Ontario

**Ministry of Health and Long-Term Care**

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

**Ministère de la Santé et des Soins de longue durée**

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


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

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

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## Amended Public Copy/Copie modifiée du public

| Report Date(s)/ Date(s) du Rapport | Inspection No/ No de l'inspection | Log #/ No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Dec 19, 2018 | 2018_720130_0010 (A1) | 003146-18 | Resident Quality Inspection |

### Licensee/Titulaire de permis

Albright Gardens Homes, Incorporated
5050 Hillside Drive Beamsville ON L0R 1B2

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

Albright Gardens Homes, Incorporated
5050 Hillside Drive Beamsville ON L0R 1B2

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

Amended by GILLIAN HUNTER (130) - (A1)

### Amended Inspection Summary/Résumé de l'inspection modifié

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**

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**This Public Inspection Report was amended to remove Personal Health Information (PHI).**

**Issued on this 19th day of December, 2018 (A1)**

**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**

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

**Ministère de la Santé et des Soins de longue durée**

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


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

Amended by GILLIAN HUNTER (130) - (A1)

## Amended Inspection Summary/Résumé de l'inspection

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

**This inspection was conducted on the following date(s): April 19, 20, 23, 24, 25, 26, 27, 30, May 1, 2, 3, 9, 10, 11, 14, 15, 2018.**

**The following inspections were conducted concurrently with the RQI:**

**Critical Incidents:**

**016918-17 related to C501-000020-17, medication management,**

**017553-17 related to C501-000021-17, abuse,**

**020560-17 related to C501-000025-17, medication management,**

**027621-17 related to C501-000029-17, falls management,**

**027691-17 related to C501-000030-17, falls management,**

**027748-17 related to C501-000031-17, falls management,**

**028663-17 related to C501-000032-17, falls management,**

**002017-18 related to C501-000002-18, falls management,**

**007499-18 related to C501-000008-18, infection control and outbreak management**

**006688-18 related to C501-000009-18, abuse**

**005928-18 related to C501-000007-18, abuse**

**007734-18 related to C501-000013-18, abuse**

**Complaints:**

**018003-17 related to IL-52226-HA, sufficient staffing,**

**021406-17 related to IL-52766-HA, sufficient staffing,**

**021411-17 related to IL-52774-HA, sufficient staffing,**

**025558-17 related to IL-53954-HA, sufficient staffing,**

**029173-17 related to IL-54637-HA, skin and wound,**

**029275-17 related to IL-54666-HA, sufficient staffing, supplies**

**Follow ups:**

**024955-17 related to Compliance Order #001 - O.Reg 79/10, s. 33. (1) specifically bathing,**

**024960-17 related to Compliance Order #002,**

**O. Reg. 79/10, s. 135 (2) medication policies,**

**024957-17 related to Compliance Order #003, related to 2007, c. 8, s. 19 (1), abuse,**

**024958-17 related to Compliance Order #004, related to O. Reg.79/10, s. 36, transfers,**

**024959-17 related to Compliance Order #005 related to O. Reg. 79/10, s. 8 (1), policies not complied with, and**

**029358-17 related to FU to Order #001 related to bed safety (s. 15)**

**Inquiry:**

**002772-18 related to IL-55360-HA, sufficient staff, nutrition and hydration, bathing.**

**During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), Chief Financial Officer (CFO), Chief Nursing Officer (CNO), Director of Nursing and Personal Care (DNPC), Manager of Program and Support Services, Director of Dietary Services, Director of Maintenance and Properties (DMP), Resident Assessment Instrument (RAI) Coordinators, administrative support staff, registered staff, personal support workers (PSWs), President of the Residents' Council, President of the Family Council, residents and families.**

**The following Inspection Protocols were used during this inspection:**

**Continence Care and Bowel Management**
**Falls Prevention**
**Family Council**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Nutrition and Hydration**
**Pain**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Residents' Council**
**Responsive Behaviours**
**Safe and Secure Home**
**Skin and Wound Care**
**Sufficient Staffing**

**During the course of the original inspection, Non-Compliances were issued.**
- **23 WN(s)**
- **9 VPC(s)**
- **8 CO(s)**
- **1 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. 135. (2) | CO #002 | 2017_560632_0013 | 130 |

| **NON-COMPLIANCE / NON - RESPECT DES EXIGENCES** | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.)<br><br>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD. |

**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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 :**

(A1)
1. The licensee failed to ensure that where the Act or the Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any

policy, the policy was complied with.

In accordance with O. Reg. 79/10, s. 68, the licensee was required to ensure that the nutrition care program included a weight monitoring system to measure and record the weight of each resident at admission and monthly thereafter.

Specifically, staff did not comply with the licensee's policy regarding Height and Weight Monitoring, D-1.26, last revised January 2018, which is part of the licensee's nutrition care and dietary service program. The policy identified that for any weight change or loss or gain of two kilograms (kg) or more from the previous month, the Unit Supervisor would verify by re-weighing the resident and that re-weighs would be completed within 24 hours and entered into Point Click Care (PCC).

A) A review of resident #070's clinical record identified they had a documented weight on a specific date in 2017 and their next documented weight one month later showed a weight loss. This change in body weight represented a weight loss in one month. Review of the progress notes identified that RD #109 completed an assessment after the second recorded weight, which identified the weight loss and had not been confirmed by re-weigh. The next recorded weight for resident #070 was completed the following month and represented an increase in weight in one month.

Interview with the Director of Dietary Services on an identified date in 2018, confirmed that a re-weigh was not done for resident #070 after their recorded weight showed a variance.

B) Review of resident #071's clinical record identified recorded weights for two consecutive months in 2018. The second recorded weight represented a weight loss variance. Review of the progress notes identified that RD #109 completed an assessment after the second recorded weight represented a weight loss. Resident #071's weight was recorded on the third and fourth month in 2018. The forth recorded weight represented an weight increase in one month.

Interview with the Director of Dietary Services on an identified date in 2018, confirmed that a re-weigh was not done for resident #071 after their weight decreased in the second month and increased in the fourth month, as per their policy.

C) Review of resident #072's clinical record identified they had a recorded weight on an identified date in 2018 and a recorded weight a month later. The second weight represented a weight increase. Review of the progress notes identified that Registered Dietician (RD) #112 completed an assessment after the second weight, which acknowledged weight fluctuations over the past two months and identified possible scale errors due to no changes in resident #072's oral intake. Resident #072's weight was recorded on the third month and represented a weight increase in one month.

Interview with the Director of Dietary Services on an identified date in 2018, confirmed that a re-weigh was not done for resident #072 after their weight variances were identified, as per their policy.

D) In accordance with s.114 (2), the long term care home was required to ensure that written policies and protocols were developed for the medication management system to ensure accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home; and (3) (a), that written policies and protocols were implemented.

The home's policy and procedure titled: Document Management, Doctor's Orders, N, 7.9, revised January 2017, indicated that orders were to be transcribed by a Registered Nurse (RN) or Registered Practical Nurse (RPN) to ensure accurate follow-through; the order as written was to be transcribed correctly onto the MAR/TAR sheet; the RN/RPN checking the order would sign the Doctor's Order sheet indicating the Doctor's Order sheet was checked and the order was correctly processed; and the second check was to be completed by the RN/RPN on the same shift or the shift immediately following. The second checks signified the validation of the completion of the orders.

i) On an identified date in 2018, the physician documented a written order for resident #056, directing staff to administer a specific medication at specific times. The medication was ordered through a third party, transcribed by pharmacy on the MAR, received and labeled with different directions.

Staff # 144 completed the first check, but did not identify the discrepancy between the physician's order on the MAR and the incorrect drug label on the medication received from pharmacy. Staff #144 was to complete the second check, but confirmed in an interview that they did not complete the second check, prior to administering the dose. As a result, the resident received the incorrect dose of

medication. The error was not discovered until staff #138 completed the second check.

The DNPC confirmed in an interview, that staff #138 and #144 did not comply with the home's policy and procedure titled: Document Management, Doctor's Orders, N, 7.9, revised June 2017.

ii) The home's policy and procedure titled: Medication Incident Reporting, No. 9-1, section 9, revised February 2017, indicated that every medication incident and adverse drug reaction involving a resident was to be reported to the resident or the resident's substitute decision-maker, the Director of Nursing and Personal Care, the resident's attending physician and the pharmacy/Clinical Consultant Pharmacist.

According to the plan of care, resident #059 had a physician's order in place that directed staff to administer a specific medication at specific times. On an identified date in 2017, the CNO submitted a critical incident report, which indicated resident #059's medication was missing on four identified dates in 2017.The home's investigation notes were reviewed and indicated that registered staff #144, who discovered the medication missing on four occasions had not completed a medication incident report for the medication incidents; they had not reported the incidents to the resident or the resident's substitute decision-maker, the Director of Nursing and Personal Care, the resident's attending physician nor the pharmacy/Clinical Consultant Pharmacist, as directed by the home's policy.

The CNO and staff #144 confirmed the above information in an interview in 2018 and verified the home's policy and procedure titled: Medication Incident Reporting, No. 9-1, section 9, revised February 2017, had not been complied with.

Please note: This non compliance was issued as a result of the following CI inspections: 016918-17 and 020560-17, which were conducted concurrently with the RQI. (130).

Please note: A previously issued CO#005 from inspection #2017_560632_0013 served on October 3, 2017, with a compliance date in 2018 was not past due at the time of the incident.

E) Under s. 30 (1) 1. relevant policies, procedures and protocols are required in relation to programs required in relation to section 8 to 16 of the Act and each of

the interdisciplinary programs required under section 48 of the Regulation. Regulation s. 48 requires the licensee to establish a fall prevention and management program.

Specifically, staff did not comply with the licensee's policy regarding, Fall and Post Fall Assessment and Management, N-9.5.6, last revised April 2017, which was part of the licensee's Falls and Management program. The policy directed registered staff that after a resident had fallen or was suspected of having fallen they would be thoroughly examined by registered staff for any potential injuries. The registered staff who attended the fall would complete a Falls Risk Assessment in PCC.

i) On an identified date in 2017, resident #012 fell and sustained an injury. Review of the clinical record identified that a falls risk assessment was not completed until three days after the fall.

A review of the resident's history of falls indicated they fell on three previous occasions in 2017; a falls risk assessment was not completed after each fall.

In an interview, the CNO stated that the falls risk assessment would be completed after the fall or the next morning at the latest but not three days later and confirmed that the registered staff did not complete a Falls Risk Assessment after the resident had fallen four times and the home's policy was not complied with.

ii) Review of the plan of care identified that resident #014 had fallen on one occasion in 2017 and five occasions in 2018 and that post fall assessments were completed; however, the falls risk assessments were not completed after any of the falls. The plan of care was reviewed and during interview with RPN #133 they stated that the falls risk assessment was to be completed after the six falls identified above and confirmed that it was not completed and that the home's policy was not complied with.

iii) Review of the plan of care for resident #011 identified they had fallen twice in 2017 and twice in 2018 and had post fall assessments completed post fall; however, the falls risk assessment was not completed after the above falls. An interview and review of the plan of care with RPN #100, confirmed that the resident had fallen and that the falls risk assessment was not completed after the resident had fallen and the home's policy was not complied with.

This non compliance was issued as a result of critical incident system inspection: 028663-17 related to C501-000031-17 which was conducted concurrently with the RQI.

Please note: A previously issued CO#005 from inspection #2017_560632_0013 served on October 3, 2017, with a compliance date of January 5, 2018 was not past due at the time of the incident.

F) The home's policy titled Head Injury Routine (HIR), N-9.6.1, revised December 2017, directed registered staff that a HIR would be initiated post fall for each resident who has an unwitnessed fall, a witnessed fall with a possible head injury and was on anti-coagulant therapy. The HIR would be completed by the registered staff using the Head Injury Routine form for a total of 72 hours.

On an identified date in 2017, resident #014 had an unwitnessed fall with injury. Review of the plan of care identified that the HIR was initiated at the time of the fall but was not completed every 15 minutes for the following hour.

On another date in 2017, the same resident had an unwitnessed fall with no injuries. Review of the HIR form identified that on an identified date after the fall, a specific shift did not complete the resident's vitals as required in the home's policy.

Interview with registered staff #103 stated the resident had two unwitnessed falls and that the HIR was to be completed by registered staff for 72 hours post unwitnessed falls. After reviewing the plan of care RN #103 confirmed that on the above two falls, the HIR was not fully completed and the home's policy was not complied with.

Please note: This non compliance was issued as a result of critical incident system inspection: 028663-17 related to C501-000031-17 which was conducted concurrently with this RQI.

Please note: A previously issued CO#005 from inspection #2017_560632_0013 served on October 3, 2017, with a compliance date of January 5, 2018 was not past due at the time of the incident. [s. 8. (1) (a),s. 8. (1) (b)]

***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**

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services**

**Specifically failed to comply with the following:**

**s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).**

**Findings/Faits saillants :**

(A1)
1. The licensee failed to ensure that there was at least one Registered Nurse who was an employee of the licensee and was member of the regular nursing staff on duty and present at all times.

Ontario Regulation 79/10, section 45, allowed for exceptions for the requirement of one RN on duty and present at all times, under specific situations, for homes with less 129 beds and for small homes at hospitals.

Albright Gardens did not qualify for any exceptions as specified in the regulations.

Albright Gardens is a long term care home with a licensed capacity of 231 beds.

The current planned staffing pattern for registered nursing staff in the home, for

the direct care of residents, was five Registered Nurses (RNs) for a total of 24 hours per day and 19 Registered Practical Nurses (RPNs) for a total of 24 hours per day, as identified on work schedules provided by the home and confirmed by the DNPC.

During an interview in 2018, the DNPC identified that the home did not have a sufficient number of Registered Nurses within the staffing plan to fill all the shifts related to staffing events such as sick calls. The DNPC confirmed that the home consistently offered additional shifts to regular registered nurses to fill these vacant shifts; however, when the registered nurses employed by the home were unwilling or unable to work one or more of the required shifts the home would fill those shifts with registered nurses employed with an employment agency. On request the home provided a list of shifts over the most recent seven month period in 2018, which identified there were 52 occasions (8.2% of total shifts worked over the period of time) where there was no RN on duty who was a member of the regular nursing staff.

On 42 of the 52 occasions, there was an agency RN on duty and on 10 of the 52 occasions there was no RN in the building.

The DNPC confirmed in an interview that the need to fill these RN shifts were not the result of emergency situations as outlined in O. Reg 79/10, s. 45(2).

The home did not ensure that there was at least one registered nurse who was an employee of the licensee and was member of the regular nursing staff on duty and present at all times. [s. 8. (3)]

This non compliance was issued as a result of the following complaint inspections: 018003-17, 021406-17, 021411-17, 025558-17, 029275-17 related to insufficient staffing. (130). [s. 8. (3)]

***Additional Required Actions:***

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

**(A1)**
**The following order(s) have been amended: CO# 002**

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**WN #3: 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) On an identified date in 2017, resident #012 fell and sustained an injury. Review of the progress notes identified the resident was found on the floor in their room with signs of injury. Registered staff assessed the resident and there was no complaints of pain to a specific area, but they had complained of pain to another area. The resident was assisted onto a chair with three staff using a specific transfer method and according to the documented progress notes from the registered staff, the resident did complain of pain when moved from the floor to the chair.

Interview with PSW #113 on an identified date in 2018, who was working on the shift of the fall stated they were aware of the home's no lift policy and that residents were to be transferred off the floor with a device. They confirmed that they assisted in transferring the resident by a different transfer method.

Interview with RN #137 stated that when a resident had fallen and was on the floor, staff were to transfer the resident with a specific device; however, confirmed resident #112 was lifted off the floor without the device.

Interview with CNO on an identified date in 2018 and review of the progress notes, confirmed that specific staff had transferred the resident without the device. The CNO confirmed the home had a no lift policy in place and that when a

resident had fallen and could not weight bear, staff were to use a a specific device to transfer the resident.

The CNO confirmed that staff did not use safe transferring and positioning techniques when assisting resident #012 from the floor post fall.

Please note: This non compliance was issued as a result of critical incident system inspection: 027691-17 related to C501-000030-17 which was conducted concurrently with the RQI.

B) On an identified date in 2017, resident #014 sustained a fall with injury.

Review of the progress notes on an identified date in 2017, identified that resident #014 was found in an identified location by PSW #128. The registered staff assessed the resident and observed they were able to move all extremities; had redness to a specific area and complained of pain. The resident was assisted off the floor by staff. Interview with RPN #127 on an identified date in 2018, who was working the shift of the fall, stated they were aware of the licensee's no lift policy and verified they had not transferred the resident with a device.

Review of the Falls Prevention and Management Program policy, N-9.5.6 revised on April 2017, directed staff that after a resident had fallen the registered staff would direct unregulated care providers on the safe transfer of the fallen resident and that staff were not to provide a manual lift and were to abide by the no lift policy and if in doubt use the specified device.

Interview with the CNO on an identified date in 2018, after they reviewed the progress notes on the shift of the fall, stated that the resident should have been transferred with the device and confirmed that staff did not use safe transferring techniques when assisting resident #014 manually off the ground post fall.

Please note: This non compliance was issued as a result of critical incident system inspection: 027748-17 related to C501-000031-17, which was conducted concurrently with the RQI. [s. 36.]

***Additional Required Actions:***

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

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails**
**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee failed to ensure that where bed rails were used, that the bed system was evaluated in accordance with prevailing practices, to minimize risk to the resident.

Prevailing practices have been identified by the Ministry of Health and Long Term Care, as a document produced by Health Canada (HC) entitled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards ", March 2008. This guidance document provides recommendations relating to bed systems and bed accessories in order to reduce life-threatening entrapments associated with adult hospital bed systems. It characterizes the body parts at risk for entrapment, identifies the locations of bed openings that are potential entrapment areas, and recommends dimensional criteria for bed rails. In addition, the HC guide provides guidance with measuring bed systems with a weighted cone and cylinder tool to identify whether any of the four identified entrapment zones fail the dimensional criteria. The four entrapment zones are within the bed rail and areas between the mattress and the bed rail.

During the previous inspection conducted in 2017, the licensee was issued a compliance order (#001) to evaluate all beds (excluding those with a compressible therapeutic mattress) in accordance with the "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008". Each bed was to be identified by serial number or unique code which corresponded to the mattress. All bed frames that received a new or different mattress or had bed rails removed and re-attached to the frame were to be re-evaluated by March 31, 2018.

According to the DMP,  all beds were evaluated or measured using a specialized weighted tool identified in the HC guidelines in April and August 2016. When reviewed during an inspection in 2017, the documented results of the bed system evaluations did not include any beds that failed entrapment zones one through four. Upon further review, the documents were missing unique identifying codes or serial numbers for the bed frames tested and the records did not include the size or type of bed rail that was attached to the bed when tested. Bed systems that were observed during the inspection in various resident rooms that were suspected of not passing entrapment, could not be verified against the records. The entrapment status of any bed at the time of inspection could not be easily ascertained. According to the DMP, since 2016, the home had purchased new bed systems (which were assumed to have passed entrapment zones one through four based on manufacturer's assurances) and bed rails were removed and re-attached, and not necessarily attached back onto the same bed frame. A re-evaluation of these beds was not completed. According to the HC Guidelines, when components of the bed system are changed or replaced (mattresses, bed rails), the bed system should be re-evaluated with the specialized tool to ensure that the zones in and around the bed rail and between the mattress and the bed rail comply with required specifications.

The licensee's policy and procedure entitled "Bedrail Entrapment Prevention Program" (N-10.2.5) dated May 2017 under the "Role of the Facility Services Staff" did not include any information regarding the importance of ensuring the mattress and bed frame remained together once measured and how that would be achieved.

According to the DMP on an identified date in 2018, the bed systems were not all evaluated and none were tagged with a code or identifier to ensure that both the mattresses and the frames remained together once measured or evaluated. A

total of 231 beds were in the home and the total number re-evaluated over a five month period in 2018 was 55. The 55 beds evaluated passed zones 1 through 4. The DMP stated that specialized stickers to attach to the mattresses and frames were ordered several months prior from a supplier, which were subsequently discontinued and the licensee was not made aware. No alternative options or actions were implemented to ensure that the order was complied with by the due date of March 31, 2018. [s. 15. (1) (a)]

***Additional Required Actions:***

**CO # - 004 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.***

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing**
**Specifically failed to comply with the following:**

**s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).**

**Findings/Faits saillants :**

(A1)
1. The licensee failed to ensure that the resident was bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

A) The plan of care for resident #053, revised on an identified date in 2018, stated

they required specific assistance with an activity of daily living (ADL), for a specific number of days per week.

According to the licensee's document tilted: The "Follow-up Question Report" for an identified week in 2018, the resident received the assistance less than was required during the identified time period.

The staffing report for this time period was reviewed and the documentation stated that on an identified date in 2018, the home was short a total of five PSWs on two different shifts.

The CNO confirmed in an interview on an identified date in 2018 that resident #053 had not received the required ADL assistance.

Please note: This non compliance was issued as a result of Follow-up inspection: 024955-17, which was conducted concurrently with the RQI. (130).

B) The plan of care for resident #052, revised on an identified date in 2018, stated they required specific assistance with an activity of daily living (ADL), for a specific number of days per week.

According to the licensee's document tilted: The "Follow-up Question Report" for an identified week in 2018, the resident received the assistance less than was required during the specific time period.

The staffing report for this time period was reviewed and documentation stated that on an identified date in 2018, the home was short a total of 11 PSWs on two different shifts.

The CNO confirmed in an interview on an identified date in 2018 that resident #052 had not received the required ADL assistance.

C) The plan of care for resident #054, revised on an identified date in 2018, stated they required specific assistance with an activity of daily living (ADL), for a specific number of days per week.

According to the licensee's document tilted: The "Follow-up Question Report" for an identified week in 2018, the resident received the assistance less than was required during the specific time period.

The staffing report for this time period was reviewed and documentation stated that on an identified date in 2018, the home was short a total of eight PSWs on two different shifts.

The CNO confirmed in an interview on an identified date in 2018 that resident #054 had not received the required ADL assistance.

On an identified date in 2018, the CNO confirmed in an interview, that the documentation contained in the "Follow-up Question Report(s)" was accurate and that during the specified weeks, the identified residents did not receive ADL care as scheduled. The CNO confirmed in this interview that despite changes made to staffing assignments and processes implemented since receiving the previous compliance order #001, issued October 3, 2017, efforts to fully comply with s. 33. (1) had not been successful. [s. 33. (1)]

***Additional Required Actions:***

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

**(A1)**
**The following order(s) have been amended: CO# 005**

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**WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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 :**

(A1)
1. The licensee failed to ensure that all residents were protected from abuse by resident #077.

O. Reg. 79/10, s. 2(1) defines sexual abuse as any non-consensual touching, behaviour or remark of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

A Critical Incident (CI) submitted on an identified date in 2018, described an incident of resident to resident responsive behaviour where resident #077 was observed by Physiotherapist (PT) #140 demonstrating responsive behaviour towards resident #078. The CI reported that resident #078 was heard saying "stop that." The residents were separated by PT #140. Resident #078 identified to PT #140 what resident #077 was attempting to do and when the PT asked if they were okay resident #078 identified yes.

A review of the clinical record identified that resident #077 was admitted to the home in 2018, with a specific diagnosis and an identified Cognitive Performance Scale (CPS) score. The resident was admitted to the home from another long-term care home and review of the clinical record and staff interviews identified that the resident was known to demonstrate responsive behaviours at their previous home; however, admission paperwork identified that the resident had not displayed responsive behaviours since 2017. Review of resident #077's clinical record identified that they demonstrated responsive behaviours towards specific staff, on eight occasions during a one month period in 2018.

Resident #077's current written plan of care identified that they demonstrated responsive behaviours which included residents and staff. Interventions in place for resident #077's responsive behaviours included documenting a summary of each episode, which included specific interventions.

Review of the clinical record for resident #078 identified that they had a specific diagnosis and an identified CPS score. In an interview with resident #078's Substitute Decision Maker (SDM), PSWs #134 and #141 and registered staff #103, they identified that they believed resident #078 would not have been able to consent to the responsive behaviours exhibited by resident #077. In an interview held on an identified date in 2018 with PT #140, who witnessed the incident, they stated that they believed the incident was not consensual.

In an interview with the DNPC on an identified date in 2018, they confirmed that resident #078 was not protected from abuse by resident #077.

Please note: This non-compliance was issued as a result of critical incident inspection: 005928-18 related to C501-000007-18, which was conducted concurrently with the RQI. [s. 19. (1)]

***Additional Required Actions:***

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

**(A1)**
**The following order(s) have been amended: CO# 006**

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**WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care**

**Specifically failed to comply with the following:**

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

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

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

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

**Findings/Faits saillants :**

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

On an identified date in 2017, resident #011 fell and sustained an injury. Review

of the physician orders identified specific instructions for interventions to be implemented for a specific time period.

Interview with PSW #102 on an identified date in 2018, stated the resident did have the intervention in place for a certain time period but would often try and remove it. Review of the written plan of care did not identify the intervention for the resident. Interview with RN #103 on an identified date in 2018, stated the resident required the intervention post fall and injury, and confirmed the written plan of care did not set out the planned care for the resident.

Please note: This non compliance was issued as a result of critical incident system inspection: 028663-17 related to C501-000032-17 which was conducted concurrently with the RQI. [s. 6. (1) (a)]

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

On an identified date in 2017, resident #014 fell and sustained an injury. Review of the current written plan of care identified the resident was transferred by a specific method with a specific number of staff assistance. Review of the Physiotherapy Assessment and documentation in the written plan of care identified the resident was receiving specific therapy and was transferred by a specific method. Observation of the logo posted above the bed was not consistent with the plan of care.

Interview with PSW #136 stated the resident required a specific method for transfers and that PSW staff decided whether to use one method of transfer versus another depending on their assessment of the resident. The PSW stated the resident was no longer transferred with a specific method of transfer.

Interview with the RN #103 and review of the plan of care confirmed there was no clear direction to staff on how the resident was to be transferred by PSW staff.

Interview with the CNO stated the following was the home's expectation of their practice related to the assessment for transferring residents with a specific device with one staff or two. CNO stated that the resident was to be assessed as a one person or two person transfer with the device by registered staff or the Physiotherapist and this assessment would be documented in the plan of care.

The assessment would identify the device as one or two person transfer as the direction needed to be clear to the PSW, who were not to be making that assessment decision.

Please note: This non compliance was issued as a result of critical incident system inspection: 027748-17 related to C501-000031-17, which was conducted concurrently with the RQI. [s. 6. (1) (c)]

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

On an identified date in 2017, resident #012 fell and sustained an injury. Review of the Minimum Data Set (MDS) significant change assessment completed on an identified date in 2017, identified they fell in the past 30 days and the past 31 to 180 days but did not indicate they had an other injury in the last 180 days. Interview with RAI Coordinator #104 stated the resident had fallen and sustained a specific injury and confirmed the MDS assessment and hospital discharge diagnosis were not integrated and consistent with each other.

Please note: This non compliance was issued as a result of critical incident system inspection: 027691-17 related to C501-000030-17 which was conducted concurrently with the RQI [s. 6. (4) (a)]

4. The licensee 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.

A) Review of the plan of care identified that resident #013 had an order as needed for the application of a specific intervention to manage their responsive behaviours. Review of the Physician's orders indicated that this order was discontinued on an identified date in 2015.

Interview and review of the plan of care with RPN #118 on an identified date in 2018, stated the resident no longer required the intervention as needed and the order was discontinued; however, confirmed that the plan of care was not reviewed and revised when the care set out in the plan was no longer necessary.

B) On an identified date in 2017, resident #014 fell and sustained an injury. Review of the Physiotherapist assessment on an identified date in 2017, identified that the resident required a specific method of transfer with two staff. Review of the progress notes dated on a specific date in 2017, indicated the resident was being transferred by a different method of transfer. Interview with RN #103 and review of the written plan of care did not identify the resident was being transferred with the latter method of transfer. They confirmed that the plan of care was not reviewed and revised when the resident's care needs changed related to the resident's transfer status.

On an identified date in 2018, the plan of care identified that resident #014 was reassessed by the Physiotherapist and required a specific method of transfer with a specific number of staff. Interview with RAI Coordinator #002 on an identified date in 2018, stated they updated the written plan of care to reflect they required a specific method of transfer and confirmed the plan of care should have been reviewed and revised when the resident's care needs changed.

Please note: This non compliance was issued as a result of critical incident system inspection: 027748-17 related to C501-000031-17, which was conducted concurrently with the RQI.

C) Resident #005 and staff who provided direct care to the resident confirmed that the resident's care needs had changed in relation to a specific intervention. When interviewed, resident #005 said they refused care from staff for the specific care need because it caused them discomfort. When interviewed, PSW #107 said that the resident required assistance for a specific care need and had for the past month refused help from staff for the reason specified by the resident. RN #108 and the clinical record identified that resident #005 experienced changes to their skin integrity over a number of areas on their body. When interviewed, RN #111 reviewed the resident's written plan of care and confirmed that there were no care directions related to the care need of the resident either prior to the resident refusing care or when staff identified that the resident began to refuse the care due to discomfort experienced during the activity.

Resident #005's written plan of care was not reviewed or revised to include care interventions to assist the resident for the specific care need when staff became aware that the resident had developed impaired skin integrity or when the resident began to refuse to allow staff to provide them care.

Resident #005 and staff who provided direct care to the resident confirmed that the resident's care needs had changed related to mobility. Resident #005 confirmed that they did not use a specific device any longer. When interviewed, PSW #107 confirmed that although the directions in the clinical record were that the resident used a specific device as an assistive device the resident had not been able to use the device. When interviewed, the DNPC acknowledged that they were aware the resident no longer used the device for mobility and care interventions related to activation, physiotherapy and mobility had not been revised to reflect this change in the resident's mobility status.

Resident #005's written plan of care was not reviewed or revised when the resident's care needs changed in relation to mobility and the use of a device. (129).

D) Resident #030's care needs changed in relation to specific care area. When interviewed, RPN #145 said that resident #030 was not able to perform the care on their own. A review of the resident's written plan of care indicated the resident was assisted to transfer using a specific method and there were no care directions identified in the plan of care for scheduled care related to the specific care area.

The DNPC and resident #030's written plan of care confirmed that the resident's plan of care had not been reviewed or revised when staff identified that the resident was no longer able to perform the specific task on their own.

Resident #030's written plan of care was not reviewed and revised when the resident's care needs changed.

(Please Note: The above noted non-compliance related to resident #030 was identified during a complaint inspection (Log # 029173-17) that was completed concurrently with this Resident Quality Inspection.) (129).

E) Resident #007's care needs changed when the resident experienced impaired skin integrity to a specific area. Treatment Administration Records (TAR) for three identified months in 2018 indicated that the resident had an area of impaired skin integrity to a specific area that was being treated by registered staff routinely. During an interview, the CNO reviewed the resident's plan of care and said that the plan of care had not been revised to include care interventions related to changes in skin integrity the resident had experienced over the above mentioned

period of time.

Resident #007's written plan of care was not reviewed and revised when the resident's care needs changed [s. 6. (10) (b)]

5. The licensee failed to ensure that when the plan of care was being revised because the care set out in the plan had not been effective, that different approaches were considered in the revision of the plan.

A) Direct care staff did not ensure that different approaches; including non-pharmacological, therapeutic or comfort approaches to assist in managing the increased pain resident #005 experienced, were considered when the written plan of care was revised by the resident's physicians.

Resident #005's written plan of care was not revised when the care set out in the plan had not been effective in relation to the management of pain the resident experienced. Resident #005's physician revised the resident's written plan of care on an identified date in 2018, and changed the interventions for pain management. On the above noted date the resident's physician ordered the resident's regularly administered medication on at least five occasions during an identified time period in 2018 due to worsening pain.

Resident #005 continued to experience pain despite the interventions and at the time of the inspection the resident said they refused to allow staff to provide specific care due to pain they experienced.

The DNPC and RN #130 acknowledged that there was no documentation in the plan to verify that different approaches to manage the pain experienced by the resident, were considered or implemented during the above noted periods of time.

B) Direct care staff did not ensure that different approaches to assist in managing the increased pain resident #030 experienced, were considered when the written plan of care was revised.

Resident #030's written plan of care was revised when the care set out in the plan of care had not been effective in relation to the management of pain the resident experienced. The Medication Administration Record (MAR) on an identified date in 2017, indicated that staff administered 41, as necessary doses of a specific

medication to the resident over a 29 day period of time. Resident #030's physician revised the resident's written plan of care on an identified date in 2017, when they changed the interventions and ordered that resident #030 was to receive a regularly scheduled dose of a specific medication routinely and receive an additional medication every four hours as necessary.

During an interview the DNPC reviewed the written plan of care and acknowledged that there was no documentation in the plan of care to verify that staff had considered or implemented different approaches in order to manage pain the resident experienced.

Staff did not ensure that different approaches; including non-pharmacological, therapeutic or comfort approaches to assist in managing the increased pain resident #005 and resident #030 experienced, were considered when the written plan of care was revised.

Please Note: The above noted non-compliance related to resident #030 was identified during a complaint inspection (Log # 029173-17) that was completed concurrently with this RQI. (129). [s. 6. (11) (b)]

***Additional Required Actions:***

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

***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 if the plan of care is being revised because the care set out in the plan is not effective, the licensee ensures that different approaches are considered in the revision of the plan, to be implemented voluntarily.***

**WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

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

A) According to the plan of care, resident #059 had a physician's order in place that directed registered staff to apply a specific medication at specific times. On an identified date in 2017, the CNO submitted a critical incident report, which indicated that resident #059's medication was missing on four identified dates in 2017. On a later date in 2017, staff #104 submitted a critical incident report, which indicated that resident #059's medication was discovered missing on a fifth date in 2017.

The CNO's internal investigation review, indicated the licensee was unable to determine the specific length of time the resident was without their medication, but confirmed in an interview on an identified date in 2018, that there would have been a period of time from the time the medication was applied until the time medication was discovered missing, that resident #056 did not receive continuous delivery of their medication on each of the identified incident dates.

Please note: This non compliance was issued as a result of the following CI inspections: 016918-17 and 020560-17, which were conducted concurrently with the RQI. (130).

B) The plan of care for resident #055 stated they had a physician's order in place, directing registered staff to administer a specific medication at specific times.

On an identified date in 2018, RPN #139 administered resident #055 an incorrect dose of their medication. The error was discovered the following day. There were no ill effects to the resident as a result of the incident.

The DNCP and RPN #139 confirmed during an interview on an identified date in 2018, that on an identified date in 2018, resident #055 received the incorrect dose of medication.

C) On an identified date in 2018, a physician's written order for resident #056, directed registered staff to administer a specific medication at specific times.The medication ordered was transcribed by the pharmacy. The MAR and medication received on an identified date in 2018 for resident #056 was labeled incorrectly.

As a result, the resident received at a lower dose of medication than what was actually prescribed.

The DNPC confirmed in an interview on an identified date in 2018, that registered staff #138 and #144 did not administer medications to resident #056 as prescribed. [s. 131. (2)]

***Additional Required Actions:***

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

**(A1)**
**The following order(s) have been amended: CO# 008**

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**WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement**

**Specifically failed to comply with the following:**

**s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:**
**1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).**
**2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).**
**3. The use of the PASD has been approved by,**
**i. a physician,**
**ii. a registered nurse,**
**iii. a registered practical nurse,**
**iv. a member of the College of Occupational Therapists of Ontario,**
**v. a member of the College of Physiotherapists of Ontario, or**
**vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).**
**4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).**
**5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the use of a Personal Assistance Services Device (PASD) under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following were satisfied:

1. Alternatives to the use of a PASD had been considered, and tried where appropriate.
2. The use of the PASD was reasonable, in light of the resident's physical and mental condition and personal history, and was the least restrictive of such reasonable PASD's that would be effective to assist the resident with the routine activity of living.
3. The use of the PASD had been approved by, a physician, a registered nurse, a registered practical nurse, a member of the College of Occupational Therapists of Ontario, a member of the College of Physiotherapists of Ontario.
4. The use of the PASD had been consented to by the resident or, if the resident was incapable, a substitute decision-maker of the resident with authority to give that consent.

A) On an identified date in 2017, resident #013 was observed with a specific device. Review of the plan of care identified the resident had the specific device since 2015, and there was no documentation related to alternatives considered and tried, approval for its use and no consent signed from the SDM for the specific device as a PASD with restraining effect. Interview with RPN #118 stated the resident had the device for a specific need as a PASD and the device belonged to the home. They confirmed there was no documentation for the use of the device as a PASD or for alternatives tried in the resident's plan of care, no documented approval for the device and no consent signed by the SDM for the device as a PASD.

B) On an identified date in 2018, resident #006 was observed with a specific device. Review of the plan of care identified they had the device as a PASD but there was no documentation that alternatives were considered and tried for the device as a PASD with restraining effects. Interview with RPN #100 stated that the resident had the device for a specific need. Interview with the Occupational Therapist (OT) stated the resident required the device as a PASD for a specific need and they obtained consent but confirmed alternatives to the use of the device were not considered or tried. [s. 33. (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 use of a Personal Assistance Services Device (PASD) under subsection (3) to assist a resident with a routine activity of living is included in a resident's plan of care only if all of the following are satisfied:***

***1. Alternatives to the use of a PASD have been considered, and tried where appropriate.***
***2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASD's that will be effective to assist the resident with the routine activity of living.***
***3. The use of the PASD has been approved by, a physician, a registered nurse, a registered practical nurse, a member of the College of Occupational Therapists of Ontario, a member of the College of Physiotherapists of Ontario.***
***4. The use of the PASD has been consented to by the resident or, if the resident was incapable, a substitute decision-maker of the resident with authority to give that consent, to be implemented voluntarily.***

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**WN #10: 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).**

**s. 50. (2) Every licensee of a long-term care home shall ensure that,**
**(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).**

**Findings/Faits saillants :**

1. The licensee 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.

The CNO, DNPC, staff and clinical documentation confirmed that resident #030 and resident #007 were not assessed by registered staff, using a clinically appropriate assessment instrument, specifically designed for skin and wound assessments.

During an interview the DNCP confirmed that staff were expected to complete the "Ulcer/Wound Record", which was considered the clinically appropriate assessment instrument, specifically designed for skin and wound assessment.

A) Resident #030's clinical record indicated the resident experienced impaired skin integrity to an identified area in 2017 and 2018, as well as another area in 2017. During an interview with the DNPC they said that although staff had been completing skin care observations notes in the computerized record, this documentation did not constitute a skin and wound assessment and staff had not completed an assessment using the home's "Ulcer/Wound Record".

A review of the clinical record confirmed that registered staff had not assessed the wounds experienced by resident #030 using the clinically appropriate assessment instrument designated by the home.

B) Resident #007's clinical record indicated that the resident experienced impaired skin integrity to a specific area over a three month period in 2018. During an interview with the CNO and following a review of the clinical record, they acknowledged that staff were documenting a skin and wound observation note which they did not consider an assessment and staff were not using the specific assessment tool identified in the licensee's policy, which was identified as being a clinically appropriate assessment instrument for the assessment of skin and wounds.

The CNO, the DNPC and clinical records indicated that when resident #030 and resident #007 demonstrated impaired skin integrity, registered staff had not assessed the residents using a clinically appropriate assessment instrument, specifically designed for skin and wound assessments. [s. 50. (2) (b) (i)]

2. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A) An interview with Registered Nurse (RN) #108 and a review of resident #005's clinical record indicated that resident #005 had multiple areas of impaired skin integrity. RN # 108 reviewed the assessment tab in the resident's computerized clinical record and verified that reassessments of the above noted areas of impaired skin integrity had not been completed for two weeks during an identified month in 2018 and also verified that the assessment tool identified as "Ulcer/Wound Assessment Record", specifically directed staff to complete the assessment weekly.

During an interview the DNPC reviewed the licensee's program, "Skin and Wound

Care Program", identified as N-9.14.1, with a revised date of March 2012 and said that it was the expectation that any resident who demonstrated impaired skin integrity was to have a weekly reassessment of the skin issue, using the Ulcer/Wound Assessment Record identified in the licensee's skin and wound program document.

The DNPC also reviewed resident #005's computerized clinical record and verified that the areas of impaired skin integrity identified above had not been reassessed over a two week period of time during an identified month in 2018. The DNPC, RN #108 and resident #005's clinical record confirmed that the resident had several identified areas of impaired skin integrity and staff had not completed weekly reassessments of these areas as was the expectation of the DNPC and the licensee's skin and wound care program.

The licensee failed to ensure that resident #005 who exhibited altered skin integrity was reassessed at least weekly, if clinically indicated. [s. 50. (2) (b) (iv)]

3. The licensee failed to ensure that any resident who was dependent on staff for repositioning was repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load.

A) During an interview RPN #135 said that resident #007 required assistance of staff for a specific task at specific times.

During an interview on an identified date in 2018, PSW #126, who provided care to the resident, indicated the resident could not perform a specific task independently at specific times and that they were not aware if the resident's plan of care directed the staff to provide assistance with the task at specific times. They confirmed they had not provided assistance with the specific task at an identified time.

Observations of the care provided to resident #007 on an identified date in 2018, indicated staff provided specific care to the resident at an observed time. On three separate observed times the resident was observed in the same position as they had been observed hours earlier.

During an interview with PSW #133 on an identified date in 2018, they said a specific shift provided care to the resident and that they had assisted the resident with a specific task at a specific time. PSW #133 confirmed they were not aware

of any directions to provide a specific task at other specific times. PSW #133 confirmed they had not provide assistance with a specific task over a specific time period.

The CNO confirmed there was no documentation in the clinical record that staff provided this care to resident #007 who was identified as requiring the assistance of staff for the specific task.

Staff providing care to resident #007 confirmed that the resident was not assisted with a specific task on two identified dates in 2018.

Resident #007 was not assisted as required. (129). [s. 50. (2) (d)]

***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 ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated and to ensure that any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, to be implemented voluntarily.***

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**WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A) Resident #005's pain was not relieved by initial interventions. When interviewed, resident #005 said their pain was not being managed and as a result the resident refused to allow staff to provide specific care to them because the activity caused them too much pain. When interviewed, the DNPC, RN #130 and PSW #107 acknowledged that the resident had refused to allow staff to provide specific care because of the pain the resident experienced. The DNPC, RN #130 and the clinical record confirmed that on an identified date in 2018, the resident's physician increased the dose of the regularly scheduled medication and also ordered the resident could receive an additional dose when necessary.

On an identified date in 2018, the DNPC confirmed that the" Pain Assessment Record" identified in the licensee's policy "Pain Management", identified as N-9.16.1, with an implementation date of March 2012, was the clinically appropriate instrument specifically designed for the assessment of pain that staff were expected to utilize.

The DNPC, RN #130 and resident #005's clinical record indicated that when the resident's pain had not been relieved by the initial interventions, the resident had not been assessed and staff had not completed the "Pain Assessment Record".

B) Resident #030's clinical record indicated the resident's pain was not managed by initial interventions, when on an identified date in 2017 the resident's physician increased the medication the resident had been receiving. The DNPC and resident #030's clinical record indicated that the pain experienced by resident #030 was not assessed and registered staff had not completed the "Pain Assessment Record".

The DNCP, staff and resident #005's and resident #030's clinical records confirmed that when the resident's pain was not relieved by the initial interventions these residents were not assessed and the clinically appropriate pain assessment tool identified in the above noted licensee policy had not been completed. (129). [s. 52. (2)]

***Additional Required Actions:***

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

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**WN #12: 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 failed to ensure that the nutrition care and hydration program included a weight monitoring system to measure and record with respect to each resident's height on admission and annually thereafter.

A) Review of the clinical record for resident #073 identified that they were admitted to the home in 2015. They had a specific height recorded on an identified date in 2015. Review of the resident's clinical record on an identified date in 2018, identified the resident's most recent height as the height recorded in 2015. There were no other documented heights for the resident, nor was documentation found of the resident refusing height measurement.

B) Review of the clinical record for resident #074 identified that they were admitted to the home in 2014. They had a specific height recorded on an identified date in 2014. Review of the resident's clinical record on an identified date in 2018, identified the resident's most recent height was recorded on an identified date in 2016. There were no other documented heights for the resident, nor was documentation found of the resident refusing height measurement.

C) Review of the clinical record for resident #075 identified that they were admitted to the home on an identified date in 2016. They had a specific height recorded on an identified date in 2016. Review of the resident's clinical record on an identified dater in 2018, identified the resident's most recent height was recorded in 2016. There were no other documented heights for the resident, nor was documentation found of the resident refusing height measurement.

Interview with the Director of Dietary Services on an identified date in 2018, confirmed that resident #073, #074 and #075's heights were not measured annually. [s. 68. (2) (e) (ii)]

***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 nutrition care and hydration program includes a weight monitoring system to measure and record with respect to each resident height on admission and annually thereafter, to be implemented voluntarily.***

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**WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training**

**Specifically failed to comply with the following:**

**s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:**
**1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).**
**2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).**
**3. Behaviour management. 2007, c. 8, s. 76. (7).**
**4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).**
**5. Palliative care. 2007, c. 8, s. 76. (7).**
**6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that all staff who provided direct care to the residents received as a condition to continuing to have contact with residents annual retraining in accordance to O. Reg. 79/10, s. 219 (1) in the area of falls prevention and management in accordance with O. Reg. 79/10, s. 221 (1) 1

A) The Manager of Program and Support Services provided 2017, falls prevention training records maintained by the home and confirmed they were aware that the records provided indicated that not all staff who provided direct care to residents in 2017 received training in this care area. A review of the spreadsheet provided, indicated,15 percent of staff who provided direct care to residents had not

received training in 2017.

Please note: This non compliance was issued as a result of critical incident system inspection: 028663-17 related to C501-000032-17, 027691-17 related to C501-000030-17 and 027748-17 related to C501-000031-17, which was conducted concurrently with the RQI.

The licensee failed to ensure that all staff who provided direct care to the residents received as a condition to continuing to have contact with residents annual retraining in accordance to O. Reg. 79/10, s. 219 (1) in the area of skin and wound in accordance with O. Reg. 79/10, s. 221(1) 2.

B) The DNPC provided 2017 skin and wound care training records maintained by the home and confirmed they were aware that the records provided indicated that not all staff who provided direct care to residents in 2017 received training in this care area. A review of the records provided, indicated, 112 staff out of 154 (79 percent) of staff who provided direct care to residents had not received training in 2017 related to this care area.

The licensee failed to ensure that all staff who provided direct care to the residents received as a condition to continuing to have contact with residents annual retraining in accordance to O. Reg. 79/10, s. 219 (1) in the area of pain management, including pain recognition of specific and non-specific signs of pain, in accordance with O. Reg. 79/10, s. 221(1) 4.

C) At the time of this inspection the DNPC acknowledged that the home did not complete learning needs assessments for staff. When asked to provide training records to verify that staff had received annual retraining in the area of pain management, the DNPC was unable to provide records to verify that any staff had received retraining in the area pf pain management in the 2017 calendar year.

The licensee failed to ensure that all staff who provided direct care to the residents received as a condition to continuing to have contact with residents annual retraining in accordance to O. Reg. 79/10, s. 219 (1) in the area of application, use and potential dangers of PASD's in accordance with O. Reg. 79/10, s. 221 (1) 6.

D) The Manager of Program and Support Services provided 2017 PASD training records maintained by the home and confirmed they were aware that the records

provided indicated that not all staff who provided direct care to residents in 2017 received training in this care area. A review of the spreadsheet provided, identified that 14 percent of staff who provided direct care to residents had not received training in 2017. [s. 76. (7) 6.]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff who provided direct care to the residents received as a condition to continuing to have contact with residents annual retraining in accordance to O. Reg. 79/10, s. 219 (1) in the area of skin and wound care, in accordance with O. Reg. 79/10, s. 221(1)2, annual retraining in accordance to O. Reg. 79/10, s. 219 (1) in the area of application, use and potential dangers of PASD's, in accordance with O. Reg. 79/10, s. 221 (1) 6, annual retraining in accordance to O. Reg. 79/10, s. 219 (1) in the area of falls prevention and management, in accordance with O. Reg. 79/10, s. 221 (1) 1 and annual retraining in accordance to O. Reg. 79/10, s. 219 (1) in the area of pain management, including pain recognition of specific and non-specific signs of pain, in accordance with O. Reg. 79/10, s. 221(1)4, to be implemented voluntarily.***

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**WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence**

**Specifically failed to comply with the following:**

**s. 101. (4) Every licensee shall comply with the conditions to which the licence is subject. 2007, c. 8, s. 101. (4).**

**Findings/Faits saillants :**

1. The licensee failed to comply with the condition to which the licensee was

subject.

The Long-Term Care Home Service Accountability Agreement (LSAA) with the Local Health Integration Network (LHIN) under the Local Health System Integration Act, 2006, required the licensee to meet the practice requirements of the RAI-MDS (Resident Assessment Instrument - Minimum Data Set) system, which required each resident's care and service needs to be reassessed using the MDS 2.0 Quarterly or Full Assessment by the interdisciplinary team within 92 days of the assessment reference date (ARD) of the previous assessment, and Resident Assessment Protocols (RAPs) to be generated and reviewed and RAPs assessment summaries completed for triggered RAPs and non-triggered clinical conditions within 7 days maximum of the Assessment Reference Date (ARD).

The licensee did not comply with the conditions to which the licensee was subject in relation to the completion of the RAP assessment summary.

A) The MDS Assessment for resident #005, for an identified date in 2017, indicated that the resident experienced pain daily. Staff #104 acknowledged pain was a non-triggered clinical condition, a RAP assessment form was not generated in response to staff coding that the resident experienced pain and the home did not have a process for completing RAP summaries for non-triggered clinical conditions. Staff #104 reviewed the triggered RAP summaries as well as clinical notes and verified that a RAP summary had not been completed for this non-triggered clinical condition when staff coded that the resident #005 had experienced pain during the observation period of the above noted MDS assessment.

B) The MDS Assessment for resident #005, for an identified date in 2018, indicated that the resident experienced pain less than daily. Staff #104 acknowledged pain was a non-triggered clinical condition, a RAP assessment form was not generated in response to staff coding that the resident experienced pain and the home did not have a process for completing RAP summaries for non-triggered clinical conditions. Staff #104 reviewed the other triggered RAP statements as well as clinical notes and verified that a RAP summary had not been completed for this non-triggered clinical condition when staff coded that resident #005 had experienced pain during the observation period of the above noted MDS assessment.

C) The MDS Assessment for resident #007, for an identified date in 2018,

indicated the resident experienced pain less than daily. Staff #122 acknowledged that pain was a non-triggered clinical condition and following a reviewed of the triggered RAPs summaries generated during this MDS assessment verified that a RAP summary had not been completed for this non-triggered clinical condition when staff coded that resident #007 had experienced pain during the observation period of the above noted MDS assessment.

D) The MDS Assessment for resident #030, for an identified date in 2017, indicated the resident experienced pain less than daily. During an interview, the DNPC acknowledged that pain was a non-triggered clinical condition and that a RAP summary had not been completed for this clinical condition when staff coded that resident #030 experienced pain during the observation period of the above noted MDS assessment.

Please Note: The above noted non-compliance related to resident #030 was identified during a complaint inspection (Log # 029173-17) that was completed concurrently with this Resident Quality Inspection.(129). [s. 101. (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 the licensee complies with the Long-Term Care Home Service Accountability Agreement (LSAA) with the Local Health Integration Network (LHIN) under the Local Health System Integration Act, 2006, which requires the licensee to meet the practice requirements of the RAI-MDS (Resident Assessment Instrument - Minimum Data Set) system, which requires each resident's care and service needs to be reassessed using the MDS 2.0 Quarterly or Full Assessment by the interdisciplinary team within 92 days of the assessment reference date (ARD) of the previous assessment, and Resident Assessment Protocols (RAPs) to be generated and reviewed and RAPs assessment summaries completed for triggered RAPs and non-triggered clinical conditions within 7 days maximum of the Assessment Reference Date (ARD), to be implemented voluntarily.***

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**WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents**

**Specifically failed to comply with the following:**

**s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):**
**3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the Director was informed of missing or unaccounted for controlled substances no later than one business day after the occurrence of the incident.

According to the plan of care, resident #059 had a physician's order in place that directed registered staff to apply an identified medication at specified times.

On an identified date in 2017, the CNO submitted a critical incident report, which indicated that resident #059's medication was missing on four identified dates in 2017.
On another identified date in 2017, the RAI Coordinator submitted a critical incident report, which indicated that resident #059's medication was discovered missing on a fifth date in 2017.

The CNO confirmed in an interview on an identified date in 2018, that critical incident reports had not been submitted to the Director within the required time frames.

Please note: This non compliance was issued as a result of the following CI inspections: 016918-17 and 020560-17, which were conducted concurrently with the RQI. (130). [s. 107. (3) 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 the Director is informed of missing or unaccounted for controlled substances no later than one business day after the occurrence of the incident, to be implemented voluntarily.***

**WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

(A1)
1. The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction was: (b) reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

A) The plan of care for resident #056 revealed they had a physician's order which directed staff to administer a specific medication at specified times.

On an identified date in 2018, RPN #138 reported that resident #056 received medication at a lower dose than what was prescribed for that time period. There were no ill effects to the resident as a result of the medication incident.

The MDS Annual Assessment completed for resident #056 on an identified date in 2018, revealed the resident had a specific CPS score. A review of the medication incident report and the resident's plan of care revealed that the resident nor the physician were made aware of the medication incident.

This information was confirmed by the DNPC during an interview in 2018.

B) On an identified date in 2018, RPN #139 administered resident #055, an incorrect dose of medication. The error was not discovered until the following day. The Quarterly Review Assessment completed on an identified date in 2017, indicated the resident had a specific CPS score. The medication incident report revealed the resident nor their SDM were informed of the medication error.

This information was confirmed by the CNO on an identified date in 2018.

RPN #139 confirmed in an interview on a date in 2018, that they administered the incorrect dose of medication on the specific date in 2018 and that they did not inform the resident nor their SDM about the incident. [s. 135. (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 every medication incident involving a resident and every adverse drug reaction is:***
***(b) reported to the resident, the resident's Substitute Decision Maker (SDM) 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, to be implemented voluntarily.***

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**WN #17: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

(A1)
1. The licensee failed to ensure that their policy to promote zero tolerance of abuse and neglect of residents was complied with.

The licensee's policy regarding Zero Tolerance of Neglect and Abuse, N – 10.11, last revised April 2018, identified that all reporting of alleged, suspected, or witnessed incidents of abuse must be reported immediately by the person first having knowledge of the incident, and will be investigated immediately by the person's supervisor/manager/department head/administrator, in accordance with the investigation procedure under "Reporting and Notifications."

A review of the clinical record identified that resident #077 was admitted to the home on an identified date in 2018, with a specific diagnosis. The resident was admitted to the home from another long-term care home and review of the clinical record identified that the resident was known to have responsive behaviours at

their previous home, however; admission paperwork identified the resident had not displayed the specific responsive behaviour since 2017. Review of resident #077's clinical record identified they demonstrated responsive behaviours on 13 occasions during a one month period in 2018, including behaviours towards resident #078.

A review of the clinical record and staff interviews identified that on an identified date in 2018, staff #142 heard an altercation between resident #078 and resident #077. Staff #142 separated the residents and reported the incident and resident #078's statement to RN #103. In an interview with staff #142 on an identified date in 2018, they acknowledged they did not see what happened and that they were unsure of what the resident meant by their specific statement; however; they identified that they assumed what happened based on resident #078's reaction to the incident.

In an interview with RN #103, they acknowledged that when they went to check on resident #077, they observed them demonstrating a specific responsive behaviour toward another resident. They identified that they could not recall if they left a voicemail for the CNO or DNPC related to the suspected incident with resident #077 and #078, but noted that there was a lot going on at that time. They acknowledged that they did not report the incident to the Director.

In an interview with the DNPC on an identified date in 2018, they acknowledged that they were not made aware of the incident on the identified date in 2018, between resident #077 and #078 until several days after the incident. They acknowledged that the home did not complete an internal investigation into the suspected incident, that the incident was reportable, and that it was not reported to the Director.

The home did not ensure that their policy regarding Zero Tolerance of Neglect and Abuse was complied with in relation to the incident between residents #077 and #078. [s. 20. (1)]

**WN #18: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone was immediately investigated.

A review of the clinical record identified that resident #077 was admitted to the home on an identified date in 2018, with a specific diagnosis. The resident was admitted to the home from another long-term care facility and review of the clinical record identified that the resident was known to have responsive behaviours at their previous facility, however; admission paperwork identified the resident had not displayed the specific responsive behaviour since 2017. Review of resident #077's clinical record identified they demonstrated responsive behaviours on 13 occasions during a one month period in 2018, including behaviours towards resident #078.

A review of the clinical record and staff interviews identified that on an identified date in 2018, staff #142 heard an altercation between resident #078 and resident #077. Staff #142 separated the residents and reported the incident and resident #078's statement to RN #103. In an interview with staff #142 on an identified date in 2018, they acknowledged they did not see what happened and that they were unsure of what the resident meant by their specific statement; however; they identified that they assumed what happened based on resident #078's reaction to the incident.

In an interview with RN #103, they acknowledged that when they went to check on resident #077, they observed them demonstrating a specific responsive behaviour toward another resident. They identified that they could not recall if they left a voicemail for the CNO or DNPC related to the suspected incident with resident #077 and #078, but noted that there was a lot going on at that time. They acknowledged that they did not report the incident to the Director.

In an interview with the DNPC on an identified date in 2018, they acknowledged that they were not made aware of the incident on the identified date in 2018, between resident #077 and #078 until several days after the incident. They acknowledged that the home did not complete an internal investigation into the suspected incident. [s. 23. (1) (a)]

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**WN #19: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

(A1)
1. The licensee failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone had occurred immediately reported the suspicion and the information upon which it was based to the Director.

A review of the clinical record identified that resident #077 was admitted to the home on an identified date in 2018, with a specific diagnosis. The resident was admitted to the home from another long-term care home and review of the clinical record identified that the resident was known to have responsive behaviours at their previous home, however; admission paperwork identified the resident had not displayed the specific responsive behaviour since 2017. Review of resident #077's clinical record identified they demonstrated responsive behaviours on 13 occasions during a one month period in 2018, including behaviours towards resident #078.

A review of the clinical record and staff interviews identified that on an identified date in 2018, staff #142 heard an altercation between resident #078 and resident #077. Staff #142 separated the residents and reported the incident and resident #078's statement to RN #103. In an interview with staff #142 on an identified date in 2018, they acknowledged they did not see what happened and that they were unsure of what the resident meant by their specific statement; however; they identified that they assumed what happened based on resident #078's reaction to the incident.

In an interview with RN #103, they acknowledged that when they went to check on resident #077, they observed them demonstrating a specific responsive behaviour toward another resident. They identified that they could not recall if they left a voicemail for the CNO or DNPC related to the suspected incident with resident #077 and #078, but noted that there was a lot going on at that time. They acknowledged that they did not report the incident to the Director.

In an interview with the DNPC on an identified date in 2018, they acknowledged that they were not made aware of the incident on the identified date in 2018, between resident #077 and #078 until several days after the incident. The DNPC acknowledged that the incident between resident #077 and #078, was a reportable incident, that it was not reported to the Director and that it should have been reported to the Director.

The home did not ensure that the person who had reasonable grounds to suspect that sexual abuse of resident #078 had occurred by resident #077 on an identified date in 2018, was immediately reported to the Director. [s. 24. (1)]

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**WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care**

**Specifically failed to comply with the following:**

**s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:**
**7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming. O. Reg. 79/10, s. 26 (3).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that a plan of care would be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident under physical functioning and the type and level of assistance that was required related to activities of daily living.

Resident #014 was assessed by the Physiotherapist (PT) on an identified date in 2017, to be transferred by a specific method after they sustained a fall with injury. On an identified date in 2018, the resident was reassessed by the PT as requiring a different method for transfers. Review of the progress notes identified that registered staff sent the PT a referral to reassess the resident's transfer status; however this referral was not responded to by the PT. Review of the current written plan of care identified a different approach to transfers, which had been updated on an identified date in 2018.

Interview with RN #135 and RPN #148 stated that when a resident's transfer status was to be changed, the registered staff would send a referral to the PT and they were responsible for assessing the resident and to document their assessment in a progress note.

RPN #148 stated they sent an electronic referral on an identified date in 2018, to the PT for a transfer assessment as PSW staff had reported the resident was not safe being transferred with a specific method. They confirmed that the PT did not reply to the referral and there was no transfer assessment completed to identify if the resident was safe to be transferred with the specified method.

Please note: This non compliance was issued as a result of critical incident system inspection: 027748-17 related to C501-000031-17, which was conducted concurrently with the RQI. [s. 26. (3) 7.]

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**WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

(A1)
1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A) The plan of care initiated on an identified date in 2012, for resident #030, directed front line staff to provide specific assistance with an ADL at specific times.The ADL records were reviewed over a three month period in 2017. The documentation reflected that the resident did not receive the required assistance on at least three occasions over the three month period.

The DNCP confirmed in an interview on an identified date in 2018, that staff had not documented whether or not the resident had received the specific ADL care or the reason for not receiving their scheduled care and not all actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Please note: This non compliance was issued as a result of the following Complaint inspection: 029173-17, which was conducted concurrently with the RQI. (#130).

B) A RAI-MDS assessment completed for resident #030 on an identified date in 2017, indicated the resident's condition under a specific area had deteriorated over the previous 90 day period. A focus related to the specific area was added the resident's plan of care which included an intervention that directed staff to assist the resident with specific care at specified times. During an interview with the DNPC and following a review of the resident's clinical record they acknowledged that there was no documentation to verify that this care had been provided to the resident.

Front line staff failed to document an intervention identified in the resident's plan of care related to the management of the specific need when they did not document that the resident had not received assistance as directed in the plan of care.

The licensee failed to ensure that actions directed in resident #030's plan of care related to the management of a specific need were documented. (129). [s. 30. (2)]

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**WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 113. Evaluation Every licensee of a long-term care home shall ensure,**

**(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;**

**(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;**

**(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;**

**(d) that the changes or improvements under clause (b) are promptly implemented; and**

**(e) that a written record of everything provided for in clauses (a), (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 were implemented is promptly prepared. O. Reg. 79/10, s. 113.**

**Findings/Faits saillants :**

1. The licensee failed to ensure that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy under section 29 of the Act and what changes and improvements were required to minimize restraining and to ensure that any restraining that was necessary was done in accordance with the Act and this Regulation.

The CNO was unable to provide written documentation during this inspection to support that an annual evaluation of the Minimizing of Restraints program including PASD's, had been completed for 2017. Interview with the CNO confirmed that the home did not complete an evaluation of their Minimizing of Restraints program including PASD's in 2017. [s. 113. (b)]

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**WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 216. Training and orientation program**

**Specifically failed to comply with the following:**

**s. 216. (2) The licensee shall ensure that, at least annually, the program is evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 216 (2).**

**Findings/Faits saillants :**

1. The licensee shall ensure that, at least annually, the program is evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The DNPC was unable to provide written documentation during this inspection to confirm that the training and orientation program had been evaluated or updated annually, specifically for the 2017 calendar year. When interviewed, the DNPC acknowledged that the training and orientation program had not been evaluated or updated annually, specifically for the 2017 calendar year. [s. 216. (2)]

**Issued on this 19th day of December, 2018 (A1)**

**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**

## Amended Public Copy/Copie modifiée du public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | Amended by GILLIAN HUNTER (130) - (A1) |
| **Inspection No. / No de l'inspection :** | 2018_720130_0010 (A1) |
| **Appeal/Dir# / Appel/Dir#:** | |
| **Log No. / No de registre :** | 003146-18 (A1) |
| **Type of Inspection / Genre d'inspection :** | Resident Quality Inspection |
| **Report Date(s) / Date(s) du Rapport :** | Dec 19, 2018(A1) |
| **Licensee / Titulaire de permis :** | Albright Gardens Homes, Incorporated<br>5050 Hillside Drive, Beamsville, ON, L0R-1B2 |
| **LTC Home / Foyer de SLD :** | Albright Gardens Homes, Incorporated<br>5050 Hillside Drive, Beamsville, ON, L0R-1B2 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | William ter Harmsel |

To Albright Gardens Homes, Incorporated, 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) (b)

**Linked to Existing Order / Lien vers ordre existant:** 2017_560632_0013, CO #005;

**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 :**

(A1)
The licensee must be compliant with s. 8(1) of O. Reg. 79/10.
Specifically, the licensee must ensure:

1. Resident #070, #071, #072 and any other resident are re-weighed when there is a change in their weight, loss or gain of 2kg, as per the home's policy.

2. The remaining 36% of registered staff are to receive education on the Height and Weight Monitoring Policy including action to be taken when a resident experiences a significant weight change, or a loss or gain of 2 kg.

3. Training records are maintained for the staff who attend the Height and Weight Monitoring training.

4. An auditing process is implemented and documented to ensure that residents with a significant weight change, or a loss or gain of 2 kg are re-weighed and nutritional referrals are submitted by the unit supervisor as appropriate.

The licensee has failed to comply with the following compliance order (CO) #005 from inspection #2017_560632_0013 served on October 3, 2017, with a compliance date of January 5, 2018.

The licensee was ordered to prepare, submit and implement a plan to ensure that the Height and Weight Monitoring Policy was implemented in the home.

The plan shall include:

1. Staff education on the Height and Weight Monitoring Policy including action to be taken when there is a discrepancy in the resident's weight.

2. Training related to Height and Weight Monitoring Policy will be recorded.

4. An auditing process to ensure that all residents' weights, including residents' #004, #008, and #016 are recorded and monitored according to the Height and Weight Monitoring Policy.

6. The plan will identify who is responsible for policy review, training and auditing of the effectiveness of the training provided.

7. The plan will identify the target audience for the specified training and how training will be addressed for those who do not attend scheduled training.

The licensee completed steps 2, 4, 6 and 7 in CO #005. The licensee failed to complete steps 1, 3 and 5 regarding training on the Height and Weight Monitoring Policy and an auditing process to ensure that all residents' weights are recorded and monitored according to the Height and Weight Monitoring Policy.

**Grounds / Motifs :**

(A1)
1. The licensee failed to ensure that where the Act or the Regulation required that licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

In accordance with O. Reg. 79/10, s. 68, the licensee was required to ensure that the nutrition care program included a weight monitoring system to measure and record the weight of each resident at admission and monthly thereafter.

Specifically, staff did not comply with the licensee's policy regarding Height and Weight Monitoring, D – 1.26, last revised January 2018, which is part of the licensee's nutrition care and dietary service program. The policy identified that for any weight change of (+/-) two kilograms (kg) or more from the previous month, the Unit Supervisor would verify by re-weighing the resident and that re-weighs would be completed within 24 hours and entered into Point Click Care (PCC).

A) A review of resident #070's clinical record identified they had a documented weight on a specific date in 2017 and their next documented weight one month later showed a weight loss. This change in body weight represented a weight loss in one month. Review of the progress notes identified that RD #109 completed an assessment after the second recorded weight, which identified the weight loss and had not been confirmed by reweigh. The next recorded weight for resident #070 was completed the following month and represented an increase in weight in one month.
Interview with the Director of Dietary Services on an identified date in 2018, confirmed that a re-weigh was not done for resident #070 after their recorded weight showed a variance.

B) Review of resident #071's clinical record identified recorded weights for two consecutive months in 2018. The second recorded weight represented a weight loss variance. Review of the progress notes identified that RD #109 completed an assessment after the second recorded weight represented a weight loss. Resident #071's weight was recorded on the third and fourth month in 2018. The forth recorded weight represented a weight increase in one month.

Interview with the Director of Dietary Services on an identified date in 2018, confirmed that a re-weigh was not done for resident #071 after their weight decreased in the second month and increased in the fourth month, as per their policy.

C) Review of resident #072's clinical record identified they had a recorded weight on

an identified date in 2018 and a recorded weight a month later. The second weight represented a weight increase. Review of the progress notes identified that Registered Dietician (RD) #112 completed an assessment after the second weight, which acknowledged weight fluctuations over the past two months and identified possible scale errors due to no changes in resident #072's oral intake. Resident #072's weight was recorded on the third month and represented a weight increase in one month.

Interview with the Director of Dietary Services on an identified date in 2018, confirmed that a re-weigh was not done for resident #072 after their weight variances were identified, as per their policy.

This Compliance Order is based upon three factors where there has been a finding of non-compliance in keeping with s. 299 (1) of Ontario Regulation 79/10.

The severity of this issue was determined to be a level 1 as there was minimum risk to the resident. The scope of the issue was a level 3 as it was related to three residents. The home had a level 5 compliance history of a previous WN issued on June 15, 2016, a VPC issued on January 24, 2017 and a previous CO served on October 3, 2017 (#2017_560632_0013).

(683)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Mar 30, 2019

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

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**Order # / Ordre no :** 002

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

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

**Order / Ordre :**

The licensee must be compliant with s. 8 (3) of the LTCHA.

Specifically, the licensee must:

1. Ensure at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

**Grounds / Motifs :**

(A1)
1. The licensee failed to ensure that there was at least one Registered Nurse who was an employee of the licensee and was member of the regular nursing staff on duty and present at all times.

Ontario Regulation 79/10, section 45, allowed for exceptions for the requirement of one RN on duty and present at all times, under specific situations, for homes with less 129 beds and for small homes at hospitals.

Albright Gardens did not qualify for any exceptions as specified in the regulations.

Albright Gardens is a long term care home with a licensed capacity of 231 beds.

The current planned staffing pattern for registered nursing staff in the home, for the direct care of residents, was five Registered Nurses (RNs) for a total of 24 hours per day and 19 Registered Practical Nurses (RPNs) for a total of 24 hours per day, as identified on work schedules provided by the home and confirmed by the DNPC.

During an interview in 2018, the DNPC identified that the home did not have a sufficient number of Registered Nurses within the staffing plan to fill all the shifts related to staffing events such as sick calls. The DNPC confirmed that the home consistently offered additional shifts to regular registered nurses to fill these vacant shifts; however, when the registered nurses employed by the home were unwilling or unable to work one or more of the required shifts the home would fill those shifts with registered nurses employed with an employment agency. On request the home provided a list of shifts over the most recent seven month period in 2018, which identified there were 52 occasions (8.2% of total shifts worked over the period of time) where there was no RN on duty who was a member of the regular nursing staff.

On 42 of the 52 occasions, there was an agency RN on duty and on 10 of the 52 occasions there was no RN in the building.

The DNPC confirmed in an interview that the need to fill these RN shifts were not the result of emergency situations as outlined in O. Reg 79/10, s. 45(2).

The home did not ensure that there was at least one registered nurse who was an employee of the licensee and was member of the regular nursing staff on duty and present at all times. [s. 8. (3)]

This non compliance was issued as a result of the following complaint inspections: 018003-17, 021406-17, 021411-17, 025558-17, 029275-17 related to insufficient staffing. (130).

The severity of this issue was determined to be a level 2 as there was potential for actual harm to the resident. The scope of the issue was a level 2 as there was a pattern.  The home had a level 3 compliance history of a previous that included: WN on January 26, 2016 and a VPC  on June 15, 2016.

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

(130)

**This order must be complied with by /**

**Vous devez vous conformer à cet ordre d’ici le :** May 31, 2019

**Order # / Ordre no :** 003

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

**Linked to Existing Order / Lien vers ordre existant:** 2017_560632_0013, CO #004;

**Pursuant to / Aux termes de :**

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.

**Order / Ordre :**

The licensee must be compliant with O. Reg. 79/10, s. 36.

Specifically, the licensee must ensure:

1. Residents #012, #014 and any other resident are transferred by staff using safe transferring and positioning devices or techniques when assisting residents.

2. All direct care staff will receive education related to the licensee's No Lift Policy. These training records will be retained.

3. All residents that have fallen and cannot weight bear or get up on their own safely will be lifted off the floor with the mechanical hoyer lift and all staff abide by the home's no-lift policy.

4. An auditing process is implemented to ensure that all staff are using safe transfers or techniques when assisting residents as directed by the plan of care.

5. The auditing process is documented and records retained.

The licensee has failed to comply with the following compliance order (CO) #004 from inspection #2017_560632_0013 served on October 3, 2017, with

a compliance date of January 5, 2018.

The licensee was ordered to complete the following:

1. Ensure staff follow the residents' plans of care when assisting residents in relation to transferring and positioning, according to their assessed needs and preferences.

2. Provide all direct care staff retraining regarding safe transferring and positioning for assisting residents.

3. Ensure staff competency related to lifts and transfers be audited annually according to the home's policy.

4. Ensure staff who do not pass the competency audit be paired with an employee who has passed their audit, re-educated, and retested.

5. Establish an auditing process to ensure that staff using transferring and positioning devices or techniques to assist residents are using safe techniques appropriate to the needs of the resident.

6. Ensure documentation be retained of training, staff audit results, and retraining.

The licensee completed steps 1, 2, 3, 4 and 6 in CO #004.

The licensee failed to complete step 5 prior to the compliance date of January 5, 2018, regarding establishing an auditing process to ensure that staff using transferring and positioning devices or techniques to assist residents are using safe techniques appropriate to the needs of the resident.

The licensee has failed to ensure this requirement of the order was met.

**Grounds / Motifs :**

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

A) On an identified date in 2017, resident #012 fell and sustained an injury. Review of the progress notes identified the resident was found on the floor in their room with signs of injury. Registered staff assessed the resident and there was no complaints of pain to a specific area, but they had complained of pain to another area. The resident was assisted onto a chair with three staff using a specific transfer method and according to the documented progress notes from the registered staff, the resident did complain of pain when moved from the floor to the chair.

Interview with PSW #113 on an identified date in 2018, who was working on the shift of the fall stated they were aware of the home's no lift policy and that residents were to be transferred off the floor with a device. They confirmed that they assisted in transferring the resident by a different transfer method.

Interview with RN #137 stated that when a resident had fallen and was on the floor, staff were to transfer the resident with a specific device; however, confirmed resident #112 was lifted off the floor without the device.

Interview with CNO on an identified date in 2018 and review of the progress notes, confirmed that specific staff had transferred the resident without the device. The CNO confirmed the home had a no lift policy in place and that when a resident had fallen and could not weight bear, staff were to use a a specific device to transfer the resident.

The CNO confirmed that staff did not use safe transferring and positioning techniques when assisting resident #012 from the floor post fall.

Please note: This non compliance was issued as a result of critical incident system inspection: 027691-17 related to C501-000030-17 which was conducted concurrently with the RQI.

B) On an identified date in 2017, resident #014 sustained a fall with injury.

Review of the progress notes on an identified date in 2017, identified that resident #014 was found in an identified location by PSW #128. The registered staff assessed the resident and observed they were able to move all extremities; had redness to a specific area and complained of pain. The resident was assisted off the floor by staff. Interview with RPN #127 on an identified date in 2018, who was

working the shift of the fall, stated they were aware of the licensee's no lift policy and verified they had not transferred the resident with a device.

Review of the Falls Prevention and Management Program policy, N-9.5.6 revised on April 2017, directed staff that after a resident had fallen the registered staff would direct unregulated care providers on the safe transfer of the fallen resident and that staff were not to provide a manual lift and were to abide by the no lift policy and if in doubt use the specified device.

Interview with the CNO on an identified date in 2018, after they reviewed the progress notes on the shift of the fall, stated that the resident should have been transferred with the device and confirmed that staff did not use safe transferring techniques when assisting resident #014 manually off the ground post fall.

Please note: This non compliance was issued as a result of critical incident system inspection: 027748-17 related to C501-000031-17, which was conducted concurrently with the RQI. [s. 36.]

The severity of this issue was determined to be a level 2 as there was potential for actual harm to the resident. The scope of the issue was a level 2 as it related to two of three residents reviewed. The home had a level 5 compliance history of a previous CO that included:
Compliance Order (CO) served on October 3, 2017 (#2017_560632_0013).

(581)

**This order must be complied with by /**

**Vous devez vous conformer à cet ordre d'ici le :** May 31, 2019

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

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**Order # / Ordre no :** 004

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

**Linked to Existing Order / Lien vers ordre existant:** 2017_539120_0059, CO #001;

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,

(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;

(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and

(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

**Order / Ordre :**

The licensee must be compliant with s.15(1)(a) of O. Reg. 79/10.

The licensee must complete the following:

1. Re-evaluate all beds (excluding those 55 bed systems completed in 2018) in accordance with Health Canada's Guideline entitled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008".

2. Each bed mattress on a bed frame shall be identified by a number or unique code that corresponds to the serial number of the bed frame or both shall have a different matching identifier if a serial number is not available.

3. Bed evaluation documentation shall include at a minimum the following additional details:

a) the type or size of bed rail(s) on the frame; and

b) the identifying code or number on the frame and mattress

4. Include #2 and #3 processes or procedures in the "Bedrail Entrapment Prevention Program" under the Role of the Facility Services Staff.

The licensee failed to comply with the following compliance order (CO) #001 from inspection #2018-539120-0059 served on February 28, 2018, with a compliance date of March 31, 2018.

The licensee was previously ordered to complete the following:
1. Immediately re-assess the three identified residents in accordance with "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" to determine if alternatives to bed rails can be implemented. If not, and bed rails have been determined to be beneficial, zones 2, 3 and 4 shall be mitigated by using appropriate interventions or accessories as referenced in "A Guide to Modifying Bed Systems Using Accessories to Prevent Entrapment, June 2016". All or any changes that have been implemented shall be reflected in the resident's written plan of care (i.e. the accessory or intervention shall be described, why used, when and where applied).

2. Evaluate all beds (excluding those with a compressible therapeutic mattress) in accordance with the "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008". Each bed shall be identified by serial number or unique code which corresponds to the mattress. All beds that have received a new or different mattress or have had bed rails removed and re-attached to the frame shall be re-evaluated.

3. Provide face to face training to all personal support workers (PSW), that shall include, at a minimum, the following;
a) the role of the PSW in ensuring residents remain safe in the use of their bed systems; and
b) the type of sleep patterns, behaviours and risks to look for when monitoring residents while in bed with bed rails applied and how to report the observations; and
c) when bed rails are to be applied (as described in plan of care, when in bed, during care only, at all times); and

d) risks associated with applying a bed rail, especially when the resident did not meet the criteria for their application; and
e) what to report to registered staff (malfunctioning bed rails, loose bed rails, broken mattress keepers, mattresses not fitting between the mattress keepers, worn or ripped mattresses) and when; and
f) the various laws that govern bed rails in Ontario (Health Canada, MOHLTC); and
g) the use of various accessories to mitigate entrapment risks.

A record shall be kept of who participated in the training, who completed the training and what was offered in the training.

4. Amend any policy related to bed safety to include how therapeutic surfaces will be evaluated and managed and include a reference to "A Guide to Modifying Bed Systems Using Accessories to Prevent Entrapment, June 2016", or additional information as necessary to direct staff in their tasks in evaluating and mitigating bed safety risks.

The licensee completed steps 1, 3 and 4 but failed to complete step 2 prior to the compliance date of March 31, 2018.

The licensee therefore failed to ensure that this requirement of the order was met.

**Grounds / Motifs :**

1. 1. The licensee failed to ensure that where bed rails were used, that the bed system was evaluated in accordance with prevailing practices, to minimize risk to the resident.

Prevailing practices have been identified by the Ministry of Health and Long Term Care, as a document produced by Health Canada (HC) entitled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards ", March 2008. This guidance document provides recommendations relating to bed systems and bed accessories in order to reduce life-threatening entrapments associated with adult hospital bed systems. It characterizes the body parts at risk for entrapment, identifies the locations of bed openings that are potential entrapment areas, and recommends dimensional criteria for bed rails. In addition, the HC guide

provides guidance with measuring bed systems with a weighted cone and cylinder tool to identify whether any of the four identified entrapment zones fail the dimensional criteria. The four entrapment zones are within the bed rail and areas between the mattress and the bed rail.

During the previous inspection conducted in 2017, the licensee was issued a compliance order (#001) to evaluate all beds (excluding those with a compressible therapeutic mattress) in accordance with the "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008". Each bed was to be identified by serial number or unique code which corresponded to the mattress. All bed frames that received a new or different mattress or had bed rails removed and re-attached to the frame were to be re-evaluated by March 31, 2018.

According to the DMP,  all beds were evaluated or measured using a specialized weighted tool identified in the HC guidelines in April and August 2016. When reviewed during an inspection in 2017, the documented results of the bed system evaluations did not include any beds that failed entrapment zones one through four. Upon further review, the documents were missing unique identifying codes or serial numbers for the bed frames tested and the records did not include the size or type of bed rail that was attached to the bed when tested. Bed systems that were observed during the inspection in various resident rooms that were suspected of not passing entrapment, could not be verified against the records. The entrapment status of any bed at the time of inspection could not be easily ascertained. According to the DMP, since 2016, the home had purchased new bed systems (which were assumed to have passed entrapment zones one through four based on manufacturer's assurances) and bed rails were removed and re-attached, and not necessarily attached back onto the same bed frame. A re-evaluation of these beds was not completed. According to the HC Guidelines, when components of the bed system are changed or replaced (mattresses, bed rails), the bed system should be re-evaluated with the specialized tool to ensure that the zones in and around the bed rail and between the mattress and the bed rail comply with required specifications.

The licensee's policy and procedure entitled "Bedrail Entrapment Prevention Program" (N-10.2.5) dated May 2017 under the "Role of the Facility Services Staff" did not include any information regarding the importance of ensuring the mattress and bed frame remained together once measured and how that would be achieved.

According to the DMP on an identified date in 2018, the bed systems were not all evaluated and none were tagged with a code or identifier to ensure that both the mattresses and the frames remained together once measured or evaluated. A total of 231 beds were in the home and the total number re-evaluated over a five month period in 2018 was 55. The 55 beds evaluated passed zones 1 through 4. The DMP stated that specialized stickers to attach to the mattresses and frames were ordered several months prior from a supplier, which were subsequently discontinued and the licensee was not made aware. No alternative options or actions were implemented to ensure that the order was complied with by the due date of March 31, 2018. [s. 15. (1) (a)]

This Compliance Order is based upon three factors where there has been a finding of non-compliance in keeping with s.299(1) of Ontario Regulation 79/10. The factors include scope (pervasiveness), severity (of the harm or risk of harm) and history of non-compliance. In relation to s. 15(1) of Ontario Regulation 79/10, the scope of the non-compliance included a pattern, as some of the resident bed systems were not evaluated in accordance with prevailing practices, the severity of the non-compliance had the potential to cause harm to residents related to their bed systems and the history of non-compliance included a Compliance Order (#001) that was issued under the same section on December 6, 2017, for an inspection (2017-539120-0059) conducted on November 1, 2017 and a Compliance Order (#001) that was issued under the same section on June 2, 2017, for an inspection (2017-555506-0011) conducted on January 4, 2017.
(120)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Feb 14, 2019

**Order # / Ordre no :** 005

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

**Linked to Existing Order / Lien vers ordre existant:** 2017_560632_0013, CO #001;

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

**Order / Ordre :**

(A1)
The licensee must be compliant with s. 33. (1) of O. Reg. 79/10.

Specifically, the licensee must:

1. Ensure all residents, including residents #052, #053 and #054, are bathed at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

2. Ensure there are adequate staffing levels to meet the needs of the residents' bathing requirements.

3. Any resident who misses a scheduled bath or shower has the missed bath or shower documented and made up the same week.

4. Ensure there is an established auditing process in place for monitoring ongoing compliance with s. 33 (1); that the process identifies the individual responsible for ongoing monitoring and that the auditing activities are documented.

The licensee has failed to comply with the following compliance order (CO) #001 from inspection #2017_560632_0013 served on October 3, 2017, with a compliance date of January 5, 2018.

The licensee was ordered to complete the following:

1. Develop and implement a system for monitoring that all residents in the home are bathed twice weekly by the method of their choice.

2. Develop a bathing plan for staff to implement when they are short staffed.

3. Ensure there is an established process for the staff to communicate shift to shift regarding completion of bathing.

4. Ensure all nursing and personal care staff are aware of this plan.

5. Any resident who misses a scheduled bath or shower due to the home being short staffed, has the missed bath or shower documented and made up the same week.

6. Develop an auditing process to ensure residents are receiving minimum bathing requirements.

The licensee completed steps 1, 2, 3, 4 and 6 in CO #001.

The licensee failed to complete step 5 prior to the compliance date of January 5, 2018, regarding ensuring any resident who missed a scheduled bath or shower due to the home being short staffed, has the missed bath or shower documented and made up the same week.

The licensee has failed to ensure this requirement of the order was met.

**Grounds / Motifs :**

1. 1. The licensee failed to ensure that the resident was bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

A) The plan of care for resident #053, revised on an identified date in 2018, stated they required specific assistance with an activity of daily living (ADL), for a specific number of days per week.

According to the licensee's document tilted: The "Follow-up Question Report" for an identified week in 2018, the resident received the assistance less than was required during the identified time period.

The staffing report for this time period was reviewed and the documentation stated that on an identified date in 2018, the home was short a total of five PSWs on two different shifts.

The CNO confirmed in an interview on an identified date in 2018 that resident #053 had not received the required ADL assistance.

Please note: This non compliance was issued as a result of Follow-up inspection: 024955-17, which was conducted concurrently with the RQI. (130).

B) The plan of care for resident #052, revised on an identified date in 2018, stated they required specific assistance with an activity of daily living (ADL), for a specific number of days per week.

According to the licensee's document tilted: The "Follow-up Question Report" for an identified week in 2018, the resident received the assistance less than was required during the specific time period.

The staffing report for this time period was reviewed and documentation stated that on an identified date in 2018, the home was short a total of 11 PSWs on two different shifts.

The CNO confirmed in an interview on an identified date in 2018 that resident #052 had not received the required ADL assistance.

C) The plan of care for resident #054, revised on an identified date in 2018, stated they required specific assistance with an activity of daily living (ADL), for a specific number of days per week.

According to the licensee's document tilted: The "Follow-up Question Report" for an identified week in 2018, the resident received the assistance less than was required during the specific time period.

The staffing report for this time period was reviewed and documentation stated that on an identified date in 2018, the home was short a total of eight PSWs on two different shifts.

The CNO confirmed in an interview on an identified date in 2018 that resident #054 had not received the required ADL assistance.

On an identified date in 2018, the CNO confirmed in an interview, that the documentation contained in the "Follow-up Question Report(s)" was accurate and that during the specified weeks, the identified residents did not receive ADL care as scheduled. The CNO confirmed in this interview that despite changes made to staffing assignments and processes implemented since receiving the previous compliance order #001, issued October 3, 2017, efforts to fully comply with s. 33. (1) had not been successful. [s. 33. (1)]

This Compliance Order is based upon three factors where there has been a finding of non-compliance in keeping with s. 33. (1) of O. Reg. 79/10. The severity of this issue was determined to be a level 1 as there was minimum risk to the resident. The scope of the issue was a level 3 as it was related to three residents. The home had a level 5 compliance history of a previously issued Voluntary Plan of correction (VPC) in January 2017 and CO served on October 3, 2017 (#2017_560632_0013). (130)

**This order must be complied with by /**

**Vous devez vous conformer à cet ordre d'ici le :** May 31, 2019

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

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**Order # / Ordre no :** 006

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

**Linked to Existing Order / Lien vers ordre existant:** 2017_560632_0013, CO #003;

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, 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 shall ensure that:

1. Resident #078 and all other residents are protected from abuse by anyone.

The licensee has failed to comply with the following compliance order (CO) #003 from inspection #2017_560632_0013 served on October 3, 2017, with a compliance date of October 30, 2017.

The licensee was ordered to complete the following:

1. Provide mandatory re-education for all staff on prevention of Abuse and Neglect, including reporting expectations, whistle-blowing protection, as well as the types of abuse and what constitutes neglect of a resident.

2. Provide mandatory re-education for all staff on the Residents' Bill of Rights.

3. Initiate quality monitoring activities and analysis to ensure ongoing compliance with the home's abuse policy.

4. Ensure documentation is available on staff retraining on Prevention of Abuse and Neglect and Resident Lifting Policy.

The licensee completed steps 1, 2, 3 and 4 in CO #003.

The licensee failed to comply with section 19 (1).

**Grounds / Motifs :**

(A1)
1. The licensee failed to ensure that all residents were protected from abuse by resident #077.

O. Reg. 79/10, s. 2(1) defines sexual abuse as any non-consensual touching, behaviour or remark of a sexual nature or sexual exploitation directed towards a

resident by a person other than a licensee or staff member.

A Critical Incident (CI) submitted on an identified date in 2018, described an incident of resident to resident responsive behaviour where resident #077 was observed by Physiotherapist (PT) #140 demonstrating responsive behaviour towards resident #078. The CI reported that resident #078 was heard saying, "Stop that". The residents were separated by PT #140. Resident #078 identified to PT #140 what resident #077 was attempting to do and when the PT asked if they were okay resident #078 identified "Yes". A review of the clinical record identified that resident #077 was admitted to the home in 2018, with a specific diagnosis and an identified Cognitive Performance Scale (CPS) score. The resident was admitted to the home from another long term care home and review of the clinical record and staff interviews identified that the resident was known to demonstrate responsive behaviours at their previous home; however, admission paperwork identified that the resident had not displayed responsive behaviours since 2017. Review of resident #077's clinical record identified that they demonstrated responsive behaviours towards specific staff, on eight occasions during a one month period in 2018. Resident #077's current written plan of care identified that they demonstrated responsive behaviours which included residents and staff. Interventions in place for resident #077's responsive behaviours included documenting a summary of each episode, which included specific interventions.

Review of the clinical record for resident #078 identified that they had a specific diagnosis and an identified CPS score. In an interview with resident #078's Substitute Decision Maker (SDM), PSWs #134 and #141 and registered staff #103, they identified that they believed resident #078 would not have been able to consent to the responsive behaviours exhibited by resident #077. In an interview with PT #140, who witnessed the incident, stated in an interview on an identified date in 2018, that they believed the incident was not consensual.

In an interview with the DNPC on an identified date in 2018, they confirmed that resident #078 was not protected from abuse by resident #077.

Please note: This non-compliance was issued as a result of critical incident inspection: 005928-18 related to C501-000007-18, which was conducted concurrently with the RQI.

The severity of this issue was determined to be a level 2 as there was minimum risk to the resident. The scope of the issue was a level 1 as it was related to one resident. The home had a level 5 compliance history of a previous CO issued on October 3, 2017 (2017_560632_0013).
(683)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Feb 14, 2019

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**Order # / Ordre no :** 007

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

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,

(a) a goal in the plan is met;

(b) the resident's care needs change or care set out in the plan is no longer necessary; or

(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

**Order / Ordre :**

The licensee must be compliant with s.6 (10)(b) of the LTCHA.

Specifically the licensee must:

1. Reassess resident #005 and any other resident, in relation changes in the amount and level of pain they experienced. Based on that reassessment, reviewed and revised the resident's plan of care, if required.

2. Reassess resident #005, resident #007 and any other resident, in relation to assistance required and care to be provided based on their changing care needs related to repositioning. Based on that reassessment, review and revise the resident's plan of care, if required.

3. Reassess resident #005 and any other resident, in relation to their changing mobility needs. Based on that reassessment, review and revise the resident's plan of care, if required.

4. Develop and implement a communication tool that will ensure when a residents care needs change, those changing needs are communicated to nursing staff who are responsible for coordinating the reassessment of the resident and the review and revision of the resident's plan of care based on the reassessment.

5. Develop and implement an auditing mechanism to ensure that when staff identify changes in the residents care needs the reassessment of the resident and decisions related to care planning related to those changes are documented.

**Grounds / Motifs :**

1. The licensee 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.

A) Review of the plan of care identified that resident #013 had an order as needed for the application of a specific intervention to manage their responsive behaviours. Review of the Physician's orders indicated that this order was discontinued on an identified date in 2015.

Interview and review of the plan of care with RPN #118 on an identified date in 2018, stated the resident no longer required the intervention as needed and the order was discontinued; however, confirmed that the plan of care was not reviewed and revised when the care set out in the plan was no longer necessary.

B) On an identified date in 2017, resident #014 fell and sustained an injury. Review of the Physiotherapist assessment on an identified date in 2017, identified that the resident required a specific method of transfer with two staff. Review of the progress notes dated on a specific date in 2017, indicated the resident was being transferred by a different method of transfer. Interview with RN #103 and review of the written plan of care did not identify the resident was being transferred with the latter method of transfer. They confirmed that the plan of care was not reviewed and revised when the resident's care needs changed related to the resident's transfer status.

On an identified date in 2018, the plan of care identified that resident #014 was reassessed by the Physiotherapist and required a specific method of transfer with a specific number of staff. Interview with RAI Coordinator #002 on an identified date in 2018, stated they updated the written plan of care to reflect they required a specific method of transfer and confirmed the plan of care should have been reviewed and revised when the resident's care needs changed.

Please note: This non compliance was issued as a result of critical incident system inspection: 027748-17 related to C501-000031-17, which was conducted concurrently with the RQI.

C) Resident #005 and staff who provided direct care to the resident confirmed that the resident's care needs had changed in relation to a specific intervention. When interviewed, resident #005 said they refused care from staff for the specific care need because it caused them discomfort. When interviewed, PSW #107 said that the resident required assistance for a specific care need and had for the past month refused help from staff for the reason specified by the resident. RN #108 and the clinical record identified that resident #005 experienced changes to their skin integrity over a number of areas on their body. When interviewed, RN #111 reviewed the resident's written plan of care and confirmed that there were no care directions related to the care need of the resident either prior to the resident refusing care or when staff identified that the resident began to refuse the care due to discomfort

experienced during the activity.

Resident #005's written plan of care was not reviewed or revised to include care interventions to assist the resident for the specific care need when staff became aware that the resident had developed impaired skin integrity or when the resident began to refuse to allow staff to provide them care.

Resident #005 and staff who provided direct care to the resident confirmed that the resident's care needs had changed related to mobility. Resident #005 confirmed that they did not use a specific device any longer. When interviewed, PSW #107 confirmed that although the directions in the clinical record were that the resident used a specific device as an assistive device the resident had not been able to use the device. When interviewed, the DNPC acknowledged that they were aware the resident no longer used the device for mobility and care interventions related to activation, physiotherapy and mobility had not been revised to reflect this change in the resident's mobility status.

Resident #005's written plan of care was not reviewed or revised when the resident's care needs changed in relation to mobility and the use of a device. (129).

D) Resident #030's care needs changed in relation to specific care area. When interviewed, RPN #145 said that resident #030 was not able to perform the care on their own. A review of the resident's written plan of care indicated the resident was assisted to transfer using a specific method and there were no care directions identified in the plan of care for scheduled care related to the specific care area.

The DNPC and resident #030's written plan of care confirmed that the resident's plan of care had not been reviewed or revised when staff identified that the resident was no longer able to perform the specific task on their own.

Resident #030's written plan of care was not reviewed and revised when the resident's care needs changed.

(Please Note: The above noted non-compliance related to resident #030 was identified during a complaint inspection (Log # 029173-17) that was completed concurrently with this Resident Quality Inspection.) (129).

E) Resident #007's care needs changed when the resident experienced impaired skin integrity to a specific area. Treatment Administration Records (TAR) for three identified months in 2018 indicated that the resident had an area of impaired skin integrity to a specific area that was being treated by registered staff routinely. During an interview, the CNO reviewed the resident's plan of care and said that the plan of care had not been revised to include care interventions related to changes in skin integrity the resident had experienced over the above mentioned period of time.

Resident #007's written plan of care was not reviewed and revised when the resident's care needs changed [s. 6. (10) (b)]

The severity of this issue was determined to be a level 3 as there was actual harm to the resident. The scope of the issue was identified as a level 2 as it related to 2 of 3 three residents reviewed. The home had a level 3 history of one or more related non-compliance in the last 36 months that included:
-VPC issued June 17, 2015 (2015_322156_0009) related to (LTCHA) 2007, c. 8, s. 6(1) (c) (clear directions in the plan of care related to positioning)
-VPC issued June 17, 2015 (2015_322156_0009) related to O. Reg. 79/10, s. 8(1) b (compliance with the licensee's Skin and Wound Care policy)
-VPC issued June 17, 2015 (2015_322156_0009) related to O. Reg. 79/10, s. 50(2) (b) (iv) (residents demonstrating altered skin integrity are reassess at least weekly)
-VPC issued February 23, 2017, (2017_569508_0002) related to O. Reg. 79/10, s. 50(2) (assessment for resident demonstrating altered skin integrity)
-VPC issued February 23, 2017, (2017_569508_0002) related to Long Term Care Home Act (LTCHA) 2007, c. 8, s. 72(2) 11 (annual training related to pain management and skin and wound care)
-VPC issued February 23, 2017, (2017_569508_0002) related to O. Reg. 79/10, s. 30(1) 3 (annual evaluation of Pain Management Program and the Skin and Wound Care Program)
-VPC issued February 23, 2017, (2017_569508_0002) related to O. Reg. 79/10, s. 8(1) (b) (compliance with the licensee's Pain Management policy and the Skin and Wound policy)
-Voluntary Plan of Corrective Action (VPC) issued October 3, 2017, (2017_560632_0013) related to O. Reg. 79/10, s. 30(1) 3 (annual evaluation of the Pain Management Program and the Skin and Wound Care Program)

(581)

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 :** May 31, 2019

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

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**Order # / Ordre no :** 008

**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:

1. Ensure drugs are administered to all residents, including residents #055, #056 and #059, in accordance with the directions for use specified by the prescriber.

2. Ensure staff #138 and #144 are provided re-education on the home's policy and procedure titled: Document Management, Doctor's Orders, N, 7.9, revised June 2017 and staff #144 receives re-education on the home's policy and procedure titled: Medication Incident Reporting, No. 9-1, section 9, revised February 2017.

3. Maintain a record of the re-education provided to staff #138 and #144.

4. Evaluate the process of monitoring the application of dermal analgesics, document the results of this evaluation, identify the person responsible for the evaluation and document what changes are made to the process, if required.

5. Establish an auditing process to ensure ongoing compliance with O. Reg. 79/10, s. 131 (2).

6. Maintain a record of the auditing activities and ensure the person responsible for conducting the activity is identified in the audit.

**Grounds / Motifs :**

(A1)
1. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A) According to the plan of care, resident #059 had a physician's order in place that directed registered staff to apply a specific medication at specific times. On an identified date in 2017, the CNO submitted a critical incident report, which indicated that resident #059's medication was missing on four identified dates in 2017. On a later date in 2017, staff #104 submitted a critical incident report, which indicated that resident #059's medication was discovered missing on a fifth date in 2017.

The CNO's internal investigation review, indicated the licensee was unable to determine the specific length of time the resident was without their medication, but confirmed in an interview on an identified date in 2018, that there would have been a period of time from the time the medication was applied until the time medication was discovered missing, that resident #056 did not receive continuous delivery of their medication on each of the identified incident dates.

Please note: This non compliance was issued as a result of the following CI inspections: 016918-17 and 020560-17, which were conducted concurrently with the RQI. (130).

B) The plan of care for resident #055 stated they had a physician's order in place, directing registered staff to administer a specific medication at specific times. On an identified date in 2018, RPN #139 administered resident #055 an incorrect dose of their medication. The error was discovered the following day. There were no ill effects to the resident as a result of the incident.

The DNCP and RPN #139 confirmed during an interview on an identified date in 2018, that on an identified date in 2018, resident #055 received the incorrect dose of medication.

C) On an identified date in 2018, a physician's written order for resident #056, directed registered staff to administer a specific medication at specific times. The medication ordered was transcribed by the pharmacy. The MAR and medication received on an identified date in 2018 for resident #056 was labelled incorrectly. As a result, the resident received a lower dose of medication than what was actually prescribed.

The DNPC confirmed in an interview on an identified date in 2018, that registered staff #138 and #144 did not administer medications to resident #056 as prescribed. [s. 131. (2)]

#144 did not administer medications to resident #056 as prescribed.

This Compliance Order is based upon three factors where there has been a finding of non-compliance in keeping with O. Reg. 79/10, s. 131 (2). The severity of this issue was determined to be a level 2 as there was potential for harm to the residents. The scope of the issue was a level 3 as it was related to three residents. The home had a level 3 compliance history of a previous WN issued on June 15, 2016 and a Compliance Order (CO) served on October 3, 2017 (#2017_560632_0013).

(130)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Feb 14, 2019

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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

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

## RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

## 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)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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

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

**Issued on this 19th day of December, 2018 (A1)**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** Amended by GILLIAN HUNTER (130) - (A1)

Ontario

**Ministry of Health and Long-Term Care**

**Ministère de la Santé et des Soins de longue durée**

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