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

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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 26, 2017	2017_542511_0011	013990-17	Resident Quality Inspection

Licensee/Titulaire de permis

ST. JOSEPH'S HEALTH SYSTEM
56 GOVERNOR'S ROAD DUNDAS ON L9H 5G7

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

ST JOSEPH'S VILLA, DUNDAS
56 GOVERNOR'S ROAD DUNDAS ON L9H 5G7

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

ROBIN MACKIE (511), CAROL POLCZ (156), CYNTHIA DITOMASSO (528), DIANNE BARSEVICH (581), JESSICA PALADINO (586), LEAH CURLE (585), LESLEY EDWARDS (506), LISA BOS (683), MELODY GRAY (123)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 6, 7, 10, 12, 13, 14, 17, 18, 19, 20, 21, 24, 25, 26, 27, 28, 31, August 1, 2, 3, 8, 9, 10, 11, 14, 15, 16, 17, 18, 2017.

The following Complaints, Critical Incidents, Inquiries and follow-up Orders were completed with this RQI: Complaint 003312-16 Abuse, Skin and Wound and Continence., Complaint 009286-16 Abuse, Skin and Wound and Pain., Complaint

018878-16 Abuse, Personal Support Services (PSS), Continence and Recreation., Complaint 025667-16 PSS and Skin and Wound., Complaint 027789-16 PSS and Responsive Behaviours., Complaint 029396-16 Falls and Pain., Complaint 031442-16 Skin and Wound, Continence and PSS., Complaint 032364-16 Pain, PSS and Nutrition and Hydration., Complaint 033821-16 PSS and Training and Orientation., Complaint 003711-17 Nutrition and Hydration, Falls, Pain, Continence and Abuse., Complaint 006724-17 Falls., Complaint 007087-17 Abuse and PSS., Complaint 011323-17., Complaint 015432-17 Abuse., Complaint 015434-17 Abuse., Complaint 016664-17 Abuse., Inquiries 026638-16 Abuse., 009002-17 Skin and Wound., 009109 -17 Medication., 009108-17 Abuse., 11289-17 Falls., 015255-17 Staffing., Follow-up Orders 005961-17 related to Abuse [s.19 (1)]., 005962-17 related to Responsive Behaviours [s.53 (4) (c)]., 006632-17 related to Continence [s.51 (2)]., Critical Incidents 012368-17 Falls, 019571-16 Falls., 023653-16 Falls., 027187-16 Falls., 035293-16 Medication., 000330-17 Falls., 008128-17 Falls.,008275-17 Abuse., 12772-17 Responsive Behaviours.,0108839-17 Abuse., 004556-17 Falls.

Intake # 003711-17 was completed concurrently with this RQI and can be referenced in Report # 2017_546585_0015.

During the course of the inspection, the inspector(s) spoke with President, Administrator, Director of Care (DOC), Assistant Director of Care (ADOC) #193, Assistant Director of Care (ADOC) #117, Resident Care Coordinator (RCC # 163), Resident Care Coordinator (RCC #152), Resident Care Coordinator (RCC #120), Resident Assessment Instrument Coordinator (RAI # 108), Resident Assessment Instrument Coordinator (RAI # 160), Food Service Manager, Food Services Supervisor (FSS), Manager/Quality and Performance, Registered Dietitian #158, Registered Dietitian #123, Infection Control Lead, Staffing personal, President of Resident Council, President of Family Council, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and family members of residents.

During the course of this inspection the Inspectors toured the home, observed the provision of resident care, dining services and reviewed the home's applicable policies, practices and procedures.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 s. 19. (1)	CO #001	2017_57610a_0002	123
O.Reg 79/10 s. 51. (2)	CO #001	2017_57610a_0004	585

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (2) The licensee shall ensure that, for all programs and services, the matters referred to in subsection (1) are,
(a) integrated into the care that is provided to all residents; O. Reg. 79/10, s. 53 (2).
(b) based on the assessed needs of residents with responsive behaviours; and O. Reg. 79/10, s. 53 (2).
(c) co-ordinated and implemented on an interdisciplinary basis. O. Reg. 79/10, s. 53 (2).

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that, for all programs and services, the matters referred to in subsection (1) are, (c) co-ordinated and implemented on an interdisciplinary basis.

Regulation 53. (1) refers to the licensee's approach, strategies for residents with responsive behaviours.

In an identified month in 2017, resident #500 was admitted to the home with no documented history of behaviours. Progress notes identified that approximately one month later, the resident began displaying inappropriate behaviours. The following month, progress notes confirmed that the behaviours continued. As a result, staff #139 provided an intervention for the resident's behaviour that was not coordinated with the interdisciplinary team or contained in the resident's plan of care. Interview with the RCC #152 confirmed they were not made aware of the resident's behaviours or intervention

until three month after the incident.
Interview with the RCC #152 and the DOC confirmed that the staff failed to identify and implement strategies to respond to the resident's ongoing behaviours when they first noticed new behaviours and the home failed to ensure the above intervention for resident #500's responsive behaviour was co-ordinated and implemented on an interdisciplinary basis. (528) [s. 53. (2) (c)]

2. The licensee failed to ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident were identified, where possible;
(b) strategies were developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident’s responses to interventions were documented.

A. The home's policy ' Management of a Resident with Responsive Behaviours', revised February 14, 2017, directed staff to utilize strategies from the care plan when there was a responsive behaviour incident and to document the incident and the effectiveness of the strategies. Post incident review was to include but not be limited to, Abbey pain scale, Depression scale, Dementia Observation Scale and the Daily Behaviour Observation sheet. When appropriate, the RCC, in consultation with the interdisciplinary care team, was to obtain physician's order and consent to utilize external consultants.
i. In an identified month in 2017, resident #500 was admitted to the home with no documented responsive behaviours. Progress notes identified that one month later, the resident began displaying inappropriate behaviours. Review of the plan of care had not included any behavioural triggers for the resident or strategies to respond to the behaviours until one month later, when an altercation occurred, which negatively affected the resident.
ii. Interview with staff #139, RPN #153, and RCC #152 confirmed the resident had ongoing behaviours for one month in 2017; however, the plan of care had not included strategies for staff to respond to the behaviours, the interdisciplinary team had not discussed the resident at behavioural rounds that month and staff had not consistently documented the behaviours, as required in the home's policy. (528)

B. Resident #750 was admitted to the home in an identified month in 2017 and a review of an identified Assessment Tool indicated that they were a low risk for responsive behaviours. Two months later, they were reassessed and a change in their risk level

was identified which required immediate care plan interventions. Review of the resident's progress notes during the two months indicated they had several responsive behaviour incidents.

Interview with ADOC #117 stated the resident had an increase in their responsive behaviours, over the past months which were triggered by a known source. They confirmed that the plan of care had not included all the triggers, strategies and interventions in place for staff to respond to the resident's responsive behaviours. (581)

C. A review of the clinical record for resident #012 indicated that the resident exhibited responsive behaviours. The resident was observed by the LTC Inspector to be exhibiting a responsive behaviour on an identified date in 2017. Interview with registered staff #146 confirmed that the resident continued to demonstrate these behaviours, was not included in the home's monthly behaviour rounds and that adequate strategies had not been developed and implemented to respond to the resident's behaviour. (156)

D. The home's policy ' Management of a Resident with Responsive Behaviours', revised February 14, 2017, directed staff to utilize strategies from the care plan when there was a responsive behaviour incident and to document the incident and the effectiveness of the strategies.

The plan of care for resident #501 identified that the resident had a cognitive impairment with responsive behaviours and identified interventions. On an identified day in August 2016, PSW #148 documented that the resident demonstrated a responsive behaviour. Interview with RN #154 confirmed the resident demonstrated a responsive behaviour. A review of the progress notes had not included documentation of the behaviour or what was done to accommodate the behaviour and or the effectiveness of the strategies for the resident. Interview with ADOC #117 confirmed that when a resident demonstrated a responsive behaviour, the registered staff were to document the behaviour and effectiveness of interventions; however, this was not completed on the identified day in August 2016. (528)

E. In an identified month in 2016, resident #800 was admitted to the home with cognitive impairment. As a result of escalating responsive behaviours, ongoing behavioural reassessments and interventions were completed. Review of the plan of care revealed that during two consecutive months, the required observational charting, that was recommended to assess the resident's behaviours and response to interventions was not consistently completed.

Interview with RPN #172 confirmed that the required observational charting was to be completed for the two consecutive months. RPN #172 confirmed that although the resident was assessed, the required observational charting was not consistently documented on 11 out of 12 days, as required in the plan of care.

During an identified month in 2017, a resource consultant recommended resident #800 receive a specified assessment. A review of the plan of care had not included the specified assessment. Interview with the RCC #163 confirmed the plan of care had not included the specified assessment after recommendations were made by the resource consultant. (528) [s. 53. (4)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

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

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff, (i) within 24 hours of the resident's admission.

A. Resident #049 was admitted to the home on an identified date in 2017 as per an admission note. Further review of the clinical record described the resident to be at risk for altered skin integrity related to their diagnosis and mobility status. A Nursing

Admission Screening/History note was completed by RPN #181 that described the resident had impaired skin integrity but had not been received a skin and wound assessment by the registered staff member. Nine days post admission, a skin and wound assessment note identified the initial skin and wound assessment had been completed by RPN #181.
Interview with the RPN #181 confirmed resident #049 was at risk for altered skin integrity and had not received a skin assessment by the registered staff within 24 hours of admission. (511)

B. The licensee has failed to ensure that a resident at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff, (ii) staff upon any return from hospital.

Resident #304 was discharged to hospital on and identified date in 2016 and was readmitted to the home a few days later. Upon return from the hospital the resident received a head to toe assessment which indicated an altered level of skin integrity. Progress notes indicated the resident's skin was not assessed until approximately two weeks later where it was noted that the resident had a new area of altered skin integrity and the existing area had worsened. This was confirmed with ADOC #117 on August 16, 2017. (156) [s. 50. (2) (a) (i)]

2. The licensee has failed to ensure that, b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (i) received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A. A review of resident #403's clinical record indicated RPN #145 documented that a PSW had observed a new area of altered skin integrity. RPN #145 documented, in the progress notes, that they went into the resident's room to check on the resident and witnessed the new areas of altered skin integrity and provided a treatment. Further review of the clinical record had not indicated a skin and wound assessment, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment, was completed when RPN #145 became aware of the new areas of altered skin integrity
Interview with RPN #145 stated they were required to document the dressing change in the progress notes of the resident's clinical file and the Treatment Administration Record (TAR).
Interview with the DOC confirmed the licensee failed to ensure resident #403, who

exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (i) received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. (511)

B. Resident #304 was noted to have altered skin integrity on an identified date in 2016. The resident was no longer in the home at the time of this inspection. A review of the resident's clinical record identified that this area of skin breakdown was not assessed by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment . This was confirmed with the ADOC #117, on August 16, 2017. (156)

2. The licensee has failed to ensure that a resident that exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (iii) was assessed by a registered dietitian who was a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration were implemented.

A. A review of the clinical record for resident #403 indicated a new area of altered skin integrity. The skin and wound assessment, completed by the registered nurse, described the impaired skin integrity. A review of dietary referrals had not included a referral for resident #403's new area of altered skin integrity. A review of the Registered Dietitian's (RD) assessment notes, in Point Click Care (PCC), had not identified an assessment of this new area. Interview with the RD confirmed they had not completed an assessment for resident #403's new area of altered skin integrity .
Interview with the DOC confirmed the RD's had not consistently received referrals for altered skin integrity.

3. The licensee has failed to ensure that, (b) a resident that exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (iv) was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated

A. Resident #008 was assessed to have altered skin integrity on an identified date in 2017. The next weekly skin assessment was not completed as confirmed with registered staff #107 on July 13, 2017. (156)

B. Observation of resident #403 identified the resident had an alteration in their skin integrity and a review of resident #403's clinical record indicated the resident had a

diagnosis that placed them at risk for altered skin integrity.

Skin assessments were reviewed for a seven month period in 2017. The resident had several areas of altered skin integrity, during this time, where there had been no further weekly wound assessments. Interview with the DOC confirmed that after their review of the skin assessments that multiple, weekly skin assessments were not completed and some assessments had been completed incompletely for resident #403 during this seven month file review in 2017. Missing and inconsistent documentation of the weekly skin and wound assessments for resident #403's multiple wounds had not allowed for the identification of which, if any, of these wounds had healed or deteriorated during the reviewed time frame. (511)

C. A six month review of the clinical record was completed for resident #049 from their admission date in 2017. During this time, the resident had greater than five alterations in their skin integrity to multiple ares of their body. Weekly skin and wound assessment were not completed, for the combination of all areas of altered skin integrity, on more than 15 occasions. Interview with RPN #181 confirmed that weekly skin and wound assessment were not completed for resident #049's multiple alterations in their skin integrity. (511)

D. Resident #304 was noted to have altered skin integrity when they were admitted to the home, on an identified date, in 2015. The altered skin integrity had worsened and was not reassessed at least weekly by a member of the registered nursing staff on 12 of the identified weeks in 2015 and 2016. This was confirmed with ADOC #117 on August 16, 2017. Resident #304 was noted to have a second are of altered skin integrity in 2016 and this wound was not reassessed at least weekly by a member of the registered nursing staff on four of the identified weeks in 2016 as confirmed with ADOC #117 on August 16, 2017. (156)

3. The licensee has failed to ensure that the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing.

A. A review of the clinical record identified that resident #049 required a dressing change for an area of altered skin integrity.
On an identified date in 2017, an RPN documented in the progress notes that they were able to do wound care on this resident, however, not with the proper wound supplies as there were none available.

Interview with RPN #181 confirmed that the home often runs out of supplies and the staff would have to use other "make shift' dressings until the prescribed wound supplies arrived.

B. A review of the clinical record for resident #304, on an identified date in 2016, documented that an RPN was unable to complete a dressing change to the resident's area of altered skin integrity because wound supply (dressings) were not available. The resident's skin was not assessed until one week later where it was noted that the resident had a new area of altered skin integrity and the previous area had worsened. This was confirmed with ADOC #117 on August 16, 2017. (156)

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A. The licensee failed to ensure the home's Falls Prevention policy was complied with. In accordance with Ontario Regulation 79/10, s. 48, required the licensee to ensure there was a falls prevention and management program in place to reduce the incidence of falls

and the risk of injury.

The home's falls policy, "Falls Prevention and Management", Policy Number POL/3", last revised October 27, 2015, identified that when a fall occurs, Head Injury Routine (Nursing Standard Head Injury Routine {H.I.R.}), will be followed for an un-witnessed fall where the resident is unable to accurately report if they hit their head.

On four identified dates in 2016, resident #200 experienced four unwitnessed falls. A clinical record review revealed that the HIR was not completed and this was confirmed by ADOC #117. Interview with RPN #106 confirmed HIR was not completed as required and reported that completing the HIR as required on night shifts was not always possible. Interview with the DOC confirmed the HIR was part of the post-fall assessment, which was part of the home's Falls prevention policy, when a resident experienced an unwitnessed fall or hit their head. (585)

B. The licensee failed to ensure the home's Responsive Behavior policy was complied with. In accordance with Ontario Regulation 79/10, s. 53, required the licensee to ensure there was a program in place to manage responsive behaviours.

The home's policy, "Management of a Resident with Responsive Behaviours", (policy number POL/10, last revised February 14, 2017) directed the RN/RPN, to notify the resident's POA/SDM as soon as possible after the incident to advise of the incident, any injury or emotional upset caused by the incident and safety measures taken to protect the resident from further incidents.

On an identified date in 2017, resident #500 was observed demonstrating a responsive behaviour. Resident #500's Substitute Decision Maker (SDM) voiced concern that they were not notified of this incident. The "SJV-Responsive Incident" tool was completed which indicated that the POA/family was not notified. Interview with RCC #152 and review of the resident's health record confirmed that the resident #500's SDM was not notified of the incident. (586)

C. The licensee failed to ensure the home's Medication Management policy was complied with. In accordance with Ontario Regulation 79/10, s.114 required the licensee to develop an interdisciplinary Medication Management system that provided safe medication management and optimized effective drug therapy outcomes for residents.

As part of the home's Medication Management system, a department standard for

ordering and receiving medications from the pharmacy was reviewed. This department standard was effective August 1998 and last reviewed on June 2015. The DOC provided and confirmed this was the standard of service for the licensee's ordering and receiving of medications from the pharmacy.

The standard described that all drugs would be accurately processed according to the following procedure:
4.1 Drug Record Book

i) 4.1.2 All new orders, re-orders and emergency orders would be entered in the book.

A review of resident #403's medication record, on an identified date, had not contained the resident's medication that had been prescribed at an earlier date.

A review of the Drug Record Book had not contained the resident's reordered medication. Interview with the DOC confirmed the prescribed medication was to be entered in the Drug record book as per the home's Department Standard for ordering and receiving medications from the pharmacy and was not.

ii) 4.1.4 The following information must be recorded for every drug order: Signature and initials of person placing/receiving order and the date the order was placed and received.

On an identified date in 2017, during an interview with RPN #171, they confirmed that they documented that resident #403's identified medication had not been administered in accordance with the directions for use specified by the prescriber because the medication was not available. RPN #171 reviewed the resident's Drug Record book and could not confirm if the resident's medication had been reordered or received as the form had not been completed in its entirety as per the home's standard as described in 4.1.4.

iii) 4.4 Re-Orders: When there were five days of medication left, staff were to remove the large drug label and place in sequence on the current Drug Record Book Page and add the initials/signature and date.

On an identified date in 2017, during an interview with RPN #171, they confirmed that they documented that resident #403's medication was not available as the medication had run out and had been entered into the Drug record book for re-ordering. RPN #171 reviewed the resident's Drug Record book and could not confirm if the resident's medication had been reordered because the fax box, that would have confirmed the

record was faxed to pharmacy, was not completed. The RPN called the home's pharmacy and the pharmacy confirmed they had not sent the medication as they had not received the fax required for reordering the medication as per the Drug Record Book. RPN #171 faxed the reorder form for the resident's medication, one day after the medication had run out.

Interview with the DOC confirmed the resident's pain medication should have been reordered when there were five days of medication left as per the home's standard described in 4.4. (511)

iv) A review of the home's Narcotics and Controlled Substances, Standard of service, last reviewed May 2016 identified 4.2.5: If a portion of an ampule was used, the remainder was discarded and noted on the Narcotic inventory record as a separate entry. Disposal must be witnessed by two registered staff (one must be an RN) and both initial the record. This must be done at the point of use or by the end of the shift.

On an identified date in 2017, the LTC Inspector observed RPN #143 provide a narcotic to an identified resident. The RPN opened up the narcotic medication and administer a portion of the medication. Once administered, they threw the partially filled vile into the Sharps container. They stated that when a narcotic was wasted the second nurse was to observe the waste and sign for the wasted narcotic but this was not a policy that had been practiced in the home.

A review of a document dated in 2017, provided to the DOC from a consultant, identified that through an audit it was identified that wasting of narcotics rarely contained a witness from the second registered nurse.
Interview with the DOC confirmed the home's policy for wasting of narcotics had not been complied with. (511)

D. The licensee failed to ensure the home's policy, "Resident Admission/Transfer/Return from Hospital Assessment", last revised on April 4, 2017, was complied with.

The home's admission policy directed registered staff to complete a head to toe assessment on the
shift of arrival when residents returned from hospital. Vital signs would be obtained on the day of return from hospital and noted on the vital sign tab in Point Click Care.

On an identified date in 2017, resident #750 was transferred to hospital. They were

admitted and discharged back to the home two days later. Review of the plan of care identified that the Return from Hospital Assessment was not completed. Interview and review of the clinical record with RPN #179 stated that the head to toe assessment and vital signs were not completed when the resident returned from hospital and confirmed that the home's policy was not complied with. (581)

E. The licensee failed to ensure the home's policy, that provided for written procedures for dealing with complaints in accordance with Ontario Regulation 79/10, s.101, was complied with.

The record of an identified resident was reviewed including progress notes and it was noted that on an identified date in 2017, a family member had reported a concern to the home. It was noted that the home would follow-up with the SDM the following week. Registered staff #193 was interviewed and reported that the staff had not completed the documentation as per the home's policy and procedure and therefore the information was not included in the home's 2017 complaint log.

The family member of an identified resident reported that they had reported numerous concerns and complaints to the home during 2016 and 2017. They also reported that they met with the home to discuss their concerns.
Registered staff #193 reported that during 2016, the family member of the resident expressed concerns to the home that were not immediately resolved; the home met with the family member but that the staff had not recorded the concerns as per the home's complaint policy and procedure. (123) [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with LTCHA, 2007, 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 there was a written policy that promotes zero tolerance of abuse and neglect of residents and that it was complied with.

A. The home's policy 'Prevention of Abuse/Neglect of a Resident' policy revised June 27, 2017, identified that staff's responsibility included reporting any suspicion, concern or evidence of abuse or neglect are reported immediately to department manager.
Furthermore, the policy outlined the following procedure, including but not limited to:
i. The first priority was to protect the person from further harm. The charge nurse or supervisor/delegate was to immediately assess the situation and institute care if required. When there was suspected injury due to physical abuse, the attending physician was to be notified.
ii. The charge nurse/manager or supervisor was to immediately advise the DOC or ADOC
iii. If, as judged by manager/Director/Administrator on call or site President the circumstances were sufficiently serious to warrant immediate suspension of the implicated employee, this action may be taken. The employee may be off work without pay pending investigation.
iv. If warranted or required transfer/medical assessment/crisis counselling for the victim could be instituted via the Social Service Worker, RN/RPN, or physician.
v. The most responsible person investigating the incident documented a detailed report describing the situation and including what, where, who, when and how. What happened, time it happened, who was involved, interview resident as soon as possible noting all responses accurately documented, etc.
vi. Immediate reporting to the Director was to be completed and the substitute decision maker (SDM) was notified of results.
vii. Resident and or family member must have been adequately informed and must have direct communication as indicated, including results of investigation. Support and assistance was to be provided.
viii. Disciplinary action and non-disciplinary action was to be taken as outlined.

On an identified date in 2017, resident #502 alleged they had been treated in an inappropriate manner during care by a PSW on more than one occasions. The resident also reported that they had told someone in the home.
i. The LTC Inspector notified ADOC #117 immediately, who was unaware of the allegations.
ii. Interview with RPN #115, on an identified date in, 2017, confirmed that resident #502 told a person in the home, who reported the allegations to registered staff. RPN #115 confirmed they did not report the allegation to management.
iii. A follow up interview was completed with ADOC #117, six days after notifying them of the allegations. At that time, it was confirmed that resident #502 had not yet been interviewed as part of the investigation, the Director had not been notified of the allegations; however, the home had determined abuse was not substantiated.

Interview with ADOC #117 confirmed that the home failed to follow the home's policy 'Prevention of Abuse/Neglect of a Resident', when on an identified date in 2017, PSW staff #114, PSW #116, and RPN #115 did not report an allegation of alleged abuse to management, the home did not report allegations to the Director, and the home did not interview resident #502 about the allegations, as soon as possible. (528)

B. The home's 'Prevention of Abuse/Neglect of a Resident' revised June 27, 2017, defines physical abuse including but not limited to, the use of physical force by a resident that causes physical injury to another resident and directs staff to immediately report abuse of a resident to the Director.

On an identified date in 2017, an altercation occurred between resident #505 and resident #508. Review of the plan of care for both residents was completed and it was described that one of the residents sustained an injury. Review of the Critical Incident Report revealed that the incident was not reported to the Director until four days later. Interview with ADOC #117 confirmed that the incident was not reported immediately, as required in the home's policy. (528)

C. The home's policy and procedure Prevention of Abuse/Neglect Of A Resident, #POL/9, revised June 27, 2017 was reviewed and included: "Utilizing the on-line Critical Incident (reporting) System (CIS), the Department Director, or designate, shall notify the Ministry of Health and Long-Term Care based on the MOHLTC decision tree guidelines (May 2012) and mandatory reporting time frame requirements."
Critical Incident (CI) report #2975-000019-17 was reviewed and it was noted that on an

identified date in 2017, residents #018 and #651 were involved in an altercation which resulted in the physical injury of resident #651. The home had not immediately submitted the CI report of the alleged physical abuse to the MOHLTC. The CI report indicated that the MOHLTC after-hours pager was not contacted about the incident.
Registered staff #117 was interviewed and confirmed the accuracy of the information contained in the CI report as above. They reported that they were not informed of the incident until the following day and they submitted the CI report at that time. They also reported that it is the home's expectation that the staff in charge of the building, call the after-hours pager number which is available in the home areas, or immediately inform the home's management staff who are available by telephone, of the incident.
The home failed to ensure that its written policy that promotes zero tolerance of abuse and neglect of residents related to immediate reporting of alleged physical abuse was complied with. (123)

D. The home's policy and procedure Prevention of Abuse/Neglect Of A Resident, #POL/9, revised June 27, 2017 was reviewed and included: "Any concern or evidence regarding abuse/neglect, witnessed or suspected, must be reported immediately to the department manager, admin on call (if after business hours-depending on the severity of the circumstances), Department Director, and resident's substitute decision maker/first contact." It also contained, "Utilizing the on-line Critical Incident (reporting) System (CIS), the Department Director, or designate, shall notify the Ministry of Health and Long-Term Care based on the MOHLTC decision tree guidelines (May 2012) and mandatory reporting time frame requirements."

The family member of resident #652 reported that resident #506 abused the resident and that the home was aware. Registered staff #193 was interviewed and confirmed that the MOHLTC was not notified of the alleged abuse as per the home's policy and procedure. (123) [s. 20. (1)]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

s. 6. (5) The licensee shall ensure that the resident, the resident’s substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident’s plan of care. 2007, c. 8, s. 6 (5).

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

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

s. 6. (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).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not

been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

A. Resident #024 was admitted to the home on an identified date in 2017. Their Minimum Data Set (MDS) Admission Assessment identified their level of continence. The following month, a St. Joseph's Villa (SJV) Continence Assessment identified a different level of continence.

Review of the care plan in Point Click Care (PCC), which was part of the written plan of care accessible to registered staff, revealed the resident's incontinence was not included in the written plan of care until four months later. Review of the PSW Kardex, which was the written plan of care used to direct PSW staff had not indicated the resident experienced incontinence. Interview with RPN # 111, PSW #132 and PSW #113, reported the resident experienced incontinence. RPN #111 confirmed resident #024's written plan of care should have included the planned care for the resident's incontinence. (585)

B. The record of resident #018 was reviewed. The Behavioural Supports Ontario (BSO) Pain Assessment Tool Activity Chart Checklist, dated on an identified date in 2017, indicated that the resident experienced pain in identified areas of their body at times. The resource consultant recommendations document, identified pain as a potential trigger for the resident's responsive behaviors and included several diagnoses that would relate to pain. The resource consultant noted that the resident had been taking medications. The home's weekly pain assessments, for two consecutive months in 2017, were reviewed and revealed the resident was experiencing pain. Registered staff #173 was interviewed and reported the resident had experienced pain and received treatment. The resident's care plan was reviewed and had not included a focus related to the resident's actual or potential pain. This was confirmed with registered staff members #173 and #117 during an interview. (123)

C. The record of resident #651 was reviewed and included the weekly pain assessments for two consecutive months in 2017. It was noted that the resident experienced mild to moderate pain during that period. The resident's care plan was reviewed and did not

include a focus for actual or potential pain. Registered staff #117 and #173 were interviewed and indicated that the resident experienced pain due to their diagnoses and received medication to treat the pain. They confirmed that the plan of care had not set out the planned care for the resident related to pain. (123)

D. Review of resident #750's progress notes identified they demonstrated responsive behaviours for an identified trigger in 2017. The ADOC #117 met with the resident and made changes to the resident care routine to address the behaviours. Review of the plan of care did not identify the changes to the resident's care routine. Interview with the ADOC #117 confirmed that the resident's change in their care routine was planned care for the resident and had not been documented in the resident's plan of care. (581)

E. Resident #012 was assessed for being a falls risk and had several falls in a three month period in 2016. A review of the progress notes identified interventions were in place; however, a review of the written plan of care had not included interventions until after the resident had experienced the falls in 2016 and they sustained an injury. This was confirmed with the DOC on July 19, 2017. (156) [s. 6. (1) (a)]

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

A. Review of resident #024’s care plan in Point Click Care (PCC), that was accessible to registered staff, identified the resident required an identified level of assistance with an activity of their daily living. Review of the resident's kardex, used by PSWs to direct planned care for the resident, identified they required a different level of assistance with this identified activity. Interview with PSW #132 and RPN #111 reported conflicting levels of assistance for the resident's activity of daily living. RPN #111 confirmed the written plan of care had not provided clear direction to staff and others who provided care to the resident. (585)

B. Resident #403 was observed on an identified date in 2017, on two separate occasions to not have an identified treatment to a part of their body. There was altered skin integrity observed to the body part.

Interview with the Physical Therapy Assistant (PTA) stated the resident required the identified treatment to be provided to the resident's body part by the front line staff. Interview with PSW #113, stated they did not provide the treatment and that the registered staff took care of this treatment due to the resident's pain. A review of resident

#403's kardex, which was part of the written plan of care that front line staff use to direct care, described the treatment to be completed but that the resident would often refuse due to pain and staff were to refer to the Treatment Administration Record (TAR) for treatment orders.

Interview with RPN #111 confirmed the resident had altered skin integrity and required the identified treatment. RPN #111 stated they noticed the resident did not have this treatment and the treatments were to be done on evenings by registered staff. A review of the resident's Treatment Administration Record (TAR) indicated the treatment was currently 'on hold' but had not identified when this was placed on hold. An alternate treatment was also indicated in the TAR, without a start or end date indicated.

Interview with the DOC confirmed that the kardex, meant for front line staff, and the TAR failed to provide clear direction for the treatment of resident #403's body part. (511) [s. 6. (1) (c)]

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

A. Resident #024's Minimum Data Set (MDS) Admission Assessment, for an identified period of time in 2017, indicated an identified level of incontinence.

In their next Quarterly MDS review assessment in 2017, the resident was identified with a different level of incontinent; however, was also coded as having no change in their level of continence in the last 90 days. Review of their continence chart, completed by PSW staff during the review period, revealed the resident had the same level of incontinence. Resident Assessment Protocol (RAP) completed for the review period stated the resident had a different level of incontinence than previously identified. Interview with RPN # 111, confirmed the the resident's incontinence level was unchanged during the same quarterly review period in May 2017. (585)

B. In 2017, a Minimum Data Set (MDS) Assessment for resident #046 included coding that the resident had an identified diagnosis. Review of the plan of care did not include the diagnosis nor had any registered staff assessed symptoms related to the diagnosis. Interview with Resident Assessment Instrument (RAI) Coordinator confirmed that the MDS Assessment for the same period in 2017, for resident #046 was not consistent with registered staff daily assessment of the resident, related to the diagnosis and the coding

was completed in error. (528) [s. 6. (4) (a)]

4. The licensee failed to ensure that the resident, the SDM, if any, and the designate of the resident / SDM been provided the opportunity to participate fully in the development and implementation of the plan of care.

A. During an identified month in 2015, a physician order for resident #501 identified that the resident required a diagnostic test and the Substitute Decision Maker (SDM) was to be notified after the results were reviewed. A file review identified the resident's test results were faxed to the home and the home's physician the following month. A progress note documented that the SDM was made aware of one abnormal test result and the home would wait to hear from the physician once they reviewed the results regarding any further actions. Review of the plan of care had not included documentation to support that the SDM was made aware of the remaining results. A progress note and a physician order form identified that approximately one month later, the SDM had not been made aware of results and was upset. Interview with ADOC #117 confirmed that the SDM was not notified when the results were available, or of any follow up actions including changes to the resident's care, as specified in the plan of care. (528)

B. Resident #501's admission physician orders included, but were not limited to, the home's Nursing Formulary that contained six basic medications commonly used for simple, short-term complaints, with time limited use of up to 48 hours. In an identified month, registered staff had assessed the resident and administered a medication for pain. Four doses of the medication were administered over the next 48 hours, at which time, the physician was notified and new orders were received for the pain medication. The SDM was notified of the change and had refused the medication administration. Interview with ADOC #117 confirmed that the SDM had not been notified prior to the medication being first administered over the 48 hours and should have been given an opportunity to participate fully in the development and implementation of the resident #501's plan of care related to the medication administration.

C. On an identified date in 2017, resident #500's SDM had been in to visit when they noted the resident had a new resident identifier attached to their body. The SDM was unaware of the reasoning for the identifier and was not contacted prior to its use to provide consent.

In an interview with the Health and Safety/Infection Control Lead, staff #184, they indicated that the identifiers were part of a newly implemented program and that

residents assessed were required to wear the identifier. Staff #184 indicated that all assessments were completed in the home and identifiers applied; however, confirmed that they had not yet had the chance to contact all SDMs regarding this, including resident #500’s SDM. Interview with RCC #152 acknowledged that resident #500’s SDM was not contacted prior to the application of identifier.

The home did not ensure that resident #500’s SDM was given the opportunity to fully participate in the development and implementation of the resident’s plan of care. (586) [s. 6. (5)]

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

A. The plan of care, for resident #012, indicated that staff were to follow the resident's scheduled routine as a falls prevention strategy. The scheduled routine was provided on the plan of care. Resident #012 was observed on an identified day in 2017 and was not provided care as per the scheduled routine. Interview with PSW #124 and #121 confirmed that the resident's scheduled routine was not followed. The care set out in the plan of care was not provided to the resident as specified in the plan. (156)

B. During an observation of resident #601 and their room it was noted that the resident did not have the identified symbol outside their door or on their mobility aide as it specified in the resident’s care plan. The care plan indicated that the resident was in a prevention program that required the use of the symbol to identify residents at risk. RPN #147 confirmed that the resident was in the program and confirmed that the symbol should have been outside the resident’s door and confirmed that the care set out in the plan was not provided to the resident as specified in the resident’s plan. (506)

C. The plan of care for resident #501 identified that the resident was to complete mouth care twice daily with the supervision of staff and to lock all hygiene products away in drawers at all times. Observations, on two separate dates in 2017, confirmed that the resident had received oral care but their hygiene products, including but not limited to, toothbrushes and toothpaste, were not locked in the resident's bathroom. Interview with RN #151 confirmed that the toiletries should be locked away when not in use and had been outlined in the resident's plan of care. (528)

D. In an identified month in 2015, the SDM of resident #501 requested that a medication be discontinued. Progress notes documented that the attending physician was notified;

however, requested that the home follow up with the physician who ordered the medication. The medication was placed on hold at that time. Review of the plan of care identified that registered staff attempted to contact the specialist with no success and no further action was noted. Review of the medication administration record (MAR) revealed the medication was placed on hold for two months , when the attending physician discontinued the medication. Interview with the ADOC #117 confirmed that care set out in the plan was not provided as specified in the plan, when the staff did not follow up with the specialist as requested by the physician. (528)

E. The plan of care for resident #304 indicated that the resident had an alteration in their skin integrity. The plan of care indicted that the identified symptom management team was to be consulted as an intervention for the symptom. The resident was noted to have multiple levels of fluctuating symptoms over approximately eight weeks in 2016, as described in the identified symptom assessments, and was on medications. Identified symptom assessments indicated that a referral to the identified symptom management team was not conducted. Care set out in the plan of care was not provided to the resident as specified in the plan as the identified symptom management team was not consulted as confirmed with the ADOC #117 on August 17, 2017. (156)

F. A review of resident #403's clinical record documented that the resident had ongoing symptoms and altered skin integrity related to their identified condition. The Medication Administration record (MAR) included the letters RN/RPN next to the treatment order. Resident #403's most recent plan of care plan directed that treatment was to be provided before care was completed to ensure the resident's comfort.

On an identified date in, 2017, the resident was observed to complain of pain. Interview with RPN #185, who stated they were the RPN assigned to the care of resident #403 on the identified date, stated they had not provided the treatment, as per the treatment order, prior to care. RPN #185 stated the PSW would have provided the treatment during routine care. Interview with PSW #113 confirmed they had not applied the treatment during care. After RPN #185 reviewed the Medication Administration Record, the RPN searched the home's unit and was unable to locate the resident's prescribed treatment. Interview with the DOC confirmed the licensee has failed to ensure that the care set out in the plan of care was provided to resident #403 when the staff had not provided the treatment to the resident, as specified in the plan of care. (511) [s. 6. (7)]

6. The licensee has failed to ensure that staff and others who provided direct care to a resident were kept aware of the contents of the resident's plan of care and had

convenient and immediate access to it.

Resident #403 had a history of a known, reoccurring condition and had been identified at a risk for this condition on a 2017 resident assessment. The resident's plan of care directed the staff to follow the facility's care protocol for this condition. On an identified date in 2017, RPN #171 stated the resident had a re-occurrence of this condition but were unsure of the facility's care protocol as identified in the resident's plan of care and had not known where to locate the protocol. RPN #171 stated the resident's Nursing Formulary and the resident's medication administration Record (MAR) may have provided further direction on the care protocol. RPN #171 reviewed the resident's chart and could not locate a prescribed Nursing Formulary and had not located the home's care protocol documentation for the resident. Interview with the DOC confirmed that the home's care protocol, which was part of the resident's plan of care, had been stored electronically and was not convenient for RPN #171 and they did not have immediate access to it. [s. 6. (8)]

7. The licensee 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. Throughout the course of the inspection, resident #501 was observed receiving assistance for an activity of daily living In May 2017, the MDS Assessment and the corresponding 'Seven Day Observation and Monitoring Form' confirmed that the resident required assistance from one staff for this activity. Review of the written plan of care and corresponding kardex read that the resident was able to complete the activity of daily living independently but staff were to remain with the resident to ensure they were doing a thorough job. Interview with PSW #150 confirmed that the resident required assistance with the activity. Interview with RAI Co-ordinator confirmed that the written plan of care and kardex had not been revised to include the level of assistance that the resident required with an identified activity of daily living and was last updated approximately seven months ago. (528)

B. Resident #705 was at a risk for falls. They required the use of a physical device to mitigate their risk of falls; however, the resident kept removing the device. The physician ordered a different physical device for the resident. Review of the resident’s documented plan of care, which front line staff use to direct care, listed the use of the original physical device, and had not been updated to include the use of the new device. This was confirmed by RCC #163. (586)

C. During an identified month in 2017, resident #500 was admitted to the home with no documented history of behaviours. Progress notes identified that the resident began displaying inappropriate behaviours. The behaviours had worsened since the previous month and a progress note written by RCC #152, indicated that the RPN/RN was responsible to communicate with the resident, immediately and privately, about the behaviour and any triggers that may have caused the behaviour. Several progress notes documented that the resident continued with behaviours. In an interview with the RCC in August 2017, they acknowledge that the identification and management of the resident’s behaviours were communicated to staff; however, was not updated into the resident's plan of care, which front line staff used to direct care. The resident’s plan of care was not updated when their care needs changed. (586) [s. 6. (10) (b)]

8. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised when care set out in the plan had not been effective.

Review of resident #200's plan of care, for 2016, revealed they were at a high risk for falls. Their plan of care, for 2016, also identified they required extensive assistance with their activities of daily living and had cognitive impairment. Interventions to prevent a fall were documented in their plan of care. During a short period of time the resident had three falls with the final fall resulting in an injury that required a transfer to a hospital. As per the post-fall note the staff documented they had witnessed the resident independently attempting to complete an activity of their daily living. No new interventions were added until after the resident experienced a fall that resulted in an injury. RPN #106 reported post-fall assessments were completed and the resident’s plan of care was reviewed; however, confirmed their plan of care was not revised when the care set out in the plan was not effective when the resident continued to experience falls. (585) [s. 6. (10) (c)]

9. The licensee failed to ensure that the resident was being reassessed and the plan of care was being revised because care set out in the plan had not been effective, different approaches had been considered in the revision of the plan of care.

Resident #012 had a previous fall in 2016, which resulted in an injury and transfer to hospital. The resident was readmitted to the home with an order for a physical device to prevent falls. Record review indicated that in a three month time period the resident continued to have greater than 10 incidents involving the removal or adjusting of the physical device that put the resident at risk for further falls and/or injury. Progress notes

indicated that the home considered an alternate device; however, the resident was not reassessed and different approaches had not been considered with respect to the physical device until after the 10 incidents described above. This was confirmed with the RCC #152 in August 2017. [s. 6. (11) (b)]

Additional Required Actions:

CO # - 002, 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used all equipment, supplies, devices, assistive aids and positioning aids in accordance with manufacturers' instruction.

A. During the initial tour of the home the arjo alenti tub lifts were observed without safety belts on seven home areas. Interview with RPN #140 revealed they were unaware of the location of the belts.

B. On July 14, 2017 before lunch time the following observations were made:
i. The Alenti tub lift in the spa room on an identified home area was observed to be used and no belt was applied. Interview with PSW #141 confirmed they did not use the safety belt when they used the lift with two residents that morning. Furthermore, there was no belt in the spa room.
ii. The Alenti tub lift on another home area was noted to be used and no belt was applied. Manufacturer's directions were observed posted on the wall. Interview with PSW #142 confirmed they they had bathed a resident using the tub lift and no belt was applied, nor was there one in the spa room.

C. Review of Alenti ArjoHuntleigh bath lift directed staff to secure a safety belt to the lift before the resident was seated on the lift and then ensured the belt was attached to the resident while on the lift. Interview with the DOC confirmed that a safety belt was to be used with the Alenti bath lift, as specified in by the manufacturer. (528) [s. 23.]

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 will ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in accordance with manufacturers' instruction, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the staffing plan, (a) provided for a staffing mix that was consistent with residents’ assessed care and safety needs and that meets the requirements set out in the Act and this Regulation.

A. On an identified date in, 2017, at approximately 1100 hours, the call bells of resident's #652, #658 and #659 were noted to be activated.

The family member of resident #652 and staff #196 were observed walking through the home area and reported they were searching for staff to assist the residents and that the staffing plan required they pull the assigned 'float' staff when they worked short. Staff #196 stated they worked short every day. The call bells rang for over 20 minutes before the PSW staff responded.

Registered staff #189 was interviewed in the office and reported they did not have enough staff and would answer the call bells when they could.
PSW #202 was interviewed and they reported that it was normal for the call bells to ring for a long time before they were provided assistance. There was a resident #654 who needed multiple people to care for them at times and the staff were in their room which is

why the call bells were ringing for so long. PSW #202 also confirmed that no staff came to check the residents whose call bells were ringing. The records of the above three residents were reviewed and all required assistance with their activities of daily living. Registered staff #203 also reported that there were not enough staff.

B. The records of residents #655, #656 and #657 were reviewed and it was noted that they all required assistance, encouragement and or supervision with eating. On an identified date in 2017, during a meal service residents #655, #656 and #657 were observed. Resident #657 was provided feeding assistance after it was brought to the attention of PSW # 204, by the LTC Inspector approximately 30 minutes later. Residents #655 and #656 were not provided any encouragement and or assistance with eating their dinner.

PSW #204 confirmed that the residents were not provided assistance with eating as per their plans of care.

The home's staffing pattern for the unit was reviewed. The day shift staff deployment was noted to be one registered staff, two full shift PSWs and a float PSW who spends half of the shift on the adjourning unit. The evening shift staffing pattern was noted as one registered staff and two full shift PSWs. This staffing deployment pattern was confirmed with registered staff #189 and through observation of staff on unit.

Also, for the example of the residents who were waiting in their rooms, the call bells rang for over 20 minutes before the staff initially attended to the residents. The home was requested to produce the call bell record and it was not produced.

The licensee failed to ensure that the staffing plan, (a) provided for a staffing mix that was consistent with residents' assessed care and safety needs and that meet the requirements set out in the Act and this Regulation. [s. 31. (3) (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 will ensure that the staffing plan, (a) provides for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident had fallen, the resident was assessed and, if required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Resident #601 reported to registered staff that they fell, on an identified day, and were complaining pain. The following day the resident #601 was sent to the hospital for assessment and the resident was diagnosed with an injury. A review of the clinical record had not included a post fall assessment. Interview with ADOC #117 on July 20, 2017, confirmed that it was the expectation that if a resident had an unwitnessed fall that a post fall assessment would be completed and confirmed that a post fall assessment was not completed for this resident. [s. 49. (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 will ensure that when a resident had fallen, the resident is assessed and, if required, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #9: 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 failed to ensure that the licensee ensured that residents with the following weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes were 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 their health status

Resident #012's monthly weights were reviewed over a five month period. There was a significant weight change in one month. This weight also represented a significant weight change over three months. The resident was seen by the RD and a reweigh was requested; however, this was not completed and the significant weight changes were not assessed as confirmed with RD #123 on July 13, 2017. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

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 residents with the weight changes as per r.69 are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that meals were served course by course unless otherwise indicated by the resident or the resident's assessed needs.

A. During the dining observation on an identified home unit on an identified date, LTC Inspector #528, observed staff serving a dessert to residents who were still eating their entree course. A total of ten residents were observed with their desserts on their table while they ate their entree. Interview with PSW #118 revealed that they did not wait until the residents were finished their entree before serving the dessert and that the expectation was to serve dessert so that they could go to the next home area for meal service.

B. During the dining observation on an identified date, on an identified home area, residents #012, #301, #302 and #303 were observed receiving soup at the same time as the main entree. A review of the plans of care for the four residents did not indicate that the residents had been assessed to receive these items at the same time. Dietary Aide #118 confirmed that the residents were not served their meals course by course. [s. 73.

(1) 8.]

2. The licensee failed to ensure that the home had a dining and snack service that included, at a minimum, the following elements: 9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

The records of residents #655, #656 and #657 were reviewed and indicated they all required the assistance from staff for eating.
On an identified date in 2017, a meal service was observed. The entree and dessert were served to residents #655, #656 and #657. The residents were not provided assistance or encouragement until brought to the attention of PSW #204, by the LTC Inspector, approximately 30 minutes later. This was confirmed with PSW #204 and registered staff members #203 and #189.

The home did not ensure that residents #655, #656 and #657 were provided personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. [s. 73. (1) 9.]

3. The licensee failed to ensure that the home had a dining and snack service that included, at a minimum, the following elements: 11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat.

On an identified date in 2017, during a meal service, the LTC Inspector #123 observed PSW #198 providing feeding assistance to resident #657 while seated on a wheeled walker. Only one feeding stool was observed in the dining room. PSW #198 was interviewed and confirmed that there was one feeding stool available for use in the dining room. There used to be three stools available a long time ago. PSW #198 reported that there are six residents in the dining room who required assistance with eating their meals. Registered staff #189 was interviewed and confirmed that there was only one feeding stool available in the dining room.

In August 2017, the DOC was interviewed by LTC Inspector #156 and reported that the day they found out about the lack of feeding stools, they ordered ten more and that they had not yet been delivered.
In July 2017, LTC Inspector #156 interviewed the DOC regarding no feeding stools, on

an identified home area, to follow-up. They reported that they do have adjustable feeding stools and were not sure why there were not any there that day and reported that they would follow-up.
In July 2017, during the dining observation on an identified home area LTC Inspector #156 observed two family members sitting on regular chairs and a PSW sitting on an office chair while providing eating assistance to residents.
Inspector #156 observed PSW #101 standing to feed a resident. The LTC Inspector asked PSW #101 if there were feeding stools and they said no and reported there were approximately six of 25 residents that required feeding. LTC Inspector #156 confirmed with registered staff #100 that there were no feeding stools. [s. 73. (1) 11.]

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 ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident’s assessed needs,
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible and
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee failed to ensure that all hazardous substances were labelled properly and kept inaccessible to residents at all times.

A. On July 6, 2017, during an initial tour of the home, the housekeeping closet on identified home area was locked but not closed all the way and was accessible without a key. Products identified with a Hazardous label were inside and included but were not limited to, "detergiside", bleach, and "proxi stain remover". Interview with PSW #126 confirmed that the door should have been locked and inaccessible at all times when not in use.

B. On July 6, 2017, on an identified home area, a clean utility room was found unlocked. A full bottle of bleach, identified with a hazardous label, was observed in the lower cupboard. RPN #100 confirmed the bleach was not to be in the clean utility room. [s. 91.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all hazardous substances are labelled properly and kept inaccessible to residents at all times, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

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

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.) O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a physical device was applied according to manufacturer’s guidelines.

A. On an identified date in 2017, the Long Term Care (LTC) Inspector observed resident #100 wearing a physical device that was not correctly applied. The resident could not remove the physical device when asked by the LTC Inspector on two separate days in the presence of RPN #106. PSW #104 and RN #105 confirmed the resident used the physical device as a restraint. Interview with RN #105 on July 6, 2017, confirmed that the physical device was not correctly applied and not applied according to manufacturer’s guidelines as stated above. The RN and PSW both confirmed that the staff were aware, based on education that they had received, that a physical device used to restrain a resident should be applied as per the manufacturer's guidelines. (506)

B. On an identified date in 2017, on a specified home area, resident #033 was observed with a physical device that had restraining properties. The device was observed to be applied incorrectly. Review of the plan of care directed staff to apply the device according to manufacturer's specifications. The manufacturer instructions were reviewed by the Inspector.

Interview with RPN #127 reported the physical device was applied incorrectly. RPN #127 stated they first became aware the device applied incorrectly that morning by an unspecified PSW who did not know how to apply the device. RPN #127 reported they left a message with the physiotherapist to assess the device. RPN #127 stated they were unaware how to adjust the physical device. At the same time, PSW #131 was able to apply the physical device to fit appropriately. The DOC confirmed the manufacturer's specifications and that it was not complied with. (585) [s. 110. (1) 1.]

2. The licensee failed to ensure that staff applied the physical device in accordance with instructions specified by the physician or registered nurse in the extended class.

Resident #012 was readmitted to the home on an identified date in 2017 with an order for a physical device to be applied. A few months later, the physician had changed the direction on how the physical device was to be applied. Approximately nine days later, resident #012 was observed with the physical device applied as per the original direction by the physician.

As confirmed with registered staff #115 the physical device was not applied in accordance with instructions specified by the physician when it was applied incorrectly and not as per the physician most recent direction. [s. 110. (2) 2.] (156) [s. 110. (2) 2.]

3. The licensee failed to ensure that where a resident was being restrained by a physical device under section 31 of the Act: that the resident was released from the physical device and repositioned at least once every two hours.

On an identified date in 2017, resident #705 was observed seated with a physical device applied for over three hours, and they were not released from the physical device or repositioned. Review of the physician's orders and progress notes identified that the resident required a physical device to reduce their risk for falls. Interview with RCC #163 confirmed the resident required the physical device. Interview with PSW #161 confirmed that the resident was not released or repositioned every two hours or as needed. The restraint flow sheet was reviewed the following day and it was noted to be left blank for

the identified shift.

Resident #705 was not released from the physical device or repositioned every two hours or as needed. [s. 110. (2) 4.]

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 physical devices are applied according to manufacturer’s guidelines, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. 1. The licensee failed to ensure that drugs were stored in an area or a medication cart that i) was used exclusively for drugs and drug-related supplies,

A. On an identified date, a bin of medicated creams was observed on a specified home area utility room, which was unlocked. The bin stored medications with a drug identification number and prescription label. Medications in the bin included but were not

limited to: Canesten cream, Voltaren Emulgel, Hydroderm cream 1%. Interview with RPN #140 confirmed that the clean utility room was left unlocked at all times and used by staff, residents and families. Interviews with RPN #140 and #156 confirmed that the medication bins were to be locked in the medication room when not being used.

B. On an identified date in, 2017, on a specified home area, inside the unlocked dry utility room, a cart was observed that contained various ointments and lotions that were identified with drug identification numbers, resident names and prescription labels. Interview with PSW #138 confirmed the lotions were to be stored in the medication room, and not in the dry utility room. (585)

2. Every licensee of a long-term care home shall ensure that, (a) drugs were stored in an area or a medication cart, (ii) that was secured and locked.

A. On an identified date in 2017, at approximately 1700 hours, the Long Term Care (LTC) Inspector observed an unlocked medication cart in the hallway, outside of a resident room, on a specified home area. Family members and residents were observed in the immediate area of the unlocked cart. The unlocked medication cart was left unattended for greater than seven minutes and the Inspector had access to prescribed medication. Interview with the RPN #143 confirmed they had left the medication cart unlocked, unattended and out of their sight while they had been in a resident room. (511)

B. On an identified date in 2017, at approximately 1115 hours, LTC Inspectors #123 and #586 observed an unlocked, unattended medication cart in the hallway of a specified home area. The cart remained unattended as the LTC Inspectors walked down the hall towards the cart. The medication cart was across the width of the hallway with drawers facing the hallway. A paper medicine cup was on top of the medication cart with two pills inside. A resident in a wheelchair was in the vicinity. LTC Inspector #123 turned the cart so that the resident could pass and the LTC Inspector opened the drawers of the medication cart. Registered staff #189 was observed inside a resident's room with their back facing the entrance, interacting with a resident who was in bed.

Registered staff #189 confirmed that the medication cart was unlocked and unattended as above. (123) [s. 129. (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 drugs are stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee failed to ensure that steps were taken to ensure the security of the drug supply, including the following: All areas where drugs are stored shall be kept locked at all times, when not in use.

A. At approximately 1100 hours on an identified date in 2017, the Long Term Care (LTC) Inspector was in the nursing station on a specified home area and observed the medication storage room was left open and unattended for at least five to ten minutes. During this time the LTC Inspector was able to go in the medication storage room and open the cupboards which contained both oral and injectable medications. Also during this time while the LTC Inspector was waiting for the registered staff to return, PSWs were walking in and out of the nursing station. RPN #145 returned to the nursing station

and confirmed the medication room should have been locked when they left the medication storage room. (506)

B. At approximately 1415 hours, on an identified date in 2017, the Long Term Care (LTC) Inspector was walking through a service corridor adjacent to the medication room on two specified home area and observed the medication storage room unlocked. PSWs were also walking through this corridor. The LTC Inspector was able to go into the medication storage room, access cupboards which contained both oral and injectable medications and had access to an unlocked medication cart. Two registered staff were observed documenting in the adjoining nursing station and had not heard the LTC Inspector enter the unlocked medication room. On approach by the LTC Inspector, the Registered staff # 208 and #209, stated they were surprised that the LTC Inspector had been able to to enter the medication room as they felt the door had been locked. Both registered staff secured the lock and confirmed the medication room should have been locked. (511)

C. On an identified date in 2017 , during an interview with resident #750 they showed the LTC Inspector two medication pouches that were sealed and dated for a previous day. They stated they kept this medication in their unlocked wardrobe. Review of the medication pouches revealed intact medications. The resident stated that they received this medication from RPN #176 and they took it to their room.
Review of the progress notes by a registered staff documented they observed the resident had medication on the night stand in the original strip package.
Interview with ADOC #117 on August 10, 2017, stated that they were aware that the resident still had medication in their room from an earlier date and confirmed that steps were not taken to ensure that the medication was locked at all times. (581) [s. 130. 1.]

2. The licensee has failed to ensure that steps were taken to ensure the security of the drug supply, including the following: 2. Access to these areas shall be restricted to, i. persons who may dispense, prescribe or administer drugs in the home, and ii. the Administrator.

A review of the Critical Incident (CI) Report, submitted by the home, on December 22, 2016 described that 20 tablets of a narcotic could not be accounted for by the home. The narcotic is a compound medication that consists of codeine and belongs to the group of medicines called narcotic analgesics. The CI report identified that the narcotic had been placed by a registered staff member in a locked bin, in a treatment room within the home, awaiting drug destruction. When the pharmacist arrived to complete drug

destruction the narcotic analgesic was not located in the locked bin. After an extensive search of the areas within the home, the drug was not located. A review of the home's internal investigative notes concluded that it was possible for a hand or arm to fit through the drug destruction bin opening. In addition, a spare key to the treatment room , where the drug destruction bin was located, was hanging in the nursing station, not secured and was accessible to non registered staff.

Interview with the DOC confirmed the key was hanging in the nursing station and had not been restricted to only persons who may dispense, prescribe or administer drugs in the home. [s. 130. 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 steps are taken to ensure the security of the drug supply, including the following: All areas where drugs are stored shall be kept locked at all times, when not in use, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

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

s. 131. (4) A member of the registered nursing staff may permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical, if,
(a) the staff member has been trained by a member of the registered nursing staff in the administration of topicals; O. Reg. 79/10, s. 131 (4).
(b) the member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and O. Reg. 79/10, s. 131 (4).
(c) the staff member who administers the topical does so under the supervision of the member of the registered nursing staff. O. Reg. 79/10, s. 131 (4).

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 review of resident #403's Medication Administration Record (MAR) was completed. The MAR for an specified month in 2017, identified a medication in the Nursing Formulary (N.F), with a signature for two dates. A progress note, described that RPN #171 had provided an identified medication, as per the N.F for comfort. Interview with RPN #171 confirmed, after looking through the resident's medical record, that there was no order for the identified medication to be administered.

Interview with the DOC confirmed the NF must be signed by the physician first and then transcribed, by the registered staff, exactly as per the orders to the MAR. The DOC confirmed that the home failed to ensure that a drug was administered to a resident in the home unless the drug had been prescribed for the resident. [s. 131. (1)]

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

A. The record of resident #750 was reviewed. The Medication Administration Record (MAR), from an identified date, was reviewed and the three identified 1700 hours medications were documented as being administered as ordered. Progress note documentation indicated the resident went to the registered staff for medications and they were given without incident.

Registered staff #176 was interviewed and reported that they handed the resident their 1700 hours medication and the medications were in unopened pouches. The confirmed that they did not observe the resident taking the medications and that they documented that the medications were administered as ordered. Registered staff #177 confirmed the resident does not self-administer medications.

The resident was interviewed and reported that they did not take their 1700 hours medication on the identified date. The resident produced two attached medication pouches with their name on them for examination by LTC Inspector #123. The note on the pouches indicated the medications were to be taken on an identified date. The pouches contained all three of the identified medications prescribed to be taken by the resident.

The medications were not administered to resident #750 according to the directions for use specified by the prescriber. (123)

B. On an identified date, this LTC Inspector went into the room of resident #403 and observed RPN #171 with a dressing cart at the bedside of resident #403. Resident #403 was observed to be crying out and indicating they were being hurt when RPN #171 was attempting to complete a treatment.

Resident #403's most recent plan of care plan described the resident to have conditions that caused pain. The plan of care directed that pain medication was to be provided as per the physician's orders before care was completed to ensure comfort. A review of the Drug Record book and the physician's orders identified a specific medication be administered on a schedule throughout the day. The medication administration record identified that the 0800 dose of medication was not administered.

Interview with RPN #171 confirmed that the 0800 medication was not administered to

resident #403 in accordance with the directions for use specified by the prescriber. (511) [s. 131. (2)]

3. The licensee has failed to ensure that a member of the registered nursing staff permitted a staff member who was not otherwise permitted to administer a drug to a resident to administer a topical, if, (a) the staff member has been trained by a member of the registered nursing staff in the administration of topicals; and (c) the staff member who administered the topical does so under the supervision of the member of the registered nursing staff.

A. Resident #403 had an identified condition. The resident had ongoing pain and altered skin integrity related to their condition. A review of the resident's clinical record indicated a treatment be applied twice a day. The Medication Administration Record (MAR) included the letters PSW next to the treatment order. This was signed for as being administered by the registered staff on the (MAR) . Interview with the PSW #113, on an identified day during the inspection, stated they had not applied the treatment to resident #403 when they cared for them. PSW #113 stated they were not comfortable and did not know how to apply this treatment to the resident without causing the resident pain. The PSW stated this was completed by the registered staff.

Interview with registered staff #111 stated they had not applied any treatment to resident #403 and that this was completed by the PSW's.

Interview with the Administrator confirmed the identified condition of resident #403 and that the treatment was required to be completed by the registered staff. The Administrator confirmed PSW #113 had not had the specific training required for the resident's condition for the application of this treatment. (511)

B. On an identified date, the Medication Administration Record (MAR) for resident #506 directed the health care aid to apply an identified treatment twice daily. The MAR for resident #507 directed the health care aid to apply an identified treatment as directed, if required. Interview with PSW #159 confirmed they applied the treatment as outlined on MARs. They denied receiving any additional training from registered staff related to the administration of the treatment stating they just followed the directions on the prescription. Interview with RPN #156 confirmed that PSW staff were administering treatments for the resident but they did not supervise whether the treatments were administered or not. (528) [s. 131. (4)]

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 has been prescribed for the resident and that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee failed to ensure that for the resident taking any drug or combination of drugs, including psychotropic drugs, there was monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of drug.

The home's 'Pain Management' policy, revision date August 7, 2016, directed staff to assess each resident for pain using the RAI MDS assessment tool on admission, readmission, absence greater than 24 hours, quarterly and with a significant change. In addition, for residents who received routine or as needed pain medication they would receive weekly pain assessments by registered staff using 'PN PR' notation and

numerical rating tool (NRT) or the Abby pain tool would be noted in 'PN PR' note. A pain referral could be made to the resident care coordinator (RCC) and would be discussed at the monthly pain rounds or urgently, if they needed to be seen sooner. Furthermore, staff were to evaluate the resident's response to and effectiveness of medication on the back of MAR and in a 'PN PR' progress notes; and when there was a new order or change in direction, pain assessments would be completed twice a day for the first three days.

A. On an identified date in 2016, resident #800 was admitted to the home. Review of the medication administration records (MAR) and progress notes for a one month period in 2016, identified that a medication was administered fourteen times over eight days; however, the effectiveness was not evaluated on five occasions. That same month, due to ongoing pain, the physician ordered a change in the medication. In the following two months, the medication order was changed three times and pain assessments were not completed twice a day for three days with each change. Interview with RCC #163 confirmed registered staff did not evaluate the effectiveness of the medication on five occasions as required in the policy, and they did not reassess the resident's pain twice a day for three days with a change in medication orders during the three month period in 2016, as required in the policy. (528)

B. An identified policy in the home, revision date Oct 2014, directed registered staff to monitor all new or changed identified medications using an identified monitoring form, which was to include documentation of target symptoms and potential adverse effects over a 21 day period.

i. Resident #800 was admitted to the home and administration medication orders included but were not limited to an identified medication. Pre admission medication records identified that the resident had had an order for the identified medication but had not received the medication. Two days after admission to the home, registered staff began administering the medication. Over the twenty one day period, the medication was administered approximately 19 times. Post administration follow-up was documented as ineffective, poor or not documented on seven occasions. Furthermore, eight days after admission, a progress note documented that the SDM reported to registered staff that historically this medication had little effect on the resident's symptoms. Review of the plan of care did not include the identified monitoring form when the staff began administering the medication. Interview with RCC #163 confirmed that as of an identified date, staff were to use the tool and the effectiveness of the medication was not monitored using the tool, as required in the home's policy. (528)

C. An identified policy in the home, revision date August 7, 2016, directed staff to record PRN effectiveness on the MAR's PRN record and to complete an identified assessment and assessment outcomes (if any), which were to be documented in the PN-PR and progress notes.

The Medication Administration Record (MAR) was reviewed for resident #801 over a one month period in 2016. The orders included but were not limited to, an identified medication, every four hours as needed. Review of the MAR and progress notes for the month, identified the medication was administered 34 times over 27 days; however, the effectiveness of the medication was not evaluated on 12 occasions. Interview with RCC #120, confirmed registered staff did not evaluate the effective of the medication on 12 occasions in the identified month, as required in the policy. (683)

D. Resident #304 was noted to receive PRN (as needed) medication. As confirmed with ADOC #117 on August 16, 2017, the resident received medication on 19 occasions that were not monitored or the response documented for the effectiveness of the PRN medication

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 for the resident taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of drug, to be implemented voluntarily.

WN #17: 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. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).
(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 failed to shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents were monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(b) the symptoms were recorded and immediate action was taken as required.

A. On an identified date in 2017, the MDS Assessment for resident #041 identified that the resident had a specified diagnosis. Progress notes confirmed that the resident had symptoms consistent with the diagnosis. Review of the plan of care did not include consistent monitoring and recording of symptoms every shift. Interview with the Infection Control Lead confirmed that the home's expectation would be that the staff complete the "Infection" User Defined Assessment in Point Click Care (PCC) identifying new ongoing and resolved infections every shift; however, was not completed in 2017 for resident #041.

B. On an identified date in 2017, the MDS Assessment for resident #048 identified that the resident had a specified diagnosis. Progress notes confirmed that the resident spent a few days in hospital and returned to the home with the diagnosis confirmed . Review of the plan of care did not include monitoring and recording of symptoms every shift. Interview with the Infection Control Lead confirmed that the home's expectation would be that the staff complete the "Infection" user defined assessment in Point Click Care (PCC) identifying new ongoing and resolved infections every shift; however, was not completed in 2017 for resident #048. [s. 229. (5)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that, b) each resident who was incontinent had an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan was implemented.

A review of resident #403's most recent plan of care indicated the resident had a medical condition that was to be monitored and staff were to initiate the home's identified care protocol as needed. A review of the home's identified care protocol, provided by the DOC, identified actions to be taken by registered staff and all actions taken were to be documented in the progress notes. A review of the clinical record indicated the resident's condition had changed over the course of eight days and the resident required interventions as identified in the care protocol. Further review of the clinical record provided that the actions taken were not as described and provided for as per the home's care protocol.

Interview with the DOC confirmed the licensee had failed to implement the home's care protocol for resident #403. [s. 51. (2) (b)]

2. The licensee failed to ensure that residents who required continence care products had sufficient changes to remain clean, dry and comfortable.

On an identified date in 2017, resident #705’s Substitute Decision Maker (SDM) voiced concern to the LTC Inspector that their loved one was not receiving appropriate assistance for an activity of their daily living. The SDM indicated the resident was not provided sufficient changes to remain clean, dry and comfortable.

The resident’s plan of care included a schedule, posted in the resident’s room, outlining the time and assistance required for the identified activity of daily living.

The resident was observed for greater than three hours. During the observation period, the resident was not provided assistance for their activity of daily living by staff. At the end of the observation period the resident was observed to not have sufficient changes to their continence product in order to remain clean, dry and comfortable The LTC Inspector brought this to the attention of PSW’s #161 and #162 who confirmed that the resident had not been provided assistance with an activity of their daily living.The home did not ensure that resident #705 was kept clean, dry and comfortable. [s. 51. (2) (g)]

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

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee failed to ensure where bed rails were used, the resident was assessed, his or her bed system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident where bed rails are used, or that steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

A. Prevailing practices were identified in a document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" (developed by the US Food and Drug Administration and adopted by Health Canada), where recommendations were made that all residents who used one or more bed rails would be evaluated by an interdisciplinary team over a period of time while in bed to determine sleeping patterns, habits and potential safety

risks posed by using one or more bed rails.

i. To guide the assessor, a series of questions would be answered to determine whether the bed rail(s) were a safe device for residents while in bed (when fully awake and while they are asleep).
ii. The Clinical Guidance document also emphasized the need to document clearly whether alternative interventions were trialled if bed rails were being considered to treat a medical symptom or condition and if the interventions were appropriate or effective and if they were previously attempted and determined not to be the treatment of choice for the resident.
iii. Where bed rails were considered for transferring and bed mobility, discussions need to be held with the resident/Substitute Decision Maker (SDM) regarding options for reducing the risks and implemented where necessary.
iv. Other questions to be considered would include the resident's medical status, cognition, behaviours, medication use and any involuntary movements, toileting habits, sleeping patterns or habits and environmental factors, all of which could more accurately guide the assessor in making a decision, with input (not direction) from the resident or their SDM about the necessity and safety of a
bed rail (medical device).
v. The final conclusion would be documented as to whether bed rails would be indicated or not, why one or more bed rails were required, the type of bed rail required, when the bed rails were to be applied, how many, on what sides of the bed and whether any accessory or amendment to the bed system was necessary to minimize any potential injury or entrapment risks to the resident.

B. On an identified date in 2015, resident #100 was admitted to the home and had not required the use of bed rails. An admission progress note identified that the resident's bed had no risks for entrapment. In 2017, the MDS Assessment for resident #100 identified that the resident used other types of side rails daily. The document the home referred to as the care plan directed staff that the resident required extensive assistance with bed mobility and used two "assist bars" to aid in bed mobility and positioning. Interview with RCC confirmed that the resident had used the assist rails on their bed in an identified month in 2016. Review of the plan of care had not included a formalized bed rail assessment that considered all of the factors required with safe bed rail use, as outlined in prevailing practice. Interview with RCC #120 confirmed that a formalized assessment of the resident was not completed, related to the use of the bed rails. Furthermore, when the bed system changed in an identified month in 2016, and "assist bars" were added to the bed system, the system was not retested for potential zones of

entrapment.

C. On an identified date 2017, resident #503 was admitted to the home with multiple comorbidites. An admission 'Bed System Entrapment Assessment' identified that the resident had used two assist bars on both sides of the bed. Review of the plan of care had not included a formalized assessment of why the resident required the use of the bed rails considering all factors required for safe bed rail use, as outlined in prevailing practice. Interview with the RCC #120 confirmed that the Bed System Entrapment Assessment identified that the resident was cognitively impaired with behaviours, had functional dependency on staff and was unable to communicate their needs effectively but had not included an assessment all factors outlined by prevailing practices.

D. On an identified date 2016, resident #504 was admitted to the home. An admission progress note identified that the resident required assistance with activities of daily living and required two "half rails" when in bed to support bed mobility and positioning. Review of the plan of care had not included a formalized bed rail assessment considering all factors required for safe bed rial use, as outlined in prevailing practice. Interview with RCC #120 confirmed the home had not completed a formalized bed rail assessment other than assessing for potential zones of entrapment. [s. 15. (1) (a)]

WN #20: The Licensee has failed to comply with LTCHA, 2007, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

At the time of this Inspection the Licensee had a Compliance Order for s.19.(1) with a compliance due date for May 30, 2017.

The family member of resident #652 reported that resident #506 was abused and that the home was aware of the incident.
The clinical record of resident #506 was reviewed. Responsive Incident progress notes, for an identified date in 2017, was reviewed. It was noted that resident #506 had been sitting in an area within the home and moved beside resident #652. Resident #506 proceeded to touch and rub the body of resident #652.
The record of resident #652 was reviewed and it indicated that the resident was cognitively impaired and could not consent to the touch.

Registered staff #193 was interviewed and confirmed that resident #652 had not consented to the inappropriate touching by resident #506. (123) [s. 19. (1)]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
19. Safety risks. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care was based on an interdisciplinary assessment with respect to the resident safety risks.

Resident #012 was observed to have a physical device applied, however, an interdisciplinary assessment for the physical device with respect to safety risks was not found as confirmed with registered staff #115 on July 13, 2017. [s. 26. (3) 19.]

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A. The home's policy 'Mouth Care', revised August 11, 2016, directed staff to ensure the documentation of mouth care is completed in the 'Resident Care Plan and Resident Record'.

The plan of care for resident #501 identified that the resident was to receive oral care twice a day. Review of the 'Nursing Flow Sheet' revealed that PSW staff did not consistently document whether the resident received mouth care as per their care plan on 38 occasions during an eight month period:

Interview with ADOC #117 confirmed that oral care should be documented twice a day and was not consistently documented as outlined above.

B. The home's policy 'Bathing', revised August 11, 2016, directed staff provide the resident assistance with bathing and documentation on the resident flow sheet. If the resident declines to have their bath, this should be reported to the registered staff and another attempt made to complete the bath at a later time.

The plan of care for resident #501 identified that the resident was to be bathed on two scheduled days per week and if the resident refuses to document refusal and notify the POA. Review of the 'Nursing Flow Sheet' revealed that staff did not consistently document that the resident received their bath according to their plan of care on 10 occasions during a 10 week review period:

Interview with ADOC #117 confirmed that the documentation for bathing for resident #501 was not completed as required in the resident's plan of care and the home's Bathing policy. (528)

C. Resident #701's family voiced concern to the LTC Inspector that the resident was often improperly positioned.

Review of the resident's documented plan of care indicated that the resident used a specified device as a Personal Assistive Services Device (PASD) and directed staff to monitor the resident's PASD hourly for comfort, safety and positioning.

The home's policy, "Restraints, PASDs and Alternatives" (policy number POL/10, last revised December 13, 2016), indicated that documentation sources for PASD use included flow sheets, for which on a daily basis and for each shift, the time of application, removal, repositioning and resident response must be recorded by PSW's or HCA's responsible for that resident.

Review of the resident's PASD/Restraint flowsheets for an eight week period identified that the entire flowsheet was left blank for 20 shifts that ranged between days, evenings and night shifts.

In an interview with the DOC on July 25, 2017, they acknowledged that it was the expectation of the home that staff monitor and document a resident's use of a PASD hourly on each shift. The DOC confirmed that resident #701's flow sheets were not completed in full, which included the reassessment and resident's response to the intervention of the resident's specific device. (586)

D. Resident #801's administration medication orders included but were not limited to a prescribed medication every four hours, as needed. Review of the progress notes described that, on an identified date in 2016, RPN #170 administered the prescribed medication as needed at 0930 hours with fair effect. Review of the 'Individual Monitored Medication Record' for the prescribed medication identified that the resident received the medication. However, a review of the Medication Administration Record (MAR) for the same month, day and time did not identify that the prescribed medication was administered.

Interview with RCC #120 on July 25, 2017, confirmed that RPN #170 did not document

on the MAR that resident #801 was given the prescribed medication.

The home did not ensure that the administration of the prescribed medication and the resident's response to the medication was documented on the identified date in 2016. (683)

E. Resident #705 was at a risk for falls due to their behaviours and experienced 11 falls in the last 180 days. The post-falls assessments, from four identified dates in 2017, indicated that staff were completing 30-minute safety checks. Review of the resident's health record did not identify any 30-minute safety checks. Interview with RCC #163 confirmed that the safety checks were being completed; however, it was not a requirement of the home that this be documented. The RCC confirmed the actions taken with respect to the resident's falls prevention management monitoring was not documented. (586)

F. Resident #047 was admitted to the home in an identified month in 2016.

Review of their admission MDS assessment observation and monitoring form for a one week period, revealed six meals where no documentation was made regarding the level of assistance provided related to eating. Documentation that was made revealed the resident was independent with eating.

Review of the resident's quarterly MDS assessment observation and monitoring form for another one week period, approximately three months later, revealed 17 shifts where no documentation was made regarding the level of assistance provided related to eating. Documentation that was made revealed the resident had a decline and required set-up help with eating.

Interview with RAI coordinator #160 reported that care was provided during the review period; however, confirmed staff did not document as required on all shifts. (585)

G. Review of the progress notes for an approximate two month period in 2017, identified that resident #750 had an increase in their responsive behaviours. Review of the progress notes identified that ADOC #117 initiated a five day observation tool during this time period. Review of the observation tool documentation completed by the PSW staff revealed that it was not fully completed on all five days. Interview with RPN #179 stated it was the home's expectation that the observation tool charting was to be completed fully and confirmed that PSW staff did not document every day for 24 hours on all five days

that it was implemented.(581)

H. On an identified date in 2017, resident #603 was experiencing symptoms and was provided a nursing intervention. The physician assessed the resident two days later and ordered a medical test. In an interview with ADOC #117 they confirmed that when a physician writes an order, the registered staff were to check off the consent box on the physician’s order sheet indicating that the SDM was called and consent was obtained, and document this in the progress notes. There was no documentation of the SDM being notified until the SDM called the home on the third day. In an interview with RPN #179, they confirmed that they spoke often to the SDM but could not recall if they spoke to the SDM regarding the resident having symptoms or an order for the medical test and confirmed that this information should have been documented. (506) [s. 30. (2)]

WN #23: The Licensee has failed to comply with LTCHA, 2007, s. 30. Protection from certain restraining

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff. 2007, c. 8, s. 30. (1).
2. Restrained, in any way, as a disciplinary measure. 2007, c. 8, s. 30. (1).
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Findings/Faits saillants :

1. The licensee failed to ensure that no resident in the home was restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36. Section 31 describes that a resident may be restrained by a physical device as described in paragraph 3 of the subsection if the restraining of the resident was included in the resident's plan of care.

Resident #705 was at a risk for falls. They required the use of a physical device to mitigate their risk of falls; however, the resident kept removing the physical device, therefore on an identified date in 2017, the physician ordered a different physical device to be applied for the resident.

Review of the resident’s documented plan of care, which front line staff use to direct care, still listed the use of the previous physical device, and had not been included the use of new physical device. Twenty one days later, the resident was observed to be wearing the original physical device. The RCC #163 confirmed that the resident had been wearing the wrong device and the physical device had not been included in the resident's plan of care in accordance with section 31 of the LTCHA. (586) [s. 30. (1) 3.]

WN #24: The Licensee has failed to comply with LTCHA, 2007, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the restraint plan of care included the alternatives to restraining that were considered, and tried, but had not been effective in addressing the risk.

Resident #012 was observed to have a physical device that had restraining properties. Alternatives to restraining that were considered, and tried, but had not been effective in addressing the risk were not found to be included in the resident's clinical record as confirmed with registered staff #115 on July 13, 2017. [s. 31. (2) 2.]

WN #25: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

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

Findings/Faits saillants :

1. The licensee failed to ensure that every written or verbal complaint made to the

licensee or a staff member concerning the care of a resident or operation of the home was dealt with as follows: 3. A response shall be made to the person who made the complaint, indicating, i. what the licensee has done to resolve the complaint.

A. On an identified date in 2017, resident #500's SDM sent a written correspondence to ADOC #192 detailing the concerns they had around their family member's care. A follow up written correspondence was sent by ADOC #192 later that same day, thanking the SDM for putting their concerns in writing and indicating they would be addressing them.

Review of the "SJV Complaint Form" in the resident's chart, written by RCC #152, summarized the concerns and indicated that the complaint was not resolved within 24 hours of receipt; however, that the complainant was updated three days later. In an interview with the SDM, by the LTC Inspector, they indicated that they had not received any follow up in writing regarding the concerns brought forward. RCC #152 could not provide any documentation to demonstrate that a response was made to the SDM in writing, indicating what had been done to resolve the complaint. [s. 101. (1) 3. i.]

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

On an identified date in 2017, resident #024 reported to Long-Term Care (LTC) Inspector #585 that on a specified shift, a staff entered their room without making an introduction. The resident reported an interaction occurred between the staff member and the resident that the resident felt was inappropriate.

Interview with PSW #113 stated they were aware of the resident's concerns but had not immediately reported to registered staff. RPN #111 confirmed staff reported something to them during the shift but they had not looked into it.

Five days later, during an interview with resident #024, they stated no one had come to follow-up regarding their concern. Interviews the same day with with RCC #120 and ADOC #117 who both reported they were unaware of any verbal complaint made by resident #024. RCC #117 confirmed the home's expectation would be that a SJV –

Complaint Form be completed when resident #024 raised concern regarding a staff member.

An interview with ADOC #117, fourteen days later, confirmed that they were in the process of investigating the resident's concerns; however, stated they had not completed the complaints form. (585) [s. 101. (2)]

WN #26: 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. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed of the following incidence in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): Subject to subsection (3.1), an incident that caused an injury to a resident for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition.

On an identified date in 2017, resident #705 experienced a fall. The resident was experiencing pain and was transferred to the hospital where they were diagnosed with an injury. During an interview, the DOC confirmed that the Director was not notified of the resident's fall that caused an injury. [s. 107. (3) 4.]

WN #27: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 116 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that an interdisciplinary team, which must have included the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who was a member of the staff of the home, had met annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

A review of the Continuous Quality Improvement (CQI) committee minutes for November 2016, indicated an update of the home's Medication Management system would be provided in January 2017. An interview with the Manager for Quality and Performance Systems stated the Medication Management committee (MMC) would conduct the annual evaluation of the effectiveness of the medication management system and provide recommendations as necessary. A review of the CQI meeting minutes for January 2017 had not identified any information of the medication management evaluation.

Interview with the DOC confirmed the MMC had not met annually to evaluate the effectiveness of the medication management system in the home and had not recommended any changes necessary to improve the system. [s. 116. (1)]

WN #28: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

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

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was, (a) documented, together with a record of the immediate actions taken to assess and maintain the resident’s health; and (b) reported to the resident, the resident’s substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident’s attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

A record review was completed for medication incidents, involving residents, for the period of January 2017 through June 2017.
The types of incidents reviewed included dose omission, provision of outdated drugs, incorrect drug administered, extra does provided, incorrect time of drug administration. The home's documents titled, Medication Incident Reports-Follow Up, were cross referenced with the Pharmacy documents titled, Medication Incidents MedeReport and the pharmacist's Medication Incident-Final Report. Multiple inconsistencies or omissions in the documentation were identified in the completion of these reports which included

sections on the Medication Incident-Final Report that indicated both the family and/or physician had not been notified of the specific incidents and/or had not documented the immediate actions taken.

Interview with the home's pharmacy provider stated the home's process was for the front line staff to complete the medication incident report online in the Mede-Report system and then this would be emailed to the pharmacy manager, DOC, HO, store and pharmacy. The pharmacist confirmed they would get this incident report through an email and respond with corrective actions to incidents that involved pharmacy. The pharmacist stated they were not consistently notified of individual nursing medication incidents and would provide information on drug interaction only. The pharmacist stated not all medication incidents would be reviewed by pharmacy and that incidents were not reviewed or documented in detail at the medication management meetings.

Interview with the DOC stated that the medication logs for each medication incident would further be reviewed and documented in the quarterly Medication Management Committee minutes for the previous quarter. The attendees at the Medication Management meeting included but was not limited to the Associate Director of Nursing and Personal Care, the Medical Director, a registered nurse and the pharmacy service provider. A review of the June 17, 2017 minutes were reviewed and indicated two incidents for January, five incidents for February and three incidents for each April and May, 2017 were documented. No medication incidents were documented for March, 2017 in the minutes. A review of the home's Medication Incident Report-Follow Up indicated the home had five medication incidents in March 2017 that had not been not been documented as reported at the Medication Management Committee June report.

Interview with the DOC confirmed that the licensee failed to ensure that every medication incident during January 2017 to June 2017, involving a resident and every adverse drug reaction was consistently, (a) documented, together with a record of the immediate actions taken to assess and maintain the resident’s health; and (b) reported to the resident, the resident’s substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident’s attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. [s. 135. (1)]

2. The licensee has failed to ensure that in addition to the requirement under clause (1) (a), the licensee shall ensure that, (a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; (b) corrective action is taken as

necessary; and (c) a written record is kept of everything required under clauses (a) and (b).

A. A record review was completed for medications incidents involving residents for the period of January 2017 through June 2017.
The types of incidents reviewed included dose omission, provision of outdated drugs, incorrect drug administered, extra does provided, incorrect time of drug administration. The home's documents titled, Medication Incident Reports-Follow Up, were cross referenced with the Pharmacy documents titled, Medication Incidents MedeReport and the pharmacist's Medication Incident-Final Report. Multiple inconsistencies or omissions in the documentation were identified in the completion of these reports which included sections not documented under investigation notes and action taken.

Interview with the DOC and the ADOC confirmed that corrective actions had been taken on the medication incidents but had not been documented consistently for all medication incidents and adverse drug reactions identified for the period of January 2017 through June 2017

B. According to the home's Standard of Service titled, Medication Incident Reporting System, last revised July 2013, Procedure 111 stated the Pharmacy and Therapeutics committee reviews medication incident reports and statistics to identify/track general trends involving similar incident and would recommend changes to the medication system to prevent recurrences.

Interview with the DOC stated that the Medication Management Committee (MMC) was the committee that acted as the Pharmacy and Therapeutics committee as per the home's Standard of Service as provided above. This change in name to the committee had been confirmed in the home's Continuous Quality Improvement Meeting on November 15, 2016 and indicated the annual review would be completed in January 2017. The MMC met quarterly to review and analyze the information from the medication logs for each medication incident for the previous quarter. The attendees at the Medication Management meeting included but was not limited to the Associate Director of Nursing and Personal Care, the Medical Director, a registered nurse and the pharmacy service provider. A review of the June 17, 2017 minutes were reviewed and indicated two incident for January, five incidents for February and three incident for each April and May, 2017 were documented as reviewed. No medication incidents were documented for March, 2017 in the minutes. A review of the home's Medication Incident Report-Follow Up indicated the home had an additional five medication incidents in

March 2017 that had not been not been documented as reported at the Medication Management Committee June minutes. A review of the January 2017 MMC minutes were reviewed with the DOC and was confirmed that all medication incidents had not been documented, reviewed and analyzed by the licensee. [s. 135. (2)]

WN #29: The Licensee has failed to comply with O.Reg 79/10, s. 305. Construction, renovation, etc., of homes

Specifically failed to comply with the following:

s. 305. (3) A licensee may not commence any of the following work without first receiving the approval of the Director:
1. Alterations, additions or renovations to the home. O. Reg. 79/10, s. 305 (3).
2. Other work on the home or work on its equipment, if doing the work may significantly disturb or significantly inconvenience residents. O. Reg. 79/10, s. 305 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that they had not commenced any work on the home or work on equipment, if doing the work may have significantly disturbed or significantly inconvenienced residents without first receiving the approval of the Director.

During stage one of the inspection on July 6, 2017, it was noted that the home was using disposable plates, cups and cutlery for residents during meals. Interview with the Food Services Supervisor (FSS) and Food Services Manager (FSM) on this date confirmed that the home was using disposable products for residents in 15/17 home areas. The FSM reported that since June 26, 2017, the home had been in the process of repairing an area of flooring in the dish washing room where standing water had been present for several years. In doing the repair, the home had to move the large dish conveyor belt as well as the dish machine and installed a grease trap on the floor as well as having leveled out the floor. The project was initially projected for approximately one to two weeks; however, the scope of the work changed and disposable products were needed to be used for resident meals and snacks for at least three to four weeks. The FSM confirmed that this had been an inconvenience to the residents and that a plan had not been submitted for approval prior to the commencement of the work without the approval of the Director. [s. 305. (3) 2.]

Issued on this 8th day of November, 2017

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

Original report signed by the inspector.

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ROBIN MACKIE (511), CAROL POLCZ (156), CYNTHIA DITOMASSO (528), DIANNE BARSEVICH (581), JESSICA PALADINO (586), LEAH CURLE (585), LESLEY EDWARDS (506), LISA BOS (683), MELODY GRAY (123)
Inspection No. / No de l'inspection :	2017_542511_0011
Log No. / No de registre :	013990-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Oct 26, 2017
Licensee / Titulaire de permis :	ST. JOSEPH'S HEALTH SYSTEM 56 GOVERNOR'S ROAD, DUNDAS, ON, L9H-5G7
LTC Home / Foyer de SLD :	ST JOSEPH'S VILLA, DUNDAS 56 GOVERNOR'S ROAD, DUNDAS, ON, L9H-5G7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	David Bakker

---

To ST. JOSEPH'S HEALTH SYSTEM, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2017_57610a_0002, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Order / Ordre :

The Licensee shall

1. Ensure all responsive behaviours demonstrated by resident #012, #500, #501, #750 and #800 are acknowledged and an interdisciplinary plan of care is developed to manage the responsive behavior. This shall include mood and behaviour patterns, the identification of triggers, reasonable goals of care, and resident-specific interventions to be put into place to manage the behaviours being demonstrated;

2. Ensure referrals are made to specialized resources where required, and in a timely manner, including BSO;

3. Ensure resident #012, #500, #501, #750 and #800 exhibiting responsive behaviours are included in the monthly behavioral rounds;

4. Ensure that when resident #012, #500, #501, #750 or #800 demonstrate responsive behaviours, staff are documenting the actions taken to respond to the needs of these resident and,

5. Provide training to all registered staff and PSW's around the importance of the appropriate and complete documentation of resident behaviours, including flow sheets and DOS charting.

Grounds / Motifs :

1. The licensee failed to ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident were identified, where possible;
(b) strategies were developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

This Order is based upon three factors where there has been a finding of noncompliance in keeping with section 299 (1) of Ontario Regulation 79/10, scope, severity and a history of noncompliance. The scope of noncompliance is a pattern (2), the severity of the non compliance is minimal harm or a potential for actual harm (2) and the history of non-compliance under the LTCH, 2007, regulation 53 (4) is ongoing (4). Regulation 53 (4) was issued as: a WN on

October 5, 2016, a Voluntary Plan of Correction (VPC) on November 22, 2016, a Written Notice (WN) on April 4, 2017 and a Compliance Order (CO) on March 3, 2017 which was amended on May 10, 2017.

A. The home's policy ' Management of a Resident with Responsive Behaviours', revised February 14, 2017, directed staff to utilize strategies from the care plan when there was a responsive behaviour incident and to document the incident and the effectiveness of the strategies. Post incident review was to include but not be limited to, Abbey pain scale, Depression scale, Dementia Observation Scale and the Daily Behaviour Observation sheet. When appropriate, the RCC, in consultation with the interdisciplinary care team, was to obtain physician's order and consent to utilize external consultants.
i. In an identified month in 2017, resident #500 was admitted to the home with no documented responsive behaviours. Progress notes identified that one month later, the resident began displaying behaviours. Review of the plan of care had not included any behavioural triggers for the resident or strategies to respond to the behaviours until one month later, when an altercation occurred, which negatively affected the resident.
ii. Interview with staff #139, RPN #153, and RCC #152 confirmed the resident had ongoing behaviours for one month in 2017; however, the plan of care had not included strategies for staff to respond to the behaviours, the interdisciplinary team had not discussed the resident at behavioural rounds that month and staff had not consistently documented the behaviours, as required in the home's policy. (528)

B. Resident #750 was admitted to the home in an identified month in 2017 and a review of an identified Assessment Tool indicated that they were a low risk for responsive behaviours. Two months later, they were reassessed and a change in their risk level was identified which required immediate care plan interventions. Review of the resident's progress notes during the two months indicated they had several responsive behaviour incidents.

Interview with ADOC #117 stated the resident had an increase in their responsive behaviours, over the past months which were triggered by a known source. They confirmed that the plan of care had not included all the triggers, strategies and interventions in place for staff to respond to the resident's responsive behaviours. (581)

C. A review of the clinical record for resident #012 indicated that the resident

exhibited responsive behaviours. The resident was observed by the LTC Inspector to be exhibiting a responsive behaviour on an identified date in 2017. Interview with registered staff #146 confirmed that the resident continued to demonstrate these behaviours, was not included in the home's monthly behaviour rounds and that adequate strategies had not been developed and implemented to respond to the resident's behaviour. (156)

D. The home's policy ' Management of a Resident with Responsive Behaviours', revised February 14, 2017, directed staff to utilize strategies from the care plan when there was a responsive behaviour incident and to document the incident and the effectiveness of the strategies.

The plan of care for resident #501 identified that the resident had a cognitive impairment with responsive behaviours and identified interventions. On an identified day in August 2016, PSW #148 documented that the resident demonstrated a responsive behaviour. Interview with RN #154 confirmed the resident demonstrated a responsive behaviour. A review of the progress notes had not included documentation of the behaviour or what was done to accommodate the behaviour and or the effectiveness of the strategies for the resident. Interview with ADOC #117 confirmed that when a resident demonstrated a responsive behaviour, the registered staff were to document the behaviour and effectiveness of interventions; however, this was not completed on the identified day in August 2016. (528)

E. In an identified month in 2016, resident #800 was admitted to the home with cognitive impairment. As a result of escalating responsive behaviours, ongoing behavioural reassessments and interventions were completed. Review of the plan of care revealed that during two consecutive months, the required observational charting, that was recommended to assess the resident's behaviours and response to interventions was not consistently completed.

Interview with RPN #172 confirmed that the required observational charting was to be completed for the two consecutive months. RPN #172 confirmed that although the resident was assessed, the required observational charting was not consistently documented on 11 out of 12 days, as required in the plan of care.

During an identified month in 2017, a resource consultant recommended resident #800 receive a specified assessment. A review of the plan of care had not included the specified assessment. Interview with the RCC #163 confirmed

the plan of care had not included the specified assessment after recommendations were made by the resource consultant. (528) [s. 53. (4)]
(528)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 22, 2017

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that the care set out in the plan of care is provided to:

1. Resident #012 in relation to their specified activity of daily living as part of the falls prevention program.

2. Resident #304 in relation to an identified symptom management team consultation.

3. Resident #403 in relation to an identified symptom management.

4. Resident #501 in relation to the provision of mouth care twice daily and storage of oral care supplies.

5. Resident #601 in relation to an identified program.

Grounds / Motifs :

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

This Order is based upon three factors where there has been a finding of noncompliance in keeping with section 299 (1) of Ontario Regulation 79/10, scope, severity and a history of noncompliance. The scope of noncompliance is a pattern (2), the severity of the non-compliance has actual harm/risk (3) and the history of non-compliance under the LTCH, 2007, section 6 (7) is ongoing (4). Section 6 (7) was issued as: a Compliance Order (CO) on May 21, 2015, re-issued a Compliance Order (CO) on September 30, 2015 (complied on March 4, 2016), a VPC on October 5, 2016 and a Voluntary Plan of Correction (VPC) on March 5, 2017 which was amended April 4, 2017.

A. The plan of care, for resident #012, indicated that staff were to follow the resident's scheduled routine as a falls prevention strategy. The scheduled routine was provided on the plan of care. Resident #012 was observed on an identified day in 2017 and was not provided care as per the scheduled routine. Interview with PSW #124 and #121 confirmed that the resident's scheduled routine was not followed. The care set out in the plan of care was not provided to the resident as specified in the plan. (156)

B. During an observation of resident #601 and their room it was noted that the resident did not have the identified symbol outside their door or on their mobility aide as it specified in the resident's care plan. The care plan indicated that the resident was in a prevention program that required the use of the symbol to identify residents at risk. RPN #147 confirmed that the resident was in the program and confirmed that the symbol should have been outside the resident's door and confirmed that the care set out in the plan was not provided to the resident as specified in the resident's plan. (506)

C. The plan of care for resident #501 identified that the resident was to complete mouth care twice daily with the supervision of staff and to lock all hygiene products away in drawers at all times. Observations, on two separate dates in 2017, confirmed that the resident had received oral care but their hygiene products, including but not limited to, toothbrushes and toothpaste, were not locked in the resident's bathroom. Interview with RN #151 confirmed that the toiletries should be locked away when not in use and had been outlined in the resident's plan of care. (528)

D. In an identified month in 2015, the SDM of resident #501 requested that a medication be discontinued. Progress notes documented that the attending physician was notified; however, requested that the home follow up with the physician who ordered the medication. The medication was placed on hold at that time. Review of the plan of care identified that registered staff attempted to contact the specialist with no success and no further action was noted. Review of the medication administration record (MAR) revealed the medication was placed on hold for two months , when the attending physician discontinued the medication. Interview with the ADOC #117 confirmed that care set out in the plan was not provided as specified in the plan, when the staff did not follow up with the specialist as requested by the physician. (528)

E. The plan of care for resident #304 indicated that the resident had an alteration in their skin integrity. The plan of care indicted that the identified symptom management team was to be consulted as an intervention for the symptom. The resident was noted to have multiple levels of fluctuating symptoms over approximately eight weeks in 2016, as described in the identified symptom assessments, and was on medications. Identified symptom assessments indicated that a referral to the identified symptom management team was not conducted. Care set out in the plan of care was not provided to the resident as specified in the plan as the identified symptom management team was not consulted as confirmed with the ADOC #117 on August 17, 2017. (156)

F. A review of resident #403's clinical record documented that the resident had ongoing symptoms and altered skin integrity related to their identified condition. The Medication Administration record (MAR) included the letters RN/RPN next to the treatment order. Resident #403's most recent plan of care plan directed that treatment was to be provided before care was completed, to ensure the resident's comfort.

On an identified date in, 2017, the resident was observed to complain of pain. Interview with RPN #185, who stated they were the RPN assigned to the care of resident #403 on the identified date, stated they had not provided the treatment, as per the treatment order, prior to care. RPN #185 stated the PSW would have provided the treatment during routine care. Interview with PSW #113 confirmed they had not applied the treatment during care. After RPN #185 reviewed the Medication Administration Record, the RPN searched the home's unit and was unable to locate the resident's prescribed treatment. Interview with the DOC confirmed the licensee has failed to ensure that the care set out in the plan of care was provided to resident #403 when the staff had not provided the treatment to the resident, as specified in the plan of care. (511) [s. 6. (7)] (506)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 08, 2017

Order # / Ordre no : 003   **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007, s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Order / Ordre :

The licensee shall

1. Ensure that resident #012, and all residents who are at risk for falls, are reassessed and their care plans are reviewed and revised, and if the plan of care is being revised because care set out in the plan has not been effective, the licensee ensures that different approaches are considered in the revision of the plan of care.

2. Ensure that different approaches to be considered will include but not be limited to the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and use of equipment, supplies, devices and assistive aids.

Grounds / Motifs :

1. The licensee failed to ensure that the resident was being reassessed and the plan of care was being revised because care set out in the plan had not been effective, different approaches had been considered in the revision of the plan of care.

This order is based upon three factors where there has been a finding of noncompliance in keeping with section 299(1) of Ontario Regulation 79/10, scope, severity and a history of non-compliance. The scope of the noncompliance is isolated (1), the severity of the non-compliance has actual harm/risk (3) and the history of non-compliance under LTCHA, 2007 for 6 (11) is ongoing (4). Section 6 (11) was issued as: a Voluntary Plan of Correction (VPC) on November 22, 2016.

Resident #012 had a previous fall in 2016, which resulted in an injury and transfer to hospital. The resident was readmitted to the home with an order for a physical device to prevent falls. Record review indicated that in a three month time period the resident continued to have greater than 10 incidents involving the removal or adjusting of the physical device that put the resident at risk for further falls and/or injury. Progress notes indicated that the home considered an alternate device; however, the resident was not reassessed and different approaches had not been considered with respect to the physical device until after the 10 incidents described above. This was confirmed with the RCC #152 in August 2017 (156)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 08, 2017

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours;
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee shall

1. Complete an evaluation of the home's Skin and Wound Care program and identify strategies to ensure all residents at risk of altered skin integrity receive a skin assessment by a member of the registered staff within 24 hours of the resident's admission and upon any return of the resident from hospital.

2. Develop strategies to ensure a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment; is assessed by a registered dietitian who is a member of the staff of the home, ensuring any changes made to the resident's plan of care related to nutrition and hydration are implemented, and ensure that the resident is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

3. Develop strategies to ensure that equipment, supplies, devices and positioning aids are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing.

4. Keep a record of the evaluation and strategies undertaken for identified issues within the Skin and Wound Care.

5. Develop and implement audit tools to ensure that assessments and referrals are completed as per applicable regulations (O. Reg 79/10 s.50) and to ensure that appropriate supplies are available as required by the resident with altered skin integrity.

Grounds / Motifs :

1. The licensee failed to ensure that the resident exhibiting altered skin integrity received a skin assessment by a member of the registered nursing staff upon any return from hospital.

Resident #304 was discharged to hospital on and identified date in 2016 and was readmitted to the home a few days later. Upon return from the hospital the resident received a head to toe assessment which indicated an altered level of skin integrity. Progress notes indicated the resident's skin was not assessed until approximately two weeks later where it was noted that the resident had a new

area of altered skin integrity and the existing area had worsened. This was confirmed with ADOC #117 on August 16, 2017. (156) (156)

2. The licensee has failed to ensure that, b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (i) received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A. A review of resident #403's clinical record indicated RPN #145 documented that a PSW had observed a new area of altered skin integrity. RPN #145 documented, in the progress notes, that they went into the resident's room to check on the resident and witnessed the new areas of altered skin integrity and provided a treatment. Further review of the clinical record had not indicated a skin and wound assessment, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment, was completed when RPN #145 became aware of the new areas of altered skin integrity
Interview with RPN #145 stated they were required to document the dressing change in the progress notes of the resident's clinical file and the Treatment Administration Record (TAR).
Interview with the DOC confirmed the licensee failed to ensure resident #403, who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (i) received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. (511)

B. Resident #304 was noted to have altered skin integrity on an identified date in 2016. The resident was no longer in the home at the time of this inspection. A review of the resident's clinical record identified that this area of skin breakdown was not assessed by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment . This was confirmed with the ADOC #117, on August 16, 2017. (156) (156)

3. The licensee has failed to ensure that the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing.

A. A review of the clinical record identified that resident #049 required a dressing change for an area of altered skin integrity.
On an identified date in 2017, an RPN documented in the progress notes that they were able to do wound care on this resident, however, not with the proper wound supplies as there were none available.
Interview with RPN #181 confirmed that the home often runs out of supplies and the staff would have to use other "make shift' dressings until the prescribed wound supplies arrived.

B. A review of the clinical record for resident #304, on an identified date in 2016, documented that an RPN was unable to complete a dressing change to the resident's area of altered skin integrity because wound supply (dressings) were not available. The resident's skin was not assessed until one week later where it was noted that the resident had a new area of altered skin integrity and the previous area had worsened. This was confirmed with ADOC #117 on August 16, 2017. (156) (511)

4. The licensee has failed to ensure that a resident at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff, (i) within 24 hours of the resident's admission.

This Order is based upon three factors where there has been a finding of noncompliance in keeping with section 299 (1) of Ontario Regulation 79/10, scope, severity and a history of non-compliance. The scope of noncompliance is a pattern (2), the severity of the non-compliance has minimal harm or a potential for actual harm (2) and the history of non-compliance under the O. Reg 79/10, s.50 is ongoing (4). Regulation 50 (2) was issued as: a Compliance Order (CO) on May 21, 2015 (complied September 2, 2015), a Voluntary Plan of Correction (VPC) on March 8, 2016 and a VPC on November 22, 2016.

Resident #049 was admitted to the home on an identified date in 2017 as per an admission note. Further review of the clinical record described the resident to be at risk for altered skin integrity related to their diagnosis and mobility status. A Nursing Admission Screening/History note was completed by RPN #181 that described the resident had impaired skin integrity but had not been received a skin and wound assessment by the registered staff member. Nine days post admission, a skin and wound assessment note identified the initial skin and wound assessment had been completed by RPN #181.

Interview with the RPN #181 confirmed resident #049 was at risk for altered skin integrity and had not received a skin assessment by the registered staff within 24 hours of admission. (511)
(511)

5. The licensee has failed to ensure that, (b) a resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (iii) was assessed by a Registered Dietitian (RD) who was a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration were implemented.

A review of the clinical record for resident #403 indicated a new area of altered skin integrity. The skin and wound assessment, completed by the registered nurse, described the impaired skin integrity. A review of dietary referrals had not included a referral for resident #403's new area of altered skin integrity. A review of the Registered Dietitian's (RD) assessment notes, in Point Click Care (PCC), had not identified an assessment of this new area. Interview with the RD confirmed they had not completed an assessment for resident #403's new area of altered skin integrity .

Interview with the DOC confirmed the RD's had not consistently received referrals for altered skin integrity. (511)

6. The licensee has failed to ensure that, (b) a resident that exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (iv) was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A. Resident #008 was assessed to have altered skin integrity on an identified date in 2017. The next weekly skin assessment was not completed as confirmed with registered staff #107 on July 13, 2017. (156)

B. Observation of resident #403 identified the resident had an alteration in their skin integrity and a review of resident #403's clinical record indicated the resident had a diagnosis that placed them at risk for altered skin integrity.

Skin assessments were reviewed for a seven month period in 2017. The resident had several areas of altered skin integrity, during this time, where there

had been no further weekly wound assessments. Interview with the DOC confirmed that after their review of the skin assessments that multiple, weekly skin assessments were not completed and some assessments had been completed incompletely for resident #403 during this seven month file review in 2017. Missing and inconsistent documentation of the weekly skin and wound assessments for resident #403's multiple wounds had not allowed for the identification of which, if any, of these wounds had healed or deteriorated during the reviewed time frame. (511)

C. A six month review of the clinical record was completed for resident #049 from their admission date in 2017. During this time, the resident had greater than five alterations in their skin integrity to multiple ares of their body. Weekly skin and wound assessment were not completed, for the combination of all areas of altered skin integrity, on more than 15 occasions. Interview with RPN #181 confirmed that weekly skin and wound assessment were not completed for resident #049's multiple alterations in their skin integrity. (511)

D. Resident #304 was noted to have altered skin integrity when they were admitted to the home, on an identified date, in 2015. The altered skin integrity had worsened and was not reassessed at least weekly by a member of the registered nursing staff on 12 of the identified weeks in 2015 and 2016. This was confirmed with ADOC #117 on August 16, 2017. Resident #304 was noted to have a second are of altered skin integrity in 2016 and this wound was not reassessed at least weekly by a member of the registered nursing staff on four of the identified weeks in 2016 as confirmed with ADOC #117 on August 16, 2017. (156)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 29, 2017

Order # / Ordre no : 005 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure the homes Falls Prevention, Responsive Behaviour, Medication Management, Resident Admission/Transfer/Return from Hospital and Complaints policies are complied with.

Specifically, the licensee shall:

1. As part of the Falls Prevention policy, ensure that the HIR is completed for all unwitnessed falls where the resident is unable to accurately report if they hit their head.

2. As part of the Responsive Behaviour policy, ensure that the SDM is notified when an aggressive resident to resident incident occurs.

3. As part of the Medication Management policy, ensure that the Drug Record book is maintained, including documentation of medications ordered, when faxed to pharmacy and when received from pharmacy. Ensure that wasted narcotics will be disposed of appropriately, including being witnessed by two registered staff.

4. As part of the home's Resident Admission/Transfer/Return from Hospital Assessment, ensure that head to toe assessments are completed on the shift of the resident's arrival from hospital.

5. As part of the home's policy that provided for written procedures for dealing with complaints, ensure that complaints are documented accurately and complaint logs are maintained. Complaints are to be audited quarterly with a record kept of the audits completed.

Grounds / Motifs :

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

This Order is based upon three factors where there has been a finding of noncompliance in keeping with section 299 (1) of Ontario Regulation 79/10, scope, severity and a history of noncompliance. The scope of noncompliance is a isolated (1), the severity of the non-compliance has actual harm/risk (3) and

the history of non-compliance under the LTCH, 2007, section 8 (1) is ongoing (4).
Section 8 (1) was issued as: a Voluntary Plan of Correction (VPC) on June 16, 2014, a VPC on September 16, 2014, a VPC on October 5, 2016 and a Compliance Order (CO) on May 10, 2017.

A. The licensee failed to ensure the home's Falls Prevention policy was complied with. In accordance with Ontario Regulation 79/10, s. 48, required the licensee to ensure there was a falls prevention and management program in place to reduce the incidence of falls and the risk of injury. The home's falls policy, "Falls Prevention and Management, Policy Number POL/3", last revised October 27, 2015, identified that when a fall occurs, Head Injury Routine (Nursing Standard – Head Injury Routine {H.I.R.}), will be followed for an un-witnessed fall where the resident is unable to accurately report if they hit their head.

On four identified dates in 2016, resident #200 experienced four unwitnessed falls. A clinical record review revealed that the HIR was not completed and this was confirmed by ADOC #117. Interview with RPN # 106 confirmed HIR was not completed as required and reported that completing HIR as required on night shifts was not always possible. Interview with the DOC confirmed the HIR was part of the post-fall assessment, which was part of the home's Falls prevention policy, when a resident experienced an unwitnessed fall or hit their head. (585)

B. The licensee failed to ensure the home's responsive behavior policy was complied with. In accordance with Ontario Regulation 79/10, s. 53, required the licensee to ensure there was a program in place to manage responsive behaviours.

The home's policy, "Management of a Resident with Responsive Behaviours" (policy number POL/10, last revised February 14, 2017), directed the RN/RPN, to notify the resident's POA/SDM as soon as possible after the incident to advise of the incident, any injury or emotional upset caused by the incident and safety measures taken to protect the resident from further incidents.

On an identified date in 2017, resident #500 was observed demonstrating a responsive behaviour. Resident #500's Substitute Decision Maker (SDM) voiced concern that they were not notified of this incident. The "SJV – Responsive Incident" tool was completed which indicated that the POA/family was not

notified. Interview with RCC #152 and review of the resident's health record confirmed that the resident #500's SDM was not notified of the incident. (586)

C. The licensee failed to ensure the home's Medication Management policy was complied with. In accordance with Ontario Regulation 79/10, s.114 required the licensee to develop an interdisciplinary Medication Management system that provided safe medication management and optimized effective drug therapy outcomes for residents.
As part of the home's Medication Management system, a department standard for ordering and receiving medications from the pharmacy was reviewed. This department standard was effective August 1998 and last reviewed on June 2015. The DOC provided and confirmed this was the standard of service for the licensee's ordering and receiving of medications from the pharmacy.
The standard described that all drugs would be accurately processed according to the following procedure:
4.1 Drug Record Book

i) 4.1.2 All new orders, re-orders and emergency orders would be entered in the book

A review of resident #403's medication record, on an identified date, had not contained the resident's medication that had been prescribed at an earlier date. A review of the Drug Record Book had not contained the resident's reordered medication. Interview with the DOC confirmed the prescribed medication was to be entered in the Drug record book as per the home's Department Standard for ordering and receiving medications from the pharmacy and was not.

ii) 4.1.4 The following information must be recorded for every drug order: Signature and initials of person placing/receiving order and the date the order was placed and received.

On an identified date in 2017, during an interview with RPN #171, they confirmed that they documented that resident #403's identified medication had not been administered in accordance with the directions for use specified by the prescriber because the medication was not available. RPN #171 reviewed the resident's Drug Record book and could not confirm if the resident's medication had been reordered or received as the form had not been completed in its entirety as per the home's standard as described in 4.1.4.

iii) 4.4 Re-Orders When there were five days of medication left, staff were to remove the large drug label and place in sequence on the current Drug Record Book Page and add the initials/signature and date.

On an identified date in 2017, during an interview with RPN #171, they confirmed that they documented that resident #403's medication was not available as the medication had run out and had been entered into the Drug record book for re-ordering. RPN #171 reviewed the resident's Drug Record book and could not confirm if the resident's medication had been reordered because the fax box, that would have confirmed the record was faxed to pharmacy, was not completed. The RPN called the home's pharmacy and the pharmacy confirmed they had not sent the medication as they had not received the fax required for reordering the medication as per the Drug Record Book. RPN #171 faxed the reorder form for the resident's medication, one day after the medication had run out.

Interview with the DOC confirmed the resident's medication should have been reordered when there were five days of medication left as per the home's standard described in 4.4. (511)

iv) A review of the home's Narcotics and Controlled Substances, Standard of service, last reviewed May 2016 identified 4.2.5: If a portion of an ampule was used, the remainder was discarded and noted on the Narcotic inventory record as a separate entry. Disposal must be witnessed by two registered staff (one must be an RN) and both initial the record. This must be done at the point of use or by the end of the shift.
On an identified date in 2017, the LTC Inspector observed RPN #143 provide a narcotic to an identified resident. The RPN opened up the narcotic medication and administer a portion of the medication. Once administered, they threw the partially filled vile into the Sharps container. They stated that when a narcotic was wasted the second nurse was to observe the waste and sign for the wasted narcotic but this was not a policy that had been practiced in the home.

A review of a document dated in 2017, provided to the DOC from a consultant, identified that through an audit it was identified that wasting of narcotics rarely contained a witness from the second registered nurse.
Interview with the DOC confirmed the home's policy for wasting of narcotics had not been complied with. (511)

D. The licensee failed to ensure the home's policy, "Resident Admission/Transfer/Return from Hospital Assessment", last revised on April 4, 2017, was complied with. The home's admission policy directed registered staff to complete a head to toe assessment on the shift of arrival when residents returned from hospital. Vital signs would be obtained on the day of return from hospital and noted on the vital sign tab in Point Click Care.
On an identified date in 2017, resident #750 was transferred to hospital. They were admitted and discharged back to the home two days later. Review of the plan of care identified that the Return from Hospital Assessment was not completed. Interview and review of the clinical record with RPN #179 stated that the head to toe assessment and vital signs were not completed when the resident returned from hospital and confirmed that the home's policy was not complied with. (581)

E. The licensee failed to ensure the home's policy, that provided for written procedures for dealing with complaints in accordance with Ontario Regulation 79/10, s.101, was complied with.
The record of an identified resident was reviewed including progress notes and it was noted that on an identified date in 2017, a family member had reported a concern to the home. It was noted that the home would follow-up with the SDM the following week. Registered staff #193 was interviewed and reported that the staff had not completed the documentation as per the home's policy and procedure and therefore the information was not included in the home's 2017 complaint log.

The family member of an identified resident reported that they had reported numerous concerns and complaints to the home during 2016 and 2017. They also reported that they met with the home to discuss their concerns.
Registered staff #193 reported that during 2016, the family member of the resident expressed concerns to the home that were not immediately resolved; the home met with the family member but that the staff had not recorded the concerns as per the home's complaint policy and procedure. (123)
(511)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 29, 2017

Order # / Ordre no : 006

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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).

Order / Ordre :

The licensee shall

1. Ensure that their written policy to promote zero tolerance of abuse and neglect for residents is complied with including but not limited to the duty under section 24 to make mandatory reports.

Grounds / Motifs :

1. The licensee has failed to ensure that there was a written policy that promotes zero tolerance of abuse and neglect of residents and that it was complied with.

This Order is based upon three factors where there has been a finding of noncompliance in keeping with section 299 (1) of Ontario Regulation 79/10, scope, severity and a history of noncompliance. The scope of noncompliance is a pattern (2), the severity of the non compliance is minimal harm or a potential for actual harm (2) and the history of non-compliance under the LTCH, 2007, regulation 53 (4) is ongoing (4). Section 20 (1) was issued as: a Written Notice (WN) on May 21, 2015, a VPC on January 15, 2016 and a Voluntary Plan of Correction (VPC) on March 8, 2016.

A. The home's policy 'Prevention of Abuse/Neglect of a Resident' policy revised June 27, 2017, identified that staff's responsibility included reporting any suspicion, concern or evidence of abuse or neglect are reported immediately to department manager. Furthermore, the policy outlined the following procedure, including but not limited to:
i. The first priority was to protect the person from further harm. The charge nurse or supervisor/delegate was to immediately assess the situation and

institute care if required. When there was suspected injury due to physical abuse, the attending physician was to be notified.
ii. The charge nurse/manager or supervisor was to immediately advise the DOC or ADOC
iii. If, as judged by manager/Director/Administrator on call or site President the circumstances were sufficiently serious to warrant immediate suspension of the implicated employee, this action may be taken. The employee may be off work without pay pending investigation.
iv. If warranted or required transfer/medical assessment/crisis counselling for the victim could be instituted via the Social Service Worker, RN/RPN, or physician.
v. The most responsible person investigating the incident documented a detailed report describing the situation and including what, where, who, when and how. What happened, time it happened, who was involved, interview resident as soon as possible noting all responses accurately documented, etc.
vi. Immediate reporting to the Director was to be completed and the substitute decision maker (SDM) was notified of results.
vii. Resident and or family member must have been adequately informed and must have direct communication as indicated, including results of investigation. Support and assistance was to be provided.
viii. Disciplinary action and non-disciplinary action was to be taken as outlined.

On an identified date in 2017, resident #502 alleged they had been treated in an inappropriate manner during care by a PSW on more than one occasions. The resident also reported that they had told someone in the home.
i. The LTC Inspector notified ADOC #117 immediately, who was unaware of the allegations.
ii. Interview with RPN #115, on an identified date in, 2017, confirmed that resident #502 told a person in the home, who reported the allegations to registered staff. RPN #115 confirmed they did not report the allegation to management.
iii. A follow up interview was completed with ADOC #117, six days after notifying them of the allegations. At that time, it was confirmed that resident #502 had not yet been interviewed as part of the investigation, the Director had not been notified of the allegations; however, the home had determined abuse was not substantiated.

Interview with ADOC #117 confirmed that the home failed to follow the home's policy 'Prevention of Abuse/Neglect of a Resident', when on an identified date in

2017, PSW staff #114, PSW #116, and RPN #115 did not report an allegation of alleged abuse to management, the home did not report allegations to the Director, and the home did not interview resident #502 about the allegations, as soon as possible. (528)

B. The home's 'Prevention of Abuse/Neglect of a Resident' revised June 27, 2017, defines physical abuse including but not limited to, the use of physical force by a resident that causes physical injury to another resident and directs staff to immediately report abuse of a resident to the Director.

On an identified date in 2017, an altercation occurred between resident #505 and resident #508. Review of the plan of care for both residents was completed and it was described that one of the residents sustained an injury. Review of the Critical Incident Report revealed that the incident was not reported to the Director until four days later. Interview with ADOC #117 confirmed that the incident was not reported immediately, as required in the home's policy. (528)

C. The home's policy and procedure Prevention of Abuse/Neglect Of A Resident, #POL/9, revised June 27, 2017 was reviewed and included: "Utilizing the on-line Critical Incident (reporting) System (CIS), the Department Director, or designate, shall notify the Ministry of Health and Long-Term Care based on the MOHLTC decision tree guidelines (May 2012) and mandatory reporting time frame requirements."
Critical Incident (CI) report #2975-000019-17 was reviewed and it was noted that on an identified date in 2017, residents #018 and #651 were involved in an altercation which resulted in the physical injury of resident #651. The home had not immediately submitted the CI report of the alleged physical abuse to the MOHLTC. The CI report indicated that the MOHLTC after-hours pager was not contacted about the incident.
Registered staff #117 was interviewed and confirmed the accuracy of the information contained in the CI report as above. They reported that they were not informed of the incident until the following day and they submitted the CI report at that time. They also reported that it is the home's expectation that the staff in charge of the building, call the after-hours pager number which is available in the home areas, or immediately inform the home's management staff who are available by telephone, of the incident.
The home failed to ensure that its written policy that promotes zero tolerance of abuse and neglect of residents related to immediate reporting of alleged physical abuse was complied with. (123)

D. The home's policy and procedure Prevention of Abuse/Neglect Of A Resident, #POL/9, revised June 27, 2017 was reviewed and included: "Any concern or evidence regarding abuse/neglect, witnessed or suspected, must be reported immediately to the department manager, admin on call (if after business hours-depending on the severity of the circumstances), Department Director, and resident's substitute decision maker/first contact." It also contained, "Utilizing the on-line Critical Incident (reporting) System (CIS), the Department Director, or designate, shall notify the Ministry of Health and Long-Term Care based on the MOHLTC decision tree guidelines (May 2012) and mandatory reporting time frame requirements."

The family member of resident #652 reported that resident #506 abused the resident and that the home was aware. Registered staff #193 was interviewed and confirmed that the MOHLTC was not notified of the alleged abuse as per the home's policy and procedure. (123) (123)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this (these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

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

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

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

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

À l'attention du/de la registrateur(e) 151, rue Bloor Ouest, 9e étage Toronto ON M5S 2T5	Directeur a/s du coordonnateur/de la coordonnatrice en matière d'appels Direction de l'inspection des foyers de soins de longue durée Ministère de la Santé et des Soins de longue durée 1075, rue Bay, 11e étage Toronto ON M5S 2B1 Télécopieur : 416 327-7603

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

Issued on this 26th day of October, 2017

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Robin Mackie

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