Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

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

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

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Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Sep 17, 2018;	2018_722630_0007 (A2)	004193-18	Resident Quality Inspection

Licensee/Titulaire de permis

Sharon Farms & Enterprises Limited
108 Jensen Road LONDON ON N5V 5A4

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

Earls Court Village
1390 Highbury Avenue North LONDON ON N5Y 0B6

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

Ontario

Ministry of Health and Long-Term Care

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Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

Amended by AMIE GIBBS-WARD (630) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

Extension to Compliance Order (CO) #005, #007 and #010 due date negotiated with MOHLTC LSAO at request of licensee/management company.

Issued on this 17 day of September 2018 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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Amended by AMIE GIBBS-WARD (630) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): March 12, 13, 14, 15, 16, 19, 20, 21, 22, 23, 26, 27, 28, 29, April 3, 4, 5, 6, 9, 10, 11, 12, 13, 16, 17, 18 and 20, 2018.

The following Critical Incident intakes were completed within this inspection:

Related to the prevention of abuse and neglect:

Critical Incident Log #025965-17 / CI 3047-000045-17

Critical Incident Log #026133-17 / CI 3047-000051-17

Critical Incident Log #027834-17 / CI 3047-000054-17

Critical Incident Log #028182-17 / CI 3047-000056-17

Critical Incident Log #028199-17 / CI 3047-000059-17

Critical Incident Log #028335-17 / CI 3047-000061-17

Critical Incident Log #000328-18 / CI 3047-000001-18

Critical Incident Log #001310-18 / CI 3047-000004-18

Critical Incident Log #001572-18 / CI 3047-000005-18

Critical Incident Log #001743-18 / CI 3047-000006-18

Critical Incident Log #002447-18 / CI 3047-000008-18

Critical Incident Log #002463-18 / CI 3047-000009-18

Critical Incident Log #003407-18 / CI 3047-000012-18

Critical Incident Log #003833-18 / CI 3047-000015-18

Critical Incident Log #004201-18 / CI 3047-000017-18

Critical Incident Log #004372-18 / CI 3047-000018-18

Critical Incident Log #004977-18 / CI 3047-000022-18

Critical Incident Log #005538-18 / CI 3047-000026-18

Critical Incident Log #005564-18 / CI 3047-000028-18

Critical Incident Log #006610-18 / CI 3047-000033-18

Critical Incident Log #007255-18 / CI 3047-000039-18

Related to medication administration:

Critical Incident Log #028432-17 / CI 3047-000057-17

Critical Incident Log #003824-18 / CI 3047-000016-18

Critical Incident Log #005268-18 / CI 3047-000024-18

Critical Incident Log #005604-18 / CI 3047-000027-18

Related to falls prevention

Critical Incident Log #028770-17 / CI 3047-000062-17

Critical Incident Log #003679-18 / CI 3047-000014-18

Critical Incident Log #005089-18 / CI 3047-000023-18

The following Complaint intakes were completed within this inspection:

Complaint Log #029061-17 / IL-54615-LO related to registered nursing staff in the home.

Complaint Log #028880-17 / IL-54582-LO related to sufficient staffing and food quality.

Complaint Log #001253-18 / IL-55034-LO related to sufficient staffing, dining and snack services and recreational programs.

Complaint Log #026143-17 / IL-54112-LO related to allegations of staff to resident abuse.

Complaint Log #004129-18 / IL-55710-LO related to sufficient staffing.

Complaint Log #001475-18 / IL-001475-LO related to availability of supplies.

Complaint Log #003718-18 / IL-55629-LO related to sufficient staffing, food quality, dining and snack services and medication administration.

Complaint Log #005211-18 / IL-56028-LO related to the infection prevention and control program, nutrition and hydration care and medication administration.

Complaint Log #005010-18 / IL-55955-LO related to falls prevention and oral care.

Complaint Log #027869-17 / IL-54381-LO related to falls prevention.

Complaint Log #005059-18 / IL-55970-LO related to allegations of neglect.

The following Follow-up intakes were completed within this inspection:

Follow-up Log #023419-17 for Compliance Order (CO) #001 from Complaint Inspection #2017_607523_0021 (A1) related to the written policy on the prevention of abuse and neglect.

Follow-up Log #023420-17 for Compliance Order (CO) #002 from Complaint Inspection #2017_607523_0021 (A1) related to immediately reporting allegations of abuse or neglect to the Director.

Follow-up Log #023422-17 for Compliance Order (CO) #003 from Complaint Inspection #2017_607523_0021 (A1) related to compliance with required policies and procedures.

Follow-up Log #023422-17 for Compliance Order (CO) #005 and Director's Order (DO) #001 from Complaint Inspection #2017_607523_0021 (A1) related to the written staffing plan of the home.

Follow-up Log #002562-18 for Compliance Order (CO) #001 from Complaint Inspection #2017_607523_0032 (A1) related to plan of care.

Follow-up Log #003883-18 for Compliance Order (CO) #001 from Critical Incident Inspection #2017_607523_0033 related to the evaluation of the required programs.

Follow-up Log #003886-18 for Compliance Order (CO) #002 from Critical Incident Inspection #2017_607523_0033 related to the evaluation of the responsive behaviours program.

Follow-up Log #003888-18 for Compliance Order (CO) #003 from Critical Incident Inspection #2017_607523_0033 related to minimizing the risk of altercations between residents.

During the course of the inspection, the inspector(s) spoke with with the President/Chief Executive Officer (CEO), the Administrator, the Administrator of Kensington Village, the Interim Director of Care (IDOC), the Assistant Director of

Care (ADOC), Vice President Clinical Services peopleCare, the Resident Care Co-ordinator (RCC), the former RCC, the Director of Environmental Services, the Director of Dietary Services, the Director of Therapeutic Recreation, the Resident Assessment Instrument (RAI) Coordinator, the Registered Dietitian (RD), the Staffing Manager, the Bookkeeper, the Consulting Pharmacist, the Consulting Pharmacy Manager, the Medical Director, the Payroll Controller, the Behavioural Supports Ontario (BSO) Registered Practical Nurse (RPN), the BSO Personal Support Workers (PSW), Registered Nurses (RN), RPNs, PSWs, Housekeepers, Laundry Aides, Cooks, Dietary Aides, Physiotherapy Aides (PTA), Recreation Assistants, family members and over forty residents.

The inspectors also observed resident rooms and common areas, observed medication storage areas, observed medication administration, observed meal and snack service, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, reviewed policies and procedures of the home, reviewed the written staffing plan of the home, reviewed various meeting minutes, reviewed written records of program evaluations and also reviewed the peopleCare Communities Report arising from the Operational Review.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Laundry

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Food Quality

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

Skin and Wound Care

Sufficient Staffing

Trust Accounts

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

31 WN(s)
9 VPC(s)
20 CO(s)
2 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
O.Reg 79/10 s. 54.	CO #003	2017_607523_0033	630

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

WN #1: The Licensee has failed to comply with LTCHA, 2007, s. 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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

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

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

Findings/Faits saillants :

1. The licensee has failed to comply with compliance order #001 from inspection 2017_607523_0032 (A1) served on January 30, 2018, with a compliance date of February 28, 2018, as it related to s. 6 (10)(b).

The licensee was ordered to ensure that residents were reassessed and the plan of care reviewed and revised when the resident's care needs changed and the care set out in the plan had not been effective.

Based on observations, interviews and clinical record reviews it was identified that the licensee failed to comply with s. 6 (10)(b) of the Long-Term Care Homes Act, 2007 (LTCHA) as they did not ensure that residents were reassessed and the plan of care reviewed and revised when the resident's care needs changed and the care set out in the plan had not been effective (as documented in finding A).

In addition, the licensee failed to ensure that the plan of care and care provided to residents met the legislative requirements related to multiple sub-sections within Section 6 of the LTCHA (as documented in finding B through G).

A) The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at any time when the resident's care needs changed.

i) During the Resident Quality Inspection (RQI) an inspector observed an identified resident tell a staff member that they required assistance with a specific type of care. This identified resident was then observed waiting for an hour and twenty minutes before they received the requested care from staff.

Identified staff members told the inspector that this resident's care needs had changed related to this specific type of care.

The clinical record for this resident showed there had not been a reassessment of the resident when their care needs changed and the plan of care was not updated to reflect the change.

During an interview the Interim Director of Care (IDOC) told the inspector that it was the expectation in the home that each resident would be assessed by registered staff with any alteration in their requirements for this specific type of care using the electronic assessment. The IDOC said that the plan of care for this identified resident was not based on a reassessment and was not updated when their care needs changed. [s. 6. (10) (b)]. (630)

ii) The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed or care set out in the plan was no longer necessary.

During the RQI inspectors observed than an identified resident had a specific injury. Staff informed an inspector that the injury was related to a specific incident.

The clinical record for this resident showed there had not been a reassessment of the resident when their care needs changed and the plan of care was not updated to reflect the change.

During an interview the Assistant Director of Care (ADOC) reviewed the clinical record for this identified resident and said that the plan of care was not updated to include interventions to address the change in condition for the resident when their risks for a specific type of incident increased. The ADOC also stated that the plan of care for the resident was not updated after the specific incident which resulted in a specific type of injury.

Based on these observations, interviews and clinical record review, this resident was not reassessed and the plan of care reviewed and revised when the resident's care needs changed [s. 6. (10) (b)]. (523)

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

During the RQI an inspector observed that an identified resident had a specific device applied and that this device was not applied correctly.

During an interview identified staff members said they thought the use of this device was included in the resident plan of care but upon review of the plan of care with the inspector acknowledged that this was not included.

The licensee has failed to ensure that there was a written plan of care for this identified resident that set out the planned care related to the use of this specific device [s. 6. (1)(a) (b)]. (523)

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

During the Resident Quality Inspection (RQI) a family member of an identified resident reported specific care concerns.

The clinical record for this resident showed that the medication administration record related to this care did not provide clear direction for the staff related to the

provision of this specific medication.

During an interview the ADOC said that the plan of care did not provide clear direction for staff regarding the administration of this specific medication.

Based on these interview and record review the licensee has failed to ensure that there was clear directions to the registered staff for this resident's protocol for this specific medication [s. 6. (1) (c)]. (563)

D) The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

i) The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) on a specific date which reported allegations of staff to resident abuse. This CIS report stated that the identified resident had requested a specific type of care and the staff provided a different type of care than what was requested. This report stated that the family had expressed concerns about the care provided.

During an interview this identified resident told an inspector that they were concerned that at times it took the staff a long time to answer their call bell. This resident reported they needed assistance from staff for this specific type of care and they had specific preferences related to the provision of this care.

The "Call Bell Log" for this resident showed that on three specific dates and times there was over a 25 minute time period between when the call response system was activated in this resident's room and when the call was cancelled.

During interviews with staff they reported that this identified resident required assistance from staff with this specific care. Staff also said that this resident would ring for assistance with this type of care. One staff member said that this resident had experienced a change in their care needs and they were not sure if the plan of care specified a schedule for the provision of this care.

During the RQI an inspector observed that during an identified time period this resident was not provided with this specific type of care during a four and a half hour time period.

This resident reported to the inspector on that day that they had not received that specific care from staff and the care provided that day was not what they preferred.

The clinical record for this resident showed the resident had a recent assessment completed which did not reflect the resident's stated preferences. The plan of care for this resident did not reflect the most recent assessment or the resident's preferences.

During an interview the Interim Director of Care (IDOC) said it was the expectation in the home was that each resident would have their care needs assessed using the electronic assessment form with any change in their status related to this specific type of care. The IDOC said that this resident had an assessment documented on a specific date and that it did not look like the plan of care had been updated based on that assessment.

Based on these observations, interviews and clinical record review this identified resident had a change in their bladder continence which was not reflected in the plan of care. The plan of care for this resident was not based on the most recent assessment of the resident. The preferences and need for care that the resident had expressed were not reflected in the assessment or the plan of care. During the inspection this resident expressed concerns related to the care they received in the home [s. 6. (2)]. (630)

ii) The licensee has failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences.

During the RQI an identified resident told an inspector that they had specific preferences related to a care program in the home. This resident said they had spoken with staff in the home about these preferences.

The clinical record for this resident showed that a staff member had documented in a progress note a discussion with the resident regarding their preferences for this program. The plan of care for the identified resident did not include interventions related to their stated preference.

During an interview an identified staff member told an inspector that they had met with this resident on several occasions and they were aware of the resident's preferences. This staff member said that those preferences would be expected to be part of the resident's plan of care. The Inspector reviewed the plan of care for

the resident with the staff member and they acknowledged that it was not based on the resident's needs and preferences related to this program [s. 6. (2)]. (523)

iii) The licensee has failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences.

The MOHLTC received a complaint from a family member for an identified resident regarding a specific type of care in the home. This family member told and inspector that the resident had specific preferences related to this care.

The clinical record for this resident showed that a staff member had documented in a progress note a discussion with the resident regarding their preferences for this program. The plan of care for the identified resident did not include interventions related to their stated preference.

During interviews with identified staff members they reported to an inspector that this resident had stated preferences related to care. These staff members said that the plan of care was not based on this resident's preferences. [s. 6. (2)]. (523)

iv) The licensee has failed to ensure the care set out in the plan of care was based on an assessment of the resident and the needs of that resident.

During the Resident Quality Inspection (RQI) an inspector observed on multiple occasions that an identified resident was in a position that placed them at risk and required assistance and assessment from staff.

During interviews with identified staff members they said that they thought that this identified resident was able to express their care needs. The staff members also said that based on the plan of care this resident did not require assistance or assessment from staff related to this type of care.

During another interview with an identified staff member they reported that this resident was not able to accurately express their care needs.

The clinical record for this resident showed that the plan of care had not been updated based on assessments related to specific incidents. The plan of care also did not reflect the resident's needs related to this care area.

During an interview with the Assistant Director of Care (ADOC) they told an

inspector that this identified resident had difficulties expressing their care needs. The ADOC said it was the expectation that registered staff would assess this resident and that the plan of care would be based on the completed assessments and identified needs of the residents related to this care area. [s. 6. (2)]. (630)

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

i) During the RQI an inspector observed that an identified resident did not have a specific device applied that was documented as required in the plan of care.

The clinical record for this resident showed that this specific device was required for safety and at the family's request.

During an interview with an identified staff member they reported that they thought this resident did not require this device. This staff member then reviewed the plan of care with the inspector and said that the device had been added to the plan of care. This staff member said they had not applied the device as per the plan of care.

During an interview the Assistant Director of Care (ADOC) said that it was the expectation in the home that changes to the plan of care would be communicated to the staff. ADOC said it was the expectation in the home that care would be provided as to the residents as specified in the plan. [s. 6. (7)]. (524)

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

During the RQI an inspector observed an identified resident with a specific device in place.

The clinical record for this identified resident showed that this device was not to be in place.

During an interview with an identified staff member they told an inspector that the plan of care directed staff to remove this device after a specific type of care had been provided. This staff member said they were unable to follow the plan of care for a specified reason.

During an interview with another staff member they reported that they were not sure if this resident was to have the device in place. An inspector reviewed the plan of care with this staff member and they acknowledged that the care set out in the plan of care was not provided to the resident [s. 6. (7)]. (523)

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

The home submitted a Critical Incident System (CIS) report to the MOHLTC related to a specified incident for an identified resident. This CIS report stated that the measures that were in place prior to the incident included the use of a specific device.

During interviews with identified staff members they reported that this resident had a history of multiple incidents of a specific nature. These staff members reported that the specific device that was to be used for this resident was not available for a time period as the device was broken.

The clinical record for this resident showed that they had multiple documented incidents of a specific nature. The clinical record showed that the specific device had been assessed as required and was included in the plan of care. The clinical record showed that the specific device was not available to be used for this resident for a time period as it was broken.

During an interview the Interim Director of Care (IDOC) told an inspector that this resident had a history of a specific type of incident. The IDOC said that the plan of care showed they required a specific device and this was not provided to the resident for a time period.

Based on these interviews and record review the care set out in the plan of care for this resident was not provided [s. 6. (7)]. (630)

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

The home submitted a CIS report to the MOHLTC which was identified as alleged staff to resident abuse. This report stated that an identified resident had a specific type of wound on their body. This report stated that through the investigation it was found that the plan of care related to a specific type of care was not provided to the

resident.

During an interview this identified resident told and inspector that they had a specific type of wound and they were not sure how they acquired the wound.

The plan of care for this resident showed that this resident required a specific type of care to help minimize the risk for damage to their skin.

During an interview and identified staff member said that this resident required a specific type of care to help promote their safety.

During an interview the Interim Director of Care (IDOC) said that they had been involved in an investigation of allegations of physical abuse for this resident. The IDOC said that through the process of their investigation they determined that the staff did not follow the plan of care. IDOC said this staff member was given a letter of expectation regarding not following the plan of care.

Based on these interviews and clinical record review the care provided to this resident was not provided as outlined in the plan of care [s. 6. (7)]. (630)

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

The home submitted a CIS report to the MOHLTC to a specific incident which resulted in an injury.

During an interview an identified staff member said this resident had a specific device in place to support the resident's safety.

During an interview the Interim Director of Care (IDOC) said that they had submitted the CIS related to the incident for this resident. The IDOC said they went to check on this specific device and found that it was not functioning properly. When asked if there was a process in the home for checking on the functionality of these devices, the IDOC said that they were to be checked at the start of every shift and they were planning on reviewing that with PSWs that week.

During an interview the Assistant Director of Care (ADOC) said that the staff in the home were supposed to check if the devices were working at the start of the shift and that was to be in the tasks in Point of Care (POC) for the residents.

An Inspector reviewed the tasks in POC for this resident and there were no current tasks related to checking or applying this device.

During an interview an identified staff member said that the expectation in the home was that staff were checking the devices and documenting that in the POC. This staff member said that this resident did not have that task in POC.

During an interview the Administrator said it was the expectation in the home that staff were checking whether devices were applied correctly and working properly for falls prevention were included as a task in POC. [s. 6. (9) 1]. (630)

G) The licensee has failed to ensure that the outcomes of the care set out in the plan of care were documented.

The home submitted a CIS report to the MOHLTC for an identified resident documented an incident where the resident was complaining of a specific type of pain.

The care plan in PCC at the time of the inspection documented that the resident had a specific type of care. The POC task included specific care requirements and the POC tasks for other care were absent from the resident's plan of care. Although the care plan documented the care required related to activities of daily living (ADLs), the PSWs were not documenting the outcomes of the care set out in the plan of care related to these specific areas of care.

During an interview the peopleCare Vice President of Clinical Services (VPCS) stated the PSWs referred to the kardex in POC for specific care interventions and documented in POC when care had been completed. The VPCS verified that there was no documentation of the assistance provided related to the ADLs that were completed for this resident. The VPCS stated PSWs were to document the outcomes of the care set out in the plan of care related to ADLs.

During an interview the Administrator verified that the "Earls Court Village Point of Care Audit Report" documented that there was no documentation of the personal care provided to resident on a specific shift.

The licensee failed to ensure that the outcomes of the care set out in the plan of care were documented for this resident [s. 6. (9) 2]. (563).

Based on these observations, interviews and clinical record reviews it was identified that the licensee failed to ensure that the plan of care for residents met the legislative requirements related to multiple sub-sections within Section 6 of the Long Term Care Homes Act, 2007. [s. 6.]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

WN #2: 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 has failed to ensure that residents were not neglected by the licensee or staff.

Section 2(1) of Ontario Regulation 79/10 defines neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or wellbeing, including inaction or a pattern of inaction that jeopardizes the health or safety of one or more residents."

The home submitted a Critical Incident System (CIS) report to the Ministry of

Health and Long-Term Care (MOHLTC) related to a specific incident with a resulting injury for an identified resident. This report stated that this resident had been identified as being at high risk for this type of incident and had experienced several previous events.

Multiple identified staff members told an inspector that this resident had a history of this type of incident and that prior to being sent to the hospital had been showing signs of pain. Multiple staff members reported that this resident was to have in place specific interventions to help minimize their risk for this type of incident. The staff said that one of the interventions included the use of a specific device and that there was a period of time when this device was broken and could not be used for the resident. Staff reported that during the time that the device was broken this resident did have incidents that placed them at risk for injury.

The clinical record for this identified resident showed that this resident had multiple documented incidents during a specific time period. The record also showed that the staff did not complete the required documented assessments after each incident. The plan of care showed that the resident required the specific device to be used as a way to decrease their risk for this type of incident and that the family had requested the use of this device.

During an interview the Interim Director of Care (IDOC) told an inspector that this resident had multiple incidents prior to the incident that led to the CIS report. The IDOC said that based on review of the CIS report and the electronic this resident had noted bruising and pain prior to the incident that led to the CIS report and that staff did not assess the bruising using a skin assessment or complete a pain assessment. The IDOC acknowledged that staff did not complete all required documented assessments for this resident for a specific time period. The IDOC said that one of the physician's recommendation was not implemented prior to the incident that led to the CIS report. When asked if they thought that the care provided to this resident provided the care and assistance required to maintain their safety and wellbeing, the IDOC stated no. The IDOC said that the specific device should have been fixed and the physician's recommended intervention should have been implemented.

Based on these interviews and record review this resident had an incident in the home which resulted in an injury with pain. Prior to this incident, the resident had multiple prior incidents for which staff did not complete documented assessments, revise the plan of care or implement new interventions. This resident had a

specific number of incidents in a specific time period when there was an identified concern with a specific device not functioning. The intervention recommendation by the physician related was not implemented prior to the incident that lead to the CIS report. Staff had identified concerns with skin integrity and pain for this resident and these were not assessed through the expected practices within the home. Based on these interviews and record review there was a pattern of inaction related to the care and assistance this resident required in the home to maintain their safety and wellbeing. [s. 19. (1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with 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 has failed to comply with compliance order #001 from inspection 2017_607523_0021 (A1) served on September 22, 2017, with a compliance date of October 31, 2017.

The licensee was ordered to ensure that the policy to promote zero tolerance of abuse and neglect of residents was complied with, specific to but not limited to when staff suspected or were informed of any witnessed or alleged abuse.

Section 2(1) of Ontario Regulation 79/10 defines neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or wellbeing, including inaction or a pattern of inaction that jeopardizes the health or safety of one or more residents."

A) The licensee has failed to ensure that the home's written policy on the prevention of abuse and neglect was complied with.

The MOHLTC received a complaint from a family member which identified concerns that they felt that an identified resident had experienced "negligent care." This family member told an inspector that they had specific care concerns and were planning to bring these concerns forward to the management in the home.

The home's policy titled "Zero Tolerance of Abuse and Neglect" with revised date December 21, 2017, included the following direction:
"The DOC/Administrator/or other designation will immediately upon notification:
- 5. Obtain written statements from all concerned parties including the resident if he/she is able.
- 8. Ensure a full medical examination has been arranged.
- 9. Advise the MOHLTC Director regarding ongoing investigation through the MOHLTC Critical Incident System (CIS).
- 13. Continue completion of Nursing Checklist for Reporting and Investigating Alleged Abuse."

The "Abuse-Checklist for Investigating Alleged Abuse" with revised date December 2017, included the following direction:
- "Immediately - Document objective observations including full assessment if physical, sexual abuse or neglect"
- "Within next 48 hours continue investigation and collate all information into one chronological report – DOC/Administrator."

During an interview the Administrator said that the family for this identified resident had expressed concerns regarding the care the resident had received in the home. The Administrator said that they had documented this concern and provided a "Concern/Complaint Record" with a written letter attached with a specific date. The written letter was addressed to the Administrator and included description of the care that they felt had not been provided to the resident

The clinical record for this identified resident did not include documentation of a "full medical examination" by the physician after the letter had been received.

During an interview the Administrator told an inspector that the written letter of complaint expressed the perception that the resident had been allowed to develop specified conditions. When asked what they had done in response to the letter, the Administrator said they followed up with the complainant to set-up a care conference date. The Administrator said they had looked into the care concerns which included reviewing progress notes and speaking with staff. Administrator said that at the time of the interview with the inspector they had not met with the complainant or had the care conference. The Administrator said that the definition of neglect was the failure to provide a resident with the treatment care, services or assistance required for safety or wellbeing. When asked if the concerns identified in the letter for this resident met the definition of alleged neglect, the Administrator said that they did. The Administrator said they had started a "high level" investigation into these allegations of neglect and that they did consider this to be an investigation into alleged neglect. The Administrator said that they had interviewed staff and had documented some of these interviews. When asked where they had documented the outcome of their investigation, the Administrator said as there were no specifics they were hoping to document further at the care conference. The Administrator said they had not notified the MOHLTC of this investigation or the allegations of neglect through the CIS system.

Based on these interviews and record reviews a family member had raised concerns that this identified resident had received "substandard care" which they felt had caused problems for the resident. The Administrator said that the concerns were investigated as alleged neglect. The home's written policy was not complied with related to documentation of the investigation, to the arrangement for a "full medical examination" or the notification to the MOHLTC of the investigation into allegations of neglect. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with (630).

B) The MOHLTC received a complaint related to concerns about rough handling of an identified resident by staff on a specific date.

The home submitted a CIS report to the MOHLTC which was identified as "unlawful conduct that resulted in harm/risk of harm to resident" for this resident. This CIS report did not include a description of the incident. It included three progress notes

related to a skin integrity concern and that management was "doing an investigation." This report stated that the resident was assessed, that staff were interviewed and "no findings of rough handling by staff." This report was completed by the former Director of Care (DOC) and there was no update to the report after the initial report was submitted to the MOHLTC.

The home's written policy titled "Zero Tolerance of Abuse and Neglect" with effective date September 2017 that was in place at the time of the incident included the following procedures:
"The Charge Nurse/RPN will:
- 3. Immediately notify the DOC/ADOC/designate. After hours the RN in charge of the home must immediately report to the Manager on Call."
The RN will:
- 6. Obtain written statements from all witnesses and document his/her account of the incident using the Incident Report Form.
- 8. Continue completion of Nursing Checklist for Reporting and Investigating Alleged Abuse."
The DOC/Administrator/or other designate will immediately upon notification:
- 3. Obtain written statements from concerned parties including the resident if he/she is able.
- 10. Complete the CIS as per MOHLTC protocols.
- 12. Continue completion of Nursing Checklist for Reporting and Investigating Alleged Abuse."

"The Abuse-Checklist for Investigating Alleged Abuse or Neglect" included "Interview those present and request written account of incident from all possible witnesses before shift ends."

The clinical record for this identified resident included a progress note by the former DOC which stated that the family member had been informed of CIS completed and that the family was still not satisfied with the results of the investigation.

During an interview the Assistant Director of Care (ADOC) said that they had been involved in assessing this resident's skin and talking to staff related to the skin integrity concern. The ADOC said they had spoken to the family related to a skin concern and had reported the concern to the former DOC. The ADOC said they had not personally interviewed staff related to an allegation of abuse and were not sure if the former DOC had spoken with the family or what had been done related

to the investigation of this CIS.

During an interview the Administrator told an inspector that the resident's family member had brought forward concerns about the care for this resident. When asked why this had been submitted to MOHLTC as "unlawful conduct that resulted in harm/risk of harm" the Administrator said that they thought it was because at the time they did not have enough evidence that it was abuse and that was the "only thing that fit." When asked if this had been investigated as an allegation of abuse as the family member had indicated that they suspected abuse, the Administrator said that it had been investigated as an allegation of abuse by the former DOC. The Administrator said they had not personally been involved in the investigation only made aware that it was being done. When asked if there was any further documentation regarding the investigation apart from the CIS report, the Administrator said that it was just the CIS report and progress notes and they could not find any documentation related to interviews with staff. When asked what the expectation was for documentation of an investigation the Administrator said that all interview with staff members involved and related staff statements would be documented as well as the follow-up to the investigation. When asked if there was any way of knowing who was interviewed or when interviews were conducted, the Administrator said that based on what they had available there was no way of knowing. The Administrator said that the CIS report was not updated with the results of the investigation. The Administrator said that the "Nursing Checklist for Reporting and Investigating Alleged Abuse" was part of the policy in November 2017, but they did not start using that in the home until January 2018.

Based on these records and interviews the licensee has failed to ensure the written policy on prevention of abuse and neglect was complied with. The staff in the home did not immediately report the allegation of rough handling to the management in the home, the "Nursing Checklist for Reporting and Investigating Alleged Abuse" was not used for the investigation, there was no documentation of interviews or written statements related to the investigation and the CIS report was not updated as per the procedures in the policy. [s. 20. (1)]

Additional Required Actions:

CO # - 003 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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with compliance order #001 from inspection 2017_607523_0021 (A1) served on September 22, 2017, with a compliance date of October 31, 2017.

The licensee was ordered to ensure that when a person had reasonable grounds to suspect that any abuse of a resident by anyone had occurred or may occur that they immediately reported the suspicion and the information upon which it was based to the Director.

Section 2(1) of Ontario Regulation 79/10 defines neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety

or wellbeing, including inaction or a pattern of inaction that jeopardizes the health or safety of one or more residents."

The licensee has failed to ensure that when a person had reasonable grounds to suspect abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident, immediately reported the suspicion and the information upon which was based to the Director.

A) During an interview the Administrator said that family member of an identified resident had expressed concerns regarding the care the resident had received in the home.

The Administrator said that they documented this concern and provided a "Concern/Complaint Record" with a written letter attached. The Administrator told the inspector that they had notified the MOHLTC of the written letter of complaint through an email one day after they had personally received the letter.

The written letter was addressed to the Administrator and identified specific concerns regarding the care for this resident.

During a follow-up interview the Administrator said that the definition of neglect was the failure to provide a resident with the treatment care, services or assistance required for safety or wellbeing. When asked if the concerns identified in the letter of concerns for resident met the definition of alleged neglect, the Administrator said that they did. The Administrator said that they had started an investigation into these allegations of neglect. The Administrator said that they had not notified the MOHLTC of this investigation or the allegations of neglect through the CIS system (630).

B) During the RQI an identified resident told and inspector that they thought that staff were not nice and did not treat them well and that they had spoken to a manager about these concerns.

During an interview an identified staff member said they had received concerns from this identified resident about the care they received. This staff member said they completed a concern form and informed the Director of Care (DOC) immediately.

During an interview the Administrator said that if a resident informed a

management team member about any allegations of abuse or neglect it was expected that the staff member would let the DOC or the Administrator know immediately and then they would investigate and report to the Director.

During an interview the Interim DOC said that they were made aware of concerns related to care not being provided to this identified resident that put them at risk. The IDOC said that the concern met the definition of neglect of the home's policy. The IDOC said that they did not report those allegations to the Director and that the expectation was to report those allegations immediately to the Director. (523) [s. 24. (1)]

Additional Required Actions:

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

WN #5: 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 comply with compliance order #001 from inspection 2017_607523_0021 (A1) served on September 22, 2017, with a compliance date

of October 31, 2017.

The licensee was ordered to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with specifically but not limited to: Medication and Treatment Administration Record.

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

A) Section 86 (1) of the Long Term Care Homes Act, 2007 states "every licensee of a long-term care home shall ensure that there is an infection prevention and control program for the home."

In accordance with O. Reg. 79/10, s. 229 (8), the licensee was required to ensure that there was in place "(a) an outbreak management system for detecting, managing and controlling infectious disease outbreaks, including defined staff responsibilities, reporting protocols based on requirements under the Health Protection and Promotion Act, communication plans and protocols for receiving and responding to health alerts; and (b) a written plan for responding to infectious disease outbreaks."

Specifically, staff did not comply with the licensee's "Infection Control Manual" policy regarding "Outbreak Management – IC-B-70 Control Measures" last revised April 2017, and the "Outbreak Management – IC-B-30 Outbreak Contingency Plan" last revised April 2017, which were part of the licensee's infection prevention and control program.

Specifically staff also did not comply with the measures documented in CIS report which was submitted to the MOHLTC, which was identified as a "disease outbreak" and was classified as an Acute Respiratory Illness (ARI). The report stated that the measures put in place in the home included "additional precaution signs posted," "staff cohorting for resident care," "resident cohorting for dining and activities where possible" and "continued case finding/surveillance for both staff and residents."

i) During the entrance conference for the Resident Quality Inspection (RQI), an identified staff member reported that the home had a respiratory infection outbreak in a specific area of the home.

During observations by an inspector it was found that multiple identified residents were eating together in an area away from the main dining room. Multiple staff members were observed going in and out of the room during the meal and then going into the main dining room. At times staff were wearing gowns, gloves and masks when in the separate dining area and at other times they were not wearing this Personal Protective Equipment (PPE). The residents in the room were not wearing masks. Identified residents were observed coughing in the room. Residents were observed being taken out of the room and down the hallway and not wearing masks.

During an interview an identified staff member told an inspector that the area was being used for residents at meals because there were so many residents in isolation that the management said the residents on isolation were to have their meals in that room. This staff member said that usually during an outbreak the residents would be in their room with tray service.

During an interview another identified staff member said that the residents who were eating in the separate location were the ones presenting with one or more symptoms related to the outbreak. This staff member said that staff were expected to wear gloves, gown and mask and stay in that area during the meals. This staff member said they had previously directed staff that the residents who were on isolation were to be wearing masks when being transferred out of their rooms.

An inspector observed “Droplet Precaution” signs posted on the doors to the rooms for the identified residents which stated "resident must wear a mask if they leave the room" and “wear mask and eye protection within two meters of the resident."

During an interview the Assistant Director of Care (ADOC) said they were the lead for the Infection Prevention and Control (IPAC) Program in the home. The ADOC said that during the outbreak all residents who were identified with symptoms were eating in the separate area. The ADOC said that all residents on the line listing did not have the same symptoms and some only had one symptom. The ADOC said that when in the separate area the residents were not wearing PPE and that staff were to be wearing PPE at all times. The ADOC said that during outbreaks Public Health would provide them with direction for the outbreak measures. The ADOC said that after initially speaking with an inspector they followed-up with a call to Public Health to discuss the practice of taking the residents to the same dining room and they were directed that the residents were to be isolated to their room. The ADOC said they informed Interim Director of Care (IDOC) and the

Administrator and they said they would direct staff to try to keep the residents in their rooms and provide more staff to that floor to help them for meals.

The licensee's "Infection Control Manual" policy regarding "Outbreak Management – IC-B-70 Control Measures" last revised April 2017, stated that "the control measures which are implemented after the outbreak is declared will be decided by the DOC/ICC in consultation with the Public Health Department (DH) in accordance with current practices."

The licensee's "Infection Control Manual" policy regarding "Outbreak Management – IC-B-30 Outbreak Contingency Plan", last revised April 2017, stated that "each home will develop an outbreak contingency plan individualized to the home in managing an outbreak in order to eliminate transmission of a disease causing agent. The plan will be in line with the Public Health recommendations."

The "Respiratory Outbreak Control Measures" which was electronically provided to the home by the Middlesex-London Health Unit on March 7, 2018, included the following:
-"Routine Practices + Droplet/Contact Precautions (PPE) Masks within two meters of cases/suspect case; gloves – direct care tasks; hand hygiene before donning and after removal."
-"Isolate cases to room – when possible for this population, five days from onset or until symptoms resolve whichever is sooner; maintain physical separation from roommates."
- "Isolate suspected cases (those with one symptom) to room – at least 24 hours using same precautions; extend isolation if symptom(s) persist or worsen."
-"Cohort health care workers when possible – dedicate staff to cases only and/or to affected or unaffected units only."

During an interview the Administrator told an inspector that the "Respiratory Outbreak Control Measures" from Public Health were considered to be part of the outbreak management plan in the home and staff were expected to comply with these measures. The Administrator said that up until a specific date they had been grouping all residents with symptoms in one dining room area and then after more education from Public Health they changed to providing trays with supervision for those residents in isolation. The Administrator said it was the expectation that staff would be wearing the appropriate PPE according to the protocols and for the current outbreak that would include wearing mask when within two meters of the residents.

Based on these observations, interviews and record review the staff in the home did not comply with the outbreak management plan and strategy that was in place. Residents who had been identified by staff in the home to have one or more symptoms related to the outbreak were eating their meals together in a separate dining area and therefore the cases and suspected cases were not isolated to their room and there was not dedicated staff providing care to the cases only during mealtimes. It was also observed during the meal that staff were not consistently following the "Droplet/Contact Precautions (PPE)" of wearing masks within two meters of cases/suspected cases when the residents were in this dining room.

ii) Observations by an inspector at specific meal found an identified resident eating their meal in the main dining room and staff were not wearing Personal Protective Equipment (PPE) when sitting beside this resident. At that time there was also a "Droplet Precaution" sign on the resident's door.

The "Respiratory Line Listing" was provided to an inspector by a staff member in the home and this identified resident was included. This document did not show that this resident was considered to be out of isolation.

During an interview an identified staff member told an inspector that this identified resident was not listed on the "Respiratory Monitoring Sheets" as being in isolation but was listed on the line listing. This staff member said that based on review in the electronic documentation system at the time of the interview they did not see any documentation that the resident had symptoms and would be considered to be clear and could be removed from isolation. This staff member said that this resident was still considered to be in isolation and should not have been in the main dining room.

The "Respiratory Outbreak Control Measures" which was electronically provided to the home by the Middlesex-London Health Unit on a specific date, included the following:
-"Surveillance criteria for line listing and case definition acute onset of at least two of the following symptoms of upper/lower respiratory tract infection" and included "runny nose or sneezing" and "stuffy nose (i.e. congestion).
-"Routine Practices + Droplet/Contact Precautions (PPE) Masks within two meters of cases/suspect case; gloves – direct care tasks; hand hygiene before donning and after removal."
-"Isolate cases to room – when possible for this population, five days from onset or

until symptoms resolve whichever is sooner; maintain physical separation from roommates."

During an interview the Administrator said that the staff in the home would know which residents were in isolation by the sign on their door, communication at change of shift and the line listing with the RN. The Administrator acknowledged that there were two versions of the line listing being used at the time of the inspection which did not include the same information on both. The Administrator also said that the "Respiratory Outbreak Control Measures" from Public Health were considered to be part of the outbreak management plan in the home and staff were expected to comply with these measures.

Based on these observations, interviews and record review the staff in the home did not comply with the outbreak management plan and strategy that was in place. An identified resident was included on the line listing as a case for the respiratory outbreak and was observed not to be isolated to their room for meals and staff were not wearing PPE when within two meters of this resident.

iii) During an interview an identified staff member told an inspector that they were in a position that involved working on two different floors in the home on a specific date, and one of the floors was considered to be in respiratory outbreak.

The "Respiratory Outbreak Control Measures" which was electronically provided to the home by the Middlesex-London Health Unit on a specific date, included the following:
-"Cohort health care workers when possible – dedicate staff to cases only and/or to affected or unaffected units only."

During an interview the Interim Director of Care (IDOC) acknowledged that the cohorting of health care workers was identified on the Public Health control measures. The IDOC said they had been doing the best they possibly could to have the staff stay on the outbreak floor at times and that there would be primary staff that would work on that floor. When asked how many different PSWs had worked on the unit since the outbreak started the IDOC provided a list which identified 26 different PSW staff. The IDOC said that the PSW float did work between the two floors on days and evenings during the outbreak and that the RPN on the night shift floated between the two floors.

Based on these observations, interviews and record review the staff in the home

did not comply with the outbreak management plan and strategy that was in place as the home did not have dedicated staff to cases or affected floors only.

iv) During the RQI an inspector observed an identified resident coughing and a staff member was in closed proximity to the resident and was not wearing PPE. There was no "Droplet Precaution" sign observed on the door at that time.

During the RQI an inspector observed that another two identified residents had a "Droplet Precaution" sign on their door. A staff member was observed going into the rooms without PPE and providing care to the residents. The inspector then observed that an identified resident had a "Droplet Precaution" sign on their door. One of the staff members told the inspector that that they did not think that the resident was on any precautions.

During the RQI an inspector observed another staff member provide care to another identified resident without wearing PPE.

The "Respiratory Line Listing" for showed that these identified residents were included as having symptoms related to the outbreak at the time that the observations were made by the inspectors.

During the RQI an inspector observed a staff member not removing gloves or doing hand hygiene when going between two resident different identified residents.

The "Respiratory Outbreak Control Measures" which was electronically provided to the home by the Middlesex-London Health Unit on a specific date, included the following:
-"Routine Practices + Droplet/Contact Precautions (PPE) Masks within two meters of cases/suspect case; gloves – direct care tasks; hand hygiene before donning and after removal."

During an interview the Administrator said that the staff in the home would know which residents were in isolation by the sign on their door, communication at change of shift and the line listing with the RN. The Administrator said it was the expectation in the home that the staff would be using the appropriate PPE and would be completing proper hand hygiene. The Administrator said the staff in the home had recently received mandatory education regarding proper hand hygiene. The Administrator told an inspector that the "Respiratory Outbreak Control Measures" from public health were considered to be part of the outbreak

management plan in the home and staff were expected to comply with these measures.

Based on these observations, interviews and record review the staff in the home did not comply with the outbreak management plan and strategy that was in place as staff were not following the routine practices and droplet precautions (630).

B) The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy and procedure the licensee was, that the policy and procedure was complied with.

In accordance with O. Reg. 79/10, s.30 (1), the licensee was required to ensure that the following was complied with in respect of each of the organized programs required under section 48 of this Regulation: "there must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required."

Section 48 of O. Reg. 79/10 states “every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed in the home: a falls prevention and management program to reduce the incidence of falls and the risk of injury."

Specifically, staff did not comply with the licensee’s “Falls Prevention” policy regarding “Falls Intervention Risk Management (FIRM) Implementation”, last revised September 2017, which was part of the licensee’s falls prevention program.

The “Falls Prevention” policy regarding “Falls Intervention Risk Management (FIRM) Implementation” last revised September 2017 included the following under post fall management:
- "If a fall is not witnessed or the resident had hit his/her head, the Head Injury Routine (HIR) will be initiated."

During the RQI an identified resident was observed by two inspectors to have a specific skin integrity concern.

During an interview an identified staff member told an inspector that this resident

had experienced a fall on a specific date.

During an interview an inspector observed the home's video recording for a specific time in a specific location with an identified staff member. During this interview specific details related to the fall were identified.

During an interview the Assistant Director of Care (ADOC) told an inspector that this identified resident had a fall on a specific date and sustained a specific injury. The ADOC said it was the expectation that the HIR was initiated and completed for the resident after this fall. The ADOC reviewed this resident's HIR and said that it was only completed 25 per cent of the times it was supposed to be completed. The ADOC said that the home's falls prevention policy was not complied with (523).

C) The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee was required to ensure that the policy was complied with.

Section 29 of the Long Term Care Homes Act, 2007 states "every licensee of a long-term care home shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with the Act and regulations."

In accordance with O. Reg. 79/10, s.109. the licensee was required to ensure that the home's written policy under section 29 of the Act dealt with:
- "(a) use of physical devices"
- "(e) how consent to the use of physical devices as set out in section 31 of the Act and the use of PASDs as set out in section 33 of the Act is to be obtained and documented"
- "(f) alternatives to the use of physical devices, including how these alternatives are planned, developed and implemented, using an interdisciplinary approach."

Specifically, staff did not comply with the licensee's "Least Restraint" policy regarding "PASD (Personal Assistance Devices) RRP-O-35" last revised January 16, 2018, which
was part of the licensee's minimizing of restraining program.

The licensee's "Least Restraint" policy regarding "PASD (Personal Assistance Devices) RRP-O-35", last revised January 16, 2018, included under the "Care

Plan" section the following:
-"1. The plan of care must reflect the goals for use of the PASD and how, when and why the device is to be used."
-"3. Intervention description will include how the PASD will be used, when, how long, who will apply and remove, frequency of monitoring and the specific risks associated (e.g. skin breakdown)."

During the RQI an inspector observed that identified residents were using specific devices and were not repositioned during an identified time period.

A clinical record review for these identified residents showed they used these devices as PASDs. A review of the plan of care showed it did not include the goals for use of the PASDs, how, when and why the devices were to be used, who would apply and remove and the frequency of monitoring or the specific risks.

During an interview the Assistant Director of Care (ADOC) reviewed the policy with an inspector and said that every resident with a PASD was to have those interventions and tasks in the plan of care. The ADOC said that the expectation would be for the staff to comply with the home's policy and have specific tasks and interventions related to the use of a PASD included in the care plan (523).

D) The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee was required to ensure that the policy was complied with.

In accordance with O. Reg. 79/10, s. 241 (5) the licensee was required to "establish a written policy and procedures for the management of resident trust accounts and the petty cash trust money."

Specifically, staff did not comply with the licensee's "Trust" policy regarding "Trust-Other Resident Expenditures FM-B-40" effective July 2014, which included:
- "invoices will be received at the front office either by mail or hand delivered. The receptionist will open the invoices to be paid out of trust and stamp the invoices with a date stamp and put in the Administrators box for initial to approve services."
- "Administrator will initial invoices and provide them to the bookkeeper responsible for the handing the Trust account or forwarding to the resident or responsible part for further payment."

The MOHLTC received a complaint which reported an identified resident had

concerns with the staffing levels in the home. During interviews this resident told inspectors that they had concerns that there were not enough staff available to help them with a specific task related to their trust account with the home.

During an interview the Bookkeeper reviewed the policy with an inspector and said that the policy of the home was not complied with. Bookkeeper said that a specific task for this identified resident was not completed as per the policy (523).

E) The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee was required to ensure that the policy was complied with.

The licensee has failed to comply with compliance order #004 from inspection 2017_607523_0021 (A1) served on February 6, 2018 (A1), with a compliance date of October 31, 2017.

The licensee was ordered to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with specifically but not limited to: Medication and Treatment Administration Record.

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

Specifically, staff did not comply with the policy "SmartMeds Pharmacy Medication Administration Policy 3-7" last updated March 2016. This policy stated the resident's identity was to be checked before giving the medication and to remain with the resident until the medication was taken. The registered staff member would then initial the Medication Administration Record to indicate that the medication had been given.

Specifically, staff also did not comply with the "Sharon Village Care Homes (SVCH) Administration of Medications NAM-F-05" policy last reviewed September 2017. The policy stated the registered staff responsible for the administration of medication was accountable and was to provide appropriate documentation.

i) During the RQI an inspector observed two identified staff completing the medication administration in a specific area. One staff member was observed

taking medication from the drawer for an identified resident, checked the medication against the electronic Medication Administration Record (eMAR) in the electronic documentation system, administered the medication in the dining room and came back and signed on the eMAR that the medications were administered. The one staff member administered medications to an identified resident and signed the eMAR under another staff member's electronic signature.

During an interview an identified staff member said they did not use their own electronic signature for the medications administered. Both identified staff members acknowledged that the signature would be of the nurse who prepared and administered the medications and registered staff should be logged in under their own name.

ii) On a specific date and identified resident was given a specific liquid medication glass instead of water with the administration of their other medications. When the resident identified a "terrible" taste, the registered staff acknowledged the error. This resident had received another resident's medication instead of water.

During an interview the Interim Director of Care (IDOC) and Assistant Director or Care (ADOC) stated that an identified staff member was assisting another staff member with the medication administration on that shift. The IDOC stated that the one staff member had passed a glass of the medication instead of water to other staff member to give with an identified resident's other medications. The IDOC stated that the one staff member poured the resident's medications and the other staff member administered them.

iii) During an interview the Administrator stated that according to documentation there was an incident when an identified staff member did not administer the injections that they had documented they had given as another identified staff member had administered the medication.

During an interview an identified staff member stated the process in the home was to have two registered staff witness the draw up into the syringe, the waste and the administration of narcotics or controlled substances and that did not happen on a specific date. This staff member said they signed the eMAR for both injections, but a different staff member administered an identified resident's in the resident's room alone.

The Administrator told an inspector that the "Subcutaneous Administration of

Controlled Substances" policy did not have an index number or revised date because it was in draft. The Administrator said the practice had been put in place in January 2018.

The "SVCH Subcutaneous Administration of Controlled Substance" policy with a proposed effective date of January 2018, stated "all controlled substances administered via injection will be drawn up, counted and administered as follows: 1) Two registered staff will be present for the drawing up of the controlled substance. 2) Both registered staff will document on the controlled count their name, indicating that they both confirm the amount drawn up via needle for injection. 3) Both registered staff will be present with administration of the controlled substance to the resident. 4) Disposal of the injection needle will continue as per best practice guidelines."

The "SmartMeds Pharmacy Narcotic and Controlled Drug Count & Ward Count Policy 6-6" last updated April 2016, stated "when a narcotic medication was administered, the nurse must document the following information on the form: date, time, quantity administered, quantity remaining and the nurse’s initials."

During an interview the Administrator stated that the SVCH Administration of Medications policy with index NAM-F-05 was the policy that provided the responsibilities of the registered staff for the administration of medications and the appropriate documentation. The Administrator shared that the registered staff were not to administer and document the administration of medications under any other registered staff member’s electronic signature in PCC.

The licensee failed to ensure that the "SmartMeds Pharmacy Medication Administration 3-7" policy, the "SVCH Administration of Medications NAM-F-05" policy, the "SmartMeds Pharmacy Narcotic and Controlled Drug Count & Ward Count 6-6" policy, and the "SVCH Subcutaneous Administration of Controlled Substance" policy were complied with (523).

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

Specifically, the staff did not comply with the "SmartMeds Pharmacy Narcotic and Controlled Drug Count & Ward Count 6-6" policy last updated April 2016. This

policy stated when a medication was administered, the nurse must document the following information on the form: date, time, quantity administered, quantity remaining, and the nurse's initials. The policy also stated that to maintain an accurate record of the physical counts, both nurses were required to verify the medications on hand against the Narcotic Ward Drug Count form and that both nurses must be physically present during the entire count.

i) The home submitted a CIS report to the MOHLTC which documented a missing controlled substance for an identified resident. It stated that at shift change there was a missing dose of a specific medication from the medication card in the medication narcotic bin.

A review of the "Resident's Narcotic/Controlled Drug Count/Ward Count" for this identified resident documented showed specific counts on specific dates with a missing dose showing in the count.

During an interview an identified staff member shared that when they looked ahead on the ward count they noticed that the numbers were off on a specific shift on the count sheet.

During an interview the Interim Director of Care (IDOC) stated a medication incident report was received where the medication count for this resident went down by three tablets on the day shift rather than by two tablets. The IDOC stated the order was for one tablet three times a day, therefore one tablet was missing. The IDOC said they investigated this incident and found that an identified staff member had pre-signed the ward count sheets before the count. The IDOC stated that the expectation related to the documentation of controlled substances was to document on the resident's count sheet at the time of the administration and then document on the ward count at the time of the count with two registered staff present.

ii) The home submitted a CIS report to the MOHLTC which documented a missing controlled substance. The report showed that a specific number of a specific medication were reported unaccounted from the stat box and the narcotic medication was not added to the narcotic ward count for tracking purposes.

During an interview the Assistant Director of Care (ADOC), visited each medication room to review the "Narcotic /Controlled Ward Drug Count" sheets in place on each home care area at the time of the inspection. It was identified that the narcotic

ward count sheets were not completed as per the home's policy.

iii) The home submitted a CIS report to the MOHLTC which documented a missing controlled substance. The Narcotic/Controlled Ward Drug Count for this date had missing registered staff signatures on the narcotic ward count form.

During an interview the ADOC and IDOC acknowledged that there were missing registered staff signatures on the narcotic ward count for a specific time period for the stat narcotic box. The ADOC also acknowledged that the Narcotic/Controlled Ward Drug Count for a specific time period was missing the count for an entire area of the home for the floor ward count and stat box count.

The licensee failed to ensure that the "SmartMeds Pharmacy Narcotic and Controlled Drug Count & Ward Count 6-6" policy was complied with.

G) The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee was required to ensure that the policy was complied with.

Ontario Regulation 79/10 s. 48 (1) states "Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable."

Specifically, staff did not comply with the policy "Bowel and Bladder Continence Care Program Implementation CP-K-20" last revised September 2017. The home's policy stated the Personal Support Workers (PSWs) would notify registered staff if the resident had not had a bowel movement in more than forty-eight (48) hours and that registered staff were to review their Resident Home Area bowel/bladder records.

A complaint intake was logged with the Ministry of Health and Long-Term Care (MOHLTC) in regards to the care for an identified resident. The complainant expressed concerns related to the care provided in the home to treat a certain condition and the staff's response regarding the bowel protocol.

The clinical record for this identified resident showed that the staff had documented that the resident had not had a bowel movement for an identified period of time.

During an interview a staff member told an inspector that bowel movements were recorded in Point of Care (POC) and a laxative list was received daily from the night report that had the resident names on it. The staff member said that that the Personal Support Workers (PSWs) would write on the list and chart on POC when residents had a BM. The staff member explained it was the role of the PSW to document on POC and on the laxative list and communicate to the nurse.

During an interview the Assistant Director of Care (ADOC) stated the registered nursing staff would know if a resident was to receive bowel management on their shift by checking the "Look Back Report" at the beginning of their shift on days and evenings and would follow the bowel protocol and then would follow up with the oncoming shift. The RN on nights would also prepare a bowel list for all the floors used the Look Back Report to create this list. The ADOC stated that the residents' bowel movements (BM) were documented in POC by the PSWs. The ADOC stated the expectation related to reporting bowel movements involved the PSWs reporting to the RPN or RN after changing the residents' briefs or the resident would report it when asked; for those residents who were independent they could also tell the nurses. The ADOC verified that the "Look Back Report" was generated from POC documentation and the clinical dashboard had alerts from POC for BMs and it was the expectation that the RN on nights and the RPNs on the day and evening shifts on all floors reviewed the report. An inspector and ADOC reviewed the home's "Bowel and Bladder Continence Care Program Implementation" policy and the ADOC identified that it stated the PSWs would notify registered staff if the resident had not had a bowel movement in more than 48 hours. The ADOC said that PSWs were not reporting bowel movements that did not occur in 48 hours. The ADOC stated that the PSWs would not know if the resident had a bowel movement in the last 48 hours as some PSWs worked on different floors for different shifts and not always two days in a row taking care of the same resident, and the home had part time and casual PSWs also working on floors and sometimes with agency PSWs. The ADOC stated there was no "Resident Home Area bowel/bladder record". The ADOC said that the policy was revised September 2017, but did not reflect the practices in the home related to bowel movement monitoring and reporting by the PSWs and registered staff. The ADOC said the policy was not followed for this identified resident.

During an interview the Administrator stated all corporate policies were reviewed between January 2017 and September 2017 and policies identified as reviewed September 2017 meant the policy was reviewed and finalized corporately. The policy titled, "Bowel and Bladder Continence Care Program Implementation" was

reviewed with the Administrator where it stated PSWs would notify registered staff if the resident had not had a bowel movement in more than 48 hours. The Administrator said that this was not the prevailing practice related to monitoring and reporting by PSWs and that the PSWs did not have access to the information necessary to report if a resident had not had a bowel movement in more than 48 hours. The Administrator also verified that the "Resident Home Area bowel/bladder record" was not the prevailing practice related to monitoring of bowel movements by the registered staff; that the "Look Back Report" was the tool used for this purpose. As part of the "Continence Management Program Evaluation" completed January 15, 2018, it documented, "Policy has been updated. No other changes recommended at this time". The Administrator verified that the "Bowel and Bladder Continence Care Program Overview" was the policy referred to in the program evaluation related to the written description of the program including goals and objectives and the only policy reviewed as part of that evaluation. The Administrator said that the "Bowel and Bladder Continence Care Program Implementation" policy and the "Bowel and Bladder Continence Care Program Overview" policy was part of the Continence Care and Bowel Management program.

The licensee failed to ensure that the "Bowel and Bladder Continence Care Program Implementation CP-K-20" policy was complied with.

Based on these observations, interviews and record reviews the licensee has failed to ensure that multiple required policies that had been instituted in the home were complied with. [s. 8. (1) (b)]

Additional Required Actions:

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

(A2)The following order(s) have been amended:CO# 005

WN #6: 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 has failed to comply with compliance order #005 from inspection 2017_607523_0021 (A1) served on February 6, 2018 (A1), with a compliance date of February 15, 2018.

The licensee was ordered to ensure that the staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs.

The licensee has failed to comply with Director's order #001 amended on December 21, 2017, with a compliance date of February 15, 2018.

The licensee was ordered to do the following:

1) To bring in a consultant from an external company with extensive experience in managing or operating LTC homes to conduct a review and make

recommendations for improvement regarding the following:
a. The nursing program within the home to ensure it is organized to meet the assessed needs of the residents;
b. The program of personal support services for the home to ensure it is organized to meet the assessed needs of the residents;
c. The staffing plan within the home to ensure it meets the assessed needs of residents and is evaluated and updated as necessary.

2) Upon completion of the review the findings and recommendations will be set out in a report which will be provided by the consultant to both the licensee and the Director under the Act. This review and findings must be finalized no later than November 30th, 2017.

Within two weeks of receiving the report from the review, the licensee will submit a plan to the Director identifying the recommendations that will be implemented and the timelines for implementation. That plan will be reviewed by the Director and may be changed based on the Director's review of the report from the review and the plan submitted by the licensee. Upon approval of the plan by the Director, the licensee will implement the actions identified.

The licensee has failed to ensure the written staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs and that met the requirements set out in the Act and this Regulation.

A) The home submitted a CIS report to the MOHLTC related to an identified resident. The CIS stated that a staff member had reported that on a specific dates this resident had to wait identified amounts of time for a requested medication.

During an interview the identified resident told an inspector that they did remember having to wait for a requested medication. This resident stated that they thought that it was taking a little longer to get narcotic medications because they needed two nurses for a witness.

During interviews with identified staff members they said that at the time of the incident this resident had to wait an identified period of time for a requested medication. One staff member said they were short registered staff on that specific weekend and there were no other registered staff available to help at the time (563).

B) The home submitted a CIS report to the MOHLTC which was identified as an incident of staff to resident neglect on a specific date. The CIS report stated that the resident had told a staff member that they required a specific type of care and this care was not provided to the resident for an identified time period.

A written "Concern/Complaint Form" related to the incident, completed by a staff member stated that the resident had told the writer that they had asked for help but was told that the staff were not available at that time to assist. Another written "Complaint/Concern Form" completed by another staff member documented that the resident was found in a condition that required care.

The clinical record for this identified resident showed they required a specific level of assistance from staff with this care.

During an interview this identified resident told an inspector that they recalled the incident and that they had to go to bathroom really bad and they could not hold it so they soiled in their brief. This resident reported that they had to wait for staff to provide care that they required.

During interviews with identified staff members they reported that this resident required a specific level of care from staff. The staff members said that on that specific time the resident did not receive the care they requested at the time as they staff were providing care to other residents.

The “Daily Assignment Sheet” for that date showed that the home had no staff shortages that day.

Documentation provided by the home related to that incident showed that they had identified that the resident had not received the care they required “in a timely manner."
During an interview the Interim Director of Care (IDOC) stated that the outcome of the investigation had determined that the resident did not receive the care they required in a timely manner (524).

C) During the RQI an identified resident said that the home was always short staffed and that they had to wait long to get to the bathroom.

A review of the call bell log for a specific time from for this resident showed that the resident on several occasions waited over 5 minutes for staff to respond to the call

bell, including seven different occasions where the resident waited 10-15 minutes.

During the RQI an identified resident said that on occasion it took staff over ten minutes to respond to the call bell that they felt that was a long time if you were waiting for a specific type of care.

A review of the call bell log for a specific time from for this resident showed that the resident on several occasions waited over 5 minutes for staff to respond to the call bell, including seven different occasions where the resident waited 10-15 minutes.

During the RQI another identified resident said they felt the home still did not have enough staff to assist residents. This resident said that sometimes they waited over 20 minutes for staff to respond to call bell.

A review of the call bell log for a specific time from for this resident showed that the resident on several occasions waited over 5 minutes for staff to respond to the call bell, including seven different occasions where the resident waited 10-15 minutes and there was an occasion when they waited over 30 minutes.

During the RQI another identified resident said that sometimes it took staff 15 to 20 minutes to respond to the call bell.

A review of the call bell log for a specific time from for this resident showed that the resident on several occasions waited over 5 minutes for staff to respond to the call bell, including seven different occasions where the resident waited 10-15 minutes and there was an occasion when they waited over 20 minutes.

In an interview the Interim Director of Care (IDOC) told an inspector that the expectation was for the staff to respond to the residents' call bells in around five minutes (523).

D) During the RQI inspectors completed multiple observations and interviews which identified that the staffing mix was not consistent with the assessed care and safety needs of the residents.

i) Observations by an inspector during a specific time period found that identified residents in a specific location of the home did not receive the assistance they required during meal service. These observations also found that there were identified residents who were brought to the dining room two hours after the

established mealtime as they had not received the care they required to allow them to attend the meal prior to that time.

Observations by an inspector during another specific time period found that identified residents in a specific location of the home did not receive the assistance they required during meal service. These observations also found that there were identified residents who were brought to the dining room two hours after the established mealtime as they had not received the care they required to allow them to attend the meal prior to that time.

Observations by an inspector during another specific time period found that identified residents in a specific location of the home did not receive the assistance they required during meal service.

During interviews multiple identified staff told an inspector that they had difficulties providing all the care that residents required. The staff reported that management and recreation staff would help in the dining rooms at some meals and at other meals they did not have enough staff to assist all the residents who required assistance. Another staff member said that they were always short staff especially at mealtimes. The staff member said that one specific care area had the heaviest care needs in the home and they needed more staff especially during mealtimes and morning care. Another staff member told an inspector that they did not feel they had enough resources available to assist the residents in a specific area especially during the respiratory outbreak (630).

ii) Observations by an inspector during a specific time period found that identified residents in a specific location of the home did not receive the assistance they required with repositioning and toileting.

During an interview an identified staff member said that they were short on staff that day and were running late all morning. They were not able to complete tasks for residents like toileting and repositioning the resident.

During an interview with another identified staff member they said that when a resident had a specific device they would take off the device, reposition the resident and reapply device as needed. This would be completed every two hours (523).

iii) Observations by an inspector during a specific time period found that an

identified resident told a staff member that they needed a specific type of care. This resident was then observed waiting for an hour and 20 minutes before they received the required care.

iv) Observations by an inspector during another specific time period found that identified residents in a specific location of the home did not receive the assistance they required with repositioning and toileting.

During an interview with an identified staff member they reported that they worked short multiple times a week most times. On those days they were not able to complete resident's tasks assigned to them. This staff member said they were not able to complete repositioning every two hours or toileting routines and this had not improved.

v) During an interview an identified resident told an inspector that they were concerned that at times it took the staff a long time to answer their call bell. This resident said that at times they would ring the bell for assistance with toileting and the staff would not arrive in time to prevent incontinence.

Review of the "Call Bell Log" for this resident showed that on three specific occasions it took staff 25 minutes or more to cancel the call.

Observations by an inspector found that this identified resident was repositioned or toileted by staff by staff for an identified time period. During an interview this resident said they had not received the care they required and preferred on that shift.

vi) Observations by another inspector during another specific time period found that identified residents in a specific location of the home did not receive the assistance they required with repositioning and toileting. During these observations it was also found that identified residents did not receive the assistance during the meal service that they required.

During an interview with an identified staff member they reported that that they thought that they did not have enough help on the floor to provide the residents with the assistance they required. Another staff member reported that they had charted that on one of the identified residents had been repositioned but they had not provided this care.

E) During an interview the Administrator told inspectors that the home had hired an external consulting company in response to the Director's Order. The Administrator said that the home had written staffing plan which identified the staffing levels for each floor on each shift. The Administrator said that they had participated in a review and evaluation of the written staffing plan along with the peopleCare consultants and the Interim Director of Care (IDOC). The Administrator said that there was one vacant PSW line but otherwise all lines were filled in the home at the time of the interview. The Administrator said that one of the floors in the home had heavier care needs than the other floors at the time of the inspection. The Administrator said that the staffing levels identified in the plan were the same on each floor. When asked how they ensured that the required care was being provided to residents, the Administrator said that they reviewed it at "huddles" daily and would then take staff off other floors to assist or re-organize on a day to day basis. The Administrator said they also reviewed the outstanding documentation. The Administrator said that there had been no concerns brought forward by staff at huddles related to care not being provided. The Administrator said that the recreation staff had been assisting with meals on a regular basis. The Administrator said that this written staffing plan did not differentiate between staff who were on modified duties and those who were on regular duties and that they did have staff in the home who were on modified duties who were unable to assist with lifts and transfer.

The Administrator provided written records used in the home as part of the written staffing plan and the evaluation of the staffing plan. The "Annual Program Evaluation – Nursing Staffing Plan Reg 31 (2)" stated "Date of Evaluation: December 13, 2017." This document indicated that the evaluation was completed by the Administrator, identified consultants and the IDOC. Under "comments/recommendations" it stated "staffing adjustments discussed:" and this was blank. The record also stated "staffing adjustments started December 13, 2017" but did not indicate what the staffing adjustments were.

The home's "Staffing Levels" document showed the number of shifts and hours to be worked by the DOC, ADOC, RNs, RPNs and PSWs in the home per day and per week. This document did not identify which floor that shifts or hours were to be worked or distinguish between modified and non-modified staff.

During an interview the peopleCare Vice President of Clinical Services (VPCS) told inspectors that they started consulting with the home at the end of November 2017, with the expectation of working on the compliance action plan with the home. The

peopleCare VPCS said that they participated in the staffing program evaluation in December 2017, which included a review of the written staffing plan. The peopleCare VPCS said they had implemented changes to the orientation and education of staff, hired staff and were working with the union to move to straight rotations on the staffing schedule. The peopleCare VPCS said that the review of the written staffing plan was done as part of the peopleCare operational review. The peopleCare VPCS said that their recommendation had been to develop a contingency plan that was consistent and communicated, to follow the absenteeism policy and to fill all the leadership positions and had not made changes to the ultimate staffing plan. The peopleCare VPCS said that they thought that all of their recommendations had been implemented. The peopleCare VPCS said that they had not included PSWs on modified duties in their staffing plan and that they would have a shadow or be given other duties. The peopleCare VPCS said they had not been involved with staff who were on modified duties and were not aware of whether there were staff who were unable to assist with lifts or transfers. The peopleCare VPCS said that the staffing levels were the same on each floor and that there were differences between the floors as some floors required more assistance at meals. The peopleCare VPCS said that the Registered Nurse (RN) would go and help at specific meals or the recreation staff would help as well. The peopleCare VPCS said they were not aware of any concerns from staff regarding the level of care residents required on third floor.

During a follow-up interview the peopleCare VPCS told inspectors that they thought the staffing mix in the home met the needs of the residents. The peopleCare VPCS said that this opinion was based on the staffing mix that they had in their peopleCare homes and the funding that the home received. The peopleCare VPCS said they thought that the home was meeting the care needs of the residents on a shift by shift basis and that this was checked through reviewing the documentation of tasks completed. When asked how they ensured that the staffing plan provided for a mix that was consistent with residents' assessed care and safety needs, the peopleCare VPCS said that they looked to see that all shifts were filled and that the care was completed. The peopleCare VPCS said that they had identified that the documentation was not always being completed and they had been doing education with staff about completing documentation. The peopleCare VPCS said that they could not tell whether it was a documentation issue or that the care had not been done by looking at the tasks but said that if it was not documented then it was not done. The peopleCare VPCS said they personally had not done audits involving talking to residents about the care. The peopleCare VPCS said they would look at the RUG score and the aggressive behaviours as

well as how many mechanical lifts were required on a floor and that they had thought someone had done that during their operation review as they had not personally looked at those. The peopleCare VPCS said they had not moved staff around in the home on a permanent basis as they were often dealing with staff shortages and they based the staffing plan on keeping all the staff even on the floor. The peopleCare VPCS said that the main focus had been on making sure each floor had the staff that had been assigned to it on each shift.

The documentation of the summary of staff call-ins and replacements for a specified time period showed that there were 16 out of 36 calendar days when the home was short PSW hours (44 per cent). This ranged from 2.08 hours to 17.5 hours per day.

During an interview the Interim Director of Care (IDOC) and Assistant Director of Care (ADOC) told Inspectors that they had both been involved in reviewing the written staffing plan for the home in December 2017. The IDOC said that the recommendations from this review were to ensure that the vacant lines were filled, hire new staff, develop a contingency plan, and implement the attendance program and "staffing up." When asked how they ensured that the staffing plan provided for a mix that was consistent with residents' assessed care and safety needs, the IDOC said that when there were modified workers they tried to put them on separate floors, by auditing to ensure the care was completed and by doing rounds on the floors. The IDOC said that they did not review the Case Mix Index (CMI) scores as part of the staffing plan review to ensure that the level of care to identify if staff needed to be moved to another floor. The ADOC said that there were some floors where there were more resident requiring mechanical lifts for transfers and that they were pulling the float to that floor or that sometimes the registered staff were assisting with the transfers. The ADOC said that on a regular basis they were pulling staff from one floor to go to another and that the registered staff or management were assisting with care on the floor. The IDOC said that they did not make changes to the staffing plan based on the review and they had talked about having four PSWs per floor on days but that had not been implemented. The ADOC said that the staffing pattern in the home had not changed at any time when they were working in the home. The ADOC said that when it was regular staff working on the floor they had an easier time than if there was casual staff or agency staff and on those days they tended to get behind and the RPN or management was needed to help. When asked if the current staffing mix in the home met the needs of the residents the ADOC said it depended on the floor and the IDOC said that the proposed adjustments to the staffing plan had not occurred.

Based on these observations, interviews and record reviews the home's written staffing plan did not provide for a staffing mix that was consistent with residents' assessed care and safety needs. [s. 31. (3)]

Additional Required Actions:

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

DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #7: 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 a resident had fallen, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A) The home submitted a CIS report to the MOHLTC related to a fall with injury for

an identified resident.

During interviews with identified staff members they reported that this resident had a history of falls. One of the staff reported that it was the expectation in the home that when a resident had fallen the registered staff would complete an assessment and then document the assessment in a post-falls assessment in the electronic documentation system.

The clinical record for this resident showed that they had a specific number of falls in an identified time period. The record showed that there was not a completed "Post Fall Assessment" documented for each of the falls included in the progress notes.

During an interview with Interim Director of Care (IDOC) told an inspector that it was the expectation in the home that after a resident had fallen that a post fall assessment would be completed and documented using the "Post Falls Assessment" in the electronic documentation system. The IDOC said it was the expectation that all aspects of the assessment would be completed. The IDOC said that it was the expectation that the registered staff who responded to the fall would be the one to assess and document the assessment in PCC. The IDOC acknowledged that this identified resident did not have post fall assessments documented for all their falls in a specified time period.

Based on these interviews and clinical record review the staff in the home did not complete a post fall assessment using a clinically appropriate assessment instrument each time that this resident fell. The licensee has failed to ensure that when a resident had fallen, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

B) During the RQI an inspector observed that an identified resident was on the floor.

During interviews with multiple identified staff members it was reported that this identified resident had a history of falls. Staff reported that they thought the plan of care for this resident included interventions providing direction to staff related to what to do if a resident was found on the floor and that they thought that a post fall assessment was usually not required for this resident.

The clinical record for this resident showed that this resident had been identified to have a specific risk level for falls for specific reasons. The record documented multiple falls in a specific time period and there was not a completed "Post Fall Assessment" documented for each of the falls included in the progress notes. The plan of care for this resident did not provide individualized instructions to staff regarding when a post fall assessment was to be completed.

During an interview the Interim Director of Care (IDOC) told an inspector that it was the expectation in the home that after a resident had fallen that a post fall assessment would be completed and documented using the "Post Falls Assessment" in PCC. The IDOC said that according to the home's policy a fall was considered to be any unintentional change of position where the resident ended up on the floor ground or other lower level. When asked if there was a way to assess if the change of position was intentional or unintentional, the IDOC said that the same process should be completed regardless of whether it was intentional or unintentional. The IDOC said that the plan of care for this resident directed that staff were to complete a post fall assessment for falls. When asked how staff were to assess this resident if the resident was found on the floor to determine if it was to be considered a fall, the IDOC said that the plan of care directed that staff were to ask the resident. The IDOC said that they thought that registered staff would need to do an assessment each time that this resident was found on the floor.

The home's policy titled "Falls Intervention Risk Management (FIRM) – Implementation" with revised date January 16, 2018, included the following:
- Under definitions it stated "a fall can be defined as any unintentional change in position where the resident ends up on the floor, ground or other lower level."
- The policy did not include direction or staff on how to assess whether a change in position was "unintentional".
- Under "Post Fall Management" it stated "if a fall has occurred, the Registered Staff will complete a Post Fall Assessment. An accompanying progress note (on PCC) will also be completed unless initiated via a structured progress note built into the assessment."

The Assistant Director of Care (ADOC) told inspectors that it was the expectation in the home that the registered staff would complete an assessment of this resident each time the resident was found on the floor by the PSW staff. The ADOC said it was the expectation that the PSWs would notify the registered staff that they had found the resident on the floor.

Based on these interviews and clinical record review the registered staff in the home did not complete a post fall assessment each time that this identified resident was found on the floor. The plan of care directed staff to complete a post fall assessment with each fall. This resident's documented assessments showed that this resident had a cognitive impairment and was at risk for not being able to effectively communicate their needs. [s. 49. (2)]

Additional Required Actions:

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

(A2)The following order(s) have been amended:CO# 007

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).

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 has failed to comply with compliance order #002 from inspection 2017_607523_0033 served on January 4, 2018, with a compliance date of January 31, 2018.

The licensee was ordered to ensure that:
a) The matters referred to in Ontario Regulation 79/10 s. 53 (1) were developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
b) At least annually, the matters referred to in subsection (1) were evaluated and updated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.
c) A written record was kept relating to each evaluation under clause (b) that

included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The licensee completed step a) and b).
The licensee failed to complete step c) regarding the written record of the annual evaluation.

On April 4, 2018, a document titled "Annual Program Evaluation" and "Responsive Behaviour Program Evaluation" was provided to the inspectors. This document stated "Date of Evaluation: Started December 15, 2017" and did not document when this was completed. This written record identified that peopleCare Vice President Clinical Services (VPCS), identified staff members, the Director Therapeutic Recreation (DTR) and a peopleCare staff member completed the evaluation. This written record included the following documentation:
- No documentation under the column "changes made" or the date that changes were made.
- A statement within the column "recommendations" which stated "paper copies of policies available updated September 2017." This did not included a date that this change in policy was implemented.
- A statement within the column "recommendations" which stated "DOS charting to be added to the task POC." This did not include documentation of the changes that were made or a date that change was implemented.

The Administrator provided an updated document titled "Annual Program Evaluation" and "Responsive Behaviour Program Evaluation" to the inspectors. This document stated "Date of Evaluation: Started December 15, 2017" and did not include other documentation related to when this record was revised or completed. This written record identified that the peopleCare VPCS, identified staff members, the Director Therapeutic Recreation (DTR), and identified peopleCare staff had completed the evaluation. This written record included the following documentation:
- A statement within the column "recommendations" which stated "paper copies of policies available updated September 2017." This did not included a date that this change in policy was implemented.
- A statement within the column "recommendations" which stated "DOS charting to be added to the task POC." The document indicated this was "complete" but did not include the date that the change was implemented.

During an interview the peopleCare VPCS said they had lead the annual program evaluations in the home. The peopleCare VPCS said that this was a "running document" and did not know the exact date that it was updated and said that it was updated when something was completed. The peopleCare VPCS said that during the evaluations they did not have access to change the policies. The peopleCare VPCS said they had updated program evaluation records and had provided these to the Administrator.

During an interview the DTR told an inspector that although their name was listed on the program evaluation record they had not participated in the annual program evaluation for the home.

During an interview with an identified staff member they said that they had been involved in the annual program evaluation for the Responsive Behaviours Program in the home. This staff member said they had not been to a meeting on December 15, 2017, when all the people listed on the program record evaluation had been in attendance. This staff member said that the record of the evaluation did not include when the policy had been revised or implemented and could not recall when this has occurred. This staff member said that some of the things identified in the program evaluation had been implemented in the home but the dates for that implementation had not been documented on the record.

During a follow-up interview peopleCare VPCS said that the evaluation was started on December 15, 2017. PeopleCare VPCS said they thought they had updated the written record of the evaluation after they met on January 3, 2018. PeopleCare VPCS said that the written record of the evaluation did not show the date that the change in the DOS charting was implemented and they were not sure of the date when this occurred. PeopleCare VPCS said that there were changes to policies made in 2017 which were not reflected in the written documentation of the program evaluation as this had occurred before they had started working in the home.

Based on these interviews and record reviews the written record relating to the Responsive Behaviours annual evaluation dated December 15, 2017, did not accurately identify the names of persons who participated in the evaluation or the date that the evaluation was completed. This written record also did not include a summary of the changes made or the date the changes were implemented. [s. 53. (3) (c)]

2. A) The licensee has failed to ensure that, for each resident demonstrating

responsive behaviours, the behavioural triggers for the resident were identified; strategies were developed and implemented to respond to these behaviours; and actions were taken to respond to the needs of the resident, including reassessments and interventions.

During interviews with identified staff members they said that an identified resident had specific responsive behaviours. One staff member reported that staff would look in the plan of care and the Behavioural Supports Ontario (BSO) binder to know about residents' responsive behaviours including the triggers and interventions for those behaviours. One staff member looked in the plan of care for this resident during the interview and said it did not identify these responsive behaviours or the triggers or interventions for these behaviours. This staff member also said that there was no documentation to show that this resident's responsive behaviours had been assessed.

The clinical record showed this resident had specific responsive behaviours during a specific time period. There was no documented re-assessments related to behaviours were completed. The plan of care did not include the identification of triggers for responsive behaviours during care or include intervention related to these behaviours.

During an interview with BSO staff members in the home it was reported that they had not been involved with this resident and there were no referrals to the BSO team for this resident. The staff reported they did not know if this resident had been having responsive behaviours. The staff reported that there was nothing in the plan of care or the BSO binder for this resident related to responsive behaviours during care. Another BSO staff member said it was the expectation in the home that the registered staff working on the floors would complete assessments for residents not involved with BSO and then develop the plan of care for the responsive behaviours which would include triggers and interventions.

Based on these observations, interviews and clinical record review this resident was demonstrating responsive behaviours. The staff in the home did not identify the behavioural triggers for the resident, strategies were not developed and implemented to respond to these behaviours; and actions were not taken to respond to the needs of the resident, including reassessments and interventions (630).

B) The licensee has failed to ensure that, for each resident demonstrating

responsive behaviours, actions were taken to respond to the needs of the resident including implementing interventions and documenting the resident's responses to interventions.

During the RQI an inspector observed an identified resident having specific responsive behaviours on multiple occasions.

During interview with identified staff members they said that this resident had specific responsive behaviours. The staff reported that another identified resident tended to be a trigger for this resident's behaviours.

The clinical record for this resident showed that the resident was at risk for a specific type of incident related to responsive behaviours and had specific interventions included in the plan of care for these behaviours.

During an interview an identified BSO staff member reported that this resident was followed by the BSO team and had been assessed as having specific triggers for responsive behaviours. This team member said that the interventions in the plan of care had not been consistently implemented by staff. Another BSO team member said that the interventions that had been put in place for this resident had not been entirely effective.

Based on these observations, interviews and clinical record review this resident was demonstrating responsive behaviours which placed them at risk. Staff in the home had identified the behavioural triggers however actions were not consistently taken to respond to the needs of this resident, including the implementation of the interventions as identified in the plan of care, the development of different interventions when those interventions were not effective or the documentation of the resident's responses to the interventions. [s. 53. (4)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 009

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Nutrition Care and Hydration Programs included the development and implementation, in consultation with a Registered Dietitian who was a member of the staff of the home, of policies and procedures relating to nutrition care including a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.

The MOHLTC received a complaint related to multiple care concerns for an identified resident. During an interview a family member reported they were

concerned that this resident had poor intake.

During interviews with identified staff members they reported that there was a process in the home to record the amount of food and fluid that residents consumed in the electronic system. One staff member reported that that the PSWs were to report to the RPN if anyone did not eat or drink enough. The staff member said there was also a fluid report from PointClickCare (PCC) that they were supposed to run each shift but sometimes that did not happen. The staff member said they were to make a referral to the Registered Dietitian (RD) immediately when a resident's food or fluid intake had declined. This staff member reported that there had been a decline in this identified resident's intake and there had not been a referral made to the RD.

During an interview the RD told an inspector that this identified resident had experienced a decline in their food and fluid intake at a specific time. The RD said that the process in the home for monitoring residents' food and fluid intake included the PSW recording the amount consumed in the electronic system at the end of each meal and snack. The RD said that the registered nursing staff were to monitor the amount of fluid and food intake over the past three days and make a referral to the RD if there has been a fluid intake less than 1000 millilitres (mLs) over three consecutive days. The RD said they should have received a referral regarding this resident's intake on a specific date and did not receive a referral at that time. The RD reported that they were not consulted on the new policies and procedures in the home and did not have access to them at the time of the interview.

The clinical record for this resident documented their food and fluid intake and showed it was below the amount recommended in the plan of care for a specific time period. The record included a "Dietary Referral/Diet Order/Change Form 2015" for this resident on a specific date, which was after an inspector had spoken with staff about this resident.
During an interview the Administrator told an inspector that there was a process in the home for monitoring the food and fluid intake of residents. The Administrator said that the PSWs were responsible for recording the intake in the electronic system at specified times. The Administrator said they did not have a specific policy in the home related to the documentation of food and fluid intake but they had some general policies that were related. The Administrator said that residents' food and fluid intake were monitored on a quarterly basis. When asked if there was somewhere in a policy or procedure that show this was an expected practice

in the home, the Administrator said that there was no policy specifically dictating that they check the dashboard but it was the expectation that staff would monitor it daily and this was a practice not a policy. The Administrator said that they thought the RD was involved in the development of the policies in September 2017 and that they did have access to them through the computer.

The home's policy titled "DTY-001 Nutrition Care and Hydration Program" with "Revision Date" September 2017 stated that the Nutrition Care and Hydration Program included "ensuring systems are in place for accurate monitoring and documentation of individual resident's food and fluid intake in order to evaluate nutrition and hydration status as indicated in the nutrition plan of care." This policy did not include further detail or direction regarding the practices or procedures in the home for monitoring or evaluating food or fluid intake.

The home's policy titled "NAM-F-35 Electronic Documentation" with "Revised date" January 2018 did not include details or direction regarding the practices or procedures in the home for monitoring or evaluating food or fluid intake.

The home's policy titled "Encouraging Fluid Intake" with "Approval date" March 2017 stated that the Nutrition Care and Hydration Program included "registered staff or the physician identify residents who are at risk of dehydration or are showing signs/symptoms of dehydration inform the interdisciplinary care team and initiate "encourage fluids" measures." This policy did not include further detail or direction regarding the practices or procedures in the home for monitoring or evaluating food or fluid intake.

During a follow-up interview the Administrator said that based on their follow-up with staff the policy and procedure in the home for monitoring food and fluid intake was not fully implemented.

Based on these interviews and record reviews this identified resident was documented to be at nutritional risk and had a decline in their food and fluid intake and a weight loss during a specific time period. This resident's food and fluid intake had been documented in POC but was not monitored or evaluated through the use of the clinical dashboard in PCC or a system of reviewing the intake through a PCC report. This resident was not referred to or assessed by the RD regarding the decreased intake until after the inspector interviewed staff. The RD reported that they were not consulted on the new policies and procedures in the home and did not have access to them at the time of the inspection. The policies and procedures

provide during the inspection did not provide direction for staff regarding the system in place to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration. [s. 68. (2) (d)]

Additional Required Actions:

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

(A2)The following order(s) have been amended:CO# 010

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:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home had a dining and snack service

that included food and fluids being served at a temperature that was both safe and palatable to the residents.

During the Resident Quality Inspection (RQI), random residents were interviewed and shared the following comments regarding food temperatures:
- Meal is served cool.
- They start from the last table and it takes a long time to serve. Food is colder by the time I get served.
- Cold soup and food most of the time, not very often that we get it right.
- A little on the cool side for most meals.
- Have our big meal at lunch and it is not always hot enough.
- Sometimes food is cold.

The MOHLTC received a complaint which indicated a family member expressed concerns that food was often cold by the time it was delivered from the kitchen and that there were concerns with the temperature of the food and meals.

The Residents' Food Committee Meeting Minutes for February 13 and March 13, 2018, documented that residents expressed concerns with the temperature of the food in the home. The minutes indicated a concern "Cold Food – Food not at proper temperature" and the "Actions" included ensuring a Personal Support Worker staff member would be in the dining room at 0800, 1200 and 1700 hours in order to start the meal service on time therefore the food was "not sitting there waiting to be served."

The home's "Food Service Temperature DTY-024" policy dated September 2017, included the following procedures:
-Dietary staff members in all servery areas were to take the temperatures of all hot food items as soon as they were placed in the steam tables and record these temperatures on a food "Temperatures Recording Chart" and initial the entries.
- Temperature of cold foods, especially perishable products such as milk and milk base desserts, were also taken, recorded and initialed. Hot foods were to be held at a minimum of 60 degrees Celsius (140 degrees Fahrenheit) and cold foods held in the refrigerator or a bed of ice to maintain a temperature of 4 degrees Celsius (40 degrees Fahrenheit).
- A random audit of hot food item temperatures at the end of the service period was conducted, once or twice weekly, to ensure that the service equipment was maintaining foods at a safe holding temperature throughout meal service and that the last residents to be served were receiving hot, palatable and safe foods.

During an interview an identified staff member told an inspector that they were not in the practice of doing random food temperatures but would occasionally check half way through the meal service. Another identified staff member said that they would only take the temperature of food items as soon as the pans were placed in the steam tables.

A review of the "Meal Service Daily Temperature Records" for December 4, 2017 to March 17, 2108, for the breakfast, dinner and supper meal service showed multiple meals when there were no recorded temperature of foods served. The records included the following incomplete documentation:
1) Brompton First Floor Servery had 39 out of 103 days (38 per cent) with at least one meal missing documented temperatures.
2) Chelsea Second Floor Servery had 36 out of 103 days (35 per cent) with at least one meal missing documented temperatures.
3) Highbury Third Floor Servery had 5 out of 103 days (five per cent) with at least one meal missing documented temperatures.
4) Windsor Fourth Floor Servery had eight out of 103 days (eight per cent) with at least one meal missing documented temperatures.

During an interview the Director of Food Services (DFS) told an inspector that dietary staff from all the servery areas would go to the kitchen prior to meal service and transfer the Cambro food carts to their designated floor and the place the food in the steam wells. The DFS said that once the food was placed into the steam wells then dietary staff were to take the temperatures and document on the temperature recording chart to verify the temperatures of the food served. The DFS acknowledged to an inspector that the food temperatures were not always taken by staff and was unable to verify the actual temperatures of the food served.

The licensee failed to ensure that the home had a dining and snack service that included food and fluids being served at a temperature that was both safe and palatable to the residents (524). [s. 73. (1) 6.]

2. The licensee has failed to ensure that the home had a dining and snack service that included providing residents with the personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

A) During the RQI an inspector observed that identified residents were not provided with the personal assistance and encouragement required to safely eat and drink

as comfortably and independently as possible during a specific meal. During this meal the following was observed:
- The posted breakfast mealtime was 0800 hours.
- There were only two identified staff members consistently in the main dining room during the meal from 0800 hours until 0900 hours.
- There was only one Personal Support Worker (PSW) consistently assisting in the dining rooms for the breakfast meal and was observed assisting residents in both the main dining room and the Harvest Dining room for the breakfast meal.
- At 0845 hours three staff arrived in the main dining room to assist residents.
- Two PSWs were not assisting in the dining room during the breakfast meal and were observed working together assisting residents in their rooms with morning care from 0800 hours until 0954 hours.
- One staff member was observed assisting three residents requiring total assistance and one resident requiring partial assistance at table two in the main dining room and no other staff were assisting at that table at the time.
- Another identified resident did not receive the assistance they required to eat their meal. The "eating" plan of care for this resident showed they needed a specific level of assistance and was not observed to have been provided that assistance.
- One identified resident was brought to the dining room almost two hours after the posted meal time and was served their meal 15 minutes after they arrived. This resident was observed to receive no assistance being provided with specific items. The "eating" plan of care for this resident stated they required a specific level of assistance with their meal and was not observed to have received that assistance (630).

B) During the RQI an inspector observed that identified residents were not provided with the personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible during another specific meal. During this meal the following was observed:
- An identified resident had their meal sitting in front of them without receiving assistance for eight minutes. The resident did not receive the assistance they required during the remained of the meal. The eating plan of care for this resident showed that the resident required a specific level of assistance for safety and this was observed not to have been provided.
- Another identified resident was not provided the assistance they required with their meal. The eating plan of care for this resident showed that the resident required a specific level of assistance and this was observed not to have been provided.

During an interview an identified staff member said that were eight residents that required total assistance with feeding and three to four that required cueing on the floor. This staff member said that there was not enough staff available to assist the residents with their meal, especially on the weekends (524).

C) During the RQI an inspector observed that identified residents were not provided with the personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible during another specific meal. During this meal the following was observed:
- At a specific time there was one PSW in the dining room assisting nine residents. Of these resident one required total assistance and four were observed to require encouragement and physical cues.
- An identified resident's meal sat uncovered on the counter beside them from for ten minutes until the PSW placed it on their tray and provided cues to start eating. This resident was observed to not receive the assistance they required to eat their meal.

D) During the RQI an inspector observed that identified residents were not provided with the personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible during another specific meal. During this meal the following was observed:
- During the meal there were nine residents observed to require total assistance and eight residents observed to require verbal or physical cues during the meal. There were four PSWs in the dining room providing assistance to residents. Additional staff started providing assistance 39 minutes after the meal started and another staff member 49 minutes after the meal had started. There were residents observed to have not received the assistance they required during the meal.
- Two identified resident did not receive the assistance they required to eat their meal. The "eating" plan of care for these residents showed they needed a specific level of assistance and was not observed to have been provided that assistance.

During interviews multiple staff members told an inspector that there were between ten to twelve residents on this floor who required staff assistance or encouragement with their meals. Staff reported it was difficult to provide the residents with their required assistance especially when there was not extra assistance from the Registered Nurse or management in the dining room.

During an interview the Interim Director of Care (IDOC) told an inspector that it was the expectation in the home that residents would be provided with the

encouragement and assistance that they require. The IDOC said that staff would know the level of assistance required by the Kardex and Point of Care (POC) in PCC. The IDOC said that on a specific floor there were several residents that required assistance with eating and that extra hands were required in that area at meals. The IDOC said that there were probably times when the extra assistance was not available. The IDOC said that staff had expressed concerns about the level of care and the ability to provide that care at mealtimes (630).

E) The MOHLTC received a complaint related to multiple care concerns for an identified resident. During an interview a family member reported concerns about the level of assistance provided to this resident at meals.

During a specific meal this resident was observed to have been sleeping through the meal and staff reported that the resident had refused the meal.

During a specific snack time this resident was observed to be sleeping and the staff left a beverage at the bedside of the resident and no encouragement or cues were provided with the fluid for a specific time period and the resident did not consume any of the beverage provided.

During interviews with identified staff member they said that they thought this resident required a specific level of assistance with meals. One staff member said that this resident required time and special attention from staff to support their intake.

The clinical record for this resident showed that they required a specific level of assistance at meals.

The licensee has failed to ensure that the home had a dining and snack service that included providing residents with the personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible (630). [s. 73. (1) 9.]

Additional Required Actions:

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

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

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

s. 101. (3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and O. Reg. 79/10, s. 101 (3).
(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record was kept in the home related to a written complaint that included: 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; the final resolution; and every date on which any response was provided to the complainant and a description of the response.

The MOHLTC received a complaint from a family member regarding concerns with staffing levels, recreation services and dining services in the home. During an interview the family member told an inspector that they still had concerns with the staffing levels and the meals served in the home. This family member said they had provided a written letter of complaint to the licensee outlining their concerns.

During an interview the Interim Director of Care (IDOC) said that a family member had submitted a written complaint to the home. The IDOC said that they did have a care conference with the family related to this written letter of complaint. The IDOC said that after that care conference they submitted a Critical Incident System (CIS) report to the MOHLTC and completed an investigation. The IDOC provided a copy of a "Response to Complaints – Complaint Record Form" which included a written letter from family member addressed to the President/CEO of Sharon Village Care Homes (SVCH).

The written letter of complaint, which was received by the Administrator on a specific date, included documentation of specific concerns.

The "Response to Complaints – Complaint Record Form" provided to the inspector by the Administrator did not include documentation related to resolution of the complaint.
During an interview the Administrator said that it was the expectation in the home that when they received a written complaint they would document using the "Response to Complaints – Complaint Record Form." The Administrator said that they had been forwarded a letter that the family member for an identified resident had sent to President/CEO of SVCH a couple days later. The Administrator said that they contacted the family to set-up a care conference to address the concerns. The Administrator acknowledged that the "Response to Complaints – Complaint Record Form" did not document the resolution to all the concerns and said they thought it had been documented in the care conference note and acknowledged that this had not occurred.

Based on these interviews and record review, the documented record that was kept in the home related to the written complaint did not include the required information. [s. 101. (2)]

2. The licensee has failed to ensure that the documented record of complaints was reviewed and analyzed for trends at least quarterly; the results of the review and

analysis were taken into account in determining what improvements were required in the home; a written record was kept of each review; and of the improvements made in response.
During an interview the Administrator said that in March 2018 they implemented a new process to review the documented record of complaints in the home. The Administrator said that prior to March 2018 all they were doing on a quarterly basis was reviewing the number of complaints and were not analyzing the trends. The Administrator said that they did not keep a written record of each review and the improvements made in response. [s. 101. (3)]

Additional Required Actions:

CO # - 012 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 012

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Findings/Faits saillants :

1. The licensee has failed to 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 was a member of the staff of the home, met annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. Where the pharmacy service provider was a corporation, the licensee shall ensure that a pharmacist from the pharmacy service provider participated in the annual evaluation. The annual evaluation of the medication management system must have included a review of the quarterly

evaluations in the previous year, have been undertaken using an assessment instrument designed specifically for this purpose; and identified changes to improve the system in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

The Annual Medication Program Evaluation dated January 29, 2018, documented that the peopleCare Vice President of Clinical Services (VPCS), Interim Director of Care (IDOC), Assistant Director of Care (ADOC), Consultant Pharmacist, and Medical Director completed the evaluation.

During an interview the Consultant Pharmacist (CP) stated there was an annual evaluation of the medication management system on December 1, 2017, just before the former Director of Care (DOC) left. The Pharmacist also verified that they were not involved in the completion of an evaluation in January 2018 where the Medical Director was present and verified that they were not asked to provide input for the Medication Program Evaluation with a start date of January 29, 2018. The CP stated a review of the quarterly evaluations in the previous year were not reviewed as part of this December 2017 annual medication program evaluation.

During an interview the Registered Dietitian (RD) shared that there was no invitation extended to attend the Medication Program Evaluation and the RD acknowledged that they should have attended and had not met annually to evaluate the effectiveness of the medication management system in the home for the entire four years the home has been opened and the RD has been working here.

During an interview the IDOC verified that the Annual Program Evaluation for the Medication Program was on January 29, 2018. The IDOC verified that the Consultant Pharmacist, the Registered Dietitian and the Medical Director were not present at the January 29, 2018 medication program evaluation. The Administrator stated they attended the annual medication program evaluation briefly for portion of it and verified that their name was not documented as attended on January 29, 2018. The Administrator and the IDOC verified that there was not a review of the quarterly evaluations in the previous year as part of the annual program evaluation for medications dated January 29, 2018.

The Annual Medication Program Evaluation dated January 29, 2018 did not include a review of the quarterly evaluations in the previous year.

During an interview the peopleCare VPCS acknowledged that the Pharmacist, the Medical Director, the RD, and the Administrator were absent from the meeting related to the medication program evaluation. The peopleCare VPCS also verified that the quarterly evaluations in the previous year were not reviewed as part of the annual evaluation.

The licensee failed to ensure the Medical Director, Administrator, pharmacy service provider and a RD who was a member of the staff of the home met annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. The quarterly evaluations in the previous year were not reviewed as part of the annual medication program evaluation. [s. 116.]

Additional Required Actions:

CO # - 013 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 013

WN #13: 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 has failed ensure that steps were taken to ensure the security of the drug supply; a monthly audit was not undertaken of the daily count sheets of controlled substances to determine if there were any discrepancies and that immediate action was taken if any discrepancies were discovered.

During an interview the Assistant Director of Care, Interim Director of Care, and Consultant Pharmacist stated that an audit of the daily narcotic count sheets was not being completed monthly.

There was no documented evidence that a monthly audit of the daily count sheets of controlled substances was being completed in the home.

The licensee failed ensure that a monthly audit was not undertaken of the daily count sheets of controlled substances to determine if there were any discrepancies. [s. 130. 3.]

Additional Required Actions:

CO # - 014 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #14: 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. (3) Subject to subsections (4) and (5), the licensee shall ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse. O. Reg. 79/10, s. 131 (3).

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.

The Medication Incident Reports from December 2017 and January 2018 were reviewed as a part of the most recent quarterly review on March 8, 2018. The following medication incidents occurred where residents were administered a medication that had not been prescribed for them:

A) On a specific date an identified resident was given a specific medication instead of the medication that was prescribed for them. The Interim Director of Care (IDOC) verified that this resident was administered this medication and did not have a prescription for this. The IDOC stated that this resident had received

another resident's medication.

The physician's orders for this identified resident did not include a prescription for this medication.

B) On a specific date an identified resident was given a specific liquid instead of water with the administration of their other medications as this resident received another resident's medication instead of water. The IDOC and ADOC verified that this resident was administered the medication and that the resident did not have a prescription for this medication.

The physician's orders for this identified resident did not include a prescription for this medication.

C) On a specific date an identified resident received a different medication than the medication that they were prescribed. The physician on call was notified and the registered staff were to "resume the right medication with the right dose". The IDOC verified that this resident received the wrong medication.

The physician's orders for this identified resident did not include a prescription for this medication.

The SVCH "Administration of Medications policy NAM-F-05" last reviewed September 2017, stated medications were to be administered only after the nine rights had been checked by the registered staff: right resident, right medication, right dose, right route, right site, right time, right reason, right frequency, and right documentation.

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 (563). [s. 131. (1)]

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

A) The Medication Incident Reports from December 2017 and January 2018 were reviewed as a part of the most recent quarterly review undertaken in the home on March 8, 2018. There were 15 specific medication incidents that occurred where the residents were not administered their medications in accordance with the

directions for use.
During an interview the Interim Director of Care (IDOC) verified the 15 specific incident involved resident that did not receive their medications according to the directions for use. The IDOC verified that there were multiple incidents where a specific medication was left on the resident. The IDOC also verified that there were multiple incidents where medications were signed as given, but the strip packages were still in the residents' bins in the medication cart.

The SmartMeds "Medication Administration Policy 3-7" last updated March 2016, stated once the medication was taken, initial the Medication Administration Record (MAR) sheet to indicate that the medication had been given.

The licensee failed to ensure that the medications prescribed to be administered were given to the residents in accordance with the directions for use specified by the prescriber (563).

B) A complaint was logged with the Ministry of Health and Long-Term Care (MOHLTC) related to an identified resident. During an interview the complainant expressed concerns about the medication administration for this resident.

During an observation at a specific time and inspector observed medications present at the bottom of a glass in this identified resident's room.

The electronic Medication Administration Record (eMAR) report for this resident for a specific time period documented specific medications for this resident with specific instructions. The "Medication Admin Audit Report" a specific date showed that the medications had been administered by an identified staff member at a specific time.

During an interview an identified staff member said there were medications at the bottom of the glass and that these were the medications for this resident.

During an interview with another identified it was reported that there were specific instructions related to the administration of medications for this resident. This staff member acknowledged that specific medications were not taken as prescribed.

The SVCH "Administration of Medications" policy with index: NAM-F-05 last revised September 2017, stated medication must not be left unattended for the resident to self-administer unless the resident performs self-administration.

The SmartMeds Medication Administration Policy 3-7 last updated March 2016, stated to remain with the resident until the medication was taken.

The licensee failed to ensure that this identified resident's medications were administered to the resident in accordance with the directions for use specified by the prescriber.

C) A complaint was logged with the Ministry of Health and Long Term Care (MOHLTC) related to the administration of medications for an identified resident.

The electronic Medication Administration Record (eMAR) documented a specific prescription for this identified resident. This record also documented that this prescription was not provided as ordered at specific times.

Review of the "Bowel and Bladder Continence Care Program Implementation CP-K-20" last revised September 2017 stated the "Personal Support Workers will notify registered staff if the resident has not had a bowel movement in more than forty-eight hours. Registered staff are to review their Resident Home Area bowel/bladder records and follow up daily and obtain and/or initiate appropriate interventions according to the physician's orders." The policy stated, "Each resident is supported to achieve an optimal level of bowel and bladder function as a significant component of improving quality of life and maintaining comfort and dignity."

During an interview the Assistant Director of Care (ADOC) stated the registered nursing staff would know if a resident was on a certain medication on their shift using the "Look Back Report" from the electronic documentation system. The ADOC said that the order for the specific medication was documented in a way that the registered nursing staff would not know that the medication was required for administration twice daily as needed. The ADOC acknowledged that the specific medication should have been increased to twice daily on specific dates based on the "Look Back Report".

D) The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) which documented a missing specific medication for an identified resident.

During an interview the Interim Director of Care (IDOC) stated a medication

incident report was received where the medication count for this identified resident went down by three tablets on the day shift rather than by two tablets. The IDOC stated the order was for one tablet three times a day at 0800, 1200 and 1700 hours, therefore one tablet was missing. The IDOC stated that in an interview with an identified staff member that the staff member said they thought they had not given the 1200 hour dose and gave it again at another time.

The Medication Incident Report dated for a specific time documented for a missing dose of for this medication where the staff member gave an extra dose at a specific time.

During an interview an identified staff member verified that this resident received an extra dose of this medication.

The physician's order documented that this resident was to take this medication at specific times.

The electronic Medication Administration Record (eMAR) for this resident for a specific time period was administered at specific times. The report documented that an identified staff member signed as administering the medication.

The licensee failed to ensure that this resident's medication was administered to the resident in accordance with the directions for use specified by the prescriber.

E) The home submitted a CIS report to the MOHLTC which documented an error in medication administration of a specific medication for an identified resident.

The Physicians Orders documented that this resident was to receive a specific medication at specific times.

During an interview an identified staff member said that they recalled the medication incident that occurred for this identified resident when they were given the wrong dose of the medication.

The licensee failed to ensure that this resident's medication was administered to the resident in accordance with the directions for use specified by the prescriber.

The licensee failed to ensure that no person administered a drug to a resident in the home unless that person was a physician, dentist, registered nurse or a

registered practical nurse. [s. 131. (2)]

3. A) The clinical record for an identified resident showed that at a specific time an identified staff member delegated another staff member to give the medications to the resident.

During an interview the Interim Director of Care (IDOC) verified that this identified staff member should not have delegated a Personal Support Worker (PSW) staff to administer medications to this resident, and that only registered nursing staff were to administer medications to residents.

During an interview an identified staff member stated that they gave the medications to a PSW to administer the medications to this resident.

B) During the RQI an identified staff member was observed by an inspector to add a specific medication into an identified resident's beverage and the left it on the table.

Another identified staff member was observed feeding the beverage with the medication to the resident.

During an interview and identified staff member said that they had fed the beverage with the medication to this resident. This staff member verified that PSWs in the home did administer medications if the residents would not take the medications from the registered staff; the registered staff would then give it to the PSWs to administer during a meal to ensure it was taken.

During an interview and identified staff member verified that a specific medication was added to this resident's beverage and the PSW administered it. This staff member acknowledged that PSWs were not to administer medications.

The SVCH "Administration of Medications policy NAM-F-05" last reviewed September 2017 stated "all medications shall be administered by a registered health care professional when prescribed by a physician or designated alternative and the medication administration process shall comply with all applicable legislation, regulations, professional standards and corporate/pharmacy policies to ensure safe, effective and ethical administration of medications."

The licensee failed to ensure that Personal Support Workers were not

administering a drug to a resident in the home unless that person was a registered nurse or a registered practical nurse. [s. 131. (3)]

Additional Required Actions:

CO # - 015, 016, 017 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #15: 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. (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).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

During an interview the Interim Director of Care (IDOC) and an inspector reviewed the original copies of the Medication Incident Reports (MIR) for December 2017 and January 2018. The IDOC verified that there were five specific notifications related to the medication incidents. The IDOC said that for three of the incidents they were not notified and for two of the incidents the pharmacy was not notified.

During an interview the Pharmacy Manager stated that four specific medication incident reports were not reported to the pharmacy service provider.

The SmartMeds "Pharmacy Medication Incident Report Policy 9-1" last reviewed April 2016, stated when a medication incident occurred, it was recorded on the Medication Incident Report form and communicated to the proper authorities "(e.g. Head Nurse/DOC/ADOC, Physician, Pharmacy)."

The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the Director of Care and the pharmacy service provider (563). [s. 135.]

2. The licensee has failed to ensure that all medication incidents and adverse drug reactions were documented, reviewed and analyzed; corrective action was taken as necessary; and a written record was kept of everything identified.

During an interview the Interim Director of Care (IDOC) and an inspector reviewed the original copies of the Medication Incident Reports (MIR) to for December 2017 and January 2018. The IDOC verified the following notification related to the following medication incidents:
- One specific MIR did not identify the registered staff member involved and the IDOC stated that they did not know the staff involved. The IDOC stated their signature was absent from the MIR and there was no documentation that the IDOC had reviewed and analyzed the incident. The IDOC stated corrective action was necessary, but that corrective action to prevent recurrence was not completed with the employee involved.

- Another specific MIR the IDOC stated that they could not verify if the MIR was reviewed and analyzed, and could not verify if corrective action was taken since there was nothing documented.
- Another specific MIR did not identify the registered staff member involved and the stated it was an agency person. The IDOC stated corrective action was necessary, but that there was no follow up with the agency staff member and corrective action to prevent recurrence was not completed. The IDOC also stated that the agency manager was not contacted.
- Another specific MIR the IDOC stated that they did not follow up with corrective action with the agency staff member involved in the incident. The Assistant Director of Care (ADOC) verified there was no documented record of corrective action.
- Another specific MIR the IDOC stated that they did not follow up with corrective action with the two registered staff involved in the incident and the ADOC verified that they did not take any action to prevent recurrence.

During an interview the Administrator verified that the home did not have their own medication incident policy. The SmartMed Pharmacy policy titled "Medication Incident Report Policy 9-1" last reviewed April 2016 was the only policy in use. The policy had an attached form called "Medication Incident Report" that required "actions taken to prevent re-occurrence" to be completed by the Director of Care or the Pharmacy Manager.

The licensee failed to ensure that all medication incidents and adverse drug reactions were documented, reviewed and analyzed; corrective action was taken as necessary; and a written record was kept of everything identified. [s. 135. (2)]

3. The licensee has failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; any changes and improvements identified in the review were implemented; and a written record was kept of everything identified.

During an interview the Administrator said that the Medication Incident Reports (MIR) were reviewed quarterly as part of the Quarterly Medication Safety Meeting on February 6, 2018, and then shared at the Professional Advisory Committee (PAC) meeting on March 8, 2018. The Administrator shared that the PAC meeting prior to March 8, 2018, was attended on December 7, 2017 and only documented an incident involving specific missing medication and there were no other

medication incidents reviewed in detail at that time. The Administrator also stated that the PAC meeting dated September 7, 2017, did not review the medication incidents that occurred between June and August 2017.

During an interview the Interim Director of Care (IDOC) stated that the Quarterly Medication Safety Meeting dated February 6, 2018 was discussed at the PAC meeting dated March 8, 2018. The IDOC stated that the quarterly review for the March 8, 2018 PAC meeting was for those medication incidents that occurred in December 2017 and January 2018 only.

The PAC meeting dated September 7, 2017, had no documentation that a quarterly review was undertaken of all medication incidents and adverse drug reactions that had occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions.

The PAC meeting dated December 7, 2017, had no documentation that a quarterly review was undertaken of all medication incidents and adverse drug reactions that had occurred in the home since the time of the last review on September 7, 2017, in order to reduce and prevent medication incidents and adverse drug reactions.

During an interview the peopleCare Vice President of Clinical Services (VPCS) shared that the primary goal for the Quarterly Medication Safety Meetings was to review the Medication Incident Reports (MIR) every quarter for every incident and to analyze them and follow-up with the registered staff as a group to discuss trends to make improvements. The peopleCare VPCS shared that the expectation was that the Quarterly Medication Safety Meeting dated February 6, 2018 was reviewed at the March 8, 2018, PAC meeting.

As part of the Quarterly Medication Safety Meetings, a list of medication incidents were documented for December 2017 and January 2018. Three specific medication incidents were reviewed by an inspector and the Administrator and the Administrator stated that the medication incident involving these specific residents should have been a part of the quarterly review and were not.

The licensee has failed to ensure that a quarterly review was undertaken of all medication incidents at the PAC meeting on December 7, 2017, that have occurred in the home since the time of the last review on September 7, 2017, in order to reduce and prevent medication incidents and adverse drug reactions. [s. 135. (3)]

Additional Required Actions:

CO # - 018 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that on every shift the symptoms indicating the presence of infection were recorded and immediate action was taken as required.

During the entrance conference for the Resident Quality Inspection (RQI) an identified staff member reported that the home had a respiratory infection outbreak on a specific floor.

The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) which identified that they had a "disease outbreak" and was classified as an Acute Respiratory Illness (ARI).

A) During an interview an identified staff member reported to an inspector that a specific resident had been one of the residents in isolation related to the outbreak.

The "Respiratory Line Listing" provided to the inspector on a specific date by an identified staff member showed that this identified resident had symptom onset on a specific date and there were no symptoms listed on this form.

During an interview and identified staff member said that the documentation for symptoms of infection was done by the staff as a health status note in the electronic documentation system. This staff member said they also used a paper "Respiratory Monitoring Sheet" on each shift but the sheets from last week could not be located and they had to start a new sheet. This staff member said they also used the "Respiratory Line Listing" to track symptoms and identify residents on isolation but this was not where the shift to shift documentation was completed. This staff member acknowledged that the line listing did not include the symptoms that this resident was showing.

During an interview the Assistant Director of Care (ADOC) said that it was the expectation in the home that staff would be documenting in the electronic documentation system the symptoms of infection on every shift. The ADOC said this would include the vital signs, the resident's condition, any signs or symptoms of infection, use of antibiotic, food and fluid intake and any lethargy or tiredness. The ADOC said that the monitoring sheets were also expected to be done on each shift and that the ones for a specific time period could not be located.

The inspector reviewed the electronic documentation for this identified resident with the ADOC and they acknowledged that the documentation did not include respiratory assessment and documentation of symptoms on every shift since the onset of the symptoms.

During an interview the Interim Director of Care (IDOC) told an inspector that it was the expectation in the home that staff would be documenting a progress note on each shift assessing and documenting the symptoms of infection for residents affected by the outbreak. The IDOC said they would expect vitals to be assessed and documented as well as an assessment of their respiratory symptoms and talking to resident to see how they were feeling. The IDOC said they would expect that to be documented in a progress note.

B) During an interview with an identified staff member they told an inspector that another identified resident was one of the residents in isolation related to respiratory symptoms. This staff member said were confused as they were told that this resident was not under outbreak just respiratory isolation for some residents.

The "Respiratory Line Listing" provided to the inspector on a specific date by an

identified staff member showed that this identified resident had symptom onset on a specific date and there was one symptom listed on this form.

During an interview an identified staff member said that this resident was considered to be one of the cases of the outbreak.

During an interview with identified staff members they reported that they had observed this resident with more than one symptom related to the respiratory outbreak.
The clinical record for this identified resident did not include documentation of all symptoms on each shift.

During an interview the Interim Director of Care (IDOC) told an inspector that it was the expectation in the home that staff would be documenting a progress note on each shift assessing and documenting the symptoms of infection for residents affected by the outbreak. The IDOC said that this identified resident was considered to be a potential case for the outbreak and it was the expectation that staff would be assessing and documenting the symptoms on every shift.

C) During an interview a family member for an identified resident expressed concerns related to the care their family member had received related to the respiratory outbreak in the home.

The "Respiratory Line Listing" provided to the inspector on a specific date by an identified staff member showed that this identified resident had symptom onset on a specific date and there was one symptom listed on this form.

During an interview with an identified staff member they reported that this specific resident had one symptom starting on a specific date. This staff member said they were not sure if this resident was still in isolation at the time of the interview as it was not clear from the documentation.

The clinical record for this identified resident did not include documentation of their symptoms on each shift.

During an interview the IDOC said that this resident was identified as a potential case for the outbreak on a specific date and it was the expectation that staff would be assessing and documenting the symptoms on every shift. The IDOC acknowledged that the symptoms for this resident were not documented on each

shift and that the symptoms for this resident listed in the progress notes in PCC did not correspond to those on the line listing.

D) During an interview an identified staff member told an inspector that another identified resident was one of the residents in isolation related to respiratory symptoms.
The "Respiratory Line Listing" provided to the inspector on a specific date by an identified staff member showed that this identified resident had symptom onset on a specific date and there were two symptom listed on this form.

During an interview the Assistant Director of Care (ADOC) said that the expectation in the home was that staff would be documenting in the electronic documentation system the symptoms of infection on every shift.

The clinical record for this identified resident did not include documentation of their symptoms on each shift.

During an interview the Interim Director of Care (IDOC) told an inspector that it was the expectation in the home that staff would be documenting a progress note on each shift assessing and documenting the symptoms of infection for residents affected by the outbreak. The ADOC said that this resident was identified as a potential case for the outbreak and it was the expectation that staff would be assessing and documenting the symptoms on every shift.

E) During an interview an identified resident told an inspector that they were feeling unwell as they had specific symptoms.

During an interview two identified staff members said that they did not think that this identified resident was in isolation. One of the PSWs said they had found that this resident was displaying a specific symptom and had told the nurse.

During an interview with another identified staff member they told an inspector that this resident had been started on isolation at a specific time due to specific symptoms. This staff member reviewed the progress notes in the electronic documentation system and acknowledged that there had been symptoms documented during a specific shift and these were not monitored or assessments documented during subsequent shifts. This staff member said that the resident should have been in isolation earlier than this was started.

The clinical record for this identified resident did not include documentation of their symptoms on each shift.

During an interview the IDOC told an inspector that it was the expectation in the home that staff would be documenting a progress note on each shift assessing and documenting the symptoms of infection for residents affected by the outbreak. The IDOC said that this resident was added to the "Respiratory Line Listing" on a specific date and it was the expectation that symptoms documented on a specific date would have been followed through on at the following shifts and staff would have assessed and documented any symptoms of infection on every shift.

Based on these observations, interviews and record reviews the staff in the home did not record the symptoms indicating the presence of infection on every shift and did not take immediate action to respond to the presence of infection in each resident during the respiratory outbreak in March 2018. [s. 229. (5) (b)]

Additional Required Actions:

CO # - 019 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must 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. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with compliance order #001 from inspection 2017_607523_0033 served on January 4, 2018, with a compliance date of January 31, 2018.
The licensee was ordered to ensure that a written record was kept relating to each evaluation under s. 30 (1) paragraph 3 that included the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The licensee has failed to ensure that each of the organized programs required under section 8 to 16 of the Act and each interdisciplinary program required under section 48 of the regulation was evaluated and updated at least annually in accordance with evidence based practices and, if there were none, in accordance with prevailing practices and that a written record was kept relating to each

evaluation that included the summary of the changes made and the date that those changes were implemented.

A) Ontario Regulation 79/10 s. 48 (1) states "Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: A falls prevention and management program to reduce the incidence of falls and the risk of injury."

During an interview the Interim Director of Care (IDOC) told an inspector that they had been involved with the Falls Prevention Program in the home since the time they had they started working in the home. The IDOC said that Assistant Director of Care was the lead for the program in the home. The IDOC said that they thought an annual evaluation of the program had been completed since peopleCare started consulting in the home and that they would provide the documentation for that evaluation.

On a specific date a document titled "Annual Program Evaluation" was provided to an inspector. This document stated "Date of Evaluation: started December 29, 2017" and did not include documentation of when this was completed. This written record identified that the peopleCare Vice President Clinical Services (VPCS), the ADOC, the IDOC, and three identified staff members had completed the evaluation. This written record did not include changes that had been made to the program or the dates those changes had been implemented.

During an interview with an identified staff member they told an inspector that they were involved in the Falls Prevention Program in the home and they participated in the annual program evaluation in December 2017. This staff member said that they were not sure if there had been a revision to the policies after this evaluation and had not seen any new policies.

During an interview the Administrator told inspectors that the annual evaluation of the Falls Prevention Program was completed December 29, 2017. When asked if they had a written record of the outcomes or changes that happened after the review, the Administrator said that they thought recommendations had been made. The Administrator reviewed the copy of the "Annual Program Evaluation" dated December 29, 2017, and said that this document did not include the changes that had been made or when the change was made at the time of the interview.

During an interview the peopleCare VPCS provided an updated copy of the written

record for the evaluation of the Falls Prevention Program to the inspectors. PeopleCare VPCS said that this was a "running document" and did not know the exact date that it was updated and said that it was updated when something was completed. When asked what changes had been made to the program during the annual evaluation the peopleCare VPCS said that not everything was done as it was recommendations and that they did not have access to change the policies. The peopleCare VPCS said that some of the recommendations had been implemented since the time of the evaluation and others had not been. The peopleCare VPCS said that they were not aware that the Falls Prevention Program policies had been updated in January 2018 after the program evaluation was completed and this was not added to the program evaluation. The peopleCare VPCS said that the program evaluation that was completed was to get them started and then the idea was to complete the record as they completed things and the inspectors should have received the updated one right away.

During a follow-up interview the IDOC and ADOC told inspectors that they had both been involved in the annual program evaluation for the Falls Prevention Program. The ADOC said they did not think they had seen a copy of the updated written record of the program evaluation and that the evaluation record had not been reviewed or discussed at the Falls Prevention Program meetings in January, February or March 2018. The IDOC and ADOC said that some of the recommendations in the evaluation had been implemented in the home but they were not sure the dates when those had been implemented. The IDOC and ADOC said that they had not been involved in the revisions to the Falls Prevention policies in the home as this was not part of the evaluation. They said they were not aware that the Falls Prevention policies had a revised date of January 2018. The ADOC acknowledged that although the written record stated that they had reviewed the care plans to ensure that interventions had been completed in January 2018, this had not been fully implemented in the home. The IDOC and ADOC said that it was the responsibility of the "all of us" to update the evaluation record and this had not been updated based on the changes that had been implemented in the home after the initial meeting for the evaluation.

Based on these interviews and record reviews the written record relating to the Falls Prevention and Management Program annual evaluation dated December 29, 2017, did not include a summary of the changes made or the date the changes were implemented. A revised version of this record was provided during the inspection, and it was identified through interviews that the staff in the home who had participated in the annual evaluation were not familiar with this revised written

record as this had not been reviewed by or discussed with those team members prior to the inspection. The revised written record did not include dates related to when the evaluation record had been updated and the staff in the home were unable to demonstrate that these updates had occurred prior to the compliance due date of January 31, 2018 (630).

B) Ontario Regulation 79/10 s. 48 (1) states "Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions."

During an interview the Administrator told inspectors that the annual evaluation of the Skin and Wound Program was completed on December 2017. When asked if the documented evaluation included documentation of what changes were made and when it was changed, the Administrator said that changes were not identified in the program evaluation.

On a specific date a document titled "Annual Program Evaluation" and "Skin and Wound Program Evaluation Earl's Court" was provided to the inspectors. This document "Date of Evaluation" was blank. This written record identified that the peopleCare VPCS, the ADOC, IDOC, the Registered Dietitian (RD) and an identified staff member had completed the evaluation. This written record included the following documentation:
-"Review of the Act/Regulations and note any specific requirements to be considered."
-"Review the policy/program in the Policy Manager. Is there a written description of the program including goals and objectives."

During an interview the ADOC said that they were the lead for the Skin and Wound Program, they said that they participated in one meeting only that included that above stated team members and that meeting happened in December 2017. The ADOC said that at that meeting they completed wound rounds on all the floors and then met in the Harvest Room to discuss cases. The ADOC said that they did not review the Act/Regulations or the policy/program in the "Policy Manager." The ADOC reviewed the Skin and Wound program written record for the evaluation and said that policies were revised in September 2017 before the evaluation. The documented evaluation had no indication of revisions in September 2017. The ADOC reviewed the policy revised in January 2018 and said that they were not

aware that the policy was changed or what were those changes and this was not documented on the program evaluation.

Based on these interviews and record reviews the written record related to the Skin and Wound Care Program annual evaluation did not include the date of the evaluation, a summary of the changes made or the date the changes were implemented (523).

C) Ontario Regulation 79/10 s. 48 (1) states "Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: A pain management program to identify pain in residents and manage pain."

On a specific date, a document titled "Annual Program Evaluation" and "Pain, Palliative/End of Life Annual Program Evaluation" was provided to the inspectors. This document stated "Date of Evaluation: January 29, 2018". This written record identified that a peopleCare consultant, the Administrator, the Director of Therapeutic Recreation (DRT), the Interim Director of Care (IDOC), the Assistant Director of Care (ADOC), the Director of Dietary Services and four identified staff members had completed the evaluation. This written record included the following documentation:
- Multiple recommendations documented including "need to ensure tasks are being implemented for better monitoring, skin, turning and repositioning, mouth care." No documentation of changes implemented or the date they were implemented.
- The home had provided "Pain Management PM-N-20" policy with "effective date January 2018" and this was not reflected in the written program evaluation.
- The home had provided "Pain Assessment and Symptom Management Overview PM-N-10" with "revised January 16, 2018" and this was not reflected in the written program evaluation.
- The home had provided "Palliative and End of Life Care-Guiding Principles EOL-M-15" policy with "revised Sept 2017" and this was not reflected in the written program evaluation.
- The written record did not identify if any of the policies were reviewed as part of the evaluation.

During an interview and two identified staff members told an inspector that they did not attend this program evaluation even though their name was included on the written record.

During an interview the IDOC reviewed the annual program evaluation and policies for the pain management program in the home with an inspector. The IDOC said the annual evaluation did not include a summary of the changes that were implemented to the policy in September 2017 or January 2018 and the date when the changes were implemented as well as who implemented them.

Based on these interviews and record review the licensee has failed to ensure that a written record was kept related to the evaluation that included the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented (523).

D) Section 10 (1) of the Long Term Care Homes Act, 2007 states "every licensee of a long-term care home shall ensure that there is an organized program of recreational and social activities for the home to meet the interests of the residents."

On a specific date, a document titled "Annual Program Evaluation" and "Recreation and Program Evaluation" was provided to the inspectors. This document stated "Date of Evaluation: started December 8, 2017" and did not indicate when it was completed. This written record identified that the peopleCare Vice President Clinical Services (VPCS), the Director of Therapeutic Recreation (DRT) and three people listed by first name with no identified job title had completed the evaluation. This written record included no documentation of changes implemented. The written record documented that the policy/program was reviewed in "policy tech."

During an interview DRT told an inspector that they were not aware that they participated in an annual program evaluation. The DRT said they thought that the meeting was a discussion about the program and answering mandatory questions that peopleCare VPCS had to ask them. The DRT said that during this evaluation they did not review the policy or program in policy tech. The DRT said that the home's policies were revised in May 2017, but a summary of those updates and revisions, and the dates that those updates and revisions had been implemented were not in this evaluation. The DRT said that in January 2018 they personally had completed a review of the policies and submitted changes recommended to the home but had not heard anything back at the time of the inspection. The DRT said their review of the policies was not identified in the evaluation (523).

E) Ontario Regulation 79/10 s. 48 (1) states "Every licensee of a long-term care

home shall ensure that the following interdisciplinary programs are developed and implemented in the home: A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable." During an interview the Administrator told inspectors that the annual evaluation of the Continence Program was completed January 15, 2018. When asked if they had a written record of the outcomes or changes that happened after the review, the Administrator said that they thought recommendations had been made and that this was documented within the annual program evaluations that had been provided.

On a specific date, a document titled "Annual Program Evaluation" and "Continence Management Program Evaluation" was provided to the inspectors. This document stated "Date of Evaluation: January 15, 2018." This written record identified that peopleCare VPCS, IDOC, two identified staff members and the Administrator completed the evaluation. This written record included the following documentation:
- No documentation under the column "changes made" or the date that changes were made.
- A statement within the column "recommendations" which stated "policy has been updated." This did not include a date that this change was implemented.
- A statement within the column "recommendations" which stated "documentation by PSWs or lack of documentation for resident bowel movements makes it difficult to follow bowel protocol." Under the column "responsibility" it documented that "education February 20, 21, 23 with PSWs to discuss documentation." This did not include documentation of the changes that were made or a date that change was implemented.

During an interview peopleCare VPCS said they had lead the annual program evaluations in the home. The peopleCare VPCS said that this was a "running document" and did not know the exact date that it was updated and said that it was updated when something was completed. The peopleCare VPCS said that during the evaluations they did not have access to change the policies.

During an interview the IDOC told inspectors that they had been involved in the annual program evaluation for the Continence Care Program. The IDOC said that they implemented some changes to the program after the meeting in January 2018 such as education. The IDOC said that they had reviewed the policy at the evaluation. The IDOC said that the evaluation documented that the policy had been updated but they did not know of an update and were not aware of revisions

to the policy. The IDOC acknowledged that the documented record of the annual program evaluation had not been updated based on the changes that had been implemented in the home.

During an interview the Administrator told an inspector that the policies for the Continence Care and Bowel Management Program were reviewed and revised between January and September 2017. The inspector asked what was meant on the annual program evaluation record when it stated that the policy had been updated and no other changes were recommended at that time and the Administrator said that this meant all the policies were reviewed and finalized as of September 2017. The Administrator said that the only policy reviewed as part of the annual evaluation was the written description of the program.

Based on these interviews and record reviews the written record relating to the Continence Management Program annual evaluation dated January 15 2018, did not include a summary of the changes made or the date the changes were implemented (630). [s. 30. (1) 4.]

Additional Required Actions:

CO # - 020 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 020

WN #18: The Licensee has failed to comply with LTCHA, 2007, s. 101. Conditions of licence

Specifically failed to comply with the following:

s.101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every order made or agreement entered into under this Act and those Acts. 2007, c. 8, s. 195 (12).

Findings/Faits saillants :

1. The licensee has failed to comply with the following requirement of the LTCHA: it is a condition of every license that the licensee shall comply with this Act and every order made under this Act 2007, c. 8, s. 195 (12).

The licensee has failed to comply with Director's Order #001 from inspection 2017_607523_0021 (A1) served on February 6, 2018 (A1), with a compliance date of February 15, 2018.

The licensee was ordered to do the following:
1) To bring in a consultant from an external company with extensive experience in managing or operating LTC homes to conduct a review and make recommendations for improvement regarding the following:
a. The nursing program within the home to ensure it is organized to meet the assessed needs of the residents;
b. The program of personal support services for the home to ensure it is organized to meet the assessed needs of the residents;
c. The staffing plan within the home to ensure it meets the assessed needs of residents and is evaluated and updated as necessary.

2) Upon completion of the review the findings and recommendations will be set out in a report which will be provided by the consultant to both the licensee and the Director under the Act. This review and findings must be finalized no later than November 30th, 2017.

Within two weeks of receiving the report from the review, the licensee will submit a plan to the Director identifying the recommendations that will be implemented and the timelines for implementation. That plan will be reviewed by the Director and may be changed based on the Director's review of the report from the review and the plan submitted by the licensee. Upon approval of the plan by the Director, the

licensee will implement the actions identified.

3) To bring in a nursing consultant from an external company with extensive experience in managing or operating LTC Homes to review the home's nursing practices and provide on-site and in-person training to all registered staff on the College of Nurses' Standards of Practice and Guidelines relating to the Safe Administration of Drugs and Documentation. This training will also be provided to the Administrator and the President/CEO of 'Sharon Farms & Enterprises Limited' to ensure that they understand the regulated practices required of their registered nursing staff in accordance with the College of Nurses' Standards of Practice.

4) To prepare and implement a plan to provide in-person training for staff on the prevention of abuse and neglect, including what constitutes abuse and neglect, mandatory reporting obligations and the licensee's policy to promote zero tolerance of abuse and neglect in accordance with the requirements of the LTCHA and O. Reg. 79/10.

5) Review, update and provide a copy of the policy to promote zero tolerance of abuse to the Director under the Act. The policy must ensure it is in compliance with the LTCHA and reflect a process that requires the person who suspects or witnesses abuse to immediately report the suspicion or observations of abuse to the Director.

The licensee completed steps 1 and 5.
The licensee failed to complete steps 2, 3 and 4.

A) The licensee failed to complete step 2.

On December 18, 2017, a correspondence between the Director of the Long-Term Care (LTC) Inspections Branch and the President/CEO Sharon Village Care Homes indicated that the compliance plan submitted by the home on December 14, 2017 had been accepted by the Director.

This compliance action plan submitted by the licensee on December 14, 2017 contained two parts:
- "Key Recommendations in the Operational Review."
- PeopleCare Communities Consulting Report arising from the Operational Review which included "Appendix C - Earl's Court Stability Action Plan."
Based on observations, interviews and clinical record reviews it was determined

throughout the RQI that there were actions within both parts of the plan that had not been implemented at the time of the inspection.

During an interview peopleCare Vice President Clinical Services (VPCS) said they were hired by the home as an external consultant and started December 1, 2017. The peopleCare VPCS said that the expectation was that they would be working on the action plan based on the operational review that they had completed.

During interviews inspectors reviewed the compliance action plan with peopleCare VPCS and it was identified that not all actions had been implemented at the time of the inspection. The peopleCare VPCS said there were some aspects of the plan that were identified as a higher priority than others and acknowledged that not all actions in the plan had been completed. The peopleCare VPCS said that their role was to make recommendations to the home on policy and procedure changes and then it was up to the leadership in the home to act on the recommendations. The peopleCare VPCS said that there were aspects of the plan that had been completed prior to them starting in the home and therefore they were not involved in the implementation.

The following areas of the action plan were not completed at the time of the inspection:
i) The "Key Recommendations in the Operational Review" included "4. Clarify the Current Payroll process: peopleCare and Sharon Village Care Homes corporate office will review the process and refine as required."

During interviews identified staff members told an inspector that they were not familiar with any review or discussions related to review of the payroll process.

During an interview peopleCare VPCS told inspectors that they did not complete the review of the payroll process as part of their consulting work in the home.

ii) The "Key Recommendations in the Operational Review" included "5. Provide orientation at another home for Food Service Manager."

During an interview the Director of Dietary Services (DDS) told an inspector that they did not receive training in another home as somebody came to the home, rewrote the job description, updated orientation checklist and did the program evaluation.

During an interview peopleCare VPCS told inspectors that they had someone from the peopleCare organization come on site to spend time with the DDS instead of orientation in a peopleCare home and that DDS had not been provided orientation at another home.

iii) The "Key Recommendations in the Operational Review" included "8. Complete the mandatory program evaluation (17) to determine program gaps, areas of non-compliance and policy updates required."

Based on interviews and a review of the written program evaluations provided to the inspectors the mandatory program evaluations were not completed as per the requirements of the legislation and required policy updates were not completed as part of the annual program evaluation. Detailed evidence is provided in Written Notification (WN) #8, WN #17, WN #12 and WN #24 of this report.

iv) The "peopleCare Communities Consulting Report arising from the Operational Review" included "Appendix C - Earl's Court Stability Action Plan." The "People" section of Appendix C included: "Build a staffing plan to ensure the assessed needs of the resident are met" and "Review and revise current ultimate staffing of the home."

Based on observations, interview and a review of the written staffing plan of the home it was determined that the staffing plan of the home had not been revised after the review of the external consulting company and it did not meet the assessed needs of the resident. Detailed evidence is provided in WN #6 of this report.

v) The "peopleCare Communities Consulting Report arising from the Operational Review" included "Appendix C - Earl's Court Stability Action Plan." The "Leadership" section of Appendix C included: "Replace, hire and train the Director of Care."

Based on interviews this had not been completed at the time of the inspection.

vi) The "peopleCare Communities Consulting Report arising from the Operational Review" included "Appendix C - Earl's Court Stability Action Plan." The "Leadership" section of Appendix C included: "Develop job descriptions for each position to ensure accountability."

During an interview with peopleCare VPCS told inspectors that only one specific position had a job description developed. They said that they made recommendations for the role and that this could not be finalized until they knew who would be in the roles in the home.

vii) The "peopleCare Communities Consulting Report arising from the Operational Review" included "Appendix C - Earl's Court Stability Action Plan." The "Agency" section of Appendix C included: "Develop a plan for minimal use of agency, when required ensure consistency and appropriate training. Meet with agency to develop a partnership to define the following: 1) Detail procedures for providing orientation, verification of identity, and designation. 2) Develop a pool of staff who are trained and orientated in the home. 3) Confirm system to ensure orientation is conducted with all agency staff."

During an interview the Administrator told an inspector that they were not involved in any meeting with staffing agency.

During an interview peopleCare VPCS told an inspector that they had a call with the agency. PeopleCare VPCS said they did not discuss orientation with the agency as that had been set-up before they had started in the home. When asked if there was a pool of agency staff, peopleCare VPCS said they thought there was a pool of staff that because "we see the same people unless those people are not available."

viii) The "peopleCare Communities Consulting Report arising from the Operational Review" included "Appendix C - Earl's Court Stability Action Plan." The "Care" section of Appendix C included: "Bed Entrapment - Develop bed entrapment policy and procedures which includes a bed safety system and tool kit and a process for assessing residents when they have a significant change."

During an interview peopleCare VPCS said that they had not identified a risk in this area and it had not been a priority. PeopleCare VPCS said they had not introduced anything in the home related to bed entrapment.

ix) The "peopleCare Communities Consulting Report arising from the Operational Review" included "Appendix C - Earl's Court Stability Action Plan." The "Abuse" section of Appendix C included "abuse and neglect task force to develop: evaluation of trends."

During an interview the Administrator said that they did not complete an analysis or evaluation of trends on incidents of allegations of abuse or neglect until April 2018.

x) The "peopleCare Communities Consulting Report arising from the Operational Review" included "Appendix C - Earl's Court Stability Action Plan." The "Education" section of Appendix C included "Introduce the following programs: Caring with Heart (customer services)."

During an interview the peopleCare VPCS said the Caring with Heart (customer services) education was not provided to the staff.

xi) The "peopleCare Communities Consulting Report arising from the Operational Review" included "Appendix C - Earl's Court Stability Action Plan." The "Immediate Education and Orientation" section included: "Complaints: to review and update the complaints policy and provide education to the leadership team to ensure a quarterly review and analysis is completed."

During an interview the Administrator said that they did not complete a quarterly review and analysis of their complaints.

B) The licensee failed to complete step 3.

During an interview the Administrator informed an inspector that a private consulting company named Silver Meridian provided education to registered staff on the College of Nurses' Standards of Practice and Guidelines relating to the Safe Administration of Drugs and Documentation. The Administrator said that the consulting company did not review the home's nursing practices before they provided on-site and in-person training to all registered staff on the College of Nurses' Standards of Practice and Guidelines relating to the Safe Administration of Drugs and Documentation as was indicated in the Director's Orders.

C) The licensee failed to complete step 4.

During an interview the Administrator told inspectors that all staff employed by the home received education on prevention of abuse and neglect as of October 31, 2017, and that education was provided by an external consulting company Silver Meridian. The Administrator said that staff employed by the home also received additional in-person training after the February 20, 21 and 23, 2018 by peopleCare. The Administrator said that the education did not include agency staff as they

received education prior to starting in the home which included a review of the policy. The Administrator said that the agency staff did not receive the updated training on the prevention of abuse and neglect.

Based on these interviews and record reviews the licensee has failed to comply with all requirements included in Director's Order #001 from inspection 2017_607523_0021 served on December 21, 2017, with a compliance date of February 15, 2018 (523). [s. 101. (3)]

Additional Required Actions:

DR # 002 – The above written notification is also being referred to the Director for further action by the Director.

WN #19: The Licensee has failed to comply with LTCHA, 2007, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

During an interview an identified resident told an inspector that they wanted to talk to the President/CEO Sharon Village Care Homes (SVCH) about their concerns with the care in the home, but they had not received a response yet. This resident said they wrote a letter to the President/CEO SVCH about those concerns.

During an interview the Administrator said that they were aware that this resident wrote a letter to the President/CEO SVCH and thought that this had been delivered. The Administrator said that there was no written record of the complaint form kept for this complaint as they did not receive a copy and therefore there was no form started yet.

During an interview the President/CEO SVCH told an inspector that they thought the letter was addressed to them to inform them of concerns so they could work on those concerns and improve them. The President/CEO SVCH said they did not think this was a complaint letter. The President/CEO SVCH said that this was their error as they had not thought to forward the letter to the Director as they did not initially think of the letter as a complaint. The President/CEO SVCH said that the letter was not forwarded to the home and there was no written record kept in the home indicating the date the complaint was received, responses to complainants or actions taken. [s. 22. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure written complaints concerning the care of a resident or the operation of the long-term care home are immediately forwarded to the Director, to be implemented voluntarily.

WN #20: The Licensee has failed to comply with LTCHA, 2007, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

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

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of neglect of a resident by the licensee or staff, that the licensee knows of or that was reported to the licensee, was immediately investigated.

During an interview an identified resident told an inspector that they had concerns about how they were treated by staff in the home.

During an interview the Director of Therapeutic Recreation (DTR) informed an inspector that they received concerns from this identified resident about the care they received in the home. The DRT said they completed a concern form and informed the Interim Director of Care (IDOC) immediately. The DTR said that they did not complete any progress notes or other documentation related to this incident and they did not complete any investigation related to this incident. The DTR said that the home's expectation was to report to the Director of Care (DOC) or Administrator immediately. The DTR said that they were not part of any investigation related to those allegations.

During an interview the Interim Director of Care (IDOC) said that they were made aware of concerns related to care not being provided to this identified resident that put them at risk. The IDOC said that the concern met the definition of neglect of the home's policy. The IDOC said that they did not complete the investigations related to allegations of neglect. The IDOC said the expectation was to immediately investigate every alleged, suspected or witnessed incident of neglect of a resident (523). [s. 23. (1) (a)]

2. The licensee has failed to ensure that the results of the abuse investigation were reported to the Director.

The home submitted a Critical Incident System (CIS) report to the MOHLTC which identified an incident of alleged staff to an identified resident abuse that occurred on a specific date. The home conducted an internal investigation and follow-up actions were initiated with the staff member involved. The CIS report showed that the Central Intake and Assessment Triage Team (CIATT) had requested an update of the report for the home to include the progress and outcome of the investigation. This report did not include the requested information.

An inspector reviewed the Long-Term Care Homes Critical Incident System, used by the home to report incidents to the Director, and found no amended CIS report.

During an interview the Administrator acknowledged to an inspector that the results of the investigation were not reported to the Director. The Administrator said that since that time the process had changed in the home and there had been education around the need for follow up related to the outcome of the investigation to the Director (524). [s. 23. (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 every alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff, that the licensee knows of or that is reported to the licensee, is immediately investigated and that the results of each investigation are reported to the Director, to be implemented voluntarily.

WN #21: The Licensee has failed to comply with LTCHA, 2007, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a Personal Assistive Services Device (PASD) was used to assist a resident with a routine activity of living only if the use of the PASD was included in the resident's plan of care.

Observations of an identified resident on a specific time by inspectors noted that the resident had a specific device in place.

Review of the resident's plan of care showed the absence of goals and interventions in the care plan related to the use of the specific device.

During an interview an identified staff member stated that they had applied this specific device for a specific reason. This staff member said that the resident would not be able to release the device without assistance.

During an interview another identified staff member said that the family for this resident had consented to the use of this device on a specific date. This staff member stated that this resident would not be able to release the device on their own. The staff member acknowledged the device had not been documented in the plan of care. The staff member stated that the use of the resident's seatbelt should have been documented in the plan of care and required monitoring and documentation by staff.

During an interview the Assistant Director of Care (ADOC) said that the use of this device should have been documented in the plan of care and it was not. The ADOC also acknowledged that there was no clinical record documentation related to the use of the device in the progress notes, in the kardex, in the Point of Care (POC) tasks for monitoring or as part of a PASD assessment.

The licensee had failed to ensure that a PASD was used to assist a resident with a routine activity of living only if the use of the PASD was included in the resident's plan of care.
[s. 33. (3)]

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 a PASD described in s 33 (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care, to be implemented voluntarily.

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

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

A) The home submitted a Critical Incident System (CIS) report to the MOHLTC on a specific date for an identified resident related to a specific incident which resulted in an injury. The report stated that the staff involved identified that there was a specific task not completed prior to transferring a resident.

The clinical record for this identified resident included specific instructions in the plan of care related to transfers.

During an interview the Administrator said that identified staff had provided specific care to this resident and a specific incident occurred. The Administrator said that a specific task had not been completed. The Administrator acknowledged that the staff did not follow the safe transfer policy when safely transferring and using positioning devices or techniques when assisting this resident.

During an interview an identified staff member stated that they did recall the incident related to the transfer of this resident. The staff member stated that a specific task had not been completed prior to doing the transfer.

The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting this identified resident (563).

B) During the RQI an inspector observed that an identified staff member transferred an identified resident using unsafe transferring techniques.

During interviews with identified staff members it was reported that this resident required a specific type of assistance with transfers. The identified staff member who was observed using the unsafe technique was unable to describe what was in the plan of care for transfers for this resident.

The clinical record for this identified resident included specific instructions in the plan of care related to transfers.

The SVCH "Lifts & Transfers – Minimal Lift LT-S-05" policy last revised September 2017, stated two staff must be present at all times during the use of any type of mechanical aid (hoyer lifts, standing lifts, ceiling lifts etc).

The SVCH "Equipment to Support Safe Lifts & Transfers LT-S-10" policy last revised September 2017, stated that for all mechanical lifts, standing lifts, hoyer lifts and ceiling lifts that two staff were to be present at all times.

The licensee failed to ensure that staff used safe transferring technique when assisting this identified resident (563). [s. 36.]

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

The MOHLTC received a complaint related to a family members concerns about a resident's specific type of care. During an interview this family member told an inspector about the specific concerns they had with the care.

During the RQI an inspector observed that this specific resident was using specific devices that were not reflected in the plan of care related to transfers and positioning.

During an interview an identified staff member said that this resident had a specific risk and there was an intervention in place to minimize that risk.

During an interview with another identified staff member they reported that the devices that were in place at the time of the interview did not correspond to the resident's plan of care.

The clinical record for this identified resident included specific instructions in the plan of care related to transfers and positioning.

The home's policy titled "Equipment to Support Safe Lifts and Transfers" with revised date September 2017, stated "once the resident has been transferred the sling must be removed from beneath the resident."

During an interview the Interim Director of Care (IDOC) said that it was the expectation in the home that unless it was included in the plan of care specific devices were not to be in place. The IDOC reviewed the plan of care for this resident and said that it did not include the device that the inspector had observed in place.

Based on these observations, interviews and clinical records the staff in the home did not use safe transferring and positioning techniques when assisting this identified resident (630). [s. 36.]

Additional Required Actions:

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

WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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.

During the RQI an inspector observed that an identified resident was exhibiting altered skin integrity in a specific location of their body.

The clinical record review for this identified resident did not include documented skin assessments for this wound apart from a "Head to Toe Skin Assessment" documented on a specific date.

During an interview the Assistant Director of Care (ADOC) told an inspector that this identified resident did not receive a skin assessment using a clinically appropriate assessment instrument after acquiring a new wound or after returning to the home from hospital. The ADOC said that it was the expectation to have completed when a resident exhibited a new wound and when a resident returned from hospital. [s. 50. (2) (b) (i)]

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 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, to be implemented voluntarily.

WN #24: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee has failed to ensure that there was an analysis of every incident of abuse or neglect of a resident at the home which was undertaken promptly after the licensee becomes aware of it; that the results of the analysis of incidents of abuse were considered in the evaluation of the effectiveness of the policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents; that the changes and improvements from the evaluation were promptly implemented and that there was a written record promptly prepared which included the date that the changes and improvements were implemented.

During an interview the Administrator said the home's current written policy on the prevention of abuse and neglect had been revised and implemented on December 21, 2017.

The Administrator told inspectors that the annual evaluation of the Prevention of Abuse and Neglect policy occurred on December 22, 2017. The Administrator said that the revision to the policy had occurred prior to that date as it had been one of the requirements of the Director's Order. The Administrator said they had implemented changes to the processes in the home and staff had been educated on the policy prior to the annual evaluation.

The Administrator provided the "Annual Program Evaluation" which stated "Date of evaluation: December 22, 2017." This written record stated "Evaluation completed by: peopleCare Vice President Clinical Services (VPCS), three identified staff members, the Interim Director of Care (IDOC) and the Administrator. This written record included the following documentation:
- A statement within the column "comments/recommendations" which included "policy revised and submitted to MOHLTC - passed." Under the column "responsibility" this stated "review and update policy consultant – complete." This record did not document the changes that were made to the policy or include a date that the changes were implemented.
- A statement within the column "comments/recommendations" which included "recommend to develop and review quality indicators" and under changes made it stated "complete – ongoing at meetings." This did not include a date that the change was implemented.
- A statement within the column "comments/recommendations" which included "some concern is that staff aren't reporting a abuse situation to Manager on call at the time and thereby missing the reporting time frames for Director and/or SDM." This record did not document changes implemented or the date that changes were implemented.

- The record showed that education for staff was planned for February 20, 21 and 23, 2018 to review the abuse definitions and scenarios.
- This document did not include that the results of the analysis of every incident of abuse or neglect were considered as part of the evaluation.

During an interview peopleCare VPCS said that they had lead the annual program evaluations in the home. PeopleCare VPCS said that the evaluation record was considered to be a "running document" and they did not know the exact date that it was updated and said that it was updated when something was completed. PeopleCare VPCS said that during the evaluations they did not have access to change the policies and no changes were made to the Prevention of Abuse and Neglect policy based on the annual evaluation.

During an interview the Administrator told an inspector that they had attended part of the meeting held on December 22, 2017, with the Abuse Task Force and that was considered to be the annual evaluation of the policy and program. The Administrator said that the original document that had been provided to the inspectors was considered to be the documented record of the evaluation and then the home had been updating the record as part of subsequent meetings with the Abuse Task Force in the home. The Administrator said they did not know when the record had been updated. When asked if there had been an analysis of every incident of abuse and neglect, the Administrator said that they had started doing this on April 13, 2018 and prior to that they were not doing an analysis of incidents. The Administrator said that a review of the analysis of incidents of abuse was not included in the annual evaluation. The Administrator said at the time of the evaluation it was recommended to start tracking the incidents of abuse to review with Continuous Quality Improvements (CQI). The Administrator said that the revision and implementation of the prevention of abuse and neglect policy occurred the day before the evaluation of the policy occurred on December 22, 2017, and this was done corporately not with the Abuse Task Force in the home. The Administrator acknowledged that the written record of the evaluation did not include the date the policy was revised or implemented.

Based on these interviews and record reviews the Prevention of Abuse and Neglect Program did not include an analysis of every incident of neglect until this was started on April 13, 2018. The evaluation for the 2017 calendar year did not include the consideration of the analysis of the incidents of abuse or neglect and did not document the changes made or the date the changes had been made. The written record of the evaluation identified that education was needed for staff and

improvement was not implemented promptly as the education was planned for two months later in February 2018. The written policy on prevention of abuse and neglect had been revised corporately and implemented the day prior to the evaluation and this was not reflected in the written record of the evaluation. The record did not include the date that changes to the program and policy were implemented (630). [s. 99.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is an analysis of every incident of abuse or neglect of a resident at the home, which is undertaken promptly after the licensee becomes aware of it; that the results of the analysis of incidents of abuse are considered in the evaluation of the effectiveness of the policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents; that the changes and improvements under from the evaluation are promptly implemented and that there is a written record promptly prepared which includes the date that the changes and improvements are implemented, to be implemented voluntarily.

WN #25: 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. (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 has failed to ensure that when a resident was being restrained by a physical device under section 31 of the Act that the resident was released from the physical device at least once every two hours.

During the RQI an inspector observed that an identified resident had specific devices in place. This resident was observed not to be able to remove the devices. During two different specific time periods this resident was not observed to be repositioned by staff.

During an interview an identified staff member told an inspector that they had charted that this identified resident had been repositioned but they had not provided this care. This staff member said that they had not provided repositioning or continence care to this resident during that shift.

The clinical record for this identified resident included a consent for a specific device which was considered to be a restraint. The plan of care for this resident included this device as a "restraint." The Point of Care (POC) response history report for a specific time period showed that there were 25 out of 140 (17.9 per cent) tasks for "resident repositioned every two hours" that the documentation showed that staff answered "no".

During an interview the Interim Director of Care (IDOC) said it was the expectation in the home that residents with specific devices would be repositioned at least every two hours. The IDOC said the expectation in the home was that residents would be moved using two staff assistance if needed and that tilting or un-tilting of the wheelchair did not count as repositioning. [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 the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act: that the resident is released from the physical device and repositioned at least once every two hours, to be implemented voluntarily.

WN #26: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were stored in an area or a medication cart that was secure and locked, and controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

A) During the RQI an inspector observed a medication cart unlocked and unattended in a resident care area. An identified staff member was in the dining room and the medication cart was not visible to them. Residents and visitors were in proximity to the cart. This staff member said the expectation was to always lock the cart when it was unattended.

At another specific time during the RQI an inspector observed a medication cart unlocked and unattended in a resident care area. An identified staff member returned to the medication cart and verified that the medication cart was to be locked when unattended. The inspector was able to open the drawers and this identified staff member acknowledged it was unlocked. The inspector then opened the bottom drawer and the narcotic bin was also unlocked and the staff member stated they thought the medication cart and narcotic bin was locked. The Administrator was informed that the medication cart and narcotic bin was left unlocked and unattended, and the Administrator said that the narcotic bin should always be locked and the medication cart was to be locked when unattended.

At another specific time an inspector observed a medication cart unlocked and unattended in a resident care area. An identified staff member was in the dining room and medication cart was not within sight or reach of the Registered Practical Nurse (RPN) with residents and visitors in proximity to the cart. The inspector was able to open the medication cart drawers including the bottom drawer where the narcotic box was stored and the narcotic box was unlocked. The staff member verified the expectation was to keep the narcotic box and the medication cart locked when unattended.

During the RQI an inspector and Assistant Director of Care (ADOC) observed the refrigerator in the medication room in a specific area was unlocked with a pad lock opened, the grey metal box in the refrigerator was locked and there was a vial of a specific medication present. An identified staff member removed the metal box from the refrigerator and acknowledged that the refrigerator should have been double locked and was not. The refrigerator in the medication room in another area was locked with a pad lock and the grey metal box in the refrigerator was locked with a separate key and there were multiple vials of a specific medication present. An identified staff member removed the portable metal box from the refrigerator. The ADOC acknowledged that the refrigerator should have been double locked and was not and that the expectation was that all refrigerated controlled substances should be double locked in a locked room.

The SVCH "Administration of Medications NAM-F-05" policy last revised September 2017, stated the medication cart must not be left unattended unless locked and would be kept in visual contact during the medication pass.

The SmartMeds "Pharmacy the Medication Cart 3-5" policy last updated March 2016, stated the medication cart was to kept locked at all times except when in a

locked medication room and while in sight of a nurse during a medication pass and all narcotic and controlled medications were to be stored in the locked narcotic bin in the medication cart.

The SmartMeds "Pharmacy Storage of Narcotics and Controlled Medications 6-5" policy last reviewed April 2016, stated all narcotics and controlled medications were to be stored separate from other medications in a locked compartment of the medication cart.

The licensee failed to ensure that drugs were stored in an area or a medication cart that was secure and locked, and the controlled substance was stored in a separate, double-locked stationary cupboard in the locked area.

B) The home submitted a Critical Incident System (CIS) report to the MOHLTC which documented a missing/unaccounted controlled substance at a specific time. The narcotic control sheets were reviewed to determine if the medication had been pulled from the stat box to be used by a resident and there was no documented evidence the medication was pulled for resident use during the course of a specific shift.

During an interview the Administrator stated that a specific medication went missing and was never recovered. The Administrator said that an identified staff member had not followed the proper practice in the home. The Administrator stated there was the process for receiving narcotic medications where the registered staff verified the medications with the delivery person, signed off that the narcotic was received and then they were to deliver the narcotic to the narcotic box it belonged to and sign it in with another registered staff member by initiating the ward count sheet and the resident's narcotic count sheet and to make sure the drug identification number (DIN) matched.

During an interview with an identified staff member they said they had no idea what happened to the missing medication. This staff member stated that they usually locked up the narcotics right away, but that the night shift was so busy and they were short two PSWs and the RPN coming onto the day shift did not properly count the narcotics in the stat box or check the ward count.

The "Receiving Narcotic and Controlled Medications 6-3" policy last updated April 2016, stated all narcotic and controlled medications received into the facility were checked for accuracy and their receipt recorded in the Drug Record Book. The

quantity was confirmed received and recorded in the Drug Record Book/E-DRB in Smart-Link. When a narcotic and controlled medication order arrived from pharmacy, the new medication was to be placed in the double locked area of the medication cart and the count sheet filed.

The home's investigation notes documented that there was a specific medication missing from the stat box that were delivered to the home at a specific time. A building search was completed floor by floor to determine if the medication was in any of the medication rooms or narcotic boxes on medication carts and the narcotic control sheets were reviewed to determine if the medication had been pulled from the stat box to be used by a resident. The medication was not found, nor any indication that it had been used during for any resident.

The "Delivery of Narcotics and Controlled Medications" Policy 6-4 last updated April 2016, stated the home would receive one large bag of narcotics and inside the large bag will be individually labelled smaller bags for each ward. The smaller narcotic bags were then delivered to the individual wards/home areas.

During an interview the Assistant Director of Care (ADOC) verified that the medication was never recovered. The "Delivery of Narcotics and Controlled Medications" Policy 6-4 last updated April 2016 was reviewed by an inspector with the ADOC where the policy stated the smaller narcotic bags were to be delivered to the individual wards/home areas and the ADOC verified that the narcotic was not delivered to the stat box. The "Receiving Narcotic and Controlled Medications" Policy 6-3 last updated April 2016 was reviewed with the ADOC where the policy stated when a narcotic and controlled medication order arrived from pharmacy, the new medication was to be placed in the double locked area of the medication cart and the count sheet filed. The ADOC verified this medication was not stored in any double locked area in the home as identified in the floor by floor search.

The licensee failed to ensure that this specific medication delivered to the home on a specific date was stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. [s. 129. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are stored in an area or a medication cart that is secure and locked and that 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, to be implemented voluntarily.

WN #27: The Licensee has failed to comply with O.Reg 79/10, s. 133. Drug record (ordering and receiving)
Every licensee of a long-term care home shall ensure that a drug record is established, maintained and kept in the home for at least two years, in which is recorded the following information, in respect of every drug that is ordered and received in the home:

1. The date the drug is ordered.
2. The signature of the person placing the order.
3. The name, strength and quantity of the drug.
4. The name of the place from which the drug is ordered.
5. The name of the resident for whom the drug is prescribed, where applicable.
6. The prescription number, where applicable.
7. The date the drug is received in the home.
8. The signature of the person acknowledging receipt of the drug on behalf of the home.
9. Where applicable, the information required under subsection 136 (4). O. Reg. 79/10, s. 133.

Findings/Faits saillants :

1. The licensee has failed to ensure that a drug record was established, maintained and kept in the home for at least two years, in which the signature of the person placing the order was recorded in respect of every drug that was ordered and received in the home.

The SmartMed electronic Drug Record Book (eDRB) details did not include the signature of the person placing the orders for the following home care areas and months:
- Brompton First Floor East home care area for November 2017, March and April 2018.
- Chelsea Second Floor East home care area for August, October, November 2017 and March 2018.

During an interview the Assistant Director of Care (ADOC), Interim Director of Care (IDOC) and Consultant Pharmacist verified that the eDRB did not print with the signature of the person placing the order and was not recorded in respect of every drug that was ordered and received in the home. As part of the SmartMed Pharmacy eDRB for the Brompton and Chelsea home care areas there were missing signatures of the person ordering for multiple medications for multiple residents in November 2017 and March 2018.

During an interview the Consultant Pharmacist, stated that the eDRB did not always include the signature of the person placing the order. The Pharmacist stated that the ordering nurse signature should be a part of the eDRB and that this was a glitch in their SmartLink system and was being reviewed by Information Technology (IT).

The licensee failed to ensure that a drug record was established, maintained and kept in the home for at least two years, in which the signature of the person placing the order was recorded in respect of every drug that was ordered and received in the home primarily in November 2017 and March 2018. [s. 133.]

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 a drug record is established, maintained and kept in the home for at least two years, in which the signature of the person placing the order is recorded in respect of every drug that is ordered and received in the home, to be implemented voluntarily.

WN #28: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that all food and fluids in the food production system were prepared and served using methods to preserve taste, nutritive value, appearance and food quality.

During stage 1 of the Resident Quality Inspection (RQI), random residents were interviewed and expressed dissatisfaction with the food being served and shared specific concerns regarding food quality in the home.

In addition, the MOHLTC received three specific complaints related to concerns with the food quality in the home.

During the RQI an inspector made observations of the food production area in the main kitchen and interviewed staff and it was found that the staff in the home did not always follow the standardized recipes that were part of the food production system in the home. This inspector focused on the planned "Week 3 Fall/Winter" dinner and supper menu for March 27, 2018, and the following was identified:

i) The recipe for the Grilled Peppers and Onions directed staff to use fresh thinly sliced white onions and fresh julienned green peppers; and to grill the onions and green peppers with oil and seasonings on the grill until the desired tenderness was reached. An identified staff member said that frozen chopped onions and chopped peppers were substituted and steamed in the oven as the grill was not functional, compromising the taste, appearance and quality of the planned menu item. The Director of Food Services (DFS) said that the grill had not been functional for a few months as there were issues with the pilot light.

ii) The recipe for the mashed Sweet Potatoes directed staff to use fresh sweet potatoes. An identified staff member stated they substituted canned sweet potatoes as fresh ones were not ordered, compromising the taste and appearance of the planned menu item.

iii) The recipe for Sautéed Spinach directed staff to heat the oil in a saucepan over medium heat and add spinach and garlic powder and to cook until tender. An identified staff member stated that they steamed the spinach in the oven and had not added any seasonings. In addition, the recipe for the pureed spinach directed staff to use vegetable broth until the desired consistency was reached. During production, it was noted the cook used an unmeasured amount of water during the blending process compromising the taste and nutritive value of the spinach.

iv) The recipe for Lamb Curry directed staff in step two to brown the lamb and one third onions in the first portion of the margarine in a braising pan. During production, an identified staff member stated that onions were not included in this step as they had not had time to slice the onions.

v) The recipe for the Quiche with Mushrooms for the supper menu, directed staff to use half and half cream, fresh broccoli, fresh cauliflower and fresh spinach to prepare the planned menu item. An identified staff member stated that half and half cream and the fresh broccoli, fresh cauliflower and fresh spinach was not available in house and used milk and frozen vegetables to substitute, compromising the taste and nutritive value of the Quiche.

vi) The recipe for Bread Pudding directed staff to use slices of white bread and to place the cubed bread into pans. An identified staff member stated they had used buns from the freezer that morning instead of white bread but could not remember the quantity substituted resulting in variations in the quality and taste of the planned

menu item.

vii) Review of the dinner and supper standardized recipes revealed the recipes were not scaled and adjusted for the number of servings required. For example, the meatloaf recipe and lamb curry recipe available for the dinner menu choices was for a multiple yield of 25, 40, 60 and 75 servings. An identified staff member stated they would use 75 servings for the first choice and 25 for the second choice however, confirmed the required servings would not be sufficient to serve all residents in the home. The DFS said that a production summary report and single yield recipes were to be followed by staff on the SureQuest software system. During production, the inspector had observed that the computer screen had not been turned on or utilized by staff. The DFS turned on the computer screen but said that the internet was not available at that time to pull up the single yield recipes and production summary report.

viii) One cook indicated in an interview that they usually would not use the recipes or the measurements as a guide as they were unreliable and they would "make it up" as they go resulting in varied quality of products prepared.

During an interview the DFS acknowledged to the inspector that staff were to follow the standardized recipes and production quantities according to the planned menu to ensure food was prepared and served using methods to preserve taste, nutritive value, appearance and food quality.

During an interview the Administrator said that the expectation of the home was that staff were to follow the standardized recipes and if products were not available to report that to their manager.

The licensee has failed to ensure that all food and fluids in the food production system were prepared and served using methods to preserve taste, nutritive value, appearance and food quality (524). [s. 72. (3) (a)]

WN #29: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's substitute decision-maker was notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation.

The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) which identified an alleged incident of staff to resident neglect which occurred on a specific date. The home conducted an internal investigation and follow-up actions were initiated with all staff members involved. Review of the CIS indicated the residents' substitute decision-maker was initially notified of the incident; however, there was no documented evidence that the home reported the results of the investigation to the residents' substitute decision-maker (SDM) upon completion of the investigation.

Review of the home's "Abuse-Checklist for Investigating Alleged Abuse or Neglect HR-J-15-03" policy revised date December 2017 stated: "Notify family of incident (preferably DOC or Administrator) and ongoing investigation with assurances to update regularly".

During an interview the Interim Director of Care (IDOC) said that they were unable to recall if they had called the resident's substitute decision-maker (SDM) to discuss the outcome of the investigation. The ADOC stated that they should be calling the SDM back to discuss the results of the investigation and should also remember to make a note in the progress notes (524). [s. 97. (2)]

WN #30: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that when making a report to the Director under subsection 23 (2) of the Act, the following material was included in writing

with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report: A description of the individuals involved in the incident, including, i. names of all residents involved in the incident, ii. names of any staff members or other persons who were present at or discovered the incident and iii. names of staff members who responded or are responding to the incident; Actions taken in response to the incident, including, whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and the outcome or current status of the individual or individuals who were involved in the incident.

A) The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) related to allegations of staff to resident abuse. Within this report the name of the family member contacted was blank. Under the title "what was the family members' response?" it documented "x".

During an interview the Substitute Decision Maker (SDM) for this identified resident told an inspector that they had been contacted regarding an investigation into an incident involving their family member.

During an interview the Interim Director of Care (IDOC) said they had been involved in the investigation of this alleged staff to resident abuse. The IDOC said that they did not personally call the family but thought it had been done by Assistant Director of Care (ADOC). The IDOC reviewed the CIS report and acknowledged that it did not include the name of the family who was contacted about the incident.

Based on this record review and interviews this CIS report did not include the name of the family member contacted in regards to the investigation or their response (630).

B) The home submitted a CIS report to the MOHLTC which showed that an identified resident's SDM was contacted. The name of the SDM or their response to the alleged abuse was not included in the report. The names of the persons allegedly responsible for the abuse were not named in the report as well as the names of staff members who responded to the incident.

During an interview the IDOC told an inspector that the name of the SDM and their response to the incident had not appeared in the critical incident report and

acknowledged that they should have been included.

Based on this record review and interviews this report did not include the name of the family member contacted in regards to the investigation or their response or the names of the staff members involved (524).

C) The home submitted a CIS report to the MOHLTC which documented suspected staff to resident abuse. The report did not document the name of the family member, person of importance or a substitute decision-maker for this identified resident.

During an interview the IDOC acknowledged that the name of the family member contacted were absent from the CI Report.

Based on this record review and interviews this CIS report did not include the name of the family member contacted in regards to the investigation (563).

D) The home submitted a CIS report to the MOHLTC which showed that a resident was allegedly neglected by staff and the resident's name was not included in the report.

During an interview the Administrator verified that this identified resident’s name had not appeared in the critical incident report and acknowledged the expectation was to respond to updates as requested to include the resident’s full name.

Based on this record review and interviews this CIS report did not include the name of the resident involved in the incident (524).

E) The home submitted a CIS report to the MOHLTC which documented suspected staff to resident abuse. The report did not document the name of the staff member who was present at the incident.

During an interview the IDOC acknowledged that the name of the staff member who was present at the incident was absent from the CIS report.

Based on this record review and interview this CIS report did not include the name of the staff member involved in the incident (563).

F) The home submitted a CIS report to the MOHLTC which documented suspected

staff to resident abuse. The report did not document the names of the staff who were present at the incident.

During an interview IDOC acknowledged that the name of the staff members who were present at the incident were absent from the CIS report.

Based on this record review and interview this CIS report did not include the name of the staff member involved in the incident (563).

G) The home submitted a CIS report to the MOHLTC related to allegations of staff to physical abuse. Within this report under "actions and follow-up" it stated "investigation being completed." The status of this report at the time of the inspection was "submitted" and there had been no amendments to the report.

During an interview IDOC said they had been involved in the investigation of this alleged staff to resident abuse. The IDOC said that as part of their investigation they had interviewed the accused staff member and determined that abuse had not occurred. The IDOC said that they did not update the CIS report after the investigation was completed to include the outcome of the investigation and the actions taken.

Based on this record review and interview this CIS report to the Director did not include the actions that were taken as a result of the incident or the outcome of the investigation (630).

Based on these record reviews and interviews there were seven CIS reports that had been submitted to the MOHLTC between December 2017 and February 2018, which did not include all the required information. [s. 104. (1) 3.]

WN #31: The Licensee has failed to comply with O.Reg 79/10, s. 241. Trust accounts

Specifically failed to comply with the following:

s. 241. (5) Every licensee shall establish a written policy and procedures for the management of resident trust accounts and the petty cash trust money, which must include,
(a) a system to record the written authorizations required under subsection (8); and O. Reg. 79/10, s. 241 (5).
(b) the hours when the resident, or the person acting on behalf of the resident, can make deposits to or withdrawals from the resident's funds in a trust account and make withdrawals from the petty cash trust money. O. Reg. 79/10, s. 241 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that there were policies and procedures for the management of trust accounts and the petty cash trust money that included the hours when the resident or persons acting on behalf of the resident could make deposits or withdrawals from the funds in a trust account and from petty cash trust money.

During an interview an identified resident told an inspector that they had concerns related to the trust account and that they had problems accessing their account.

The home's policy titled "Resident's Monies and Belongings BM-B-10" with effective date: July 2014, included "Trust account funds are received or withdrawn through the main office which is open weekdays during the hours previously communicated with the resident or responsible party."

During an interview with an identified staff member they told an inspector that residents could usually access their accounts on Wednesdays, Thursdays and Fridays between 1300 and 1500 hours. This staff member said residents were also allowed to come in anytime during the day, but every other Monday and Tuesday they were away from the home at the corporate office and residents were unable to access it on those days. This staff member said that those hours were not included in the policy.

During an interview the Administrator told an inspector that they believed the residents could access their accounts Wednesday to Friday 1300 to 1500 hours, but was not sure if those hours were specified in the policy. The Administrator reviewed the specific home's policy with the inspector and said that the hours were not specified in the policy.

Based on these interviews and record review the home's policies for the management of trust accounts and the petty cash trust money did not include the hours when the resident or persons acting on behalf of the resident could make deposits or withdrawals from the funds (524). [s. 241. (5)]

Issued on this 17 day of September 2018 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : Amended by AMIE GIBBS-WARD (630) - (A2)

Inspection No. / No de l'inspection : 2018_722630_0007 (A2)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 004193-18 (A2)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Sep 17, 2018;(A2)

Licensee / Titulaire de permis : Sharon Farms & Enterprises Limited
108 Jensen Road, LONDON, ON, N5V-5A4

LTC Home / Foyer de SLD : Earls Court Village
1390 Highbury Avenue North, LONDON, ON, N5Y-0B6

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Leslie Ducharme

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

To Sharon Farms & Enterprises Limited, 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_607523_0032, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007, s. 6. Plan of care

Order / Ordre :

The licensee must be compliant with s. 6 of the LTCHA.

Specifically the licensee must:

a) Ensure two identified residents and any other resident has their needs and preferences reassessed using a clinically appropriate assessment instrument whenever their care needs change. The plan of care must then be reviewed and revised to ensure it is based on the assessed care needs.

b) Ensure two identified residents and any other resident has their needs reassessed when there is an identified change in their risk or have experienced a specific type of incident. The plan of care must then be reviewed and revised to ensure it is based on the assessed needs of the resident.

c) Ensure that an identified resident and any other resident who is using a specific device has a written plan of care that sets out the planned care for the resident related to when and how the device is to be applied.

d) Ensure that an identified resident and any other resident has a written plan of care, including the electronic medication orders, that sets out clear direction to staff related to the resident's individual bowel protocol.

e) Ensure that two identified residents and any other resident has a plan of care that is based on an assessment and the resident's needs and preferences related to a specific type of care.

f) Ensure that the directions set out in the plan of care related to a specific type of care are followed by staff for two identified residents and any other resident.

g) Ensure that the directions set out in the plan of care related to the use of Personal Assistive Services Devices (PASD) and/or restraints are followed by staff for an identified resident and any other resident.

h) Ensure that if an identified resident or any other resident's plan of care identifies the use of a specific device that the staff document in the home's electronic documentation system that they have checked the functionality of the device on each shift.

i) Ensure that staff document the provision of care that has been set out in the plan of care for an identified resident and any other resident within the home's electronic documentation system in accordance with the home's internal processes and policies.

Grounds / Motifs :

1. The licensee has failed to comply with compliance order #001 from inspection 2017_607523_0032 (A1) served on January 30, 2018, with a compliance date of February 28, 2018, as it related to s. 6 (10)(b).

The licensee was ordered to ensure that residents were reassessed and the plan of care reviewed and revised when the resident's care needs changed and the care set out in the plan had not been effective.

Based on observations, interviews and clinical record reviews it was identified that the licensee failed to comply with s. 6 (10)(b) of the Long-Term Care Homes Act, 2007 (LTCHA) as they did not ensure that residents were reassessed and the plan of care reviewed and revised when the resident's care needs changed and the care set out in the plan had not been effective (as documented in finding A).

In addition, the licensee failed to ensure that the plan of care and care provided to residents met the legislative requirements related to multiple sub-sections within Section 6 of the LTCHA (as documented in finding B through G).

A) The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at any time when the resident's care needs changed.

i) During the Resident Quality Inspection (RQI) an inspector observed an identified resident tell a staff member that they required assistance with a specific type of care. This identified resident was then observed waiting for an hour and twenty minutes before they received the requested care from staff.

Identified staff members told the inspector that this resident's care needs had changed related to this specific type of care.

The clinical record for this resident showed there had not been a reassessment of the resident when their care needs changed and the plan of care was not updated to reflect the change.

During an interview the Interim Director of Care (IDOC) told the inspector that it was the expectation in the home that each resident would be assessed by registered staff with any alteration in their requirements for this specific type of care using the electronic assessment. The IDOC said that the plan of care for this identified resident was not based on a reassessment and was not updated when their care needs changed. [s. 6. (10) (b)]. (630)

ii) The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs change or care set out in the plan was no longer necessary.

During the Resident Quality Inspection (RQI) inspectors observed than an identified resident had a specific injury. Staff informed an inspector that the injury was related to a specific incident.

The clinical record for this resident showed there had not been a reassessment of the resident when their care needs changed and the plan of care was not updated to reflect the change.

During an interview the Assistant Director of Care (ADOC) reviewed the clinical record for this identified resident and said that the plan of care was not updated to include interventions to address the change in condition for the resident when their risks for a specific type of incident increased. The ADOC also stated that the plan of care for the resident was not updated after the specific incident which resulted in a specific type of injury.

Based on these observations, interviews and clinical record review, this resident was not reassessed and the plan of care reviewed and revised when the resident's care needs changed [s. 6. (10) (b)]. (523)

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

During the Resident Quality Inspection (RQI) an inspector observed that an identified resident had a specific device applied and that this device was not applied correctly.

During an interview identified staff members said they thought the use of this device was included in the resident plan of care but upon review of the plan of care with the inspector acknowledged that this was not included.
The licensee has failed to ensure that there was a written plan of care for this identified resident that set out the planned care related to the use of this specific device [s. 6. (1)(a) (b)]. (523)

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

During the Resident Quality Inspection (RQI) a family member of an identified resident reported specific care concerns.

The clinical record for this resident showed that the medication administration record related to this care did not provide clear direction for the staff related to the provision of this specific medication.

During an interview the ADOC said that the plan of care did not provide clear direction for staff regarding the administration of this specific medication.

Based on these interview and record review the licensee has failed to ensure that there was clear directions to the registered staff for this resident's protocol for this specific medication [s. 6. (1) (c)]. (563)

D) The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

i) The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) on a specific date which reported allegations of staff to resident abuse. This CIS report stated that the identified resident had requested a specific type of care and the staff provided a different type of care than what was requested. This report stated that the family had expressed frustration and anger about the care provided.

During an interview this identified resident told an inspector that they were concerned that at times it took the staff a long time to answer their call bell. This resident reported they needed assistance from staff for this specific type of care and they had specific preferences related to the provision of this care.

The "Call Bell Log" for this resident showed that on three specific dates and times there was over a 25 minute time period between when the call response system was activated in this resident's room and when the call was cancelled.

During interviews with staff they reported that this identified resident required assistance from staff with this specific care. Staff also said that this resident would ring for assistance with this type of care. One staff member said that this resident had experienced a change in their care needs and they were not sure if the plan of care specified a schedule for the provision of this care.

During the RQI an inspector observed that during an identified time period this resident was not provided with this specific type of care during a four and a half hour time period. This resident reported to the inspector on that day that they had not received that specific care from staff and the care provided that day was not what they preferred.

The clinical record for this resident showed the resident had a recent assessment completed which did not reflect the resident's stated preferences. The plan of care

for this resident did not reflect the most recent assessment or the resident's preferences.

During an interview the Interim Director of Care (IDOC) said it was the expectation in the home was that each resident would have their care needs assessed using the electronic assessment form with any change in their status related to this specific type of care. The IDOC said that this resident had an assessment documented on a specific date and that it did not look like the plan of care had been updated based on that assessment.

Based on these observations, interviews and clinical record review this identified resident had a change in their bladder continence which was not reflected in the plan of care. The plan of care for this resident was not based on the most recent assessment of the resident. The preferences and need for care that the resident had expressed were not reflected in the assessment or the plan of care. During the inspection this resident expressed concerns related to the care they received in the home [s. 6. (2)]. (630)

ii) The licensee has failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences.

During the Resident Quality Inspection (RQI) an identified resident told an inspector that they had specific preferences related to a care program in the home. This resident said they had spoken with staff in the home about these preferences.

The clinical record for this resident showed that a staff member had documented in a progress note a discussion with the resident regarding their preferences for this program. The plan of care for the identified resident did not include interventions related to their stated preference.

During an interview an identified staff member told an inspector that they had met with this resident on several occasions and they were aware of the resident's preferences. This staff member said that those preferences would be expected to be part of the resident's plan of care. The Inspector reviewed the plan of care for the resident with the staff member and they acknowledged that it was not based on the resident's needs and preferences related to this program [s. 6. (2)]. (523)

iii) The licensee has failed to ensure that the plan of care was based on an

assessment of the resident and the resident's needs and preferences.

The MOHLTC received a complaint from a family member for an identified resident regarding a specific type of care in the home. This family member told and inspector that the resident had specific preferences related to this care.

The clinical record for this resident showed that a staff member had documented in a progress note a discussion with the resident regarding their preferences for this program. The plan of care for the identified resident did not include interventions related to their stated preference.

During interviews with identified staff members they reported to an inspector that this resident had stated preferences related to care. These staff members said that the plan of care was not based on this resident's preferences. [s. 6. (2)]. (523)

iv) The licensee has failed to ensure the care set out in the plan of care was based on an assessment of the resident and the needs of that resident.

During the Resident Quality Inspection (RQI) an inspector observed on multiple occasions that an identified resident was in a position that placed them at risk and required assistance and assessment from staff.

During interviews with identified staff members they said that they thought that this identified resident was able to express their care needs. The staff members also said that based on the plan of care this resident did not require assistance or assessment from staff related to this type of care.

During another interview with an identified staff member they reported that this resident was not able to accurately express their care needs.

The clinical record for this resident showed that the plan of care had not been updated based on assessments related to specific incidents. The plan of care also did not reflect the resident's needs related to this care area.

During an interview with the Assistant Director of Care (ADOC) they told an inspector that this identified resident had difficulties expressing their care needs. ADOC said it was the expectation that registered staff would assess this resident and that the plan of care would be based on the completed assessments and identified needs of the

residents related to this care area. [s. 6. (2)]. (630)

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

i) During the Resident Quality Inspection (RQI) an inspector observed that an identified resident did not have a specific device applied that was documented as required in the plan of care.

The clinical record for this resident showed that this specific device was required for safety and at the family's request.

During an interview with an identified staff member they reported that they thought this resident did not require this device. This staff member then reviewed the plan of care with the inspector and said that the device had been added to the plan of care. This staff member said they had not applied the device as per the plan of care.

During an interview the Assistant Director of Care (ADOC) said that it was the expectation in the home that changes to the plan of care would be communicated to the staff. ADOC said it was the expectation in the home that care would be provided as to the residents as specified in the plan. [s. 6. (7)]. (524)

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

During the RQI an inspector observed an identified resident with a specific device in place.

The clinical record for this identified resident showed that this device was not to be in place.

During an interview with an identified staff member they told an inspector that the plan of care directed staff to remove this device after a specific type of care had been provided. This staff member said they were unable to follow the plan of care for a specified reason.

During an interview with another staff member they reported that they were not sure if this resident was to have the device in place. An inspector reviewed the plan of

care with this staff member and they acknowledged that the care set out in the plan of care was not provided to the resident [s. 6. (7)]. (523)

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

The home submitted a Critical Incident System (CIS) report to the MOHLTC related to a specified incident for an identified resident. This CIS report stated that the measures that were in place prior to the incident included the use of a specific device.

During interviews with identified staff members they reported that this resident had a history of multiple incidents of a specific nature. These staff members reported that the specific device that was to be used for this resident was not available for a time period as the device was broken.

The clinical record for this resident showed that they had multiple documented incidents of a specific nature. The clinical record showed that the specific device had been assessed as required and was included in the plan of care. The clinical record showed that the specific device was not available to be used for this resident for a time period as it was broken.

During an interview the Interim Director of Care (IDOC) told an inspector that this resident had a history of a specific type of incident. The IDOC said that the plan of care showed they required a specific device and this was not provided to the resident for a time period.

Based on these interviews and record review the care set out in the plan of care for this resident was not provided [s. 6. (7)]. (630)

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

The home submitted a CIS report to the MOHLTC which was identified as alleged staff to resident abuse. This report stated that an identified resident had a specific type of wound on their body. This report stated that through the investigation it was found that the plan of care related to a specific type of care was not provided to the resident.

During an interview this identified resident told and inspector that they had a specific type of wound and they were not sure how they acquired the wound.

The plan of care for this resident showed that this resident required a specific type of care to help minimize the risk for damage to their skin.

During an interview an identified staff member said that this resident required a specific type of care to help promote their safety.

During an interview Interim Director of Care (IDOC) said that they had been involved in an investigation of allegations of physical abuse for this resident. IDOC said that through the process of their investigation they determined that the staff did not follow the plan of care. IDOC said this staff member was given a letter of expectation regarding not following the plan of care.

Based on these interviews and clinical record review the care provided to this resident was not provided as outlined in the plan of care [s. 6. (7)]. (630)

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

The home submitted a CIS report to the MOHLTC to a specific incident which resulted in an injury.

During an interview an identified staff member said this resident had a specific device in place to support the resident's safety.

During an interview the Interim Director of Care (IDOC) said that they had submitted the CIS related to the incident for this resident. IDOC said they went to check on this specific device and found that it was not functioning properly. When asked if there was a process in the home for checking on the functionality of these devices, the IDOC said that they were to be checked at the start of every shift and they were planning on reviewing that with PSWs that week.

During an interview the Assistant Director of Care (ADOC) said that the staff in the home were supposed to check if the devices were working at the start of the shift and that was to be in the tasks in Point of Care (POC) for the residents.

An Inspector reviewed the tasks in POC for this resident and there were no current tasks related to checking or applying this device.

During an interview an identified staff member said that the expectation in the home was that staff were checking the devices and documenting that in the POC. This staff member said that this resident did not have that task in POC.

During an interview the Administrator said it was the expectation in the home that staff were checking whether devices were applied correctly and working properly for falls prevention were included as a task in POC. [s. 6. (9) 1]. (630)

G) The licensee has failed to ensure that the outcomes of the care set out in the plan of care were documented.

The home submitted a CIS report to the MOHLTC for an identified resident documented an incident where the resident was complaining of a specific type of pain.

The care plan in PCC at the time of the inspection documented that the resident had a specific type of care. The POC task included specific care requirements and the POC tasks for other care were absent from the resident's plan of care. Although the care plan documented the care required related to activities of daily living (ADLs), the PSWs were not documenting the outcomes of the care set out in the plan of care related to these specific areas of care.

During an interview the peopleCare Vice President of Clinical Services (VPCS) stated the PSWs referred to the kardex in POC for specific care interventions and documented in POC when care had been completed. The VPCS verified that there was no documentation of the assistance provided related to the ADLs that were completed for this resident. The VPCS stated PSWs were to document the outcomes of the care set out in the plan of care related to ADLs.

During an interview the Administrator verified that the "Earls Court Village Point of Care Audit Report" documented that there was no documentation of the personal care provided to resident on a specific shift.
The licensee failed to ensure that the outcomes of the care set out in the plan of care were documented for this resident [s. 6. (9) 2]. (563).

Based on these observations, interviews and clinical record reviews it was identified that the licensee failed to ensure that the plan of care for residents met the legislative requirements related to multiple sub-sections within Section 6 of the Long Term Care Homes Act, 2007.

The severity of this issue was determined to be a level 3 as there was actual risk. The scope of the issue was a level 2 as it was related to 11 out of 23 residents reviewed. The home had a level 4 history as they had on-going noncompliance with this section of the LTCHA that included:

• Written Notification (WN) and Compliance Order (CO) issued January 30, 2018 (2017_607523_0032 (A1);
• WN and Voluntary Plan of Correction (VPC) issued July 11, 2017 (2017_263524_0015);
• WN and VPC issued July 11, 2017 (2017_263524_0013);
• WN and VPC issued May 5, 2017 (2017_538144_0014);
• WN and VPC issued July 11, 2017 (2017_263524_0013);
• WN issued April 13, 2017 (2017_536537_0015);
• WN, CO and Director??s Referral (DR) issued June 24, 2016 (2016_229213_0018) with a compliance due date of July 4, 2016. The CO was complied July 21, 2016 (2016_303563_0023);
• WN and VPC issued July 8, 2016 (2016_303563_0017);
• WN, VPC and CO issued May 11, 2016 (2016_229213_0013) with compliance due date of June 6, 2016;
• WN, VPC and CO issued March 8, 2016 (2016_229213_0005) with compliance due date of April 4, 2016;
• WN and VPC issued January 4, 2016 (2015_303563_0055);
• WN and VPC issued January 4, 2016 (2015_303563_0054);
• WN and VPC issued June 26, 2015 (2015_229213_0022). (630)

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

Oct 30, 2018(A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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).

Order / Ordre :

The licensee must be compliant with s. 19 (1) of the LTCHA.

Specifically the licensee must:

a) Ensure that when a specific device is broken and/or not available to be used for an identified resident or any other resident, as specified in the plan of care that actions are taken immediately to ensure the safety of that resident.

b) Develop and implement measures in the home to ensure that an identified resident and every other resident is provided with the required assessments, treatments, care or assistance required for their safety. The home must maintain a documented record of the measures that have been developed and implemented; the persons involved in the implementation, and monitoring of interventions as they relate to the safety needs of residents living in the home, and the dates when changes were implemented.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were not neglected by the licensee or staff.

Section 2(1) of Ontario Regulation 79/10 defines neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or wellbeing, including inaction or a pattern of inaction that jeopardizes the health or safety of one or more residents."

The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) related to a specific incident with a resulting injury for an identified resident. This report stated that this resident had been identified as being at high risk for this type of incident and had experienced several previous events.

Multiple identified staff members told an inspector that this resident had a history of this type of incident and that prior to being sent to the hospital had been showing signs of pain. Multiple staff members reported that this resident was to have in place specific interventions to help minimize their risk for this type of incident. The staff said that one of the interventions included the use of a specific device and that there was a period of time when this device was broken and could not be used for the resident. Staff reported that during the time that the device was broken this resident did have incidents that placed them at risk for injury.

The clinical record for this identified resident showed that this resident had multiple documented incidents during a specific time period. The record also showed that the staff did not complete the required documented assessments after each incident. The plan of care showed that the resident required the specific device to be used as a way to decrease their risk for this type of incident and that the family had requested the use of this device.

During an interview the Interim Director of Care (IDOC) told an inspector that this resident had multiple incidents prior to the incident that led to the CIS report. The IDOC said that based on review of the CIS report and the electronic this resident had noted bruising and pain prior to the incident that led to the CIS report and that staff did not assess the bruising using a skin assessment or complete a pain assessment. IDOC acknowledged that staff did not complete all required documented assessments for this resident for a specific time period. The IDOC said that one of the physician's recommendation was not implemented prior to the incident that led to the CIS report. When asked if they thought that the care provided to this resident provided the care and assistance required to maintain their safety and wellbeing, the

IDOC stated no. The IDOC said that the specific device should have been fixed and the physician's recommended intervention should have been implemented.

Based on these interviews and record review this resident had an incident in the home which resulted in an injury with pain. Prior to this incident, the resident had multiple prior incidents for which staff did not complete documented post fall assessments, revise the plan of care or implement new interventions. This resident had a specific number of falls in a specific time period when there was an identified concern with a specific device not functioning. The intervention recommendation by the physician related was not implemented prior to the incident that lead to the CIS report. Staff had identified concerns with skin integrity and pain for this resident and these were not assessed through the expected practices within the home. Based on these interviews and record review there was a pattern of inaction related to the care and assistance this resident required in the home to maintain their safety and wellbeing.

The severity of this issue was determined to be a level 3 as there was actual harm. The scope of the issue was a level 1 as it was related to 1 resident reviewed. The home had a level 3 history as they had one or more related non-compliance with this section of the LTCHA that included:

• WN and CO issued May 30, 2016 (2016_303563_0011) with compliance due date May 31, 2016. This CO was complied June 22, 2016. (630)

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

Sep 28, 2018

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 003

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

Linked to Existing Order / Lien vers ordre existant: 2017_607523_0021, CO #001;

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 must be compliant with s. 20 (1) of the LTCHA.

Specifically the licensee must:

a) Ensure that the policy to promote zero tolerance of abuse and neglect of residents is complied with, specific to but not limited to:
1) the immediate reporting of the allegation of abuse or neglect to the management in the home;
2) the documentation of the home's investigation.

b) Complete an analysis promptly after of each incident of alleged abuse or neglect to ensure that the policy to promote zero tolerance of abuse and neglect of residents has been complied with and that changes and improvements are promptly implemented. The analysis and improvements implemented must be documented.

Grounds / Motifs :

1. The licensee has failed to comply with compliance order #001 from inspection 2017_607523_0021 (A1) served on September 22, 2017, with a compliance date of October 31, 2017.

The licensee was ordered to ensure that the policy to promote zero tolerance of

abuse and neglect of residents was complied with, specific to but not limited to when staff suspected or were informed of any witnessed or alleged abuse.

Section 2(1) of Ontario Regulation 79/10 defines neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or wellbeing, including inaction or a pattern of inaction that jeopardizes the health or safety of one or more residents."

A) The licensee has failed to ensure that the home's written policy on the prevention of abuse and neglect was complied with.

The MOHLTC received a complaint from a family member which identified concerns that they felt that an identified resident had experienced "negligent care." This family member told an inspector that they had specific care concerns and were planning to bring these concerns forward to the management in the home.
The home's policy titled "Zero Tolerance of Abuse and Neglect" with revised date December 21, 2017, included the following direction:
"The DOC/Administrator/or other designation will immediately upon notification:
- 5. Obtain written statements from all concerned parties including the resident if he/she is able.
- 8. Ensure a full medical examination has been arranged.
- 9. Advise the MOHLTC Director regarding ongoing investigation through the MOHLTC Critical Incident System (CIS).
- 13. Continue completion of Nursing Checklist for Reporting and Investigating Alleged Abuse."
The "Abuse-Checklist for Investigating Alleged Abuse" with revised date December 2017, included the following direction:
- "Immediately - Document objective observations including full assessment if physical, sexual abuse or neglect"
- "Within next 48 hours continue investigation and collate all information into one chronological report – DOC/Administrator."

During an interview the Administrator said that the family for this identified resident had expressed concerns regarding the care the resident had received in the home. The Administrator said that they had documented this concern and provided a "Concern/Complaint Record" with a written letter attached with a specific date. The written letter was addressed to the Administrator and included description of the care that they felt had not been provided to the resident.

The clinical record for this identified resident did not include documentation of a "full medical examination" by the physician after the letter had been received.

During an interview the Administrator told an inspector that the written letter of complaint expressed the perception that the resident had been allowed to develop specified conditions. When asked what they had done in response to the letter, the Administrator said they followed up with the complainant to set-up a care conference date. The Administrator said they had looked into the care concerns which included reviewing progress notes and speaking with staff. Administrator said that at the time of the interview with the inspector they had not met with the complainant or had the care conference. The Administrator said that the definition of neglect was the failure to provide a resident with the treatment care, services or assistance required for safety or wellbeing. When asked if the concerns identified in the letter for this resident met the definition of alleged neglect, the Administrator said that they did. The Administrator said they had started a "high level" investigation into these allegations of neglect and that they did consider this to be an investigation into alleged neglect. The Administrator said that they had interviewed staff and had documented some of these interviews. When asked where they had documented the outcome of their investigation, the Administrator said as there were no specifics they were hoping to document further at the care conference. The Administrator said they had not notified the MOHLTC of this investigation or the allegations of neglect through the CIS system.

Based on these interviews and record reviews a family member had raised concerns that this identified resident had received "substandard care" which they felt had caused problems for the resident. The Administrator said that the concerns were investigated as alleged neglect. The home's written policy was not complied with related to documentation of the investigation, to the arrangement for a "full medical examination" or the notification to the MOHLTC of the investigation into allegations of neglect. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with (630).

B) The MOHLTC received a complaint related to concerns about rough handling of an identified resident by staff on a specific date.

The home submitted a CIS report to the MOHLTC which was identified as "unlawful conduct that resulted in harm/risk of harm to resident" for this resident. This CIS

report did not include a description of the incident. It included three progress notes related to a skin integrity concern and that management was "doing an investigation." This report stated that the resident was assessed, that staff were interviewed and "no findings of rough handling by staff." This report was completed by former Director of Care (DOC) and there was no update to the report after the initial report was submitted to the MOHLTC.

The home's written policy titled "Zero Tolerance of Abuse and Neglect" with effective date September 2017 that was in place at the time of the incident included the following procedures:
"The Charge Nurse/RPN will:
- 3. Immediately notify the DOC/ADOC/designate. After hours the RN in charge of the home must immediately report to the Manager on Call."
The RN will:
- 6. Obtain written statements from all witnesses and document his/her account of the incident using the Incident Report Form.
- 8. Continue completion of Nursing Checklist for Reporting and Investigating Alleged Abuse."
The DOC/Administrator/or other designate will immediately upon notification:
- 3. Obtain written statements from concerned parties including the resident if he/she is able.
- 10. Complete the CIS as per MOHLTC protocols.
- 12. Continue completion of Nursing Checklist for Reporting and Investigating Alleged Abuse."

"The Abuse-Checklist for Investigating Alleged Abuse or Neglect" included "Interview those present and request written account of incident from all possible witnesses before shift ends."
The clinical record for this identified resident included a progress note by the former DOC which stated that the family member had been informed of CIS completed and that the family was still not satisfied with the results of the investigation.

During an interview the Assistant Director of Care (ADOC) said that they had been involved in assessing this resident's skin and talking to staff related to the skin integrity concern. The ADOC said they had spoken to the family related to a skin concern and had reported the concern to the former DOC. The ADOC said they had not personally interviewed staff related to an allegation of abuse and were not sure if the former DOC had spoken with the family or what had been done related to the

investigation of this CIS.

During an interview the Administrator told an inspector that the resident's family member had brought forward concerns about the care for this resident. When asked why this had been submitted to MOHLTC as "unlawful conduct that resulted in harm/risk of harm" the Administrator said that they thought it was because at the time they did not have enough evidence that it was abuse and that was the "only thing that fit." When asked if this had been investigated as an allegation of abuse as the family member had indicated that they suspected abuse, the Administrator said that it had been investigated as an allegation of abuse by the former DOC. The Administrator said they had not personally been involved in the investigation only made aware that it was being done. When asked if there was any further documentation regarding the investigation apart from the CIS report, the Administrator said that it was just the CIS report and progress notes and they could not find any documentation related to interviews with staff. When asked what the expectation was for documentation of an investigation the Administrator said that all interview with staff members involved and related staff statements would be documented as well as the follow-up to the investigation. When asked if there was any way of knowing who was interviewed or when interviews were conducted, the Administrator said that based on what they had available there was no way of knowing. The Administrator said that the CIS report was not updated with the results of the investigation. The Administrator said that the "Nursing Checklist for Reporting and Investigating Alleged Abuse" was part of the policy in November 2017, but they did not start using that in the home until January 2018.

Based on these records and interviews the licensee has failed to ensure the written policy on prevention of abuse and neglect was complied with. The staff in the home did not immediately report the allegation of rough handling to the management in the home, the "Nursing Checklist for Reporting and Investigating Alleged Abuse" was not used for the investigation, there was no documentation of interviews or written statements related to the investigation and the CIS report was not updated as per the procedures in the policy.

The severity of this issue was determined to be a level 2 as there was potential for harm. The scope of the issue was a level 1 as it was related to 2 residents reviewed. The home had a level 4 history as they had on-going non-compliance with this section of the LTCHA that included:

• WN issued January 4, 2018 (2017_607523_0033);
• WN and CO issued September 22, 2017 (2017_607523_0021 (A1)) with compliance due date October 31, 2017.
• WN issued January 4, 2016 (2015_303563_0055). (630)

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

Sep 28, 2018

Order # /
Ordre no : 004

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

Linked to Existing Order /
Lien vers ordre existant: 2017_607523_0021, CO #002;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 24 of the LTCHA.

Specifically the licensee must:

a) Ensure that when a person has reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it is based to the Director: abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

Grounds / Motifs :

1. The licensee has failed to comply with compliance order #001 from inspection 2017_607523_0021 (A1) served on September 22, 2017, with a compliance date of October 31, 2017.

The licensee was ordered to ensure that when a person had reasonable grounds to suspect that any abuse of a resident by anyone had occurred or may occur that they immediately reported the suspicion and the information upon which it was based to the Director.

Section 2(1) of Ontario Regulation 79/10 defines neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or wellbeing, including inaction or a pattern of inaction that jeopardizes the health or safety of one or more residents."

The licensee has failed to ensure that when a person had reasonable grounds to suspect abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident, immediately reported the suspicion and the information upon which was based to the Director.

A) During an interview the Administrator said that family member of an identified resident had expressed concerns regarding the care the resident had received in the home. The Administrator said that they documented this concern and provided a "Concern/Complaint Record" with a written letter attached. The Administrator told the inspector that they had notified the MOHLTC of the written letter of complaint through an email one day after they had personally received the letter.

The written letter was addressed to the Administrator and identified specific concerns regarding the care for this resident.

During a follow-up interview the Administrator said that the definition of neglect was the failure to provide a resident with the treatment care, services or assistance required for safety or wellbeing. When asked if the concerns identified in the letter of concerns for resident met the definition of alleged neglect, the Administrator said that they did. The Administrator said that they had started an investigation into these allegations of neglect. The Administrator said that they had not notified the MOHLTC of this investigation or the allegations of neglect through the CIS system (630).

B) During the RQI an identified resident told and inspector that they thought that staff were not nice and did not treat them well and that they had spoken to a manager about these concerns.

During an interview an identified staff member said they had received concerns from this identified resident about the care they received. This staff member said they completed a concern form and informed the Director of Care (DOC) immediately.

During an interview the Administrator said that if a resident informed a management team member about any allegations of abuse or neglect it was expected that the staff member would let the DOC or the Administrator know immediately and then they would investigate and report to the Director.

During an interview the Interim DOC said that they were made aware of concerns related to care not being provided to this identified resident that put them at risk. The IDOC said that the concern met the definition of neglect of the home's policy. The IDOC said that they did not report those allegations to the Director and that the expectation was to report those allegations immediately to the Director. (523)

The severity of this issue was determined to be a level 1 as there was minimum risk. The scope of the issue was a level 1 as it was related to 2 residents reviewed. The home had a level 4 history as they had on-going non-compliance with this section of the LTCHA that included:

• WN and CO issued September 22, 2017 (2017_607523_0021 (A1)) with compliance due date October 31, 2017;
• WN and VPC issued March 20, 2017 (2017_607523_0001);

• WN, VPC and CO issued March 8, 2016 (2016_229213_0005) with compliance due date of April 4, 2016. This CO was complied April 26, 2016 (2016_229213_0013);
• WN and CO issued January 4, 2016 (2015_303563_0054) with compliance due date of January 4, 2016;
• WN and VPC issued June 26, 2015 (2015_229213_0022). (630)

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

Sep 28, 2018

Order # /
Ordre no : 005

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

Linked to Existing Order /
Lien vers ordre existant: 2017_607523_0021, CO #004;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s. 8 (1)(b).

Specifically the licensee must:

a) Ensure that the home's Infection Prevention and Control program policies and strategies related to outbreak management are complied with.

b) Ensure that all leadership team members, Registered Nurses (RNs) and Registered Practical Nurses (RPNs) working in the home are re-educated on the Infection Prevention and Control program policies and strategies related to outbreak. The home must keep a documented record of the education provided.

c) Ensure that the home's Falls Prevention and Management program policies and procedures are complied with.

d) Ensure that all leadership team members, Registered Nurses (RNs), Registered Practical Nurses (RPNs) and Personal Support Workers (PSWs) working in the home are re-educated on all of the home's Falls Prevention and Management Program policies and procedures. The home must keep a documented record of the education provided.

e) Ensure that the home's policy and procedures for the management of resident trust accounts and the petty cash trust money are complied with.

f) Ensure that the home's policy and procedures related to the Medication Management System are complied with.

g) Ensure the home's Continence Care and Bowel Management program policies related to monitoring resident bowel movements are complied with.

Grounds / Motifs :

1. The licensee has failed to comply with compliance order #001 from inspection 2017_607523_0021 (A1) served on September 22, 2017, with a compliance date of October 31, 2017.

The licensee was ordered to ensure that any plan, policy, protocol, procedure,

strategy or system instituted or otherwise put in place was complied with specifically but not limited to: Medication and Treatment Administration Record.

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

A) Section 86 (1) of the Long Term Care Homes Act, 2007 states "every licensee of a long-term care home shall ensure that there is an infection prevention and control program for the home."

In accordance with O. Reg. 79/10, s. 229 (8), the licensee was required to ensure that there was in place "(a) an outbreak management system for detecting, managing and controlling infectious disease outbreaks, including defined staff responsibilities, reporting protocols based on requirements under the Health Protection and Promotion Act, communication plans and protocols for receiving and responding to health alerts; and (b) a written plan for responding to infectious disease outbreaks."

Specifically, staff did not comply with the licensee's "Infection Control Manual" policy regarding "Outbreak Management – IC-B-70 Control Measures" last revised April 2017, and the "Outbreak Management – IC-B-30 Outbreak Contingency Plan" last revised April 2017, which were part of the licensee's infection prevention and control program.

Specifically staff also did not comply with the measures documented in CIS report which was submitted to the MOHLTC, which was identified as a "disease outbreak" and was classified as an Acute Respiratory Illness (ARI). The report stated that the measures put in place in the home included "additional precaution signs posted," "staff cohorting for resident care," "resident cohorting for dining and activities where possible" and "continued case finding/surveillance for both staff and residents."

i) During the entrance conference for the Resident Quality Inspection (RQI), an identified staff member reported that the home had a respiratory infection outbreak in a specific area of the home.

During observations by an inspector it was found that multiple identified residents were eating together in an area away from the main dining room. Multiple staff members were observed going in and out of the room during the meal and then

going into the Main Dining Room. At times staff were wearing gowns, gloves and masks when in the separate dining area and at other times they were not wearing this Personal Protective Equipment (PPE). The residents in the room were not wearing masks. Identified residents were observed coughing in the room.

Residents were observed being taken out of the room and down the hallway and not wearing masks.

During an interview an identified staff member told an inspector that an area was being used for residents at meals because there were so many residents in isolation that the management said the residents on isolation were to have their meals in that room. This staff member said that usually during an outbreak the residents would be in their room with tray service.

During an interview another identified staff member said that the residents who were eating in the separate location were the ones presenting with one or more symptoms related to the outbreak. This staff member said that staff were expected to wear gloves, gown and mask and stay in that area during the meals. This staff member said they had previously directed staff that the residents who were on isolation were to be wearing masks when being transferred out of their rooms.

An inspector observed “Droplet Precaution” signs posted on the doors to the rooms for the identified residents which stated "resident must wear a mask if they leave the room" and “wear mask and eye protection within two meters of the resident."

During an interview the Assistant Director of Care (ADOC) said they were the lead for the Infection Prevention and Control (IPAC) Program in the home. The ADOC said that during the outbreak all residents who were identified with symptoms were eating in the separate area. The ADOC said that all residents on the line listing did not have the same symptoms and some only had one symptom. The ADOC said that when in the separate area the residents were not wearing PPE and that staff were to be wearing PPE at all times. The ADOC said that during outbreaks Public Health would provide them with direction for the outbreak measures. The ADOC said that after initially speaking with an inspector they followed-up with a call to Public Health to discuss the practice of taking the residents to the same dining room and they were directed that the residents were to be isolated to their room. The ADOC said they informed Interim DOC and the Administrator and they said they would direct staff to try to keep the residents in their rooms and provide more staff to

that floor to help them for meals.

The licensee's "Infection Control Manual" policy regarding "Outbreak Management – IC-B-70 Control Measures" last revised April 2017, stated that "the control measures which are implemented after the outbreak is declared will be decided by the DOC/ICC in consultation with the Public Health Department (DH) in accordance with current practices."

The licensee's "Infection Control Manual" policy regarding "Outbreak Management – IC-B-30 Outbreak Contingency Plan", last revised April 2017, stated that "each home will develop an outbreak contingency plan individualized to the home in managing an outbreak in order to eliminate transmission of a disease causing agent. The plan will be in line with the Public Health recommendations."
The "Respiratory Outbreak Control Measures" which was electronically provided to the home by the Middlesex-London Health Unit on March 7, 2018, included the following:
-"Routine Practices + Droplet/Contact Precautions (PPE) Masks within two meters of cases/suspect case; gloves – direct care tasks; hand hygiene before donning and after removal."
-"Isolate cases to room – when possible for this population, five days from onset or until symptoms resolve whichever is sooner; maintain physical separation from roommates."
- "Isolate suspected cases (those with one symptom) to room – at least 24 hours using same precautions; extend isolation if symptom(s) persist or worsen."
-"Cohort health care workers when possible – dedicate staff to cases only and/or to affected or unaffected units only."

During an interview the Administrator told an inspector that the "Respiratory Outbreak Control Measures" from Public Health were considered to be part of the outbreak management plan in the home and staff were expected to comply with these measures. The Administrator said that up until a specific date they had been grouping all residents with symptoms in one dining room area and then after more education from Public Health they changed to providing trays with supervision for those residents in isolation. The Administrator said it was the expectation that staff would be wearing the appropriate PPE according to the protocols and for the current outbreak that would include wearing mask when within two meters of the residents.

Based on these observations, interviews and record review the staff in the home did

not comply with the outbreak management plan and strategy that was in place. Residents who had been identified by staff in the home to have one or more symptoms related to the outbreak were eating their meals together in a separate dining area and therefore the cases and suspected cases were not isolated to their room and there was not dedicated staff providing care to the cases only during mealtimes. It was also observed during the meal that staff were not consistently following the "Droplet/Contact Precautions (PPE)" of wearing masks within two meters of cases/suspected cases when the residents were in this dining room.

ii) Observations by an inspector at specific meal found an identified resident eating their meal in the main dining room and staff were not wearing Personal Protective Equipment (PPE) when sitting beside this resident. At that time there was also a "Droplet Precaution" sign on the resident's door.

The "Respiratory Line Listing" was provided to an inspector by a staff member in the home and this identified resident was included. This document did not show that this resident was considered to be out of isolation.
During an interview an identified staff member told an inspector that this identified resident was not listed on the "Respiratory Monitoring Sheets" as being in isolation but was listed on the line listing. This staff member said that based on review in the electronic documentation system at the time of the interview they did not see any documentation that the resident had symptoms and would be considered to be clear and could be removed from isolation. This staff member said that this resident was still considered to be in isolation and should not have been in the main dining room.

The "Respiratory Outbreak Control Measures" which was electronically provided to the home by the Middlesex-London Health Unit on a specific date, included the following:
-"Surveillance criteria for line listing and case definition acute onset of at least two of the following symptoms of upper/lower respiratory tract infection" and included "runny nose or sneezing" and "stuffy nose (i.e. congestion).
-"Routine Practices + Droplet/Contact Precautions (PPE) Masks within two meters of cases/suspect case; gloves – direct care tasks; hand hygiene before donning and after removal."
-"Isolate cases to room – when possible for this population, five days from onset or until symptoms resolve whichever is sooner; maintain physical separation from roommates."

During an interview the Administrator said that the staff in the home would know which residents were in isolation by the sign on their door, communication at change of shift and the line listing with the RN. The Administrator acknowledged that there were two versions of the line listing being used at the time of the inspection which did not include the same information on both. The Administrator also said that the "Respiratory Outbreak Control Measures" from Public Health were considered to be part of the outbreak management plan in the home and staff were expected to comply with these measures.

Based on these observations, interviews and record review the staff in the home did not comply with the outbreak management plan and strategy that was in place. An identified resident was included on the line listing as a case for the respiratory outbreak and was observed not to be isolated to their room for meals and staff were not wearing PPE when within two meters of this resident.

iii) During an interview an identified staff member told an inspector that they were in a position that involved working on two different floors in the home on a specific date, and one of the floors was considered to be in respiratory outbreak.

The "Respiratory Outbreak Control Measures" which was electronically provided to the home by the Middlesex-London Health Unit on a specific date, included the following:
-"Cohort health care workers when possible – dedicate staff to cases only and/or to affected or unaffected units only."

During an interview the Interim Director of Care (IDOC) acknowledged that the cohorting of health care workers was identified on the Public Health control measures. The IDOC said they had been doing the best they possibly could to have the staff stay on the outbreak floor at times and that there would be primary staff that would work on that floor. When asked how many different PSWs had worked on the unit since the outbreak started the IDOC provided a list which identified 26 different PSW staff. The IDOC said that the PSW float did work between the two floors on days and evenings during the outbreak and that the RPN on the night shift floated between the two floors.

Based on these observations, interviews and record review the staff in the home did not comply with the outbreak management plan and strategy that was in place as the home did not have dedicated staff to cases or affected floors only.

iv) During the RQI an inspector observed an identified resident coughing and a staff member was in closed proximity to the resident and was not wearing PPE. There was no "Droplet Precaution" sign observed on the door at that time.

During the RQI an inspector observed that another two identified residents had a "Droplet Precaution" sign on their door. A staff member was observed going into the rooms without PPE and providing care to the residents. The inspector then observed that an identified resident had a "Droplet Precaution" sign on their door. One of the staff members told the inspector that that they did not think that the resident was on any precautions.
During the RQI an inspector observed another staff member provide care to another identified resident without wearing PPE.

The "Respiratory Line Listing" for showed that these identified residents were included as having symptoms related to the outbreak at the time that the observations were made by the inspectors.
During the RQI an inspector observed a staff member not removing gloves or doing hand hygiene when going between two resident different identified residents.

The "Respiratory Outbreak Control Measures" which was electronically provided to the home by the Middlesex-London Health Unit on a specific date, included the following:
-"Routine Practices + Droplet/Contact Precautions (PPE) Masks within two meters of cases/suspect case; gloves – direct care tasks; hand hygiene before donning and after removal."
During an interview the Administrator said that the staff in the home would know which residents were in isolation by the sign on their door, communication at change of shift and the line listing with the RN. The Administrator said it was the expectation in the home that the staff would be using the appropriate PPE and would be completing proper hand hygiene. The Administrator said the staff in the home had recently received mandatory education regarding proper hand hygiene. The Administrator told an inspector that the "Respiratory Outbreak Control Measures" from public health were considered to be part of the outbreak management plan in the home and staff were expected to comply with these measures.

Based on these observations, interviews and record review the staff in the home did not comply with the outbreak management plan and strategy that was in place as

staff were not following the routine practices and droplet precautions (630).

B) The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy and procedure the licensee was, that the policy and procedure was complied with.

In accordance with O. Reg. 79/10, s.30 (1), the licensee was required to ensure that the following was complied with in respect of each of the organized programs required under section 48 of this Regulation: "there must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required."

Section 48 of O. Reg. 79/10 states “every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed in the home: a falls prevention and management program to reduce the incidence of falls and the risk of injury."

Specifically, staff did not comply with the licensee’s “Falls Prevention” policy regarding “Falls Intervention Risk Management (FIRM) Implementation”, last revised September 2017, which was part of the licensee’s falls prevention program.

The “Falls Prevention” policy regarding “Falls Intervention Risk Management (FIRM) Implementation” last revised September 2017 included the following under post fall management:
- "If a fall is not witnessed or the resident had hit his/her head, the Head Injury Routine (HIR) will be initiated."
During the RQI an identified resident was observed by two inspectors to have a specific skin integrity concern.
During an interview an identified staff member told an inspector that this resident had experienced a fall on a specific date.

During an interview an inspector observed the home’s video recording for a specific time in a specific location with an identified staff member. During this interview specific details related to the fall were identified.

During an interview the Assistant Director of Care (ADOC) told an inspector that this identified resident had a fall on a specific date and sustained a specific injury. The ADOC said it was the expectation that the HIR was initiated and completed for the resident after this fall. The ADOC reviewed this resident's HIR and said that it was only completed 25 per cent of the times it was supposed to be completed. The ADOC said that the home's falls prevention policy was not complied with (523).

C) The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee was required to ensure that the policy was complied with.

Section 29 of the Long Term Care Homes Act, 2007 states "every licensee of a long-term care home shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with the Act and regulations."
In accordance with O. Reg. 79/10, s.109. the licensee was required to ensure that the home's written policy under section 29 of the Act dealt with:
- "(a) use of physical devices"
- "(e) how consent to the use of physical devices as set out in section 31 of the Act and the use of PASDs as set out in section 33 of the Act is to be obtained and documented"
- "(f) alternatives to the use of physical devices, including how these alternatives are planned, developed and implemented, using an interdisciplinary approach."
Specifically, staff did not comply with the licensee's "Least Restraint" policy regarding "PASD (Personal Assistance Devices) RRP-O-35" last revised January 16, 2018, which was part of the licensee's minimizing of restraining program.

The licensee's "Least Restraint" policy regarding "PASD (Personal Assistance Devices) RRP-O-35", last revised January 16, 2018, included under the "Care Plan" section the following:
-"1. The plan of care must reflect the goals for use of the PASD and how, when and why the device is to be used."
-"3. Intervention description will include how the PASD will be used, when, how long, who will apply and remove, frequency of monitoring and the specific risks associated (e.g. skin breakdown)."

During the RQI an inspector observed that identified residents were using specific PASDs and were not repositioned during an identified time period.

A clinical record review for these identified residents showed they used these devices as PASDs. A review of the plan of care showed it did not include the goals for use of the PASDs, how, when and why the devices were to be used, who would apply and remove and the frequency of monitoring or the specific risks.

During an interview the Assistant Director of Care (ADOC) reviewed the policy with an inspector and said that every resident with a PASD was to have those interventions and tasks in the plan of care. The ADOC said that the expectation would be for the staff to comply with the home's policy and have specific tasks and interventions related to the use of a PASD included in the care plan (523).

D) The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee was required to ensure that the policy was complied with.

In accordance with O. Reg. 79/10, s. 241 (5) the licensee was required to "establish a written policy and procedures for the management of resident trust accounts and the petty cash trust money."
Specifically, staff did not comply with the licensee's "Trust" policy regarding "Trust-Other Resident Expenditures FM-B-40" effective July 2014, which included:

- "invoices will be received at the front office either by mail or hand delivered. The receptionist will open the invoices to be paid out of trust and stamp the invoices with a date stamp and put in the Administrators box for initial to approve services."
- "Administrator will initial invoices and provide them to the bookkeeper responsible for the handing the Trust account or forwarding to the resident or responsible part for further payment."

The MOHLTC received a complaint which reported an identified resident had concerns with the staffing levels in the home. During interviews this resident told inspectors that they had concerns that there were not enough staff available to help them with a specific task related to their trust account with the home.
During an interview the Bookkeeper reviewed the policy with an inspector and said that the policy of the home was not complied with. Bookkeeper said that a specific task for this identified resident was not completed as per the policy (523).

E) The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any

policy, the licensee was required to ensure that the policy was complied with.

The licensee has failed to comply with compliance order #004 from inspection 2017_607523_0021 (A1) served on February 6, 2018 (A1), with a compliance date of October 31, 2017.

The licensee was ordered to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with specifically but not limited to: Medication and Treatment Administration Record.

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

Specifically, staff did not comply with the policy "SmartMeds Pharmacy Medication Administration Policy 3-7" last updated March 2016. This policy stated the resident's identity was to be checked before giving the medication and to remain with the resident until the medication was taken. The registered staff member would then initial the Medication Administration Record to indicate that the medication had been given.

Specifically, staff also did not comply with the "Sharon Village Care Homes (SVCH) Administration of Medications NAM-F-05" policy last reviewed September 2017. The policy stated the registered staff responsible for the administration of medication was accountable and was to provide appropriate documentation.

i) During the RQI an inspector observed two identified staff completing the medication administration in a specific area. One staff member was observed taking medication from the drawer for an identified resident, checked the medication against the electronic Medication Administration Record (eMAR) in the electronic documentation system, administered the medication in the dining room and came back and signed on the eMAR that the medications were administered. The one staff member administered medications to an identified resident and signed the eMAR under another staff member's electronic signature.

During an interview an identified staff member said they did not use their own electronic signature for the medications administered. Both identified staff members

acknowledged that the signature would be of the nurse who prepared and administered the medications and registered staff should be logged in under their own name.

ii) On a specific date and identified resident was given a specific liquid medication glass instead of water with the administration of their other medications. When the resident identified a "terrible" taste, the registered staff acknowledged the error. This resident had received another resident's medication instead of water.

During an interview the Interim Director of Care (IDOC) and Assistant Director or Care (ADOC) stated that an identified staff member was assisting another staff member with the medication administration on that shift. The IDOC stated that the one staff member had passed a glass of the medication instead of water to other staff member to give with an identified resident's other medications. The IDOC stated that the one staff member poured the resident's medications and the other staff member administered them.

iii) During an interview the Administrator stated that according to documentation there was an incident when an identified staff member did not administer the injections that they had documented they had given as another identified staff member had administered the medication.

During an interview an identified staff member stated the process in the home was to have two registered staff witness the draw up into the syringe, the waste and the administration of narcotics or controlled substances and that did not happen on a specific date. This staff member said they signed the eMAR for both injections, but a different staff member administered an identified resident's in the resident's room alone.
The Administrator told an inspector that the "Subcutaneous Administration of Controlled Substances" policy did not have an index number or revised date because it was in draft. The Administrator said the practice had been put in place in January 2018.

The "SVCH Subcutaneous Administration of Controlled Substance" policy with a proposed effective date of January 2018, stated "all controlled substances administered via injection will be drawn up, counted and administered as follows: 1) Two registered staff will be present for the drawing up of the controlled substance. 2) Both registered staff will document on the controlled count their name, indicating that

they both confirm the amount drawn up via needle for injection. 3) Both registered staff will be present with administration of the controlled substance to the resident. 4) Disposal of the injection needle will continue as per best practice guidelines."

The "SmartMeds Pharmacy Narcotic and Controlled Drug Count & Ward Count Policy 6-6" last updated April 2016, stated "when a narcotic medication was administered, the nurse must document the following information on the form: date, time, quantity administered, quantity remaining and the nurse's initials."

During an interview the Administrator stated that the SVCH Administration of Medications policy with index NAM-F-05 was the policy that provided the responsibilities of the registered staff for the administration of medications and the appropriate documentation. The Administrator shared that the registered staff were not to administer and document the administration of medications under any other registered staff member's electronic signature in PCC.

The licensee failed to ensure that the "SmartMeds Pharmacy Medication Administration 3-7" policy, the "SVCH Administration of Medications NAM-F-05" policy, the "SmartMeds Pharmacy Narcotic and Controlled Drug Count & Ward Count 6-6" policy, and the "SVCH Subcutaneous Administration of Controlled Substance" policy were complied with (523).

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

Specifically, the staff did not comply with the "SmartMeds Pharmacy Narcotic and Controlled Drug Count & Ward Count 6-6" policy last updated April 2016. This policy stated when a medication was administered, the nurse must document the following information on the form: date, time, quantity administered, quantity remaining, and the nurse's initials. The policy also stated that to maintain an accurate record of the physical counts, both nurses were required to verify the medications on hand against the Narcotic Ward Drug Count form and that both nurses must be physically present during the entire count.

i) The home submitted a CIS report to the MOHLTC which documented a missing controlled substance for an identified resident. It stated that at shift change there

was a missing dose of a specific medication from the medication card in the medication narcotic bin.

A review of the "Resident's Narcotic/Controlled Drug Count/Ward Count" for this identified resident documented showed specific counts on specific dates with a missing dose showing in the count.

During an interview an identified staff member shared that when they looked ahead on the ward count they noticed that the numbers were off on a specific shift on the count sheet.

During an interview Interim Director of Care (IDOC) stated a medication incident report was received where the medication count for this resident went down by three tablets on the day shift rather than by two tablets. The IDOC stated the order was for one tablet three times a day, therefore one tablet was missing. The IDOC said they investigated this incident and found that an identified staff member had pre-signed the ward count sheets before the count. The IDOC stated that the expectation related to the documentation of controlled substances was to document on the resident's count sheet at the time of the administration and then document on the ward count at the time of the count with two registered staff present.

ii) The home submitted a CIS report to the MOHLTC which documented a missing controlled substance. The report showed that a specific number of a specific medication were reported unaccounted from the stat box and the narcotic medication was not added to the narcotic ward count for tracking purposes.

During an interview the Assistant Director of Care (ADOC), visited each medication room to review the "Narcotic /Controlled Ward Drug Count" sheets in place on each home care area at the time of the inspection. It was identified that the narcotic ward count sheets were not completed as per the home's policy.

iii) The home submitted a CIS report to the MOHLTC which documented a missing controlled substance. The Narcotic/Controlled Ward Drug Count for this date had missing registered staff signatures on the narcotic ward count form.

During an interview the ADOC and IDOC acknowledged that there were missing registered staff signatures on the narcotic ward count for a specific time period for the stat narcotic box. The ADOC also acknowledged that the Narcotic/Controlled

Ward Drug Count for a specific time period was missing the count for an entire area of the home for the floor ward count and stat box count.

The licensee failed to ensure that the "SmartMeds Pharmacy Narcotic and Controlled Drug Count & Ward Count 6-6" policy was complied with.

G) The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee was required to ensure that the policy was complied with.

Ontario Regulation 79/10 s. 48 (1) states "Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable."

Specifically, staff did not comply with the policy "Bowel and Bladder Continence Care Program Implementation CP-K-20" last revised September 2017. The home's policy stated the Personal Support Workers (PSWs) would notify registered staff if the resident had not had a bowel movement in more than forty-eight (48) hours and that registered staff were to review their Resident Home Area bowel/bladder records.

A complaint intake was logged with the Ministry of Health and Long-Term Care (MOHLTC) in regards to the care for an identified resident. The complainant expressed concerns related to the care provided in the home to treat a certain condition and the staff's response regarding the bowel protocol.

The clinical record for this identified resident showed that the staff had documented that the resident had not had a bowel movement for an identified period of time.

During an interview a staff member told an inspector that bowel movements were recorded in Point of Care (POC) and a laxative list was received daily from the night report that had the resident names on it. The staff member said that that the Personal Support Workers (PSWs) would write on the list and chart on POC when residents had a BM. The staff member explained it was the role of the PSW to document on POC and on the laxative list and communicate to the nurse.

During an interview the Assistant Director of Care (ADOC) stated the registered nursing staff would know if a resident was to receive bowel management on their

shift by checking the "Look Back Report" at the beginning of their shift on days and evenings and would follow the bowel protocol and then would follow up with the oncoming shift. The RN on nights would also prepare a bowel list for all the floors used the Look Back Report to create this list. The ADOC stated that the residents' bowel movements (BM) were documented in POC by the PSWs. The ADOC stated the expectation related to reporting bowel movements involved the PSWs reporting to the RPN or RN after changing the residents' briefs or the resident would report it when asked; for those residents who were independent they could also tell the nurses. The ADOC verified that the "Look Back Report" was generated from POC documentation and the clinical dashboard had alerts from POC for BMs and it was the expectation that the RN on nights and the RPNs on the day and evening shifts on all floors reviewed the report. An inspector and ADOC reviewed the home's "Bowel and Bladder Continence Care Program Implementation" policy and the ADOC identified that it stated the PSWs would notify registered staff if the resident had not had a bowel movement in more than 48 hours. The ADOC said that PSWs were not reporting bowel movements that did not occur in 48 hours. The ADOC stated that the PSWs would not know if the resident had a bowel movement in the last 48 hours as some PSWs worked on different floors for different shifts and not always two days in a row taking care of the same resident, and the home had part time and casual PSWs also working on floors and sometimes with agency PSWs. The ADOC stated there was no "Resident Home Area bowel/bladder record". The ADOC said that the policy was revised September 2017, but did not reflect the practices in the home related to bowel movement monitoring and reporting by the PSWs and registered staff. The ADOC said the policy was not followed for this identified resident.

During an interview the Administrator stated all corporate policies were reviewed between January 2017 and September 2017 and policies identified as reviewed September 2017 meant the policy was reviewed and finalized corporately. The policy titled, "Bowel and Bladder Continence Care Program Implementation" was reviewed with the Administrator where it stated PSWs would notify registered staff if the resident had not had a bowel movement in more than 48 hours. The Administrator said that this was not the prevailing practice related to monitoring and reporting by PSWs and that the PSWs did not have access to the information necessary to report if a resident had not had a bowel movement in more than 48 hours. The Administrator also verified that the "Resident Home Area bowel/bladder record" was not the prevailing practice related to monitoring of bowel movements by the registered staff; that the "Look Back Report" was the tool used for this purpose. As part of the "Continence Management Program Evaluation" completed January 15,

2018, it documented, "Policy has been updated. No other changes recommended at this time". The Administrator verified that the "Bowel and Bladder Continence Care Program Overview" was the policy referred to in the program evaluation related to the written description of the program including goals and objectives and the only policy reviewed as part of that evaluation. The Administrator said that the "Bowel and Bladder Continence Care Program Implementation" policy and the "Bowel and Bladder Continence Care Program Overview" policy was part of the Continence Care and Bowel Management program.

The licensee failed to ensure that the "Bowel and Bladder Continence Care Program Implementation CP-K-20" policy was complied with.

Based on these observations, interviews and record reviews the licensee has failed to ensure that multiple required policies that had been instituted in the home were complied with.

The severity of this issue was determined to be a level 2 as there was potential for harm. The scope of the issue was a level 3 as it was related to non-compliance that had potential to affect a large number of residents in the home. The home had a level 5 history as they had multiple non-compliances with at least one related Compliance Order (CO) to this section of the LTCHA that included:

• WN issued January 4, 2018 (2017_607523_0033);
• WN and CO issued September 22, 2017 (2017_607523_0021 (A1)) with compliance due date October 31, 2017;
• WN and VPC issued March 8, 2016 (2016_229213_0005). (630)

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

Nov 30, 2018(A2)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 006

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

Linked to Existing Order / Lien vers ordre existant: 2017_607523_0021, CO #005;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s. 31 (3)(a).

Specifically the licensee must:

a) Develop, document and implement a process in the home to identify the assessed care and safety needs of the residents in each home area.

b) Based on the identification of the assessed care and safety needs of the residents in each home area, review and update the written staffing plan in the home to ensure it provides for a staffing mix that is consistent with the residents' needs.

Grounds / Motifs :

1. The licensee has failed to comply with compliance order #005 from inspection 2017_607523_0021 (A1) served on February 6, 2018 (A1), with a compliance date of February 15, 2018.

The licensee was ordered to ensure that the staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs.

The licensee has failed to comply with Director's order #001 amended on December 21, 2017, with a compliance date of February 15, 2018.

The licensee was ordered to do the following:
1) To bring in a consultant from an external company with extensive experience in managing or operating LTC homes to conduct a review and make recommendations for improvement regarding the following:
a. The nursing program within the home to ensure it is organized to meet the assessed needs of the residents;
b. The program of personal support services for the home to ensure it is organized to meet the assessed needs of the residents;
c. The staffing plan within the home to ensure it meets the assessed needs of residents and is evaluated and updated as necessary.

2) Upon completion of the review the findings and recommendations will be set out in a report which will be provided by the consultant to both the licensee and the Director under the Act. This review and findings must be finalized no later than November 30th, 2017.

Within two weeks of receiving the report from the review, the licensee will submit a plan to the Director identifying the recommendations that will be implemented and the timelines for implementation. That plan will be reviewed by the Director and may be changed based on the Director's review of the report from the review and the plan submitted by the licensee. Upon approval of the plan by the Director, the licensee will implement the actions identified.

The licensee has failed to ensure the written staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs and that met the

requirements set out in the Act and this Regulation.

A) The home submitted a CIS report to the MOHLTC related to an identified resident. The CIS stated that a staff member had reported that on a specific dates this resident had to wait identified amounts of time for a requested medication.

During an interview the identified resident told an inspector that they did remember having to wait for a requested medication. This resident stated that they thought that it was taking a little longer to get narcotic medications because they needed two nurses for a witness.

During interviews with identified staff members they said that at the time of the incident this resident had to wait an identified period of time for a requested medication. One staff member said they were short registered staff on that specific weekend and there were no other registered staff available to help at the time (563).

B) The home submitted a CIS report to the MOHLTC which was identified as an incident of staff to resident neglect on a specific date. The CIS report stated that the resident had told a staff member that they required a specific type of care and this care was not provided to the resident for an identified time period.

A written "Concern/Complaint Form" related to the incident, completed by a staff member stated that the resident had told the writer that they had asked for help but was told that the staff were not available at that time to assist. Another written "Complaint/Concern Form" completed by another staff member documented that the resident was found in a condition that required care.

The clinical record for this identified resident showed they required a specific level of assistance from staff with this care.

During an interview this identified resident told an inspector that they recalled the incident and that they had to go to bathroom really bad and they could not hold it so they soiled in their brief. This resident reported that they had to wait for staff to provide care that they required.

During interviews with identified staff members they reported that this resident required a specific level of care from staff. The staff members said that on that specific time the resident did not receive the care they requested at the time as they

staff were providing care to other residents.

The "Daily Assignment Sheet" for that date showed that the home had no staff shortages that day.
Documentation provided by the home related to that incident showed that they had identified that the resident had not received the care they required "in a timely manner."

During an interview the Interim Director of Care (IDOC) stated that the outcome of the investigation had determined that the resident did not receive the care they required in a timely manner (524).

C) During the RQI an identified resident said that the home was always short staffed and that they had to wait long to get to the bathroom.
A review of the call bell log for a specific time from for this resident showed that the resident on several occasions waited over 5 minutes for staff to respond to the call bell, including seven different occasions where the resident waited 10-15 minutes.

During the RQI an identified resident said that on occasion it took staff over ten minutes to respond to the call bell that they felt that was a long time if you were waiting for a specific type of care.

A review of the call bell log for a specific time from for this resident showed that the resident on several occasions waited over 5 minutes for staff to respond to the call bell, including seven different occasions where the resident waited 10-15 minutes.

During the RQI another identified resident said they felt the home still did not have enough staff to assist residents. This resident said that sometimes they waited over 20 minutes for staff to respond to call bell.

A review of the call bell log for a specific time from for this resident showed that the resident on several occasions waited over 5 minutes for staff to respond to the call bell, including seven different occasions where the resident waited 10-15 minutes and there was an occasion when they waited over 30 minutes.

During the RQI another identified resident said that sometimes it took staff 15 to 20 minutes to respond to the call bell.

A review of the call bell log for a specific time from for this resident showed that the resident on several occasions waited over 5 minutes for staff to respond to the call bell, including seven different occasions where the resident waited 10-15 minutes and there was an occasion when they waited over 20 minutes.

In an interview the Interim Director of Care (IDOC) told an inspector that the expectation was for the staff to respond to the residents' call bell in around five minutes (523).

D) During the RQI inspectors completed multiple observations and interviews which identified that the staffing mix was not consistent with the assessed care and safety needs of the residents.

i) Observations by an inspector during a specific time period found that identified residents in a specific location of the home did not receive the assistance they required during meal service. These observations also found that there were identified residents who were brought to the dining room two hours after the established mealtime as they had not received the care they required to allow them to attend the meal prior to that time.

Observations by an inspector during a specific time period found that identified residents in a specific location of the home did not receive the assistance they required during meal service. These observations also found that there were identified residents who were brought to the dining room two hours after the established mealtime as they had not received the care they required to allow them to attend the meal prior to that time.

Observations by an inspector during another specific time period found that identified residents in a specific location of the home did not receive the assistance they required during meal service.

During interviews multiple identified staff told an inspector that they had difficulties providing all the care that residents required. The staff reported that management and recreation staff would help in the dining rooms at some meals and at other meals they did not have enough staff to assist all the residents who required assistance. Another staff member said that they were always short staff especially at mealtimes. The staff member said that one specific care area had the heaviest care needs in the home and they needed more staff especially during mealtimes and morning care.

Another staff member told an inspector that they did not feel they had enough resources available to assist the residents in a specific area especially during the respiratory outbreak (630).

ii) Observations by an inspector during a specific time period found that identified residents in a specific location of the home did not receive the assistance they required with repositioning and toileting.

During an interview an identified staff member said that they were short on staff that day and were running late all morning. They were not able to complete tasks for residents like toileting and repositioning the resident.

During an interview with another identified staff member they said that when a resident had a specific device they would take off the device, reposition the resident and reapply device as needed. This would be completed every two hours (523).

iii) Observations by an inspector during a specific time period found that an identified resident told a staff member that they needed a specific type of care. This resident was then observed waiting for an hour and 20 minutes before they received the required care.

iv) Observations by an inspector during another specific time period found that identified residents in a specific location of the home did not receive the assistance they required with repositioning and toileting.

During an interview with an identified staff member they reported that they worked short multiple times a week most times. On those days they were not able to complete resident's tasks assigned to them. This staff member said they were not able to complete repositioning every two hours or toileting routines and this had not improved.

v) During an interview an identified resident told an inspector that they were concerned that at times it took the staff a long time to answer their call bell. This resident said that at times they would ring the bell for assistance with toileting and the staff would not arrive in time to prevent incontinence.

Review of the "Call Bell Log" for this resident showed that on three specific occasions it took staff 25 minutes or more to cancel the call.

Observations by an inspector found that this identified resident was repositioned or toileted by staff by staff for an identified time period. During an interview this resident said they had not received the care they required and preferred on that shift.

vi) Observations by another inspector during another specific time period found that identified residents in a specific location of the home did not receive the assistance they required with repositioning and toileting. During these observations it was also found that identified residents did not receive the assistance during the meal service that they required.

During an interview with an identified staff member they reported that that they thought that they did not have enough help on the floor to provide the residents with the assistance they required. Another staff member reported that they had charted that on one of the identified residents had been repositioned but they had not provided this care.

E) During an interview the Administrator told inspectors that the home had hired an external consulting company in response to the Director's Order. The Administrator said that the home had written staffing plan which identified the staffing levels for each floor on each shift. The Administrator said that they had participated in a review and evaluation of the written staffing plan along with the peopleCare consultants and Interim Director of Care (IDOC). The Administrator said that there was one vacant PSW line but otherwise all lines were filled in the home at the time of the interview. The Administrator said that one of the floors in the home had heavier care needs than the other floors at the time of the inspection. The Administrator said that the staffing levels identified in the plan were the same on each floor. The Administrator said that in the past they used to use Resource Utilization Group (RUG) scores or Case Mix Index (CMI) to assess the care needs on the floor but they were not using those anymore. When asked how they ensured that the required care was being provided to residents, the Administrator said that they reviewed it at "huddles" daily and would then take staff off other floors to assist or re-organize on a day to day basis. The Administrator said they also reviewed the outstanding documentation. The Administrator said that there had been no concerns brought forward by staff at huddles related to care not being provided. The Administrator said that the recreation staff had been assisting with meals on a regular basis. The Administrator said that this written staffing plan did not differentiate between staff who were on modified duties and those who were on

regular duties and that they did have staff in the home who were on modified duties who were unable to assist with lifts and transfer.
The Administrator provided written records used in the home as part of the written staffing plan and the evaluation of the staffing plan. The "Annual Program Evaluation – Nursing Staffing Plan Reg 31 (2)" stated "Date of Evaluation: December 13, 2017." This document indicated that the evaluation was completed by the Administrator, identified consultants and the IDOC. Under "comments/recommendations" it stated "staffing adjustments discussed:" and this was blank. The record also stated "staffing adjustments started December 13, 2017" but did not indicate what the staffing adjustments were.

The home's "Staffing Levels" document showed the number of shifts and hours to be worked by the DOC, ADOC, RNs, RPNs and PSWs in the home per day and per week. This document did not identify which floor that shifts or hours were to be worked or distinguish between modified and non-modified staff.

During an interview the peopleCare Vice President of Clinical Services (VPCS) told inspectors that they started consulting with the home at the end of November 2017, with the expectation of working on the compliance action plan with the home. The peopleCare VPCS said that they participated in the staffing program evaluation in December 2017, which included a review of the written staffing plan. The peopleCare VPCS said they had implemented changes to the orientation and education of staff, hired staff and were working with the union to move to straight rotations on the staffing schedule. The peopleCare VPCS said that the review of the written staffing plan was done as part of the peopleCare operational review. The peopleCare VPCS said that their recommendation had been to develop a contingency plan that was consistent and communicated, to follow the absenteeism policy and to fill all the leadership positions and had not made changes to the ultimate staffing plan. The peopleCare VPCS said that they thought that all of their recommendations had been implemented. The peopleCare VPCS said that they had not included PSWs on modified duties in their staffing plan and that they would have a shadow or be given other duties. The peopleCare VPCS said they had not been involved with staff who were on modified duties and were not aware of whether there were staff who were unable to assist with lifts or transfers. The peopleCare VPCS said that the staffing levels were the same on each floor and that there were differences between the floors as some floors required more assistance at meals. The peopleCare VPCS said that the Registered Nurse (RN) would go and help at specific meals or the recreation staff would help as well. The peopleCare VPCS said

they were not aware of any concerns from staff regarding the level of care residents required on third floor.

During a follow-up interview the peopleCare VPCS told inspectors that they thought the staffing mix in the home met the needs of the residents. The peopleCare VPCS said that this opinion was based on the staffing mix that they had in their peopleCare homes and the funding that the home received. The peopleCare VPCS said they thought that the home was meeting the care needs of the residents on a shift by shift basis and that this was checked through reviewing the documentation of tasks completed. When asked how they ensured that the staffing plan provided for a mix that was consistent with residents' assessed care and safety needs, the peopleCare VPCS said that they looked to see that all shifts were filled and that the care was completed. The peopleCare VPCS said that they had identified that the documentation was not always being completed and they had been doing education with staff about completing documentation. The peopleCare VPCS said that they could not tell whether it was a documentation issue or that the care had not been done by looking at the tasks but said that if it was not documented then it was not done. The peopleCare VPCS said they personally had not done audits involving talking to residents about the care. The peopleCare VPCS said they would look at the RUG score and the aggressive behaviours as well as how many mechanical lifts were required on a floor and that they had thought someone had done that during their operation review as they had not personally looked at those. The peopleCare VPCS said they had not moved staff around in the home on a permanent basis as they were often dealing with staff shortages and they based the staffing plan on keeping all the staff even on the floor. The peopleCare VPCS said that the main focus had been on making sure each floor had the staff that had been assigned to it on each shift.

The documentation of the summary of staff call-ins and replacements for a specified time period showed that there were 16 out of 36 calendar days when the home was short PSW hours (44 per cent). This ranged from 2.08 hours to 17.5 hours per day.

During an interview the Interim Director of Care (IDOC) and Assistant Director of Care (ADOC) told Inspectors that they had both been involved in reviewing the written staffing plan for the home in December 2017. The IDOC said that the recommendations from this review were to ensure that the vacant lines were filled, hire new staff, develop a contingency plan, and implement the attendance program and "staffing up." When asked how they ensured that the staffing plan provided for a

mix that was consistent with residents' assessed care and safety needs, the IDOC said that when there were modified workers they tried to put them on separate floors, by auditing to ensure the care was completed and by doing rounds on the floors. The IDOC said that they did not review the Case Mix Index (CMI) scores as part of the staffing plan review to ensure that the level of care to identify if staff needed to be moved to another floor. The ADOC said that there were some floors where there were more resident requiring mechanical lifts for transfers and that they were pulling the float to that floor or that sometimes the registered staff were assisting with the transfers. The ADOC said that on a regular basis they were pulling staff from one floor to go to another and that the registered staff or management were assisting with care on the floor. The IDOC said that they did not make changes to the staffing plan based on the review and they had talked about having four PSWs per floor on days but that had not been implemented. The ADOC said that the staffing pattern in the home had not changed at any time when they were working in the home. The ADOC said that when it was regular staff working on the floor they had an easier time than if there was casual staff or agency staff and on those days they tended to get behind and the RPN or management was needed to help. When asked if the current staffing mix in the home met the needs of the residents the ADOC said it depended on the floor and the IDOC said that the proposed adjustments to the staffing plan had not occurred.

Based on these observations, interviews and record reviews the home's written staffing plan did not provide for a staffing mix that was consistent with residents' assessed care and safety needs.

The severity of this issue was determined to be a level 2 as there was potential for harm. The scope of the issue was a level 3 as it was related to non-compliance that had potential to affect a large number of residents in the home. The home had a level 5 history as they had multiple non-compliances with at least one related CO to this section of the LTCHA that included:

• Director's Order (DO) served on December 21, 2017, with a compliance date of February 15, 2018;
• WN and CO issued February 6, 2018 (A1) (2017_607523_0021 (A1)) with compliance due date February 15, 2018 (A1). (523)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

Sep 28, 2018

Order # /
Ordre no : 007

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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).

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s. 49. (2)

Specifically the licensee must:

a) Ensure when two identified residents and any other resident has fallen that the resident is assessed by a registered nursing staff member.

b) Ensure that the home's Falls Prevention and Management program policies and procedures are complied with regarding the completion and documentation of post fall assessments for two identidfied residents and any other resident.

c) Ensure that all leadership team members, Registered Nurses, Registered Practical Nurses and Personal Support Workers working in the home are re-educated on all of the home's Falls Prevention and Management policies and procedures including the procedures in the home for falls prevention and post fall assessments. The home must keep a documented record of the education provided.

Grounds / Motifs :

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

A) The home submitted a CIS report to the MOHLTC related to a falls with injury for an identified resident.

During interviews with identified staff members they reported that this resident had a history of falls. One of the staff reported that it was the expectation in the home that when a resident had fallen the registered staff would complete an assessment and then document the assessment in a post-falls assessment in the electronic documentation system.

The clinical record for this resident showed that they had a specific number of falls in an identified time period. The record showed that there was not a completed "Post Fall Assessment" documented for each of the falls included in the progress notes.

During an interview with Interim Director of Care (IDOC) told an inspector that it was the expectation in the home that after a resident had fallen that a post fall assessment would be completed and documented using the "Post Falls Assessment" in the electronic documentation system. The IDOC said it was the expectation that all aspects of the assessment would be completed. The IDOC said that it was the expectation that the registered staff who responded to the fall would be the one to assess and document the assessment in PCC. The IDOC acknowledged that this identified resident did not have post fall assessments documented for all their falls in a specified time period.

Based on these interviews and clinical record review the staff in the home did not complete a post fall assessment using a clinically appropriate assessment instrument each time that this resident fell. The licensee has failed to ensure that when a resident had fallen, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

B) During the RQI an inspector observed that an identified resident was on the floor.

During interviews with multiple identified staff members it was reported that this identified resident had a history of falls. Staff reported that they thought the plan of care for this resident included interventions providing direction to staff related to what to do if a resident was found on the floor and that they thought that a post fall assessment was usually not required for this resident.

The clinical record for this resident showed that this resident had been identified to have a specific risk level for falls for specific reasons. The record documented multiple falls in a specific time period and there was not a completed "Post Fall Assessment" documented for each of the falls included in the progress notes. The plan of care for this resident did not provide individualized instructions to staff regarding when a post fall assessment was to be completed.

During an interview the Interim Director of Care (IDOC) told an inspector that it was the expectation in the home that after a resident had fallen that a post fall assessment would be completed and documented using the "Post Falls Assessment" in PCC. The IDOC said that according to the home's policy a fall was considered to

be any unintentional change of position where the resident ended up on the floor ground or other lower level. When asked if there was a way to assess if the change of position was intentional or unintentional, the IDOC said that the same process should be completed regardless of whether it was intentional or unintentional. The IDOC said that the plan of care for this resident directed that staff were to complete a post fall assessment for falls. When asked how staff were to assess this resident if the resident was found on the floor to determine if it was to be considered a fall, the IDOC said that the plan of care directed that staff were to ask the resident. The IDOC said that they thought that registered staff would need to do an assessment each time that this resident was found on the floor.

The home's policy titled "Falls Intervention Risk Management (FIRM) – Implementation" with revised date January 16, 2018, included the following:
- Under definitions it stated "a fall can be defined as any unintentional change in position where the resident ends up on the floor, ground or other lower level."
- The policy did not include direction or staff on how to assess whether a change in position was "unintentional".
- Under "Post Fall Management" it stated "if a fall has occurred, the Registered Staff will complete a Post Fall Assessment. An accompanying progress note (on PCC) will also be completed unless initiated via a structured progress note built into the assessment."

The Assistant Director of Care (ADOC) told inspectors that it was the expectation in the home that the registered staff would complete an assessment of this resident each time the resident was found on the floor by the PSW staff. The ADOC said it was the expectation that the PSWs would notify the registered staff that they had found the resident on the floor.

Based on these interviews and clinical record review the registered staff in the home did not complete a post fall assessment each time that this identified resident was found on the floor. The plan of care directed staff to complete a post fall assessment with each fall. This resident's documented assessments showed that this resident had a cognitive impairment and was at risk for not being able to effectively communicate their needs.

The severity of this issue was determined to be a level 3 as there was actual harm. The scope of the issue was a level 3 as it was related to 2 of 4 residents reviewed and the same residents were affected by repeated occurrences. The home had a

level 3 history as they had one or more related non-compliance with this section of the LTCHA that included:

• WN and VPC issued May 28, 2015 (2015_182128_0011). (630)

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

Nov 30, 2018(A2)

Order # /
Ordre no : 008

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

Linked to Existing Order /
Lien vers ordre existant: 2017_607523_0033, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices;
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s. 53 (3)(c)

Specifically the licensee must:

a) Develop and implement a documented procedure in the home to ensure that the evaluation of the Responsive Behaviours program required under 53 of the Regulations is completed in accordance with the legislation.

b) Ensure that the written record of Responsive Behaviours program evaluation that was completed in response to compliance order #002 from inspection 2017_607523_0033 served on January 4, 2018, with a compliance date of January 31, 2018, is updated to include:
1) the date the evaluation was completed
2) the full names and signatures of the persons who participated in the evaluation and the dates when they participated
3) a summary of the changes made to the program and the date that those changes were implemented.

Grounds / Motifs :

1. The licensee has failed to comply with compliance order #002 from inspection 2017_607523_0033 served on January 4, 2018, with a compliance date of January 31, 2018.

The licensee was ordered to ensure that:
a) The matters referred to in Ontario Regulation 79/10 s. 53 (1) were developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
b) At least annually, the matters referred to in subsection (1) were evaluated and updated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.
c) A written record was kept relating to each evaluation under clause (b) that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The licensee completed step a) and b).

The licensee failed to complete step c) regarding the written record of the annual evaluation.
On April 4, 2018, a document titled "Annual Program Evaluation" and "Responsive Behaviour Program Evaluation" was provided to the inspectors. This document stated "Date of Evaluation: Started December 15, 2017" and did not document when this was completed. This written record identified that peopleCare Vice President Clinical Services (VPCS), identified staff members, the Director Therapeutic Recreation (DTR) and a peopleCare staff member completed the evaluation. This written record included the following documentation:
- No documentation under the column "changes made" or the date that changes were made.
- A statement within the column "recommendations" which stated "paper copies of policies available updated September 2017." This did not included a date that this change in policy was implemented.
- A statement within the column "recommendations" which stated "DOS charting to be added to the task POC." This did not include documentation of the changes that were made or a date that change was implemented.

The Administrator provided an updated document titled "Annual Program Evaluation" and "Responsive Behaviour Program Evaluation" to the inspectors. This document stated "Date of Evaluation: Started December 15, 2017" and did not include other documentation related to when this record was revised or completed. This written record identified that the peopleCare VPCS, identified staff members, the Director Therapeutic Recreation (DTR), and identified peopleCare staff had completed the evaluation. This written record included the following documentation:
- A statement within the column "recommendations" which stated "paper copies of policies available updated September 2017." This did not included a date that this change in policy was implemented.
- A statement within the column "recommendations" which stated "DOS charting to be added to the task POC." The document indicated this was "complete" but did not include the date that the change was implemented.

During an interview the peopleCare VPCS said they had lead the annual program evaluations in the home. The peopleCare VPCS said that this was a "running document" and did not know the exact date that it was updated and said that it was updated when something was completed. The peopleCare VPCS said that during the evaluations they did not have access to change the policies. The peopleCare

VPCS said they had updated program evaluation records and had provided these to the Administrator.

During an interview the DTR told an inspector that although their name was listed on the program evaluation record they had not participated in the annual program evaluation for the home.

During an interview with an identified staff member they said that they had been involved in the annual program evaluation for the Responsive Behaviours Program in the home. This staff member said they had not been to a meeting on December 15, 2017, when all the people listed on the program record evaluation had been in attendance. This staff member said that the record of the evaluation did not include when the policy had been revised or implemented and could not recall when this has occurred. This staff member said that some of the things identified in the program evaluation had been implemented in the home but the dates for that implementation had not been documented on the record.

During a follow-up interview peopleCare VPCS said that the evaluation was started on December 15, 2017. PeopleCare VPCS said they thought they had updated the written record of the evaluation after they met on January 3, 2018. PeopleCare VPCS said that the written record of the evaluation did not show the date that the change in the DOS charting was implemented and they were not sure of the date when this occurred. PeopleCare VPCS said that there were changes to policies made in 2017 which were not reflected in the written documentation of the program evaluation as this had occurred before they had started working in the home.

Based on these interviews and record reviews the written record relating to the Responsive Behaviours annual evaluation dated December 15, 2017, did not accurately identify the names of persons who participated in the evaluation or the date that the evaluation was completed. This written record also did not include a summary of the changes made or the date the changes were implemented.

The severity of this issue was determined to be a level 2 as there was potential for harm. The scope of the issue was a level 3 as it was related to non-compliance that had potential to affect a large number of residents in the home. The home had a level 5 history as they had multiple non-compliances with at least one related CO to this section of the LTCHA that included:

• WN and CO issued January 4, 2018 (2017_607523_0033) with compliance due date January 31, 2018. (630)

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

Sep 28, 2018

Order # /
Ordre no : 009

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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 must be compliant with O.Reg. 79/10, s. 53 (4)

Specifically the licensee must:

a) Ensure there is a process developed and implemented for an identified resident and any other resident demonstrating responsive behaviours to ensure triggers for the resident are identified and documented.

b) Ensure there is a process developed and implemented for an identified resident and any other resident demonstrating responsive behaviours to ensure strategies are developed and implemented to respond to these behaviours.

c) Ensure there is a process developed and implemented for two identified residents and any other resident demonstrating responsive behaviours, to ensure actions are taken to respond to the needs of the resident, including documented reassessments and consistent implementation of interventions. The process shall include staff roles and responsibilities including which staff are responsible for monitoring the implementation of the interventions.

Grounds / Motifs :

1. A) The licensee has failed to ensure that, for each resident demonstrating responsive behaviours, the behavioural triggers for the resident were identified; strategies were developed and implemented to respond to these behaviours; and actions were taken to respond to the needs of the resident, including reassessments and interventions.

During interviews with identified staff members they said that an identified resident had specific responsive behaviours. One staff member reported that staff would look in the plan of care and the Behavioural Supports Ontario (BSO) binder to know about residents' responsive behaviours including the triggers and interventions for those behaviours. One staff member looked in the plan of care for this resident during the interview and said it did not identify these responsive behaviours or the triggers or interventions for these behaviours. This staff member also said that there was no documentation to show that this resident's responsive behaviours had been assessed.

The clinical record showed this resident had specific responsive behaviours during a specific time period. There was no documented re-assessments related to behaviours were completed. The plan of care did not include the identification of triggers for responsive behaviours during care or include intervention related to these behaviours.

During an interview with BSO staff members in the home it was reported that they had not been involved with this resident and there were no referrals to the BSO team for this resident. The staff reported they did not know if this resident had been having responsive behaviours. The staff reported that there was nothing in the plan of care or the BSO binder for this resident related to responsive behaviours during care. Another BSO staff member said it was the expectation in the home that the registered staff working on the floors would complete assessments for residents not involved with BSO and then develop the plan of care for the responsive behaviours which would include triggers and interventions.

Based on these observations, interviews and clinical record review this resident was demonstrating responsive behaviours. The staff in the home did not identify the behavioural triggers for the resident, strategies were not developed and implemented to respond to these behaviours; and actions were not taken to respond to the needs of the resident, including reassessments and interventions (630).

B) The licensee has failed to ensure that, for each resident demonstrating responsive behaviours, actions were taken to respond to the needs of the resident including implementing interventions and documenting the resident's responses to interventions.

During the RQI an inspector observed an identified resident having specific responsive behaviours on multiple occasions.

During interview with identified staff members they said that this resident had specific responsive behaviours. The staff reported that another identified resident tended to be a trigger for this resident's behaviours.
The clinical record for this resident showed that the resident was at risk for a specific type of incident related to responsive behaviours and had specific interventions included in the plan of care for these behaviours.

During an interview an identified BSO staff member reported that this resident was

followed by the BSO team and had been assessed as having specific triggers for responsive behaviours. This team member said that the interventions in the plan of care had not been consistently implemented by staff. Another BSO team member said that the interventions that had been put in place for this resident had not been entirely effective.

Based on these observations, interviews and clinical record review this resident was demonstrating responsive behaviours which placed them at risk. Staff in the home had identified the behavioural triggers however actions were not consistently taken to respond to the needs of this resident, including the implementation of the interventions as identified in the plan of care, the development of different interventions when those interventions were not effective or the documentation of the resident's responses to the interventions.

The severity of this issue was determined to be a level 2 as there was potential for harm. The scope of the issue was a level 2 as it was related to 2 of 3 of residents reviewed. The home had a level 4 history as they had on-going non-compliance with this section of the LTCHA that included:

• WN and VPC issued January 4, 2016 (2015_303563_0055);
• WN and VPC issued December 24, 2015 (2015_229213_0060). (630)

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

Oct 30, 2018(A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration;
(b) the identification of any risks related to nutrition care and dietary services and hydration;
(c) the implementation of interventions to mitigate and manage those risks;
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s. 68. (2) (a)(d)

Specifically the licensee must:

a) Ensure that the Nutrition Care and Hydration Programs includes the development and implementation, in consultation with a Registered Dietitian who is a member of the staff of the home, of policies and procedures relating to a system to monitor and evaluate the food and fluid intake of an identified resident and any other resident with identified risks related to nutrition and hydration.

b) Ensure that all Personal Support Workers (PSWs), Registered Practical Nurses (RPNs) and Registered Nurses (RNs) are educated on the policies related to the system to monitor and evaluate the food and fluid intake of residents. The home must keep a documented record of the education provided.

Grounds / Motifs :

1. The licensee has failed to ensure that the Nutrition Care and Hydration Programs included the development and implementation, in consultation with a Registered Dietitian who was a member of the staff of the home, of policies and procedures relating to nutrition care including a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.

The MOHLTC received a complaint related to multiple care concerns for an identified resident. During an interview a family member reported they were concerned that this resident had poor intake.

During interviews with identified staff members they reported that there was a process in the home to record the amount of food and fluid that residents consume in the electronic system. One staff member reported that that the PSWs were to report to the RPN if anyone did not eat or drink enough. The staff member said there was also a fluid report from PointClickCare (PCC) that they were supposed to run each shift but sometimes that did not happen. The staff member said they were to make a referral to the Registered Dietitian (RD) immediately when a resident's food or fluid intake had declined. This staff member reported that there had been a decline in this identified resident's intake and there had not been a referral made to the RD.

During an interview the Registered Dietitian told an inspector that this identified resident had experienced a decline in their food and fluid intake at a specific time. The RD said that the process in the home for monitoring residents' food and fluid intake included the PSW recording the amount consumed in the electronic system at the end of each meal and snack. The RD said that the registered nursing staff were to monitor the amount of fluid and food intake over the past three days and make a referral to the RD if there has been a fluid intake less than 1000 mL over three consecutive days. The RD said they should have received a referral regarding this resident's intake on a specific date and did not receive a referral at that time. The RD reported that they were not consulted on the new policies and procedures in the home and did not have access to them at the time of the interview.
The clinical record for this resident documented their food and fluid intake and showed it was below the amount recommended in the plan of care for a specific time period. The record included a "Dietary Referral/Diet Order/Change Form 2015" for this resident on a specific date, which was after an inspector had spoken with staff about this resident.

During an interview the Administrator told an inspector that there was a process in the home for monitoring the food and fluid intake of residents. The Administrator said that the PSWs were responsible for recording the intake in the electronic system at specified times. The Administrator said they did not have a specific policy in the home related to the documentation of food and fluid intake but they had some general policies that were related. The Administrator said that residents' food and fluid intake were monitored on a quarterly basis. When asked if there was somewhere in a policy or procedure that show this was an expected practice in the home, the Administrator said that there was no policy specifically dictating that they check the dashboard but it was the expectation that staff would monitor it daily and this was a practice not a policy. The Administrator said that they thought the RD was involved in the development of the policies in September 2017 and that they did have access to them through the computer.

The home's policy titled "DTY-001 Nutrition Care and Hydration Program" with "Revision Date" September 2017 stated that the Nutrition Care and Hydration Program included "ensuring systems are in place for accurate monitoring and documentation of individual resident's food and fluid intake in order to evaluate nutrition and hydration status as indicated in the nutrition plan of care." This policy did not include further detail or direction regarding the practices or procedures in the home for monitoring or evaluating food or fluid intake.

The home's policy titled "NAM-F-35 Electronic Documentation" with "Revised date" January 2018 did not include details or direction regarding the practices or procedures in the home for monitoring or evaluating food or fluid intake.

The home's policy titled "Encouraging Fluid Intake" with "Approval date" March 2017 stated that the Nutrition Care and Hydration Program included "registered staff or the physician identify residents who are at risk of dehydration or are showing signs/symptoms of dehydration inform the interdisciplinary care team and initiate "encourage fluids" measures." This policy did not include further detail or direction regarding the practices or procedures in the home for monitoring or evaluating food or fluid intake.

During a follow-up interview the Administrator said that based on their follow-up with staff the policy and procedure in the home for monitoring food and fluid intake was not fully implemented.

Based on these interviews and record reviews this identified resident was documented to be at nutritional risk and had a decline in their food and fluid intake and a weight loss during a specific time period. This resident's food and fluid intake had been documented in POC but was not monitored or evaluated through the use of the clinical dashboard in PCC or a system of reviewing the intake through a PCC report. This resident was not referred to or assessed by the RD regarding the decreased intake until after the inspector interviewed staff. The RD reported that they were not consulted on the new policies and procedures in the home and did not have access to them at the time of the inspection. The policies and procedures provide during the inspection did not provide direction for staff regarding the system in place to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.

The severity of this issue was determined to be a level 2 as there was potential for harm. The scope of the issue was a level 3 as it was related to non-compliance that had potential to affect a large number of residents in the home. The home had a level 2 history as they had one or more unrelated non-compliance with this section of the LTCHA. (630)

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

Nov 30, 2018(A2)

Order # /
Ordre no : 011

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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:

1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
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.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
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).

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s. 73. (1) 9.

Specifically the licensee must:

a) Ensure that the dining and snack services include providing six identified residents and any other resident with the personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

Grounds / Motifs :

1. The licensee has failed to ensure that the home had a dining and snack service that included providing residents with the personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

A) During the RQI an inspector observed that identified residents were not provided with the personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible during a specific meal. During this meal the following was observed:
- The posted breakfast mealtime was 0800 hours.
- There were only two identified staff members consistently in the main dining room during the meal from 0800 hours until 0900 hours.
- There was only one Personal Support Worker (PSW) consistently assisting in the dining rooms for the breakfast meal and was observed assisting residents in both the main dining room and the Harvest Dining room for the breakfast meal.
- At 0845 hours three staff arrived in the main dining room to assist residents.
- Two PSWs were not assisting in the dining room during the breakfast meal and were observed working together assisting residents in their rooms with morning care from 0800 hours until 0954 hours.
- One staff member was observed assisting three residents requiring total assistance and one resident requiring partial assistance at table two in the main dining room and no other staff were assisting at that table at the time.
- Another identified resident did not receive the assistance they required to eat their meal. The "eating" plan of care for this resident showed they needed a specific level of assistance and was not observed to have been provided that assistance.
- One identified resident was brought to the dining room almost two hours after the posted meal time and was served their meal 15 minutes after they arrived. This resident was observed to receive no assistance being provided with specific items. The "eating" plan of care for this resident stated they required a specific level of assistance with their meal and was not observed to have received that assistance (630).

B) During the RQI an inspector observed that identified residents were not provided with the personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible during another specific meal. During this meal the following was observed:
- An identified resident had their meal sitting in front of them without receiving assistance for eight minutes. The resident did not receive the assistance they

required during the remained of the meal. The eating plan of care for this resident showed that the resident required a specific level of assistance for safety and this was observed not to have been provided.
- Another identified resident was not provided the assistance they required with their meal. The eating plan of care for this resident showed that the resident required a specific level of assistance and this was observed not to have been provided.

During an interview an identified staff member said that were eight residents that required total assistance with feeding and three to four that required cueing on the floor. This staff member said that there was not enough staff available to assist the residents with their meal, especially on the weekends (524).

C) During the RQI an inspector observed that identified residents were not provided with the personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible during another specific meal. During this meal the following was observed:
- At a specific time there was one PSW in the dining room assisting nine residents. Of these resident one required total assistance and four were observed to require encouragement and physical cues.
- An identified resident's meal sat uncovered on the counter beside them from for ten minutes until the PSW placed it on their tray and provided cues to start eating. This resident was observed to not receive the assistance they required to eat their meal.

D) During the RQI an inspector observed that identified residents were not provided with the personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible during another specific meal. During this meal the following was observed:
- During the meal there were nine residents observed to require total assistance and eight residents observed to require verbal or physical cues during the meal. There were four PSWs in the dining room providing assistance to residents. Additional staff started providing assistance 39 minutes after the meal started and another staff member 49 minutes after the meal had started. There were residents observed to have not received the assistance they required during the meal.
- Two identified resident did not receive the assistance they required to eat their meal. The "eating" plan of care for these residents showed they needed a specific level of assistance and was not observed to have been provided that assistance.

During interviews multiple staff members told an inspector that there were between

ten to twelve residents on this floor who required staff assistance or encouragement with their meals. Staff reported it was difficult to provide the residents with their required assistance especially when there was not extra assistance from the Registered Nurse or management in the dining room.

During an interview the Interim Director of Care (IDOC) told an inspector that it was the expectation in the home that residents would be provided with the encouragement and assistance that they require. The IDOC said that staff would know the level of assistance required by the Kardex and Point of Care (POC) in PCC. The IDOC said that on a specific floor there were several residents that required assistance with eating and that extra hands were required in that area at meals. The IDOC said that there were probably times when the extra assistance was not available. The IDOC said that staff had expressed concerns about the level of care and the ability to provide that care at mealtimes (630).

E) The MOHLTC received a complaint related to multiple care concerns for an identified resident. During an interview a family member reported concerns about the level of assistance provided to this resident at meals.
During a specific meal this resident was observed to have been sleeping through the meal and staff reported that the resident had refused the meal.

During a specific snack time this resident was observed to be sleeping and the staff left a beverage at the bedside of the resident and no encouragement or cues were provided with the fluid for a specific time period and the resident did not consume any of the beverage provided.
During interviews with identified staff member they said that they thought this resident required a specific level of assistance with meals. One staff member said that this resident required time and special attention from staff to support their intake.

The clinical record for this resident showed that they required a specific level of assistance at meals.

The licensee has failed to ensure that the home had a dining and snack service that included providing residents with the personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible (630).

The severity of this issue was determined to be a level 2 as there was potential for harm. The scope of the issue was a level 2 as it was related to non-compliance that

had potential to affect a large number of residents in one location in the home. The home had a level 3 history as they had one or more related non-compliance with this section of the LTCHA that included:

- WN and VPC issued March 8, 2016 (2016_229213_0005). (524)

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

Sep 28, 2018

Order # /
Ordre no : 012

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 101. (3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly;
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and
(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s. 101. (3).

Specifically the licensee must:

a) Ensure that the home's documented record of complaints is reviewed and analyzed for trends at least quarterly, the results of the review and analysis are taken into account in determining what improvements are required in the home; and a written record is kept of each review and of the improvements made in response which includes the documentation of the date of the review and the full names of the persons who completed the review.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Grounds / Motifs :

1. The licensee has failed to ensure that the documented record of complaints was reviewed and analyzed for trends at least quarterly; the results of the review and analysis were taken into account in determining what improvements were required in the home; a written record was kept of each review; and of the improvements made in response.

During an interview the Administrator said that in March 2018 they implemented a new process to review the documented record of complaints in the home. The Administrator said that prior to March 2018 all they were doing on a quarterly basis was reviewing the number of complaints and were not analyzing the trends. The Administrator said that they did not keep a written record of each review and the improvements made in response.

The severity of this issue was determined to be a level 2 as there was potential for harm. The scope of the issue was a level 2 as it was related to non-compliance that had potential to affect a large number of residents. The home had a level 5 history as they had multiple non-compliances with at least one related CO to this section of the LTCHA that included:

• WN and CO issued May 11, 2016 (2016_229213_0013) with compliance due date July 4, 2016. This CO was complied July 21, 2016 (2016_229213_0018);
• WN, CO and Director's Referral (DR) issued March 8, 2016 (2016_229213_0005) with compliance due date April 4, 2016;
• WN and CO issued January 4, 2016 (2016_303563_0052) with compliance due date January 31, 2016;
• WN and CO issued May 28, 2015 (2015_182128_0011) with compliance due date July 31, 2015. (630)

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

Oct 30, 2018(A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 013

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 116. Annual evaluation

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s. 116.

Specifically the licensee must:

a) Develop and implement a documented procedure in the home to ensure that the evaluation of the medication management system required under 116 of this Regulation is completed in accordance with the legislation.

b) Ensure there is a follow-up to the evaluation of the medication management system program evaluation that was completed in the home on January 29, 2018. This follow-up must be a meeting that includes the Medical Director, the Administrator, the Director of Nursing, the pharmacy service provider and a Registered Dietitian who was a member of the staff of the home. During this meeting the following must be completed:
1) an evaluation of the effectiveness of the medication management system in the home and recommendation made on any changes necessary to improve the system
2) a review of the quarterly evaluations from the previous year
3) a documented record of the meeting which includes the date of the meeting, the full names and signatures of the persons who participated, a summary of what was completed as part of the evaluation and a summary of the recommendations for improvement.

Grounds / Motifs :

1. The licensee has failed to 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 was a member of the staff of the home, met annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. Where the pharmacy service provider was a corporation, the licensee shall ensure that a pharmacist from the pharmacy service provider participated in the annual evaluation. The annual evaluation of the medication management system must have included a review of the quarterly evaluations in the previous year, have been undertaken using an assessment instrument designed specifically for this purpose; and identified changes to improve the system in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.
The Annual Medication Program Evaluation dated January 29, 2018, documented that the peopleCare Vice President of Clinical Services (VPCS), Interim Director of Care (IDOC), Assistant Director of Care (ADOC), Consultant Pharmacist, and Medical Director completed the evaluation.

During an interview the Consultant Pharmacist (CP) stated there was an annual evaluation of the medication management system on December 1, 2017, just before former Director of Care (DOC) left. The Pharmacist also verified that they were not involved in the completion of an evaluation in January 2018 where the Medical Director was present and verified that they were not asked to provide input for the Medication Program Evaluation with a start date of January 29, 2018. The CP stated a review of the quarterly evaluations in the previous year were not reviewed as part of this December 2017 annual medication program evaluation.

During an interview the Registered Dietitian (RD) shared that there was no invitation extended to attend the Medication Program Evaluation and the RD acknowledged that they should have attended and had not met annually to evaluate the effectiveness of the medication management system in the home for the entire four years the home has been opened and the RD has been working here.

During an interview the IDOC verified that the Annual Program Evaluation for the Medication Program was on January 29, 2018. The IDOC verified that the Consultant Pharmacist, the Registered Dietitian and the Medical Director were not present at the January 29, 2018 medication program evaluation. The Administrator

stated they attended the annual medication program evaluation briefly for portion of it and verified that their name was not documented as attended on January 29, 2018. The Administrator and the IDOC verified that there was not a review of the quarterly evaluations in the previous year as part of the annual program evaluation for medications dated January 29, 2018.

The Annual Medication Program Evaluation dated January 29, 2018 did not include a review of the quarterly evaluations in the previous year.

During an interview the peopleCare VPCS acknowledged that the Pharmacist, the Medical Director, the RD, and the Administrator were absent from the meeting related to the medication program evaluation. The peopleCare VPCS also verified that the quarterly evaluations in the previous year were not reviewed as part of the annual evaluation.

The licensee failed to ensure the Medical Director, Administrator, pharmacy service provider and a RD who was a member of the staff of the home met annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. The quarterly evaluations in the previous year were not reviewed as part of the annual medication program evaluation.

The severity of this issue was determined to be a level 1 as there was minimum risk. The scope of the issue was a level 3 as it was related to non-compliance that had potential to affect a large number of residents in the home. The home had a level 2 history as they had one or more unrelated non-compliance with this section of the LTCHA. (563)

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

Oct 30, 2018(A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 014

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 130. 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.

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s. 130. 3.

Specifically the licensee must:

a) Ensure a monthly audit is completed 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.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Grounds / Motifs :

1. The licensee has failed ensure that steps were taken to ensure the security of the drug supply; a monthly audit was not undertaken of the daily count sheets of controlled substances to determine if there were any discrepancies and that immediate action was taken if any discrepancies were discovered.

During an interview the Assistant Director of Care, Interim Director of Care, and Consultant Pharmacist stated that an audit of the daily narcotic count sheets was not being completed monthly.

There was no documented evidence that a monthly audit of the daily count sheets of controlled substances was being completed in the home.

The licensee failed ensure that a monthly audit was not undertaken of the daily count sheets of controlled substances to determine if there were any discrepancies.

The severity of this issue was determined to be a level 1 as there was minimum risk. The scope of the issue was a level 3 as it was related to non-compliance that had potential to affect a large number of residents in the home. The home had a level 3 history as they had one or more related non-compliance with this section of the LTCHA that included:

• WN and VPC issued March 8, 2016 (2016_229213_0005). (563)

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

Sep 28, 2018

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 015

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s. 131 (1).

Specifically the licensee must:

a) Ensure that no drug is used by or administered to a resident in the home unless the drug had been prescribed for the resident.

Grounds / Motifs :

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.

The Medication Incident Reports from December 2017 and January 2018 were reviewed as a part of the most recent quarterly review on March 8, 2018. The following medication incidents occurred where residents were administered a medication that had not been prescribed for them:

A) On a specific date an identified resident was given a specific medication instead of the medication that was prescribed for them. The Interim Director of Care (IDOC) verified that this resident was administered this medication and did not have a prescription for this. The IDOC stated that this resident had received another resident's medication.

The physician's orders for this identified resident did not include a prescription for this medication.

B) On a specific date an identified resident was given a specific liquid instead of water with the administration of their other medications as this resident received another resident's medication instead of water. The IDOC and ADOC verified that this resident was administered the medication and that the resident did not have a prescription for this medication.

The physician's orders for this identified resident did not include a prescription for this medication.

C) On a specific date an identified resident received a different medication than the medication that they were prescribed. The physician on call was notified and the registered staff were to "resume the right medication with the right dose". The IDOC verified that this resident received the wrong medication.

The physician's orders for this identified resident did not include a prescription for this medication.

The SVCH "Administration of Medications policy NAM-F-05" last reviewed September 2017, stated medications were to be administered only after the nine rights had been checked by the registered staff: right resident, right medication, right dose, right route, right site, right time, right reason, right frequency, and right documentation.

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 (563).

The severity of this issue was determined to be a level 2 as there was potential for harm. The scope of the issue was a level 2 as it was related to a pattern. The home had a level 4 history as they had on-going non-compliance with this section of the LTCHA that included:

• WN and VPC issued April 13, 2017 (2017_536537_0015);
• WN and VPC issued March 8, 2016 (2016_229213_0005);
• WN and VPC issued May 28, 2015 (2015_182128_0011). (563)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

Sep 28, 2018

Order # /
Ordre no : 016

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s. 131 (2).

Specifically the licensee must:

a) Ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Grounds / Motifs :

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

A) The Medication Incident Reports from December 2017 and January 2018 were reviewed as a part of the most recent quarterly review undertaken in the home on March 8, 2018. There were 15 specific medication incidents that occurred where the residents were not administered their medications in accordance with the directions

for use.

During an interview the Interim Director of Care (IDOC) verified the 15 specific incident involved resident that did not receive their medications according to the directions for use. The IDOC verified that there were multiple incidents where a specific medication was left on the resident. The IDOC also verified that there were multiple incidents where medications were signed as given, but the strip packages were still in the residents' bins in the medication cart.

The SmartMeds "Medication Administration Policy 3-7" last updated March 2016, stated once the medication was taken, initial the Medication Administration Record (MAR) sheet to indicate that the medication had been given.

The licensee failed to ensure that the medications prescribed to be administered were given to the residents in accordance with the directions for use specified by the prescriber (563).

B) A complaint was logged with the Ministry of Health and Long-Term Care (MOHLTC) related to an identified resident. During an interview the complainant expressed concerns about the medication administration for this resident.

During an observation at a specific time and inspector observed medications present at the bottom of a glass in this identified resident's room.

The electronic Medication Administration Record (eMAR) report for this resident for a specific time period documented specific medications for this resident with specific instructions. The "Medication Admin Audit Report" a specific date showed that the medications had been administered by an identified staff member at a specific time. During an interview an identified staff member said there were medications at the bottom of the glass and that these were the medications for this resident.

During an interview with another identified it was reported that there were specific instructions related to the administration of medications for this resident. This staff member acknowledged that specific medications were not taken as prescribed.

The SVCH "Administration of Medications" policy with index: NAM-F-05 last revised September 2017, stated medication must not be left unattended for the resident to self-administer unless the resident performs self-administration.

The SmartMeds Medication Administration Policy 3-7 last updated March 2016, stated to remain with the resident until the medication was taken.

The licensee failed to ensure that this identified resident's medications were administered to the resident in accordance with the directions for use specified by the prescriber.

C) Another complaint was logged with the Ministry of Health and Long Term Care (MOHLTC) related to the administration of medications for an identified resident.

The electronic Medication Administration Record (eMAR) documented a specific prescription for this identified resident. This record also documented that this prescription was not provided as ordered at specific times.

Review of the "Bowel and Bladder Continence Care Program Implementation CP-K-20" last revised September 2017 stated the "Personal Support Workers will notify registered staff if the resident has not had a bowel movement in more than forty-eight hours. Registered staff are to review their Resident Home Area bowel/bladder records and follow up daily and obtain and/or initiate appropriate interventions according to the physician's orders." The policy stated, "Each resident is supported to achieve an optimal level of bowel and bladder function as a significant component of improving quality of life and maintaining comfort and dignity."

During an interview the Assistant Director of Care (ADOC) stated the registered nursing staff would know if a resident was on a certain medication on their shift using the "Look Back Report" from the electronic documentation system. The ADOC said that the order for the specific medication was documented in a way that the registered nursing staff would not know that the medication was required for administration twice daily as needed. The ADOC acknowledged that the specific medication should have been increased to twice daily on specific dates based on the "Look Back Report".

D) The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) which documented a missing specific medication for an identified resident.

During an interview the Interim Director of Care (IDOC) stated a medication incident

report was received where the medication count for this identified resident went down by three tablets on the day shift rather than by two tablets. The IDOC stated the order was for one tablet three times a day at 0800, 1200 and 1700 hours, therefore one tablet was missing. The IDOC stated that in an interview with an identified staff member that the staff member said they thought they had not given the 1200 hour dose and gave it again at another time.

The Medication Incident Report dated for a specific time documented for a missing dose of for this medication where the staff member gave an extra dose at a specific time.

During an interview an identified staff member verified that this resident received an extra dose of this medication.
The physician's order documented that this resident was to take this medication at specific times.

The electronic Medication Administration Record (eMAR) for this resident for a specific time period was administered at specific times. The report documented that an identified staff member signed as administering the medication.

The licensee failed to ensure that this resident's medication was administered to the resident in accordance with the directions for use specified by the prescriber.

E) The home submitted a CIS report to the MOHLTC which documented an error in medication administration of a specific medication for an identified resident.

The Physicians Orders documented that this resident was to receive a specific medication at specific times.
During an interview an identified staff member said that they recalled the medication incident that occurred for this identified resident when they were given the wrong dose of the medication.

The licensee failed to ensure that this resident's medication was administered to the resident in accordance with the directions for use specified by the prescriber.

The licensee failed to ensure that no person administered a drug to a resident in the home unless that person was a physician, dentist, registered nurse or a registered practical nurse.

The severity of this issue was determined to be a level 2 as there was potential for harm. The scope of the issue was a level 2 as it was related to a pattern. The home had a level 4 history as they had on-going non-compliance with this section of the LTCHA that included:

• WN and VPC issued April 13, 2017 (2017_536537_0015);
• WN and VPC issued March 8, 2016 (2016_229213_0005);
• WN and VPC issued May 28, 2015 (2015_182128_0011). (563)

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

Sep 28, 2018

Order # /
Ordre no : 017

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (3) Subject to subsections (4) and (5), the licensee shall ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse. O. Reg. 79/10, s. 131 (3).

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s. 131 (3).

Specifically the licensee must:

a) Ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse.

Grounds / Motifs :

1. A) The clinical record for an identified resident showed that at a specific time an identified staff member delegated another staff member to give the medications to the resident.

During an interview the Interim Director of Care (IDOC) verified that this identified staff member should not have delegated a Personal Support Worker (PSW) staff to administer medications to this resident, and that only registered nursing staff were to administer medications to residents.

During an interview an identified staff member stated that they gave the medications to a PSW to administer the medications to this resident.

B) During the RQI an identified staff member was observed by an inspector to add a specific medication into an identified resident's beverage and the left it on the table. Another identified staff member was observed feeding the beverage with the medication to the resident.

During an interview and identified staff member said that they had fed the beverage with the medication to this resident. This staff member verified that PSWs in the home did administer medications if the residents would not take the medications from the registered staff; the registered staff would then give it to the PSWs to administer during a meal to ensure it was taken.

During an interview and identified staff member verified that a specific medication was added to this resident's beverage and the PSW administered it. This staff member acknowledged that PSWs were not to administer medications.

The SVCH "Administration of Medications policy NAM-F-05" last reviewed

September 2017 stated "all medications shall be administered by a registered health care professional when prescribed by a physician or designated alternative and the medication administration process shall comply with all applicable legislation, regulations, professional standards and corporate/pharmacy policies to ensure safe, effective and ethical administration of medications."

The licensee failed to ensure that Personal Support Workers were not administering a drug to a resident in the home unless that person was a registered nurse or a registered practical nurse.

The severity of this issue was determined to be a level 2 as there was potential for harm. The scope of the issue was a level 2 as it was related to a pattern. The home had a level 4 history as they had on-going non-compliance with this section of the LTCHA that included:

• WN and VPC issued April 13, 2017 (2017_536537_0015);
• WN and VPC issued March 8, 2016 (2016_229213_0005);
• WN and VPC issued May 28, 2015 (2015_182128_0011). (563)

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

Sep 28, 2018

Order # /
Ordre no : 018

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s. 135

Specifically the licensee must:

a) Ensure that every medication incident involving a resident and every adverse drug reaction is 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.

b) Ensure that all medication incidents and adverse drug reactions are documented, reviewed and analyzed; corrective actions are taken as necessary and a written record is kept of everything.

c) Ensure that a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; any changes and improvements identified in the review were implemented; and a written record is kept of everything.

Grounds / Motifs :

1. A) The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

During an interview the Interim Director of Care (IDOC) and an inspector reviewed the original copies of the Medication Incident Reports (MIR) for December 2017 and January 2018. The IDOC verified that there were five specific notifications related to the medication incidents. The IDOC said that for three of the incidents they were not notified and for two of the incidents the pharmacy was not notified.

During an interview the Pharmacy Manager stated that four specific medication incident reports were not reported to the pharmacy service provider.

The SmartMeds "Pharmacy Medication Incident Report Policy 9-1" last reviewed April 2016, stated when a medication incident occurred, it was recorded on the Medication Incident Report form and communicated to the proper authorities "(e.g. Head Nurse/DOC/ADOC, Physician, Pharmacy)."

The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the Director of Care and the pharmacy service provider (563).

B) The licensee has failed to ensure that all medication incidents and adverse drug reactions were documented, reviewed and analyzed; corrective action was taken as necessary; and a written record was kept of everything identified.

During an interview the Interim Director of Care (IDOC) and an inspector reviewed the original copies of the Medication Incident Reports (MIR) to for December 2017 and January 2018. The IDOC verified the following notification related to the following medication incidents:
- One specific MIR did not identify the registered staff member involved and the IDOC stated that they did not know the staff involved. The IDOC stated their signature was absent from the MIR and there was no documentation that the IDOC had reviewed and analyzed the incident. The IDOC stated corrective action was necessary, but that corrective action to prevent recurrence was not completed with the employee involved.
- Another specific MIR the IDOC stated that they could not verify if the MIR was reviewed and analyzed, and could not verify if corrective action was taken since there was nothing documented.
- Another specific MIR did not identify the registered staff member involved and the stated it was an agency person. The IDOC stated corrective action was necessary, but that there was no follow up with the agency staff member and corrective action to prevent recurrence was not completed. The IDOC also stated that the agency manager was not contacted.
- Another specific MIR the IDOC stated that they did not follow up with corrective action with the agency staff member involved in the incident. The Assistant Director of Care (ADOC) verified there was no documented record of corrective action.

- Another specific MIR the IDOC stated that they did not follow up with corrective action with the two registered staff involved in the incident and the ADOC verified that they did not take any action to prevent recurrence.

During an interview the Administrator verified that the home did not have their own medication incident policy. The SmartMed Pharmacy policy titled "Medication Incident Report Policy 9-1" last reviewed April 2016 was the only policy in use. The policy had an attached form called "Medication Incident Report" that required "actions taken to prevent re-occurrence" to be completed by the Director of Care or the Pharmacy Manager.

The licensee failed to ensure that all medication incidents and adverse drug reactions were documented, reviewed and analyzed; corrective action was taken as necessary; and a written record was kept of everything identified.

C) The licensee has failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; any changes and improvements identified in the review were implemented; and a written record was kept of everything identified.

During an interview the Administrator said that the Medication Incident Reports (MIR) were reviewed quarterly as part of the Quarterly Medication Safety Meeting on February 6, 2018, and then shared at the Professional Advisory Committee (PAC) meeting on March 8, 2018. The Administrator shared that the PAC meeting prior to March 8, 2018, was attended on December 7, 2017 and only documented an incident involving specific missing medication and there were no other medication incidents reviewed in detail at that time. The Administrator also stated that the PAC meeting dated September 7, 2017, did not review the medication incidents that occurred between June and August 2017.

During an interview the Interim Director of Care (IDOC) stated that the Quarterly Medication Safety Meeting dated February 6, 2018 was discussed at the PAC meeting dated March 8, 2018. The IDOC stated that the quarterly review for the March 8, 2018 PAC meeting was for those medication incidents that occurred in December 2017 and January 2018 only.

The PAC meeting dated September 7, 2017, had no documentation that a quarterly

review was undertaken of all medication incidents and adverse drug reactions that had occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions.

The PAC meeting dated December 7, 2017, had no documentation that a quarterly review was undertaken of all medication incidents and adverse drug reactions that had occurred in the home since the time of the last review on September 7, 2017, in order to reduce and prevent medication incidents and adverse drug reactions.

During an interview the peopleCare Vice President of Clinical Services (VPCS) shared that the primary goal for the Quarterly Medication Safety Meetings was to review the Medication Incident Reports (MIR) every quarter for every incident and to analyze them and follow-up with the registered staff as a group to discuss trends to make improvements. The peopleCare VPCS shared that the expectation was that the Quarterly Medication Safety Meeting dated February 6, 2018 was reviewed at the March 8, 2018, PAC meeting.

As part of the Quarterly Medication Safety Meetings, a list of medication incidents were documented for December 2017 and January 2018. Three specific medication incidents were reviewed by an inspector and the Administrator and the Administrator stated that the medication incident involving these specific residents should have been a part of the quarterly review and were not.

The licensee has failed to ensure that a quarterly review was undertaken of all medication incidents at the PAC meeting on December 7, 2017, that have occurred in the home since the time of the last review on September 7, 2017, in order to reduce and prevent medication incidents and adverse drug reactions.

The severity of this issue was determined to be a level 2 as there was potential for harm. The scope of the issue was a level 2 as it was related to a pattern. The home had a level 4 history as they had on-going non-compliance with this section of the LTCHA that included:

• WN and VPC issued July 11, 2017 (2017_263524_0015);
• WN and VPC issued April 13, 2017 (2017_263537_0015);
• WN and VPC issued March 8, 2016 (2016_229213_0005);
• WN and VPC issued January 4, 2016 (2015_303563_0053). (563)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

Sep 28, 2018

Order # /
Ordre no : 019

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) the symptoms are recorded and that immediate action is taken as required.
O. Reg. 79/10, s. 229 (5).

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s. 229. (5) (b)

Specifically the licensee must:

a) Review and revise the home's Infection Prevention and Control program policies related to outbreak management to ensure it provides clear direction to staff on the procedure for recording symptoms indicating the presence of infection on each shift.

b) Ensure that all leadership team members, Registered Nurses (RNs) and Registered Practical Nurses (RPNs) working in the home are re-educated on the Infection Prevention and Control program policies and strategies related to outbreak management. The home must keep a documented record of the education provided.

c) Implement the revised Infection Prevention and Control program policies related to outbreak management to ensure that on every shift the symptoms indicating the presence of infection are recorded and immediate action is taken as required.

Grounds / Motifs :

1. The licensee has failed to ensure that on every shift the symptoms indicating the presence of infection were recorded and immediate action was taken as required.

During the entrance conference for the Resident Quality Inspection (RQI) an identified staff member reported that the home had a respiratory infection outbreak on a specific floor.

The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) which identified that they had a "disease outbreak" and was classified as an Acute Respiratory Illness (ARI).

A) During an interview an identified staff member reported to an inspector that a specific resident had been one of the residents in isolation related to the outbreak.

The "Respiratory Line Listing" provided to the inspector on a specific date by an identified staff member showed that this identified resident had symptom onset on a

specific date and there were no symptoms listed on this form.
During an interview and identified staff member said that the documentation for symptoms of infection was done by the staff as a health status note in the electronic documentation system. This staff member said they also used a paper "Respiratory Monitoring Sheet" on each shift but the sheets from last week could not be located and they had to start a new sheet. This staff member said they also used the "Respiratory Line Listing" to track symptoms and identify residents on isolation but this was not where the shift to shift documentation was completed. This staff member acknowledged that the line listing did not include the symptoms that this resident was showing.

During an interview the Assistant Director of Care (ADOC) said that it was the expectation in the home that staff would be documenting in PCC the symptoms of infection on every shift. The ADOC said this would include the vital signs, the resident's condition, any signs or symptoms of infection, use of antibiotic, food and fluid intake and any lethargy or tiredness. The ADOC said that the monitoring sheets were also expected to be done on each shift and that the ones for a specific time period could not be located. The inspector reviewed the electronic documentation for this identified resident with the ADOC and they acknowledged that the documentation did not include respiratory assessment and documentation of symptoms on every shift since the onset of the symptoms.

During an interview the Interim Director of Care (IDOC) told an inspector that it was the expectation in the home that staff would be documenting a progress note on each shift assessing and documenting the symptoms of infection for residents affected by the outbreak. The IDOC said they would expect vitals to be assessed and documented as well as an assessment of their respiratory symptoms and talking to resident to see how they were feeling. The IDOC said they would expect that to be documented in a progress note.

B) During an interview with an identified staff member they told an inspector that another identified resident was one of the residents in isolation related to respiratory symptoms. This staff member said were confused as they were told that this resident was not under outbreak just respiratory isolation for some residents.

The "Respiratory Line Listing" provided to the inspector on a specific date by an identified staff member showed that this identified resident had symptom onset on a specific date and there was one symptom listed on this form.

During an interview an identified staff member said that this resident was considered to be one of the cases of the outbreak.

During an interview with identified staff members they reported that they had observed this resident with more than one symptom related to the respiratory outbreak.

The clinical record for this identified resident did not include documentation of all symptoms on each shift.

During an interview the Interim Director of Care (IDOC) told an inspector that it was the expectation in the home that staff would be documenting a progress note on each shift assessing and documenting the symptoms of infection for residents affected by the outbreak. The IDOC said that this identified resident was considered to be a potential case for the outbreak and it was the expectation that staff would be assessing and documenting the symptoms on every shift.

C) During an interview a family member for an identified resident expressed concerns related to the care their family member had received related to the respiratory outbreak in the home.

The "Respiratory Line Listing" provided to the inspector on a specific date by an identified staff member showed that this identified resident had symptom onset on a specific date and there was one symptom listed on this form.

During an interview with an identified staff member they reported that this specific resident had one symptom starting on a specific date. This staff member said they were not sure if this resident was still in isolation at the time of the interview as it was not clear from the documentation.

The clinical record for this identified resident did not include documentation of their symptoms on each shift.

During an interview the IDOC said that this resident was identified as a potential case for the outbreak on a specific date and it was the expectation that staff would be assessing and documenting the symptoms on every shift. The IDOC acknowledged that the symptoms for this resident were not documented on each shift and that the

symptoms for this resident listed in the progress notes in PCC did not correspond to those on the line listing.

D) During an interview an identified staff member told an inspector that another identified resident was one of the residents in isolation related to respiratory symptoms.

The "Respiratory Line Listing" provided to the inspector on a specific date by an identified staff member showed that this identified resident had symptom onset on a specific date and there were two symptom listed on this form.

During an interview the Assistant Director of Care (ADOC) said that the expectation in the home was that staff would be documenting in the electronic documentation system the symptoms of infection on every shift.

The clinical record for this identified resident did not include documentation of their symptoms on each shift.

During an interview the Interim Director of Care (IDOC) told an inspector that it was the expectation in the home that staff would be documenting a progress note on each shift assessing and documenting the symptoms of infection for residents affected by the outbreak. The ADOC said that this resident was identified as a potential case for the outbreak and it was the expectation that staff would be assessing and documenting the symptoms on every shift.

E) During an interview an identified resident told an inspector that they were feeling unwell as they had specific symptoms.

During an interview two identified staff members said that they did not think that this identified resident was in isolation. One of the PSWs said they had found that this resident was displaying a specific symptom and had told the nurse.

During an interview with another identified staff member they told an inspector that this resident had been started on isolation at a specific time due to specific symptoms. This staff member reviewed the progress notes in the electronic documentation system and acknowledged that there had been symptoms documented during a specific shift and these were not monitored or assessments documented during subsequent shifts. This staff member said that the resident

should have been in isolation earlier than this was started.

The clinical record for this identified resident did not include documentation of their symptoms on each shift.

During an interview the IDOC told an inspector that it was the expectation in the home that staff would be documenting a progress note on each shift assessing and documenting the symptoms of infection for residents affected by the outbreak. The IDOC said that this resident was added to the "Respiratory Line Listing" on a specific date and it was the expectation that symptoms documented on a specific date would have been followed through on at the following shifts and staff would have assessed and documented any symptoms of infection on every shift.

Based on these observations, interviews and record reviews the staff in the home did not record the symptoms indicating the presence of infection on every shift and did not take immediate action to respond to the presence of infection in each resident during the respiratory outbreak in March 2018.

The severity of this issue was determined to be a level 2 as there was potential for harm. The scope of the issue was a level 3 as five out of five residents reviewed. The home had a level 3 history as they had one or more related non-compliance with this section of the LTCHA that included:

• WN and VPC issued April 13, 2017 (2017_536537_0015);
• WN and VPC issued March 8, 2016 (2016_229213_0005). (630)

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

Sep 28, 2018

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 020

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

Linked to Existing Order / Lien vers ordre existant: 2017_607523_0033, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:

1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition.
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s 30 (1) 4.

Specifically the licensee must:

a) Develop and implement a documented procedure in the home to ensure that the evaluations of organized programs required under 8 to 16 of the Act and each of the interdisciplinary programs required under 48 of this Regulation are completed in accordance with the legislation.

b) Ensure that the written record of each of the program evaluation that was completed in response to Director's Order #001 from inspection 2017_607523_0021 served on December 21, 2017, with a compliance date of February 15, 2018, is updated to include:
1) the date the evaluation was completed;
2) the full names and signatures of the persons who participated in the evaluation and the dates when they participated;
3) a summary of the changes made to the program and the date that those changes were implemented.

Grounds / Motifs :

1. The licensee has failed to comply with compliance order #001 from inspection 2017_607523_0033 served on January 4, 2018, with a compliance date of January 31, 2018.

The licensee was ordered to ensure that a written record was kept relating to each evaluation under s. 30 (1) paragraph 3 that included the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The licensee has failed to ensure that each of the organized programs required under section 8 to 16 of the Act and each interdisciplinary program required under section 48 of the regulation was evaluated and updated at least annually in accordance with evidence based practices and, if there were none, in accordance with prevailing practices and that a written record was kept relating to each evaluation that included the summary of the changes made and the date that those changes were implemented.

A) Ontario Regulation 79/10 s. 48 (1) states "Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: A falls prevention and management program to reduce the incidence of falls and the risk of injury."

During an interview the Interim Director of Care (IDOC) told an inspector that they had been involved with the Falls Prevention Program in the home since the time they had they started working in the home. The IDOC said that Assistant Director of Care was the lead for the program in the home. The IDOC said that they thought an annual evaluation of the program had been completed since peopleCare started consulting in the home and that they would provide the documentation for that evaluation.

On a specific date a document titled "Annual Program Evaluation" was provided to an inspector. This document stated "Date of Evaluation: started December 29, 2017" and did not include documentation of when this was completed. This written record identified that the peopleCare Vice President Clinical Services (VPCS), the ADOC, the IDOC, and three identified staff members had completed the evaluation. This written record did not include changes that had been made to the program or the dates those changes had been implemented.

During an interview with an identified staff member they told an inspector that they were involved in the Falls Prevention Program in the home and they participated in the annual program evaluation in December 2017. This staff member said that they were not sure if there had been a revision to the policies after this evaluation and had not seen any new policies.

During an interview the Administrator told inspectors that the annual evaluation of the Falls Prevention Program was completed December 29, 2017. When asked if they had a written record of the outcomes or changes that happened after the review, the Administrator said that they thought recommendations had been made. The Administrator reviewed the copy of the "Annual Program Evaluation" dated December 29, 2017, and said that this document did not include the changes that had been made or when the change was made at the time of the interview.

During an interview the peopleCare VPCS provided an updated copy of the written record for the evaluation of the Falls Prevention Program to the inspectors. PeopleCare VPCS said that this was a "running document" and did not know the

exact date that it was updated and said that it was updated when something was completed. When asked what changes had been made to the program during the annual evaluation the peopleCare VPCS said that not everything was done as it was recommendations and that they did not have access to change the policies. The peopleCare VPCS said that some of the recommendations had been implemented since the time of the evaluation and others had not been. The peopleCare VPCS said that they were not aware that the Falls Prevention Program policies had been updated in January 2018 after the program evaluation was completed and this was not added to the program evaluation. The peopleCare VPCS said that the program evaluation that was completed was to get them started and then the idea was to complete the record as they completed things and the inspectors should have received the updated one right away.

During a follow-up interview the IDOC and ADOC told inspectors that they had both been involved in the annual program evaluation for the Falls Prevention Program. The ADOC said they did not think they had seen a copy of the updated written record of the program evaluation and that the evaluation record had not been reviewed or discussed at the Falls Prevention Program meetings in January, February or March 2018. The IDOC and ADOC said that some of the recommendations in the evaluation had been implemented in the home but they were not sure the dates when those had been implemented. The IDOC and ADOC said that they had not been involved in the revisions to the Falls Prevention policies in the home as this was not part of the evaluation. They said they were not aware that the Falls Prevention policies had a revised date of January 2018. The ADOC acknowledged that although the written record stated that they had reviewed the care plans to ensure that interventions had been completed in January 2018, this had not been fully implemented in the home. The IDOC and ADOC said that it was the responsibility of the "all of us" to update the evaluation record and this had not been updated based on the changes that had been implemented in the home after the initial meeting for the evaluation.
Based on these interviews and record reviews the written record relating to the Falls Prevention and Management Program annual evaluation dated December 29, 2017, did not include a summary of the changes made or the date the changes were implemented. A revised version of this record was provided during the inspection, and it was identified through interviews that the staff in the home who had participated in the annual evaluation were not familiar with this revised written record as this had not been reviewed by or discussed with those team members prior to the inspection. The revised written record did not include dates related to when the

evaluation record had been updated and the staff in the home were unable to demonstrate that these updates had occurred prior to the compliance due date of January 31, 2018 (630).

B) Ontario Regulation 79/10 s. 48 (1) states "Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions."

During an interview the Administrator told inspectors that the annual evaluation of the Skin and Wound Program was completed on December 2017. When asked if the documented evaluation included documentation of what changes were made and when it was changed, the Administrator said that changes were not identified in the program evaluation.

On a specific date a document titled "Annual Program Evaluation" and "Skin and Wound Program Evaluation Earl's Court" was provided to the inspectors. This document "Date of Evaluation" was blank. This written record identified that the peopleCare VPCS, the ADOC, IDOC, the Registered Dietitian (RD) and an identified staff member had completed the evaluation. This written record included the following documentation:
-"Review of the Act/Regulations and note any specific requirements to be considered."
-"Review the policy/program in the Policy Manager. Is there a written description of the program including goals and objectives."

During an interview the ADOC said that they were the lead for the Skin and Wound Program, they said that they participated in one meeting only that included that above stated team members and that meeting happened in December 2017. The ADOC said that at that meeting they completed wound rounds on all the floors and then met in the Harvest Room to discuss cases. The ADOC said that they did not review the Act/Regulations or the policy/program in the "Policy Manager." The ADOC reviewed the Skin and Wound program written record for the evaluation and said that policies were revised in September 2017 before the evaluation. The documented evaluation had no indication of revisions in September 2017. The ADOC reviewed the policy revised in January 2018 and said that they were not aware that the policy was changed or what were those changes and this was not

documented on the program evaluation.

Based on these interviews and record reviews the written record related to the Skin and Wound Care Program annual evaluation did not include the date of the evaluation, a summary of the changes made or the date the changes were implemented (523).

C) Ontario Regulation 79/10 s. 48 (1) states "Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: A pain management program to identify pain in residents and manage pain."

On a specific date, a document titled "Annual Program Evaluation" and "Pain, Palliative/End of Life Annual Program Evaluation" was provided to the inspectors. This document stated "Date of Evaluation: January 29, 2018". This written record identified that a peopleCare consultant, the Administrator, the Director of Therapeutic Recreation (DRT), the Interim Director of Care (IDOC), the Assistant Director of Care (ADOC), the Director of Dietary Services and four identified staff members had completed the evaluation. This written record included the following documentation:
- Multiple recommendations documented including "need to ensure tasks are being implemented for better monitoring, skin, turning and repositioning, mouth care." No documentation of changes implemented or the date they were implemented.
- The home had provided "Pain Management PM-N-20" policy with "effective date January 2018" and this was not reflected in the written program evaluation.
- The home had provided "Pain Assessment and Symptom Management Overview PM-N-10" with "revised January 16, 2018" and this was not reflected in the written program evaluation.
- The home had provided "Palliative and End of Life Care-Guiding Principles EOL-M-15" policy with "revised Sept 2017" and this was not reflected in the written program evaluation.
- The written record did not identify if any of the policies were reviewed as part of the evaluation.

During an interview and two identified staff members told an inspector that they did not attend this program evaluation even though their name was included on the written record.

During an interview the IDOC reviewed the annual program evaluation and policies

for the pain management program in the home with an inspector. The IDOC said the annual evaluation did not include a summary of the changes that were implemented to the policy in September 2017 or January 2018 and the date when the changes were implemented as well as who implemented them.

Based on these interviews and record review the licensee has failed to ensure that a written record was kept related to the evaluation that included the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented (523).

D) Section 10 (1) of the Long Term Care Homes Act, 2007 states "every licensee of a long-term care home shall ensure that there is an organized program of recreational and social activities for the home to meet the interests of the residents."

On a specific date, a document titled "Annual Program Evaluation" and "Recreation and Program Evaluation" was provided to the inspectors. This document stated "Date of Evaluation: started December 8, 2017" and did not indicate when it was completed. This written record identified that the peopleCare Vice President Clinical Services (VPCS), the Director of Therapeutic Recreation (DRT) and three people listed by first name with no identified job title had completed the evaluation. This written record included no documentation of changes implemented. The written record documented that the policy/program was reviewed in "policy tech."

During an interview DRT told an inspector that they were not aware that they participated in an annual program evaluation. The DRT said they thought that the meeting was a discussion about the program and answering mandatory questions that peopleCare VPCS had to ask them. The DRT said that during this evaluation they did not review the policy or program in policy tech. The DRT said that the home's policies were revised in May 2017, but a summary of those updates and revisions, and the dates that those updates and revisions had been implemented were not in this evaluation. The DRT said that in January 2018 they personally had completed a review of the policies and submitted changes recommended to the home but had not heard anything back at the time of the inspection. The DRT said their review of the policies was not identified in the evaluation (523).

E) Ontario Regulation 79/10 s. 48 (1) states "Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: A continence care and bowel management program to

promote continence and to ensure that residents are clean, dry and comfortable."

During an interview the Administrator told inspectors that the annual evaluation of the Continence Program was completed January 15, 2018. When asked if they had a written record of the outcomes or changes that happened after the review, the Administrator said that they thought recommendations had been made and that this was documented within the annual program evaluations that had been provided.

On a specific date, a document titled "Annual Program Evaluation" and "Continence Management Program Evaluation" was provided to the inspectors. This document stated "Date of Evaluation: January 15, 2018." This written record identified that peopleCare VPCS, IDOC, two identified staff members and the Administrator completed the evaluation. This written record included the following documentation:
- No documentation under the column "changes made" or the date that changes were made.
- A statement within the column "recommendations" which stated "policy has been updated." This did not include a date that this change was implemented.
- A statement within the column "recommendations" which stated "documentation by PSWs or lack of documentation for resident bowel movements makes it difficult to follow bowel protocol." Under the column "responsibility" it documented that "education February 20, 21, 23 with PSWs to discuss documentation." This did not include documentation of the changes that were made or a date that change was implemented.

During an interview peopleCare VPCS said they had lead the annual program evaluations in the home. The peopleCare VPCS said that this was a "running document" and did not know the exact date that it was updated and said that it was updated when something was completed. The peopleCare VPCS said that during the evaluations they did not have access to change the policies.

During an interview the IDOC told inspectors that they had been involved in the annual program evaluation for the Continence Care Program. The IDOC said that they implemented some changes to the program after the meeting in January 2018 such as education. The IDOC said that they had reviewed the policy at the evaluation. The IDOC said that the evaluation documented that the policy had been updated but they did not know of an update and were not aware of revisions to the policy. The IDOC acknowledged that the documented record of the annual program evaluation had not been updated based on the changes that had been implemented in the home.

During an interview the Administrator told an inspector that the policies for the Continence Care and Bowel Management Program were reviewed and revised between January and September 2017. The inspector asked what was meant on the annual program evaluation record when it stated that the policy had been updated and no other changes were recommended at that time and the Administrator said that this meant all the policies were reviewed and finalized as of September 2017. The Administrator said that the only policy reviewed as part of the annual evaluation was the written description of the program.

Based on these interviews and record reviews the written record relating to the Continence Management Program annual evaluation dated January 15 2018, did not include a summary of the changes made or the date the changes were implemented (630).

The severity of this issue was determined to be a level 2 as there was potential for harm. The scope of the issue was a level 3 as it was related to non-compliance that had potential to affect a large number of residents in the home. The home had a level 5 history as they had multiple non-compliances with at least one related CO to this section of the LTCHA that included:

• WN and CO issued January 4, 2018 (2017_607523_0033) with compliance due date January 31, 2018. (630)

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

Nov 30, 2018(A1)

Ontario

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

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

À l'attention du/de la registrateur(e)
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 17 day of September 2018 (A2)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by AMIE GIBBS-WARD - (A2)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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Service Area Office / Bureau régional de services : London