a documentation identifying the resident's return home, information pertaining to the outcome of the examination, documentation orders for treatments, medications or any other directions required for the resident's care, and an update to the resident's care plan. The DOC identified that there were gaps in the home's process, and that resident #004's written plan of care did not provide clear directions to staff and others providing care, with respect to use of a specific medical device. [s. 6. (1) (c)]

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

A Critical Incident System (CIS) report was received by the Director on a date in May 2019, for an incident of alleged staff to resident neglect of resident #003. The CIS report identified that on another specific date in May 2019, resident #003 communicated to PSW #110 that when PSW #009 worked on a particular shift, and they activated the call bell system to get assistance with a particular care activity, PSW #009 shut off the alarm, informed them that they would return with assistance, but never did. Additionally, resident #003 reported that on the specified date in May 2019, instead of assisting them with their personal hygiene, as part of their identified care routine, PSW #009 placed specific items in proximity to them, and then left without providing assistance.

Inspector #621 reviewed resident #003's healthcare record, including a specific care plan, in effect at the time of the incident. The care plan identified that resident #003 required assistance from a specific number of staff, for a identified care activity, at a particular time of day, and that the resident used the call response system to notify staff. Additionally, the care plan identified that resident #003 required a particular level of assistance, from a specified number of staff, for another care activity.

During an interview with the DOC, they reported to Inspector #621 that the outcome of their investigation identified that PSW #009 had neglected resident #003 with respect to assistance with two specified care activities, and had not provided care to resident #003, as set out in their plan of care. [s. 6. (7)]

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

a) A CIS report was received by the Director, on a date in June 2019, for improper or incompetent treatment of resident #006. The CIS report identified that resident #006's substitute-decision maker (SDM) had made a complaint to the home regarding several care concerns.

Inspector #693 reviewed resident #006's care plan that was current at the time of the CIS report. The care plan listed a focus relating to a specific therapy intervention that was initiated on a particular day in September 2019, and last revised on a date in January 2019. The care plan indicated that PSW staff were to monitor a certain piece of

equipment and assure its readiness for use; and assist the resident in switching out the piece of equipment from one type to another.

During an interview with PSW #105, they stated that resident #006 required a particular type of care. They identified that the PSWs were to monitor a certain piece of equipment and assure its readiness for use; and assist the resident in switching out the equipment from one specific type to another. The PSW indicated that the PSW staff were to document all care provided in Point of Care (POC), but identified that they did not document any care that they provided to resident #006 regarding the identified therapy, as there was no place on the record where it could be documented.

During an interview with the DOC, they stated that the nursing staff were to document once a shift that they had monitored resident #006's specific therapy, and as per the resident's plan of care, PSW staff were responsible to monitor a certain piece of equipment and assure its readiness for use; and assist the resident in switching out the equipment from one specific type to another. The DOC stated that the care interventions provided by the PSW staff for resident #006, related to the specific care activity to support an identified therapy for this resident, were not documented.

b) During an interview with Nurse Practitioner (NP) #108 regarding additional residents who required a specific type of therapy in the home, it was identified that resident #008 utilized the identified therapy.

Inspector #693 obtained a copy of resident #008's current care plan, from the DOC. The care plan listed a specific focus, and an intervention, initiated in November 2018, and last revised in March 2019, which indicated that PSW staff were to monitor a certain piece of equipment and assure its readiness for use; and assist the resident in switching out the piece of equipment from one specific type to another.

During an interview with PSW #106, they stated that the PSW staff documented care that they provided in POC. PSW #106 indicated that resident #008 was on a specific type of therapy and that it was the role of the PSWs to monitor a certain piece of equipment and assure its readiness for use; and assist the resident in switching out the equipment from one specific type to another when leaving a certain location of the home. PSW #106 stated that they did not document any care that they provided to resident #008 related to their specified therapy, as there was no where in POC for it to be documented.

During an interview with the DOC, they stated that the care interventions provided by the

PSW staff for resident #008, related to the specific care activity to support an identified therapy for this resident, were not documented. [s. 6. (9) 1.]

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

A Critical Incident System (CIS) report was received by the Director on a date in May 2019, which identified that on a earlier date in May 2019, resident #004 had an incident with injury.

Inspector #621 reviewed resident #004's healthcare record, including their most current care plan at the time of inspection, which identified that resident #004 was at moderate risk for a specific activity. On review however, other documentation, including an assessment from a specific date in May 2019, the resident was identified at high risk. The Inspector found no further risk assessments completed after the specified date in May 2019.

During an interview with the DOC, they reviewed resident #004's care plan, and confirmed with the Inspector that resident #004's care plan had not been revised to reflect the resident's change in their risk status for a particular activity, on or after the specified date in May 2019, and should have. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written plan of care for each resident that set out clear directions to staff and others who provide direct care to the resident; to ensure that care set out in the plan of care, is provided, as specified in the plan; to ensure that the provision of care set out in the plan of care is documented; and to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months, and at any other time when the resident's care needs change, or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that that the home was equipped with a resident-staff communication and response system that, could be easily seen, accessed and used by residents, staff and visitors at all times.

A Critical Incident System (CIS) report was received by the Director on a specific date in May 2019, for an incident of alleged staff to resident neglect, which was reported to have occurred on an earlier date in May 2019, involving PSW #100 towards resident #005, where the resident sustained a fall.

Inspector #693 reviewed resident #005's health record, which identified that on a certain date in May 2019, RN #101 reported that resident #005 was found in a specific area of the home, with their mobility aide turned over, and their call bell not within reach. A assessment completed by RN #101 identified that the root cause of the incident was that resident #005 had been left alone, in a specific location of the home, an unable to access the call bell response system.

During an interview with PSW #100, they stated that on the same date in May 2019, they had brought resident #005 to a certain area of the home in their mobility aide, after a particular care activity had been completed, and left the resident in order to attend to other residents. The PSW stated that the resident's call bell was beside them. PSW #100 identified that it was only when the resident fell that they could not reach the call bell system.

A review of the home's investigation file for the CIS report, identified that the home's Administrator had interviewed resident #005 on the same date as the incident, and that the resident stated that they could not get close enough to access their call bell when they required assistance for a particular care activity. The investigation notes identified that PSW #100 had apologized that they hadn't provided resident #005 their call bell, as they had been overwhelmed at the time and forgot. Additionally, the investigation file included a letter of verbal warning to PSW #100, which indicated that during the home's investigation, PSW #100 confirmed that they had not positioned the call bell close enough to resident #005 prior to the incident and as a result, the resident fell.

During an interview with the home's DOC, they stated that at the time of resident #005's fall on the identified date in May 2019, the call bell was not easily accessible to the resident, and the resident could not reach it from where they were positioned. [s. 17. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that that the home is equipped with a resident-staff communication and response system that, can be easily seen, accessed and used by residents, staff and visitors at all times, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was in place a written policy to promote zero tolerance of abuse and neglect of residents, and that the policy was complied with.

A Critical Incident System (CIS) report was received by the Director on a date in May 2019, for an incident of alleged staff to resident neglect of resident #003. The CIS report identified that on an earlier date in May 2019, resident #003 communicated to PSW #110 that when PSW #009 worked on a particular shift, and the resident activated the call bell system to get assistance with a certain care activity, PSW #009 would shut off the alarm, inform them they would return with assistance, and never did. Additionally, resident #003 reported that on the specified shift in May 2019, instead of assisting the resident with a specific aspect of their personal care, PSW #009 placed specific items in proximity to them, and then left without providing assistance.

Inspector #621 reviewed resident #003's healthcare record, including a specific care plan, in effect at the time of the incident. The care plan identified that resident #003 required assistance from a specific number of staff, for a identified care activity, at a particular time of day, when the resident notified staff. Additionally, the care plan identifiec

that resident #003 required a particular level of assistance, from a specified number of staff for another care activity.

A review of the home's CIS investigation notes, identified during an interview of PSW #009 on a subsequent date in May 2019, the PSW confirmed that they had forgotten to return to the resident after shutting off the call bell; and that with regards to personal care assistance, they had placed the items for the required care in proximity to the resident, in order for the resident to start the task on their own. It was documented that PSW #009 was advised by the Director of Care (DOC) that they would be provided with written and verbal re-instruction regarding neglect, even if it had not been intended. The Inspector reviewed PSW #009's employee file, which included a letter of counsel from the DOC, from a specific date in June 2019, which identified re-instruction was provided to the employee with regards to not providing care as identified in the resident's care plan.

A review of the home's policy titled "Abuse and Neglect Zero Tolerance Policy – ORG-11-PAT-10", last revised June 26, 2019, identified that the licensee was committed to providing an environment of zero tolerance of abuse or neglect of residents by any person. The policy also identified that signs of neglect included incidents when a resident needs were not being met.

During an interview with the DOC, they reported to Inspector #621 that the outcome of their investigation into the incident was that PSW #009 had neglected resident #003 with respect to assistance with two specified care needs, as identified in their plan of care. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and that the policy is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents with the following weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes evaluated: 1. A change of five per cent of body weight, or more, over one month.

A CIS report was received by the Director, on a date in June 2019, for improper or incompetent treatment of resident #006. The CIS report identified that resident #006's substitute-decision maker (SDM) had made a complaint to the home regarding several care concerns, including, a concern that the resident had a significant weight change.

Inspector #693 reviewed the home's policy titled, "Height and Weight Monitoring-RC-18-01-06", last updated February 2017. The policy indicated that it was the responsibility of nurses in the home to review weights and determine whether there was a significant weight change, including, a change of five per cent or more over one month. Additionally, the policy indicated that all significant weight changes were to be communicated to the RD.

Inspector #693 reviewed resident #006's monthly weights, as documented electronically in Point Click Care (PCC), for the second quarter of 2019, and identified a total weight change greater than five per cent, between May and June 2019, within the period reviewed.

Inspector #693 also reviewed the RD referrals in PCC, for the previous four months, and

identified only one referral that was made later in July 2019, for resident #006's significant weight change.

During an interview with RPN #104, they stated that PSW staff were responsible for weighing residents monthly and that if there was a significant change in weight, PCC would alert the nurses, who would then be responsible for creating a referral in PCC to the Registered Dietitian (RD).

During an interview with the home's RD, they stated that the resident, between a two month period in the summer of 2019, had a significant weight change. Additionally, the RD stated that they had not been informed of the significant weight change, and that the nursing staff should have made a referral to them in PCC when the significant weight change had occurred, but did not.

During an interview with the DOC, they confirmed that the nursing staff had not sent a referral to the RD for resident #005 when the resident experienced a significant weight change during a two month period, in the summer of 2019, and consequently, there was lack of an interdisciplinary team approach taken with regards to the resident's significant weight change. [s. 69. 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes evaluated: 1. A change of 5 per cent of body weight, or more, over one month, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident.

a) A CIS report was received by the Director on a day in June 2019, for improper or incompetent treatment of resident #006. The CIS report identified that resident #006's substitute-decision maker (SDM) had made a complaint to the home regarding several care concerns, including a concern related to a particular therapy.

Inspector #693 reviewed resident #006's care plan that was current at the time of the CIS report. The care plan listed a focus related to a specific therapeutic intervention that was initiated on a day in September 2018, which indicated that the resident was to be given medications as ordered by the Physician or Nurse Practitioner. In addition, an intervention that was initiated on that day in September 2018, and last revised in January 2019, indicated that resident #006 was to be on a specific therapy for a particular medical condition.

Inspector #693 reviewed the physician's orders for resident #006. The current quarterly medication review, from a particular date in June 2019, indicated that all previous orders had been discontinued. On further review of the residents medication records, the Inspector was unable to identify a current prescription for resident #006's identified therapy. Further, Inspector #693 found that on a specific date in April 2017, there had been a physician's order for resident #006, which indicated that the resident was to be administered the identified therapy, with specifics as to amounts and duration of the therapy.

During separate interviews with RPN #102 and RPN #104, they identified that resident #006 utilized a particular therapy, over a specified duration. Together with the Inspector, RPN #102 reviewed the physician's orders for resident #006 and identified that there was not a current order for resident #006's specified therapy requirements.

During an interview with the DOC, they stated that that the specified therapy in the home was treated as a medication, and required an order from a physician or nurse practitioner. The DOC stated that there was no current order for resident #006's specified therapy, and that the original order from April 2017, had never been processed and therefore, since that date, resident #006's specified therapy had been administered without a prescriber's order.

b) During an interview with Nurse Practitioner (NP) #108 regarding additional residents who required a specific type of therapy in the home, it was identified that resident #008 utilized the identified therapy.

Inspector #693 obtained a copy of resident #008's current care plan, from the DOC. The care plan listed an intervention that was initiated on a specific date in September 2018, and revised on a later date in January 2019, which indicated that the resident was to be given medications as ordered by the Physician or Nurse Practitioner. In addition, an intervention that was initiated in November 2018, and last revised on a date in January 2019, indicated that resident #008 was to have a specific therapy administered using a specific delivery mode, at a certain rate, to ensure that resident achieved certain therapy targets.

Inspector #693 reviewed the physician's orders for resident #008. The current quarterly medication review, dated form July 2019, indicated that all previous orders had been discontinued. On further review of the quarterly medication review, Inspector #693 was unable identify a current prescription for resident #008's specified therapy. Inspector #693 identified that on a particular date in November 2018, there was a physician's order for resident #008, which indicated that the resident was to be administered the specified therapy, at a specific rate, to achieve certain therapy targets.

During an interview with RPN #107, they stated that resident #008 utilized the specified therapy and that it was administered at a particular rate, to achieve certain therapy targets. RPN #107 identified they knew that the specified therapy was ordered, as it was documented on resident #008's Medication Administration record (MAR).

During an interview with the DOC, they stated that there was no current order by a prescriber for resident #008's identified therapy, and that the most recent order was from November 2018. The DOC identified that resident #008 had been administered the identified therapy without a prescriber's order. [s. 131. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that no drug is used by or administered to a resident in the home unless the drug had been prescribed for the resident, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to inform the Director of an incident under subsection (1), (3) or (3.1), within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director, setting out the following with respect to the incident: Actions taken in response to the incident, including, the outcome or current status of the individual or individuals who were involved in the incident.

A CIS report was received by the Director, on a specific date in June 2019, for improper or incompetent treatment of resident #006. The CIS report identified that resident #006's substitute-decision maker (SDM) had made a complaint to the home regarding several care concerns.

Inspector #693 reviewed the CIS report and its amendments, to determine the outcome of this occurrence. The reports identified that the resident was admitted to hospital, but there were no further updates to identify the resident's current status, or the outcome of the investigation.

Inspector #693 reviewed the home's policy, titled, "Abuse and Neglect Zero Tolerance Policy", last reviewed on June 26, 2019. The policy indicated that the home's administrative procedure included the submission of a report to the Ministry of Health and Long-Term Care (MOHLTC) within 10 days or earlier, which included the results of the investigation.

During an interview with the DOC, they identified that after the home's investigation, they did not substantiate any findings of neglect, improper, or incompetent care in relation to resident #006, but that the staff in the home had missed aspects of resident #006's care. The DOC stated that the CIS did not include the outcome of the investigation and it should have. [s. 107. (4) 3. v.]

Issued on this 8th day of August, 2019

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

Original report signed by the inspector.