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
Nov 12, 2019	2019_598570_0020	008881-18, 011099-18, 015052-18, 019268-18, 021023-18, 031058-18, 031554-18, 033736-18, 015400-19, 016999-19, 017503-19	Critical Incident System

Licensee/Titulaire de permis

Regional Municipality of Durham
605 Rossland Road East WHITBY ON L1N 6A3

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

Hillsdale Terraces
600 Oshawa Blvd. North OSHAWA ON L1G 5T9

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

SAMI JAROUR (570), JENNIFER BATTEN (672)

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): September 3-6, 9-13, 16-20, 2019

The following logs related to Critical Incident Reports (CIR) were included during this inspection:
- Log #008881-18, related to a fall of a resident resulting in an injury
- Log #011099-18, related to a medication incident, resulting in transfer to hospital
- Log #015052-18, related to a fall of a resident resulting in an injury
- Log #019268-18, related to a fall of a resident resulting in an injury
- Log #021023-18, related to a missing resident
- Log #031058-18, related to an alleged staff to resident abuse
- Log #031554-18, related to a fall of a resident resulting in an injury
- Log #033736-18, related to an unexpected death
- Log #015400-19, related to an alleged staff to resident neglect
- Log #016999-19, related to a fall of a resident resulting in an injury
- Log #017503-19, related to an unexpected death

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), RAI Coordinator, Resident Care Coordinators (RCC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Dietary Aides (DA), Social Worker (SW), Environmental Services Manager (ESM), Environmental Services Workers (ESW), Physicians (MD), Staffing Clerks, Nursing Admin Assistants, Infection Control Nurse (ICN), residents, and family members.

During the course of this inspection, the Inspectors, toured specific resident rooms and common resident areas, observed resident to resident and staff to resident interactions, reviewed clinical records, relevant policies to this inspection and the licensee's internal investigations documentation.

Inspector Jack Shi #760 was shadowing.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Hospitalization and Change in Condition
Medication
Pain
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **9 WN(s)**
- **7 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. (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).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #003's care was provided as specified in the plan.

Related to Log #011099-18:

A Critical Incident Report (CIR) was submitted to the Director related to a medication incident involving resident #003.

Inspector #672 reviewed the CIR, which stated that on specified date, RPN #104 accidentally administered resident #004's medications to resident #003. RPN #104 reported the medication error to RN #105, who notified the Manager of Nursing Practice (MNP). The MNP instructed the registered staff to monitor resident #003 frequently and to notify the physician. Physician #120 instructed RN #105 to transfer resident #003 to the hospital for further assessment and monitoring. The resident returned to the home on the following day, with no adverse effects noted.

A review of the progress notes and physician's orders for resident #003 showed that upon the resident's return to the Long-Term Care (LTC) home, physician#120 was notified and instructed that resident #003's to be monitored for a specified period of time.

Inspector #672 reviewed resident #003's electronic and hard copy health care records, and observed the documentation indicated resident #003 was not monitored as frequently as ordered by the physician.

During separate interviews, Resident Care Coordinators (RCC) #103 and #118 reviewed resident #003's health care record with Inspector #672 and indicated that it did not appear that resident #003 had been assessed as indicated in the physician's order. RCCs #103 and #118 further indicated that the expectation in the home was for every resident to receive care as specified in their plan of care.

During an interview, the DOC indicated the expectation in the home was for care to be provided to each resident as specified in the plan of care, which included checking residents as per physician's orders.

The licensee failed to ensure that resident #003's care was provided to the resident as specified in the plan, when staff did not assess resident #003 as indicated in a physician's order. [s. 6. (7)]

2. The licensee failed to ensure that the care specified in resident #005's plan of care was provided to the resident as specified.

Related to Log #021023-18:

A Critical Incident Report (CIR) was submitted to the Director related to an incident of resident #005 specific to an identified responsive behaviour on a specified date. The CIR stated that staff at the long-term care home had not realized resident #005 was missing until the local hospital contacted the LTCH to report that resident #005 had been transported to the hospital. Resident #005 had a specified injury and complained of pain.

A review of resident #005's written plan of care in place following the incident included a focus that identified a specified responsive behaviour, with interventions that registered staff were to complete and document specified assessments for specified responsive behaviour.

Inspector #672 reviewed resident #005's progress notes and written plans of care specified period, but could not locate a completed assessments for the specified responsive behaviour following an incident of specified month. Inspector #672 then reviewed resident #005's electronic health records and the physical chart from the time of resident #005's admission to the home until a specified date, but could not locate any completed assessments for the specified behaviour except for four identified dates.

During an interview, the DOC indicated the specified assessment to be completed was a document included in each resident's admission package. The DOC stated that if staff felt the document was relevant to the resident being admitted to the home due to a specified behaviour, the document would only be completed during the resident's admission conference. The DOC further indicated that when the licensee moved to a new documentation system, the specified assessment documents were no longer used. The DOC indicated the interventions related to the registered staff completing an assessment and accompanying progress note should not have been entered into a resident's written plan of care. The DOC further indicated they could not recall if an assessment had been completed for resident #005 following a specified incident, and could not locate completed assessment in resident #005's health care record.

The licensee failed to ensure that the care listed in resident #005's written plan of care was provided to the resident as specified in the plan, when a specified assessment was not completed quarterly for two specified quarters and following an incident of a specified date. [s. 6. (7)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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 failed to ensure that the internal policy related to resident abuse and neglect was complied with.

During review of resident #017's progress notes, Inspector #672 observed a progress note written by RPN #138 on an identified date, which stated that resident #017 had reported an allegation of being abused several times by a co-resident. The progress note further stated that RPN #138 reported resident #017's allegation to the Behavioural Supports Ontario (BSO) RPN #134, who informed the RPN that resident #017 had a previous history of making false allegations of abuse, therefore they did not need to report the allegation further or implement any interventions in an attempt to protect resident #017 from possible ongoing incidents of abuse, as the allegation was likely false.

Inspector #672 reviewed the internal policy entitled "Abuse and Neglect – Prevention, Reporting and Investigation"; policy number: ADM-01-03-05; Date Approved: March 25, 2019, pertaining to reporting, notification, investigation and Management and Enforcement of Consequences.

During an interview, BSO RPN #134 indicated that on a specified date, RPN #138 reported to them that resident #017 had alleged that a co-resident had been abusing them several times. BSO RPN #134 further indicated they informed RPN #138 that resident #017 had a history of making false accusations of abuse, and that they did not need to report the allegation further or implement any interventions to protect resident #017 from possible ongoing incidents of abuse, as the allegation was likely false. BSO RPN #134 further indicated on June 27, 2019, they did not inform the RN or a member of the management team of the allegation and had not documented anything regarding the allegation in the resident's health care record due to a belief that the accusation was false.

During the interview, BSO RPN #134 also indicated that at another day resident #017 reported an allegation of an incident of abuse by staff. Management team and resident #017's SDM were not notified of the allegation due to the belief the incident had not occurred. BSO RPN #134 indicated the expectation in the home when a resident made an allegation of abuse or neglect was that staff always had to take the allegation seriously and report the allegation.

Inspector #672 reviewed resident #017's MDS assessment of a specified date, indicated resident #017 had some concerns with both short and long-term memory, had cognitive decline and was able to "usually understand" others. Inspector #672 reviewed resident #017's current written plan of care related to cognition and responsive behaviours and could not locate any information related to resident #017 having a previous history of making false abuse allegations.

During an interview, RCC #103 indicated they were not aware of the allegations made by resident #017 towards co-residents regarding abuse, or about the staff to resident alleged abuse. RCC #103 indicated that every allegation of abuse or neglect brought forward by a resident should be immediately reported to a member of the management team and be internally investigated. RCC #103 further indicated that if a resident was known to make false allegations against others, there should be a behavioural focus specific to the behaviour documented in the resident's plan of care, and staff should be aware of the resident's exhibited behaviours. RCC #103 reviewed resident #017's written plan of care with Inspector #672 and could not locate any information related to resident #017 having a previous history of making false abuse allegations.

During an interview, RCC #118 indicated they could not recall if a staff member had reported resident #017's allegation of abuse by a co-resident. RCC #118 further indicated

they did not inform the DOC, other members of the management team in the home or the Director of resident #017's allegation of abuse. RCC #118 indicated they did not report the allegation due to not believing the resident that the incident had occurred. RCC #118 further indicated they were not aware of resident #017's allegation of staff to resident abuse. RCC #118 stated they would "not necessarily" expect staff members to report resident allegations of abuse or neglect to a member of the management team if the resident was known to have a history of making false accusations and felt that the incident being reported by the resident did not occur. RCC #118 indicated they would expect to see a care plan focus specific to responsive behaviours of making false accusations in the resident's written plan of care if the resident had a known history of making false accusations. RCC #118 reviewed resident #017's written plan of care with Inspector #672 and could not locate any information related to resident #017 having a previous history of making false abuse allegations.

During an interview, the DOC indicated they were not aware of resident #017's allegations of resident to resident abuse and staff to resident abuse. The DOC further indicated the expectation in the home would be for the staff member who received the resident's allegation to immediately report the allegation to a member of the management team, most likely the RCC responsible for that resident home area. The RCC would be expected to conduct an immediate internal investigation into the allegation, and report the allegation to the Director, unless they were able to ascertain within the first few hours that the resident's allegation was false. The DOC further indicated that staff would still be expected to report each allegation brought forward by a resident, even if the resident had a history of making false abuse allegations, to the RCC for them to immediately investigate.

Inspector #672 reviewed the critical incident system portal along with the Ministry of Long-Term Care internal intake portal and did not observe any documentation or reports to indicate that resident #017's allegations of resident to resident abuse or staff to resident abuse were reported to the Director. Inspector #672 then reviewed resident #017's progress notes which did not indicate that resident #017's SDM had been notified of either of the allegation brought forward by the resident and the written plan of care did not state that resident #017 was known to exhibit responsive behaviours related to making false accusations of abuse.

During an interview, the DOC indicated they were not aware if RCC #118 had initiated an internal investigation into resident #017's allegations of resident to resident abuse or staff to resident abuse. The DOC further indicated they did not believe that the Director or the

police were notified of resident #017's allegations due to no one believed that the incidents had actually occurred. The DOC indicated they were aware of the legislative requirements to notify the Director of all allegations brought forward regarding resident abuse and neglect but did not feel that resident #017's allegations required reporting due to the resident having a previous history of making false accusations.

The licensee failed to ensure that the internal policy entitled "Abuse and Neglect – Prevention, Reporting and Investigation" was complied with when BSO RPN #134 did not report resident #017's allegation of resident to resident abuse, or resident #017's allegation of staff to resident abuse to a member of the management team or to the resident's SDM. RCC #118 did not report resident #017's allegations to the Director or to the local police force and did not initiate an internal investigation into the allegations. The DOC also did not ensure that necessary actions were taken in response to the allegations. [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 the internal policy to promote zero tolerance of abuse and neglect was complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #017's allegation of resident to resident abuse and allegation of staff to resident abuse were immediately investigated.

During review of resident #017's progress notes, Inspector #672 observed a progress note written by RPN #138 on an identified date, which stated that resident #017 had reported an allegation of being abused several times by a co-resident. The progress note further stated that RPN #138 reported resident #017's allegation to BSO RPN #134, who informed the RPN that resident #017 had a previous history of making false allegations of abuse, therefore they did not need to report the allegation further or implement any interventions in an attempt to protect resident #017 from possible ongoing incidents of abuse, as the allegation was likely false.

During an interview, BSO RPN #134 indicated that RPN #138 reported to them that resident #017 had alleged that a co-resident had been abusing them several times. BSO RPN #134 further indicated they informed RPN #138 that resident #017 had a history of making false accusations of abuse, and that they did not need to report the allegation further or implement any interventions to protect resident #017 from possible ongoing incidents of abuse, as the allegation was likely false. During the interview, BSO RPN #134 indicated resident #017 reported an allegation of an incident of abuse by staff. BSO RPN #134 stated they spoke to the staff on the resident home area, who reported no knowledge of that an alleged staff to resident abuse.

During an interview , RCC #118 indicated they had been aware of the allegation of resident to resident abuse. RCC #118 further indicated they did not immediately investigate resident #017's allegation of resident to resident abuse due to not believing the resident that the incidents had occurred. RCC #118 further indicated they were not aware of resident #017's allegation of staff to resident abuse until reported by Inspector #672 but indicated they would begin an investigation into the allegation.

During an interview, the DOC indicated they were not aware of resident #017's allegations of resident to resident abuse or staff to resident abuse. The DOC further indicated the expectation in the home would be for the staff member who received the resident's allegation to immediately report the allegation to a member of the management team, most likely the RCC responsible for that resident home area. The RCC would then be expected to conduct an immediate internal investigation into the allegation, unless they were able to ascertain within the first few hours that the resident's allegation was false. The DOC further indicated that staff would still be expected to report each allegation brought forward by a resident, even if the resident had a history of making false abuse allegations and the RCC would still be expected to immediately investigate.

Inspector #672 requested to review the internal investigation notes into resident #017's allegations. The DOC indicated they could not locate any investigation notes. The DOC further indicated they were not aware if RCC #118 had initiated an internal investigation into resident #017's allegations of resident to resident abuse or staff to resident abuse, as RCC #118 had not reported anything about the allegations to the DOC and the DOC had not inquired about the state of the internal investigation.

The licensee failed to ensure that resident #017's allegation of resident to resident abuse and allegation of staff to resident abuse were immediately investigated. [s. 23. (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 every alleged, suspected or witnessed incident of abuse and neglect of a resident is immediately investigated, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that an allegation of staff to resident physical abuse was immediately reported to the Director.

Related to Log #031058-18

A Critical Incident Report (CIR) was submitted by resident care coordinator (RCC) #118 to the Director on an identified date and time, regarding an allegation of staff to resident abuse. A review of the CIR indicated that on an identified date, an email was received from RN #135 advising that resident #013's SDM had expressed concerns regrading the way PSW #136 spoke to them. The SDM was told by the resident that PSW #136 grabbed their hand.

A review of the email sent by RN #135 to RCC #118, indicated that resident #013's SDM approached RN #135 and expressed concerns about PSW #136 and the way the PSW spoke to the resident. The resident told the SDM that PSW #136 grabbed their arm when they went in to provide care for the resident.

An interview with RCC #118 indicated that they received the email on an identified date,

and that the RN should have immediately reported the allegation to the Director using the after hours number. The RCC indicated that the incident was not immediately reported to the Director when the allegation was brought forward to RN #135.

The licensee failed to ensure RN #135 immediately notified the Director of allegations of staff to resident abuse. [s. 24. (1)]

2. The licensee has failed to ensure that an allegation of staff to resident abuse and neglect was immediately reported to the Director.

Related to Log #015400-19

A Critical Incident Report (CIR) was submitted to the Director on an identified date and time, regarding an allegation of staff to resident neglect. The CIR stated that on an identified date, resident #012 reported to RCC #118 that a couple of days prior, a staff member on a specified shift had failed to provide the care when the resident requested to be assisted. The CIR further stated that on an identified date, RN #121 overheard PSW #122 speaking to residents in an inappropriate manner and had reported this concern to RCC #118 through an email on the same date.

Inspector #760 reviewed the CIR and observed that the report did not indicate the after hours Ministry Action Line had been contacted, in order to immediately inform the Director of the allegation of staff to resident neglect.

During an interview, RN #121 indicated on an identified date, they observed several interactions of PSW #122 speaking in an inappropriate manner to residents. RN #121 further indicated that they sent an email to RCC #118 to report their concerns regarding PSW #122, but could not recall notifying the Director. RN #121 indicated they were aware of the legislative requirements to immediately report allegations of resident abuse and neglect to the Director.

In an interview, RCC #118 indicated that the Director had not been notified, when resident #012 brought forward concerns regarding an allegation of resident neglect. RCC #118 further indicated that the expectation in the home was for Registered Nurses (RN) working in the facility to report allegations of resident abuse and neglect to the Director through the after hours Ministry Action Line if allegations were brought forward outside of business hours. RCC #118 further indicated that they were aware of the legislative requirement to immediately report any allegation of resident abuse and neglect to the

Director.

Inspector #760 and Inspector #672 interviewed resident #012. Resident #012 indicated that a staff member had been rough during care. Following the interview, Inspector #760 and Inspector #672 immediately reported resident #012's statements to RCC #118.

On September 12, 2019, RCC #118 indicated to Inspector #760 and Inspector #672 that they did not immediately notify the Director after receiving the report regarding resident #012's statements.

The licensee failed to ensure that RCC #118 immediately notified the Director of allegations of resident abuse and neglect on two identified dates. [s. 24. (1)]

3. The licensee has failed to ensure that an allegation of resident to resident abuse and an allegation of staff to resident abuse was immediately reported to the Director.

During a review of resident #017's progress notes, Inspector #672 observed a progress note written by RPN #138 on an identified date, which stated that resident #017 had reported an allegation of being abused several times by a co-resident. The progress note further stated that RPN #138 reported resident #017's allegation to BSO RPN #134, who informed the RPN that resident #017 had a previous history of making false allegations of abuse, therefore they did not need to report the allegation further or implement any interventions in an attempt to protect resident #017 from possible ongoing incidents of abuse.

During an interview, BSO RPN #134 indicated that on an identified date, RPN #138 reported to them that resident #017 had alleged that a co-resident had been abusing them several times over a period of time. BSO RPN #134 further indicated they informed RPN #138 that resident #017 had a history of making false accusations of abuse, and that they did not need to report the allegation further or implement any interventions to protect resident #017 from possible ongoing incidents of abuse. During the interview, BSO RPN #134 also indicated that resident #017 reported an incident of alleged abuse by staff. BSO RPN #134 stated they spoke to the staff on the resident home area, who reported no knowledge of any incidents of staff to resident abuse.

During an interview, RCC #118 indicated being aware of resident #017's allegation of resident to resident abuse. RCC #118 further indicated they did not inform the DOC, other members of the management team in the home or the Director of resident #017's

allegation of resident to resident abuse due to not believing the resident that the incidents had occurred. RCC #118 further indicated they had not been aware of resident #017's allegation of staff to resident abuse, until reported by Inspector #672. RCC #118 indicated they would look into the allegations.

During an interview, the DOC indicated they were not aware of resident #017's allegations of resident to resident abuse or staff to resident abuse. The DOC further indicated the expectation in the home would be for the staff member who received the resident's allegation to immediately report the allegation to a member of the management team, most likely the RCC responsible for that resident home area. The RCC would then be expected to immediately report the allegation to the Director, unless they were able to ascertain within the first few hours that the resident's allegation was false. The DOC further indicated that staff would still be expected to report each allegation brought forward by a resident, even if the resident had a history of making false abuse allegations.

During an interview, the DOC indicated they were not aware if RCC #118 had reported resident #017's allegations of resident to resident abuse or staff to resident abuse to the Director.

The licensee failed to ensure that resident #017's allegations of resident to resident abuse and staff to resident abuse were immediately reported to the Director. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that allegations of abuse of a resident by anyone or neglect of a resident by the licensee or staff was immediately reported to the Director, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when residents #005, #016 and #017's pain was not relieved by initial interventions, the residents were assessed using a clinically appropriate assessment instrument specifically designed for that purpose.

Inspector #672 reviewed the internal policy entitled "Pain Management", policy number: INTERD-03-10-01, date approved: December 14, 2018.

Related to Log #017503-19:

A Critical Incident Report (CIR) was submitted to the Director on an identified date, related to the unexpected death of resident #005, which occurred in the home on an identified date, several hours after the resident had been found to have sustained an unwitnessed fall in the bedroom area.

Inspector #672 reviewed resident #005's progress notes from a specified period. The progress notes indicated resident #005 often presented responsive behaviours. A physician's progress note from an identified date, stated resident #005 had an injury during a fall, had suffered from identified conditions. Physician #120 documented they felt that resident #005's identified responsive behaviours were a result of uncontrolled pain and recommended resident #005 receive a specified medication for pain.

Inspector #672 reviewed resident #005's physician's orders and medication list, and observed that resident #005 had physician's orders for of specified medications to assist with pain control during a four months period.

A review of resident #005's written plan of care stated resident #005 had pain management concerns related to acute and chronic pain as a result of specified conditions. The written plan of care also indicated that resident #005 had skin wound to a specified area which caused pain. Resident #005 required assistance from staff to

complete activities of daily living as a result of pain. According to the written plan of care, resident #005's pain also presented as responsive behaviours. Resident #005 had cognitive decline and had a difficult time communicating with staff due to cognition and a language barrier which created an inability to report and rate their pain to staff.

Inspector #672 reviewed resident #005's eMARs and progress notes for three months period, which indicated that resident #005 expressed complaints and exhibited symptoms of pain and received pain medications.

A review of resident #005's most recent Minimum Data Set (MDS) assessment, stated resident #005 did not have any pain management issues and did not experience pain symptoms.

Inspector #672 reviewed resident #005's progress notes for a specified period, which indicated that during that time, resident #005 had complaints of pain and received interventions which included breakthrough analgesics on a number of occasions. The interventions implemented on those occasions were noted to have a poor effect in relieving resident #005's pain, as the resident continued to have complaints of pain and exhibited responsive behaviours. Staff also documented resident #005's numerical pain scores remained between a four and ten out of ten, one hour following the implementation of the pain relief interventions.

The progress notes further indicated that on an identified date, a care conference was held with resident #005's family members due to concerns with the effectiveness of resident #005's pain control interventions. New pain medications orders were received following the conference. Then on a specified date new pain medications were ordered due to continued poor pain control.

During separate interviews, RN #127 and RPN #128 indicated the expectation in the home was for Comprehensive Pain Assessments to be completed monthly for residents who received pain medications. If a resident complained of pain during the month, or a pain medication was found to have not been effective, RN #127 indicated staff would document the resident's assessed numerical level of pain in the electronic Medication Administration Record (eMAR).

During an interview, RPN #129 indicated the expectation in the home was for Comprehensive Pain Assessments to be completed monthly for residents who received pain medications, were considered to be stable and had no complaints of pain. RPN

#129 further indicated a Comprehensive Pain Assessment should also be completed each time a pain medication was found to be ineffective or each time a resident had a new or worsening complaint of pain.

During an interview, RPN #130 indicated the expectation in the home was for Comprehensive Pain Assessments to be completed quarterly for residents who received regular pain medications, or weekly if the pain medications were found to be ineffective in managing the resident's pain.

During an interview, RPN #131 indicated the expectation in the home was for Comprehensive Pain Assessments to be completed each time a resident had a complaint of pain which was “out of the norm” for the resident, or if the resident had been consistently complaining of pain for several days with no relief.

During an interview, RPN #132 indicated the expectation in the home was for Comprehensive Pain Assessments to be completed each time a resident had a new complaint of pain, if a new pain medication was ordered, or each time the resident’s current pain medication was found to be ineffective.

Inspector #672 then reviewed the completed Comprehensive Pain Assessments for resident #005 during a specified period of time, and observed pain assessments were completed on four occasions.

Inspector #672 then expanded the scope of the inspection related to the completion of assessments using clinically appropriate pain assessment instruments specifically designed for the purpose of assessing a resident’s pain. The inspection was expanded to include two more residents who experienced frequent pain and/or changes to their analgesics due to uncontrolled pain, to observe if assessments using clinically appropriate pain assessment instruments had been completed as required. RPN #129 indicated that residents #016 and #017 had experienced frequent pain and/or changes to their pain medications due to uncontrolled pain in the last 180 days.

Related to resident #016:

A review of resident #016's written plan of care, stated resident #016 complained of pain related to specified medical conditions. The written plan of care further stated resident #016 required assistance from staff with activities of daily living due to pain. pharmacological and non-pharmacological interventions to assist with resident #016’s

pain management were listed in the written plan of care.

Inspector #672 reviewed resident #016's progress notes for a specified period of time, related to pain symptoms, which stated the resident continued to express complaints of pain on multiple occasions even after receiving interventions for pain management, which had poor effect.

A review of resident #016's most recent MDS assessment, stated the resident experienced pain on a daily basis in identified body parts.

On an identified date, resident #016 received a referral for a specified intervention to assist with pain control and management.

Inspector #672 reviewed resident #016's eMARs and progress notes for a three months period, which indicated that resident #016 expressed complaints of pain and received pain medications.

Inspector #672 then reviewed the Comprehensive Pain Assessments completed for resident #016 during a specified period, and observed there were no pain assessments completed during that period. There were two pain assessments completed after that specified period.

Related to resident #017:

A review of resident #017's written plan of care, stated the resident complained of pain related to specified medical conditions. The written plan of care included pharmacological and non-pharmacological interventions to assist with resident #017's pain management. Resident #017's written plan of care did not address pain as a focus or concern for the resident.

Review of resident #017's MDS assessment of specified date, stated the resident experienced pain less than daily.

Inspector #672 reviewed resident #017's progress notes for a specified period related to pain symptoms. The progress notes indicated that during that time frame, resident #017 was assessed multiple times by the physician related to ongoing pain and several new pain medications orders were implemented. The progress notes further indicated that resident #017 had frequent complaints of pain and stated that the current pain

management interventions, which included pain medications, were not effective. Resident #017's uncontrolled pain led to the resident spending a lot of time in their bed.

Inspector #672 reviewed resident #017's eMARs and progress notes for three months period, which indicated that resident #017 expressed complaints of pain and received both routine and breakthrough pain medications.

Inspector #672 then reviewed the Comprehensive Pain Assessments completed for resident #017 during a specified period of time, and observed a pain assessment was completed on three occasions.

During an interview, the DOC indicated the expectation in the home was for Comprehensive Pain Assessments to be completed upon admission to the home, following any resident's change in status, if a resident sustained a fall with an injury or if the resident had complaints of pain. The DOC further indicated the Comprehensive Pain Assessment Tools used to be completed on a quarterly basis in the home but were no longer being completed quarterly. The DOC indicated the cause of the comprehensive pain assessments no longer being completed quarterly as a result of the registered staff completing the numerical pain assessment available in the eMAR system, which staff were expected to complete when administering a pain medication instead. The DOC further indicated the numerical pain assessment available in the eMAR system was not a comprehensive pain assessment and it was not an acceptable practice for the numerical assessment to be completed in place of the Comprehensive Pain Assessment Tool.

The licensee failed to ensure that when residents #005, #016 and #017's pain was not relieved by initial interventions, the residents were assessed using a clinically appropriate assessment instrument specifically designed for that purpose during a specified period of time. [s. 52. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents #003, #011 and #020 in accordance with the directions for use as specified by the prescriber.

Related to Log #011099-18:

A Critical Incident Report (CIR) was submitted to the Director related to a medication incident involving resident #003, which occurred on an identified date, and resulted in the resident being transferred to the hospital.

Inspector #672 reviewed the CIR, which stated that on an identified date RPN #104 accidentally administered resident #004's medications to resident #003. RPN #104 reported the medication error to RN #105, who notified the Manager of Nursing Practice (MNP). The MNP instructed the registered staff to monitor resident #003 frequently and to notify the physician. Physician #120 instructed RN #105 to transfer resident #003 to the hospital for further assessment and monitoring. Resident #003 returned to the home with no adverse effects noted.

Inspector #672 reviewed the medication incident report (MIR), which stated RPN #104 administered resident #004's medications to resident #003. RPN #104 became aware of the medication incident, when resident #004 approached the nurse to request their medications, and immediately reported the incident to RN #105. Physician #120 was notified of the incident, and an order was received to transfer resident #003 to the hospital due to concerns of a possible adverse effect.

Review of the physician's orders for resident #004 showed medications were accidentally administered to resident #003.

Review of the physician's orders for resident #003 showed the resident had also received identified medications.

During an interview, the DOC indicated an investigation into the medication incident had been conducted, and found that RPN #104 made an error in administering resident #004's medications to resident #003 by not following the internal medication management policy and the best practice guidelines from the College of Nurses of Ontario related to medication administration, by not ensuring the correct resident was receiving the correct medications, as per the physician's orders.

Inspector #672 then expanded the scope of inspection to review medication incidents which occurred in the home for a specified period of time, related to medication incidents which had occurred when pain medications were not administered to residents according to the physician's orders.

During review of a specified medication incident reports, Inspector #672 observed two medication incidents which involved pain medications not being administered to residents according to the physician's orders. The first incident occurred on a specified date, when RPN #143 did not administer several of resident #020's pain medications as per the physician's order. The second incident was observed on a specified date, identified pain medication was not administered according to the physician's orders.

Related to resident #020:

Inspector #672 reviewed the medication incident report (MIR) which stated on a specified date, resident #020 was noted to be unwell when RPN #143 approached the resident to administer their routine medications. RPN #143 decided to hold the medications until resident was settled. RPN #144 arrived on duty the following shift and found resident

#020's medications still not administered. RPN #143, the charge nurse and MD #145 were informed of the incident and an order was received to monitor the resident for symptoms of uncontrolled pain and complete a pain assessment, due to resident #020 not receiving their medications as prescribed.

Review of the May 2019 physician's orders for resident #020 showed the resident had not received the identified medications.

During an interview, RPN #143 indicated when they approached the resident on an identified date, to administer the resident's routine medications, they found the resident to be unwell, therefore decided to hold the medications and planned on returning to administer the medications at a later time, after resident #020 settled, but had forgotten to do so.

Further review of the physician's orders for resident #020 showed the resident had physician's orders for specified medications.

Review of the electronic Medication Administration Record (eMAR) of identified month showed neither medication appeared to have been administered to resident #020 on identified date. The eMAR also showed that RPN #143 had documented that all scheduled medications had been administered as prescribed to the resident. The pain level documented showed that resident #020's pain had increased.

Review of resident #020's progress notes did not indicate if there were any side effects experienced by the resident as a result of the medication incident. Review of resident #020's written plan of care in place at the time of the medication incident indicated resident #020 had an identified condition that causes pain in identified body part. The goal in the written plan of care was for resident #020's pain to be controlled and included pharmacological and non-pharmacological interventions.

During an interview, the DOC indicated an investigation into the medication incident had been conducted, and found that RPN #143 made an error in administering resident #020's medications by not following the internal medication management policy and the best practice guidelines from the College of Nurses of Ontario related to medication administration. The DOC further indicated that RPN #143 should have documented in the progress notes that resident #020 was exhibiting identified symptoms therefore the routine medications were held, and RPN #143 should not have signed the eMAR to state the medications had been administered until the medications had actually been taken by

the resident.

Related to resident #011:

Inspector #672 reviewed the medication incident report which stated that on identified date, RPN #115 found that resident #011 had not had their specified medication for an identified period. The incident report further indicated that on an identified date, a nurse had accidentally discontinued the prescription order, which was the cause of the resident not having the medication since an identified date.

Review of the physician's orders during an identified month for resident #011 showed the resident had a specified order for the prescription, which had been discontinued on identified date, in error. The identified medication prescription was reordered at an identified date.

Review of resident #011's written plan of care in place at the time of the medication incident stated that resident #011 complained of pain related to identified condition. The plan of care further indicated resident #011 required assistance from staff for specified activities of daily living due to pain.

Review of resident #011's progress notes during an identified period indicated a specified medication was discontinued in error. Resident #011 presented with complaints of pain and the resident received pain medications.

During an interview, the DOC indicated an investigation into the medication incident had been conducted and found that RPN #115 had administered resident #011's identified medication during a specified period without a physician's order.

During an interview, RPN #115 indicated they did not follow the internal medication management policy or the best practice guidelines from the College of Nurses of Ontario related to medication administration when administering resident #011's medications during specified period, when they administered specified medication on a number of occasions without a physician's order.

The licensee failed to ensure that drugs were administered to residents #003, #011 and #020 in accordance with the directions for use specified by the prescriber. [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 to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff recorded symptoms of infection in residents on every shift, as required.

Related to Log #017503-19:

A Critical Incident Report (CIR) was submitted to the Director on an identified date, related to the unexpected death of resident #005, which occurred in the home on identified date and time after the resident sustained a fall.

Review of resident #005's health care records showed a physician's progress note from an identified date, which stated that resident #005's clinical status had been declining.

Review of resident #005's progress notes for identified period, showed that on identified date, resident #005 was observed to have been presenting with identified symptoms and diagnosed with specified condition.

Inspector #672 reviewed resident #005's physician's orders, and observed that a specified medication was ordered on identified date to be administered for a specified

period. Inspector #672 reviewed resident #005's progress notes for same identified period, and observed there was no documentation on a number of identified shifts regarding the resident's identified symptoms.

Further review of resident #005's progress notes showed that on identified date, resident #005 was observed to exhibit identified symptoms and received a diagnosis of identified condition.

Inspector #672 reviewed resident #005's physician's orders, and observed another identified medication was ordered on identified date to be administered for a specified period of time. Inspector #672 reviewed resident #005's progress and observed there was no documentation on the multiple identified shifts regarding the resident's symptoms.

During review of resident #005's progress notes for identified period, resident #005 was observed to exhibit identified responsive behaviours and signs of pain and discomfort, and was noted to have identified symptoms on an identified date. A specified test was done and was positive for identified condition. The physician was notified, and a new order for specified medication was received to be administered for a specified period of time. Inspector #672 reviewed resident #005's progress notes, and observed there was no documentation on a number of shifts regarding the resident's identified symptoms.

Inspector #672 then expanded the scope of the inspection to include two more residents who had recently received identified medications within the home, to assess if staff had recorded identified symptoms on every shift, as required. Inspector #672 was provided with the names of residents #014 and #015 from RPN #129, who indicated both residents had received identified medications within the previous month.

Related to resident #014:

During review of resident #014's progress notes for identified period, Inspector #672 observed on identified date, resident #014 was observed to have identified symptoms. Resident #014 was diagnosed with an identified condition and specified medication was ordered by the physician to be administered for a specified period. Inspector #672 reviewed resident #014's progress notes, and observed there was no documentation on a number of identified shifts regarding the resident's identified symptoms.

Related to resident #015:

During review of resident #015's progress notes for an identified period, Inspector #672 observed on identified date, resident #014 was observed to have identified symptoms and an identified medication was ordered by the physician to be administered to a specified period. Inspector #672 reviewed resident #015's progress notes, and observed there was no documentation on identified shifts regarding the resident's identified symptoms.

During review of resident #016 and #017's pain assessments, Inspector #672 observed both residents had also received specified medications therapy within an identified month.

Related to resident #016:

During review of resident #016's progress notes for an identified period, Inspector #672 observed resident #016 had an identified condition to a body part, which was observed to exhibit identified symptoms and the resident had complaints of pain. An assessment of the identified condition was completed which physician #120 was notified of. Physician #120 provided instructions for a specified intervention and gave an order for a specified medication to be administered for a specified period. Inspector #672 reviewed resident #016's progress notes, and observed there was no documentation on identified shifts regarding the resident's identified symptoms.

Related to resident #017:

During review of resident #017's progress notes for an identified month, Inspector #672 observed on identified date, resident #017 presented with identified symptoms. An identified test was completed. The physician was notified of the results of the test, resident #017 was diagnosed with a specified condition and an order was received for a specified medication to be administered for a specified period. Inspector #672 reviewed resident #017's progress notes, and observed there was no documentation on identified shifts regarding the resident's identified symptoms.

During separate interviews, RN #127 and RPNs #128, #129, #130, #131 and #132 all indicated the expectation in the home was for registered staff to assess the condition of a resident who was receiving specified medications on every shift and document the findings for the duration that the resident was receiving the medication.

During an interview, the Infection Control Practitioner (ICP) indicated they expect registered staff to document on every shift regarding a resident's exhibited symptoms. The ICP indicated the DOC was responsible for overseeing the nursing department, therefore directed Inspector #672 to verify with the DOC the expectations in the home were, regarding documentation related to resident's who exhibited signs and symptoms and were receiving specified medication.

During an interview, the DOC indicated the expectation in the home was for registered staff to assess and document on each resident who received specified medication on every shift while the resident actively received the identified medication and at any other time if the resident was observed to exhibit identified symptoms.

The licensee has failed to ensure that staff recorded symptoms of a specified condition of residents #005, #014, #015, #016 and #017 on every shift, as required. [s. 229. (5) (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 symptoms of infection ares recorded on every shift and immediate action is taken as required, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (6) The licensee shall ensure that the care set out in the care plan is provided to the resident as specified in the plan. O. Reg. 79/10, s. 24 (6).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the care plan is provided to the resident as specified in the plan.

Under O. Reg. 79/10, s.24. (1), every licensee of a long-term care home shall ensure

that a 24-hour admission care plan is developed for each resident and communicated to direct care staff within 24 hours of the resident's admission to the home.

Related to Log #015052-18

The home had submitted CIR to the Director on identified date and time, for an incident that caused an injury to resident #006 for which the resident was taken to hospital. The CIR indicated staff found resident #006 laying on the floor with specified falls prevention interventions were in place. The resident was assessed at a later date and diagnosed with an injury to a body part.

A review of clinical records for resident #006 indicated the resident wad identified at risk for falls on the date of admission.

A review of progress notes for resident #006 was completed by Inspector #570 and indicated that a specified intervention for falls prevention was to be used on admission date, but was not used until the resident was found on floor on identified date.

A review of the plan of care for resident #006 related to falls prevention was initiated by RN #123 on identified date after the resident sustained a fall. The plan of care indicated several intervention for falls prevention.

An interview with PSW #119 indicated to Inspector #570 that resident #006 was at risk of falling due to attempts to climb out of bed. The PSW indicated they do not recall if the resident had a specified intervention for falls prevention prior to the resident fall on identified date.

An interview with RPN #116 indicated to Inspector #570 that resident #006 was at risk for falls and specified interventions in place, but did not recall if the resident had an identified intervention when the resident was found on the floor on identified date. The RPN indicated that the resident should have a specified intervention in place as indicated in the admission assessment note which was considered the 24 hours care plan.

A interview with RPN #117 indicated to Inspector #570 that they completed the admission assessment for resident #006 on identified date, and that the admission assessment represented the 24 hours care plan. The RPN confirmed their recommendation regarding the use of a specified intervention for falls prevention as noted on the admission assessment note. Review of the progress notes with RPN #117, the RPN indicated that

the progress notes did not indicate that a specified intervention was used prior to the fall on identified date. The RPN further indicated that the resident needed to have the specified intervention as their SDM was concerned that the resident had previous falls that would put them at risk of falling.

An interview with RN #123 indicated to Inspector #570 upon review of progress notes for resident #006 that the resident had specified interventions for falls prevention when the resident fell on identified date. The RN confirmed to Inspector #570 that they recommended the use of a specified intervention which the resident did not have in place when they fell on the identified date.

An interview with resident care coordinator (RCC) #118 indicated to Inspector #570 upon review of progress notes for resident #006, there was no documentation of a specified intervention being used for the resident as directed in the admission note. The RCC indicated that the specified intervention should have been implemented on the day of admission as indicated in the admission note which represented the 24 hour care plan.

The licensee failed to ensure the 24 care plan specific to the use of specified intervention for falls prevention was implemented. [s. 24. (6)]

WN #9: 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. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

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:
1. A description of the incident, including the type of incident, the area or location

of the incident, the date and time of the incident and the events leading up to the incident.
O. Reg. 79/10, s. 107 (4).
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).
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).
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).
5. The name and title of the person who made the initial report to the Director under subsection (1) or (3), the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector.
O. Reg. 79/10, s. 107 (4).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed no later than one business day after the occurrence of the incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital.

Related to Log #019268-18

A Critical Incident Report (CIR) was submitted to the Director on identified date and time, for an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. The CIR indicated resident #008 was found on the floor with no new injuries noted. At a later date, the resident was assessed by the physician and the resident had confirmed diagnosis of an injury that required a transfer to hospital.

A review of the CIR indicated the CIR was submitted to the Director on identified date, six days after the resident was diagnosed with an injury.

Interview with RCC #118 indicated to Inspector #570 that the incident involving resident #008 was not reported within one business day and that the incident should have been reported when the resident had a confirmed diagnosis of an injury. [s. 107. (3) 4.]

2. The licensee has failed to ensure that when making a report of an incident to the Director the names of any staff members who were present or who discovered the incident were included in that report.

Related to Log #015052-18

A Critical Incident Report (CIR) was submitted to the Director on identified date and time, for an incident that caused an injury to resident #006 for which the resident was taken to hospital. The CIR indicated staff found resident #006 laying on the floor with specified falls prevention interventions were in place. The resident was assessed at a later date and diagnosed with an injury to a body part.

A review of the CIR did not provide any documentation related to the name of the staff member who found the resident on the floor and reported the incident to RPN #116.

An interview with RPN #116 indicated to Inspector #570 that resident #006 was assessed post fall. The RPN indicated that they did not recall the staff who found the resident on the floor and reported the fall to them as they did not include staff name due to privacy.

An interview with resident care coordinator (RCC) #118 indicated to Inspector #570 upon review of the CIR that they did not include the name of the staff member who discovered and reported the incident to RPN #116. The RCC indicated that they did not have the name of the staff member readily available and that the name of the staff member should have been included in the CIR. [s. 107. (4)]

3. The licensee has failed to ensure that the Critical Incident Report to the Director included the name of the Manager of Nursing Practice, who was informed of the medication incident and provided instructions and directions to the staff involved.

Related to Log #011099-18:

A Critical Incident Report (CIR) was submitted to the Director related to a medication incident involving resident #003, which occurred on identified date, and resulted in the resident being admitted to the hospital for observation.

Inspector #672 reviewed the CIR, which stated that on identified date, when RPN #104 went back at the end of the medication pass to administer the medications to resident #004, they accidentally administered the medications to resident #003. RPN #104 reported the medication error to RN #105, who notified the Manager of Nursing Practice (MNP). The MNP instructed the registered staff to assess and monitor resident #003 and to notify the physician. When physician #120 was notified of the incident they instructed RN #105 to transfer resident #003 to the hospital for further assessment and monitoring. The critical incident report was submitted to the Director by RCC #103 and did not appear to include the name of the Manager of Nursing practice.

During an interview, Inspector #672 reviewed the CIR report with RCC #103, who verified the name of the Manager of Nursing practice was not included in the report submitted to the Director and that they had left the name of the MNP out as an oversight.

The licensee failed to ensure that the Critical Incident Report submitted to the Director following a medication incident involving resident #003, included the name of the

Manager of Nursing Practice, who the report indicated was informed of the medication incident and provided instructions and directions to the staff involved, which included an intervention for resident #003 and notification of the most responsible physician. [s. 107. (4) 2. iii.]

Issued on this 4th day of December, 2019

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

Original report signed by the inspector.