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
Nov 08, 2019	2019_616722_0018 (A2)	005801-18, 008432-18, 015088-18, 016344-18, 016606-18, 026243-18, 000050-19, 002959-19, 004952-19, 013007-19, 014575-19	Critical Incident System

Licensee/Titulaire de permis

Vigour Limited Partnership on behalf of Vigour General Partner Inc.
302 Town Centre Blvd Suite 300 MARKHAM ON L3R 0E8

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

Altamont Care Community
92 Island Road SCARBOROUGH ON M1C 2P5

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

Amended by COREY GREEN (722) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

The following revisions were made to the Licensee Inspection Report and Orders:
- Compliance Order (CO) #001: The compliance plan due date was revised from October 29, 2019, to November 8, 2019, as requested by the home during a phone call with Inspector #722.
- CO #002: Requirement (c) was deleted from the report, and potentially identifying information was removed from item (b).
- All references to "critical incident (CI) report" in the public report were revised to "critical incident system (CIS) report".
- Under O. Reg. 79/10, s. 48 (1) 1.: On page (p.) 7, paragraph (para) 5, "PCC" was revised to "PointClickCare (PCC)"; on p. 11, para 5, "risk identified on their care plan" was revised to "risk identified in their care plan"; on p. 11, para 5 , "should have been repeated" was revised to "should have been completed"; on p. 12, para 2, "Falls Prevention policy" was replaced with "Falls Prevention and Management Program".
- Under LTCHA, 2007, s. 5: On p. 16, para 1, "the resident was initially out of the way" was revised to "the resident was initially not in the way".
- Under LTCHA, 2007, s. 19 (1): On p. 21, para 4, "The investigation notes" was revised to "The home's investigation notes".
- Under O. Reg. 79/10, s. 53 (4): On p. 30, para 2, "The ADOC indicated that resident #003 did not have responsive behaviours that they were aware of that needed to be captured in the resident's care plan." was revised to "The ADOC indicated that they were not aware that resident #003 had responsive behaviours that needed to be captured in their care plan."; on p. 30, para 2, "The ADOC also did not identity the behaviours" was revised to "The ADOC also did not identify the behaviours"; on p. 35, top of page, "plans of care for residents #003, #004, #008, or #012." was revised to "plans of care for residents #003, #004, #008, and #012."
- Under O. Reg. 79/10, s. 129 (1): On p. 36, para 2, both references to "Inspector" without the inspector number specified were changed to "inspector".
- Under O. Reg. 79/10, s. 229 (4): On p. 37, para 5, "bathroom" was revised to "washroom". In Finding (B), any references to "wash basins" were made consistent throughout the text.

Issued on this 8 th day of November, 2019 (A2)

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

Original report signed by the inspector.

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92 Island Road SCARBOROUGH ON M1C 2P5

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

Amended by COREY GREEN (722) - (A2)

Amended Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 21-23, 26-30, and September 3-5, 2019.

The following critical incidents were inspected during this inspection:

Log #002959-19 (CIS #0956-000007-19), log #014575-19 (CIS #0956-000022-19), and log #004952-19 (CIS #0956-000010-19) related to alleged staff-to-resident abuse or neglect.

Log #016344-18 (CIS #0956-000020-18) and log #016606-18 (CIS #0956-000018-18) related to resident-to-resident physical altercations and responsive behaviours.

Log #005801-18 (CIS #0956-000006-18) related to a fall with injury and unsafe transfer.

Log #026243-18 (CIS #0956-000031-18), and log #008432-18 (CIS #0956-000010-18) related to falls with injury.

Log #015088-18 (CIS #0956-000019-18) related to a resident-to-resident physical altercation and fall with injury.

Log #013007-19 (CIS #0956-000018-19) and log #000050-19 (CIS #0956-000043-18) related to alleged neglect and improper care of a resident.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Director of Environmental Services (DES), Assistant Directors of Care (ADOCs), the Resident Relations Coordinator (RRC), the Physiotherapist (PT), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), resident family members, and residents.

During the course of the inspection, the Inspectors made observations of residents, resident home areas, and staff-to-resident and resident-to-resident interactions. The Inspectors reviewed resident clinical health records and relevant administrative records, including specified policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of the original inspection, Non-Compliances were issued.
14 WN(s)
8 VPC(s)
2 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury. O. Reg. 79/10, s. 48 (1).
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions. O. Reg. 79/10, s. 48 (1).
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. O. Reg. 79/10, s. 48 (1).
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the falls prevention and management program, as detailed in the home's Falls Prevention policy, was implemented in the home for residents #009, #010, and #011.

Review of the home's Falls Prevention policy (Policy #VII-G-30.00), revised January 2015, indicated that registered staff were required to complete the Falls Risk Assessment in the electronic documentation system within 24 hours of admission or re-admission, when triggered by the Resident Assessment Instrument - Minimum Data Set (RAI-MDS) assessments protocol, and with a significant change in the resident's status. Upon completion of the Falls Risk Assessment, registered staff were expected to update the resident's care plan with associated risk level and interventions.

The policy also indicated that when a fall occurred, the registered staff were expected to update the resident's care plan and complete a referral to the appropriate discipline, such as the physiotherapist (PT), occupational therapist (OT), or recreation staff. The policy indicated that the members of the interdisciplinary team were expected to complete their respective assessments, discuss the appropriate interventions with the multidisciplinary care team, and document all new interventions in the care plan. It also indicated that staff were to inform the registered nurse if an item (e.g., an assistive device) was introduced to

a resident, and registered staff were expected to update the resident's care plan to include new interventions.

The evidence below will show that (i) care plans were not updated related to falls prevention interventions, mobility and transfers, (ii) falls risk assessments were not completed, and (iii) that PT did not consistently complete post fall assessments for residents #009, #010, and #011.

(A) A critical incident system (CIS) report (CIS #0956-000006-18) was submitted to the Director on a specified date for an injury involving resident #009.

Review of the CIS report and progress notes indicated that resident #009 sustained a fall on a specified date, was sent to hospital for assessment, returned on the same day, and was treated in the home. The resident sustained another fall on a later specified date, was assessed without injury, and remained in the home. A specified diagnostic test on a later specified date showed that the resident had sustained a specified injury. The resident was later admitted to hospital, received treatment for their injury, and returned to the home.

The progress notes for resident #009 were reviewed and indicated the following related to resident care for falls prevention, mobility, and transfers:
- Resident #009 remained in bed for a specified period after their first fall.
- Various notes indicated that the resident began using an identified mobility device for a specified duration.
- On a specified date, registered staff sent a referral to the PT to assess the resident due to a specified change in transfer status and ambulation.
- On a later specified date, the PT assessed the resident, and gave identified instructions related to mobility until assessed by the physician.
- On a later specified date, PT #106 assessed the resident and identified changes to their transfer and mobility status; the PT indicated that they changed the transfer logo above the resident's bed, and informed registered staff of the changes.
- On a later specified date, resident was admitted to hospital for a specified procedure and an identified period of time.
- On a later specified date, PT #106 indicated that they had difficulties assessing the resident for identified reasons but would attempt to assist resident to participate in physiotherapy treatment; the PT did not specify the resident's transfer status.

(i) Care Plan: Review of the health records for resident #009 indicated that the resident had an admission Falls Risk Assessment completed on a specified date, which indicated that the resident was at risk for falls. The admission care plan for resident #009 did not include any interventions related to falls prevention or mobility, and the specified direction for transfers was not applicable to the resident.

From admission until a specified date, there were no revisions or additions to resident #009's care plan related to falls prevention, mobility, or transfer status. There were no revisions to the resident's care plan after their first fall; when registered staff identified a change in the resident's transfer status and ability to ambulate on a specified date; or after the PT assessed the resident on a later specified date, and changed their transfer status.

On a specified date, nearly one month after resident #009's initial fall, the care plan was updated and revised with a specified method for transfers and toileting. On a later specified date, the resident's care plan was updated to identify that the resident had sustained a specified injury from a fall, and a falls prevention intervention was added. However, the DOC acknowledged during an interview that the new falls prevention intervention was not individualized or specific to the resident.

RPN #128 indicated during an interview that they had provided care to resident #009 and witnessed their second fall. The RPN indicated that after the resident's first fall they required specified assistance for transfers, and use of a specified mobility aid for locomotion in the home. They acknowledged that resident #009's care plan did not have any falls prevention interventions, or specify that the resident used a specified mobility aid when the resident sustained their second fall.

PSW #117 indicated during an interview that they had worked with resident #009 and could not recall how the resident was being transferred in the time after the resident's falls and when the resident began to use their specified mobility aid. PSW #117 was aware of the resident's transfer status.

(ii) Falls Risk Assessments: Review of the assessments in PointClickCare (PCC) indicated that resident #009 had two Falls Risk Assessments completed with an identified risk for falls; the first was on admission to the home, and the other was over a month after the resident had their second fall, and had returned from

hospital after they had specified treatment.

As per the falls prevention policy noted above, registered staff were required to complete the Falls Risk Assessment with a significant change in the resident's status. Specifically, there were no Falls Risk Assessments identified on the following dates:
- Specified date of first fall: resident sustained a fall and remained in bed for a specified period of time.
- Later specified date (seven days after first fall): staff began using a specified assistive device for locomotion in the home.
- Later specified date: resident was identified by registered staff to have a change in transfer ability and ambulation, referral was sent to PT.
- Specified date of second fall: resident sustained a second fall that involved their mobility aid.
- Later specified date: resident's transfer status was changed.

(iii) Physiotherapy Post Fall Assessments: Review of the progress notes indicated that a referral was not sent by registered staff to the PT after resident #009's first fall. The notes indicated that the registered staff submitted a referral to the PT on a later specified date after the resident sustained another fall.

Assessments were reviewed in PCC, and a PT assessment was not identified for resident #009 after their first fall. A PT assessment was identified on a specified date, four days after the referral for the second fall, and nine days after a previous PT referral by registered staff when they were concerned about the resident's transfer ability.

RPN #128 stated during an interview that registered staff were expected to refer residents to the PT for assessment after every fall; and acknowledged that a referral was not sent to the PT after resident #009's first fall.

PT #106 indicated during an interview that they assessed residents after they sustained falls, or had a change in their transfer status, when they received referrals from registered staff. The PT stated that they had not received a referral after resident #009's first fall on a specified date, and confirmed that they did not assess the resident when they returned from the hospital. The PT acknowledged that they received a referral for resident #009 11 days after their first fall, and were not able to explain why they waited nine days to assess the resident. The PT indicated that they only worked in the home four days per week, and

acknowledged that residents should be assessed when they are referred.

(B) A CIS report (CIS #0956-000019-18) was submitted to the Director on a specified date, when resident #010 sustained a fall and was transferred to hospital where they received treatment for an injury.

Review of the CIS report and progress notes indicated that on a specified date, resident #010 sustained a fall as a result of a physical altercation with resident #012. Resident #010 was assessed and sustained two specified injuries, one of which was treated in the hospital.

(i) Care Plan: Resident #010's care plan was reviewed, including the revision history, from admission until their discharge on a specified date. No falls prevention interventions were identified in the resident's care plan during this period, including after being identified as being at risk for falls in the Falls Risk Assessment nearly three months after admission to the home.

(ii) Falls Risk Assessment: Review of the health record for resident #010 indicated that they were admitted to the home on a specified date. As per the falls prevention policy, registered staff were required to complete the Falls Risk Assessment within 24 hours of admission to the home.

Resident #010's assessments were reviewed in PCC, and there were no Falls Risk Assessments identified for the resident on admission. A Falls Risk Assessment was not completed for resident #010 until nearly three months later, which identified the resident as being at risk for falls.

(iii) Physiotherapy Post Fall Assessments: The progress notes and assessments were reviewed for resident #010's fall, and there was no referral to PT, or assessment by PT, identified for resident #010 after they fell.

RPN #108 confirmed during an interview that a referral was not sent to the PT after resident #010 fell. RPN #108 acknowledged that PT referrals were supposed to be sent for every resident fall, and that the registered staff would work with the PT to determine if any additional interventions for mobility, transfers, and falls prevention were needed for the resident.

PT #106 confirmed during an interview that they had not received a referral from the registered staff after resident #010 fell, and they did not assess the resident at

that time. The PT indicated that they were notified of the fall and fracture by the Nurse Practitioner (NP) on a specified date several weeks after the resident fell, and assessed the resident at that time.

(C) A CIS report (CIS #0956-000010-18) was submitted to the Director on a specified date, for resident #011, who sustained a fall in their room on a specified date, and another fall five days later that resulted in injuries.

Review of the progress notes indicated that there were no injuries identified when the resident was assessed after their first fall. After the resident's second fall, injuries were identified, and the resident was transferred to the hospital the next day, where they were diagnosed with specified injuries.

(i) Care Plan: Review of resident #011’s care plan and assessments indicated that prior to their first fall, they were identified as being at risk for falls; however, their care plan did not include a falls prevention focus area. Three interventions were identified in other focus areas of resident #011’s care plan prior to their fall, that would also help to reduce their risk of falls. The care plan prior to the fall also did not identify the resident’s mobility needs. Resident #011’s care plan was revised on a specified date just prior to their first fall related to their transfer status. There were no revisions or additions identified in resident #011’s care plan related to their falls risk, falls prevention interventions, transfer status, or mobility after either of the falls identified in this CIS report.

Review of the post fall huddle note indicated that staff implemented a specified intervention after the resident's first fall. The progress notes indicated that staff continued to implement the specified intervention for approximately six days post fall; however, this intervention was not identified in the resident’s care plan.

A PT assessment completed on a specified date was reviewed, and indicated that the resident needed constant monitoring as they were at risk for falls for specified reasons. In addition, the PT provided a specified device to the resident, and indicated that it was required to reduce the resident's risk for falls. None of these interventions were added to the resident’s care plan.

PSW #135 indicated during an interview that they had worked with resident #011 during and after their two falls, and stated that the resident was provided a specified device to reduce their risk of falls. The PSW could not recall if there were any directions specified in the plan of care for transferring the resident after

they sustained their injury. No directions were identified when the care plan was reviewed by the inspector.

RPN #119 stated during an interview that the resident was provided a specified device but was unsure if it was applied before or after the second fall. They also stated that if the PT had recommended any new falls prevention interventions, this would be communicated to the registered staff, who were responsible for updating the resident's care plan.

(ii) Physiotherapy Post Fall Assessments: Review of the progress notes for resident #011 indicated that the registered staff had not sent a referral to the PT using the PT 1:1 Referral form in PCC to assess the resident after either of their falls, where the second fall resulted in injuries.

The PT assessments in PCC were reviewed and indicated that PT #106 had assessed the resident on a specified date, after the NP made a verbal request to the PT to assess the resident. There was no PT assessment documented after the second fall. The resident was assessed by the PT on a specified date 10 days after their second fall, at the request of the NP.

RPN #119 indicated during an interview that a referral should have been sent to the PT by registered staff after resident #011's falls and confirmed that no referrals were submitted for either fall.

The DOC and ADOC #103, the Falls Prevention Lead in the home, stated in separate interviews that the plan of care for residents' transfer status, mobility, and falls prevention interventions should have been documented in their care plans in PCC. They indicated that registered staff were responsible for updating resident care plans, specifically when recommendations were made by the PT, and acknowledged that was not done as specified above for residents #009, #010, and #011.

They also stated that the Falls Risk Assessment should have been completed for residents #009 and #010 as per the home's policy, using the Falls Risk Assessment tool in PCC, and their risk identified in their care plan. They also indicated that the Falls Risk Assessment should have been completed when the residents' ambulation status changed, and that this was not done.

In separate interviews, they confirmed that according to their falls prevention

program and policy, registered staff were expected to always refer residents to the PT after they sustained a fall, so that their transfer status, mobility, and falls risk could be assessed. They indicated that the PT should have assessed residents #009, #010, and #011 when they received the referral, or the next shift they were in the home, for changes in their transfer status, mobility and risk for falls.

PT #106 indicated during an interview that when they determined from an assessment that a resident's transfer or mobility status had changed, they placed a transfer logo above the resident's bed and notified registered staff, who were responsible for updating the resident's care plan in PCC. They stated that they should have received a referral from registered staff after every resident fall, and that they were expected to assess the resident on the day the referral was received, or the next shift they were working in the home. PT #106 acknowledged that they did not assess residents #009, #010, and #011 after falls as specified above.

Both the DOC and ADOC confirmed that the home's Falls Prevention and Management program was not implemented by various staff in the home, specifically related to updating resident care plans with falls prevention interventions, completing Falls Risk Assessments, and post fall PT assessments for residents #009, #010, and #011. [s. 48. (1) 1.]

Additional Required Actions:

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

(A2)
The following order(s) have been amended: CO# 001

WN #2: 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 :

(A2)
1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

(A) A CIS report (CIS #0956-000043-18) was submitted to the Director on a specified date regarding a medication administration incident and alleged improper/incompetent treatment of resident #005 by staff members resulting in a specified medical emergency and transfer to hospital.

Review of the medical records indicated that resident #005 was admitted to the home on a specified date with specified medical diagnoses. A review of the electronic medication administration record (eMAR) indicated that the resident required specified medications to manage one of their medical conditions. Review of the physician's orders in PCC indicated that the resident's medication orders for the specified condition were changed multiple times over a specified period post admission.

On three specified dates, the physician's orders indicated that staff members were to perform a specified test for resident #005 at specified times during each day, and notify the physician when the result was outside a specified range. Review of resident #005's clinical records indicated that on one day, registered staff had not completed the identified test for the whole day. The specified test was completed on the two following days, results were identified on both days that were outside the specified range, and the physician was not notified on either day.

On three later specified dates, the physician's orders indicated that a medication for resident #005 was not to be administered if an identified test result was outside a specified range. Review of the home's investigation notes related to this incident indicated that on each of the days, identified test results were outside the

specified range, which indicated that the medication should have been held. Review of the eMAR indicated that registered staff administered the specified medication on each day.

Review of the clinical records indicated that on a specified date and time, resident #005 was found in a specified clinical condition and transferred to hospital. A specified test should have been done by registered staff at a specified time earlier in the day, and it had not been done. When the specified test was done prior to transferring the resident to hospital, the result was significantly outside the normal range.

RPN #122 confirmed during an interview that resident #005's test result was outside the specified range on two identified dates, that the specified medication should have been held, and that they administered the medication on both days in error. They acknowledged that the physician order directed them to hold the medication if the test result was outside a specified range. They indicated that the specified medication was a high alert drug and, in the future, they would pay extra attention to the physician order prior to administering any medication. They acknowledged that it was the expectation of the home and the College of Nurses of Ontario (CNO) to administer medication safely. RPN #122 indicated that they received training on safe medication administration as a disciplinary action and had learned from the situation.

Interview with RPN #130 confirmed that on another specified date, resident #005's test result was outside a specified range, and that they also administered the specified medication. They indicated that the physician order directed them to hold the medication if the test result was outside a specified range. They confirmed that on that day they made a mistake and acknowledged the importance of checking the physician order prior to administering any medications. RPN #130 stated that the home provided them education regarding safe drug administration and clinical management of a specified condition.

ADOC #104 was interviewed and confirmed that resident #005 was hospitalized due to a specified condition following three identified medication administration errors. The ADOC indicated that RPN #122, #130 and #131 did not follow the physician orders and administered a medication to resident #005 when their test results were outside the specified range for safe administration of the medication. The ADOC also confirmed that on several occasions, registered staff did not complete the specified test as prescribed. They indicated that the specified

medication was a high alert drug and staff were always required to check and recheck the physician order prior to dispensing and administering the medication. They indicated that the staff members involved were disciplined, and appropriate training was provided.

(B) Review of the home's Quarterly Medication Review and Adverse Drug Reaction documentation indicated that there were medication administration incidents that involved residents #014, #015 and #016. The records indicated the following incidents:

- On a specified date and time, registered staff did not administer a specified medication to resident #016 as prescribed. The physician order directed staff members to administer the medication one hour before an outpatient appointment. The resident was sent to hospital without receiving the prescribed dose.

- On another specified date and time, the physician ordered a specified drug one time a day for two days. Resident #014 was given a third dose of the drug on day three. The incident report indicated that the medication was not given as prescribed.

- Resident #013 had an order for a specified dose of an identified drug. On a specified date and time, RPN #132 administered six times the prescribed dose all at once, and was terminated immediately for this medication incident.

The DOC confirmed during an interview that it was the expectation of the home and the CNO that registered staff administer medications as prescribed by the prescriber. The DOC indicated that registered staff were always to check and recheck the physician's order prior to dispensing and administering medications. The DOC indicated that the staff members involved were disciplined, and appropriate training was provided to mitigate the risk of medication incidents. [s. 131. (2)]

Additional Required Actions:

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

(A2)
The following order(s) have been amended: CO# 002

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe environment for resident #010.

A CIS report (CIS #0956-000031-18) was submitted to the Director on a specified date for an incident that involved resident #010, where the resident was standing in the hallway waiting to enter the dining room and sustained a fall when they were impacted by a staff member carrying a recliner. The resident was transported to the hospital, where they were diagnosed with an injury that required a specified treatment in hospital. The home was notified that the resident died while in the hospital.

A member of the staff stated during an interview that they were involved in moving the recliner on a specified date, and that another staff member assisted them to move the recliner at their request. They indicated that they were walking backwards down the hallway in the home while carrying the recliner, and the other staff person was walking forwards. The staff member confirmed that they did not see resident #010, made physical contact with the resident, and the resident fell as a result of the impact. They acknowledged that moving the recliner with only two staff was unsafe, and stated that in the future they would take precautions to ensure resident safety when furniture in the home was being moved, such as ensuring that hallways were clear, getting additional assistance from other staff

members, or request environmental services staff to move the furniture.

Another staff member of the home confirmed during an interview that they assisted with moving the recliner, and that they were walking forward and the other staff person was walking backwards while they carried the recliner. They stated that they observed resident #010 standing in the hallway by the dining room, and indicated that the resident was initially not in the way, but moved suddenly and made contact with the other staff member. They also stated that resident movements could be unpredictable and suggested that it would have been safer to ask maintenance to move the furniture.

RPN #109 and RPN #133 indicated in separate interviews that they had witnessed the incident, and confirmed that the incident occurred prior to a meal service as residents were waiting to enter the dining room. The RPNs observed resident #010 standing in the hallway facing the wall, and indicated that they were not aware that staff would be moving furniture. Both RPNs indicated that they did not see resident #010 move, and observed one of the staff members make contact with the resident while carrying the recliner with the other staff member, which caused the resident to fall. RPN #105 stated that it was unsafe to move furniture in this manner. They explained that the proper process was to put in a maintenance request, ensure residents were safe and out of the way, choose a better time to move the furniture, and to move furniture with the flatbed from the maintenance department. RPN #133 stated that upon assessment, the resident had pain and was sent to the hospital.

The Director of Environmental Services (DES) indicated during an interview that staff were required to submit a maintenance request to have furniture and other large items moved in the home, and the maintenance department would arrange to move the furniture. The DES indicated that in this case, maintenance staff would have moved the furniture while residents were in the dining room to ensure that residents were not in the hallway.

The DOC stated during an interview that the staff members involved should not have moved the furniture, they should have submitted a maintenance request, and they did not ensure it was a safe environment for residents when they carried the recliner down the hallway. [s. 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #4: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for resident #001 that set out clear directions to staff and others who provided direct care to the resident related to their continence care.

A CIS report (CIS #0956-000010-19) was submitted to the Director on a specified date, related to an allegation of neglect involving resident #001, where the resident was allegedly not provided specified continence care by staff.

Inspector #722 reviewed resident #001's care plan related to their continence care. The care plan identified the resident's continence status and specified level of assistance to support their continence care needs; however, the frequency of one of the interventions was not specified, and another intervention described by

staff was not identified in the care plan.

PSW #129 indicated during an interview with Inspector #722 that, at the time of the incident, they had routinely provided care to resident #001. They stated that they provided specified continence care at an identified frequency. The PSW also described another intervention they used daily to support the resident's continence care needs. The PSW confirmed that the resident’s care plan, and the Kardex available to the PSWs, did not indicate the frequency of one of the specified continence care interventions, or that another specified intervention was appropriate for the resident. PSW #136 also indicated during an interview that they had routinely assisted other PSWs with the specified intervention that was not identified in the care plan.

RPN #127 and #136 both indicated in separate interviews that they were aware that resident #001 required support for continence care, and confirmed that the two interventions described by the PSWs above were in place for the resident. Both RPNs confirmed that the care plan did not specify the frequency for one of the interventions, and that the other intervention was not specified in the care plan.

The DOC and ADOC #104, the Continence Care Lead in the home, both confirmed in separate interviews with Inspector #722 that details about resident #001’s continence care, including the frequency of the specified interventions, were not specified and should have been included in the resident's plan of care. [s. 6. (1) (c)]

2. The licensee has failed to ensure that there was a written plan of care for resident #011 that set out clear directions to staff and others who provided direct care to the resident related to transferring.

A CIS report (CIS #0956-000010-18) was submitted to the Director on a specified date for resident #011, who sustained a fall in their room without injury on a specified date, and another fall approximately a week later that resulted in transfer to hospital and treatment for specified injuries.

Resident #011's care plan at the time of the inspection indicated that the resident was to be transferred using specified transfer equipment. Review of the progress notes and PT assessment indicated that on a specified date, the PT recommended that the resident was to be transferred using a different transfer

method and equipment at specified times, but to use the original transfer equipment when the resident was found to be unsafe.

Inspector #646 observed the resident's room during the inspection, and identified two green transfer logos on the wall above the resident's bed that specified two different transfer methods using different equipment; both logos were signed by PT #106. The Inspector observed PSWs #116 and #117 during the inspection, together transferring resident #011 using a transfer method specified on one of the logos.

PSWs #116 and #117 stated in separate interviews that resident #011 was to be transferred using a specified method and transfer equipment. PSW #116 stated that approximately a week prior to the interview they had received direction from registered staff that they could use the specified transfer method and equipment to transfer the resident, and they had previously used a different transfer method and equipment. PSW #117 stated that having two different transfer logos in the resident's room was confusing and they would have to speak with the PT to clarify directions for the resident's transfer.

PT #106 was interviewed and indicated that they updated resident #011's transfer status on a specified date, so that one method could be used during the day, and another method in the evening if the resident was found to be unsafe. They stated that it was not common for residents to have two transfer logos above their bed. PT #106 reviewed the resident's care plan and also acknowledged that it did not include one of the transfer methods identified on one of the logos above the resident's bed. The PT stated that this transfer method was communicated to the registered staff, who were responsible for updating the resident's care plan related to their transfer needs.

The DOC stated that resident #011's care plan should have been updated with PT #106's recommendation that direct care staff could use the new transfer method and equipment to transfer the resident during the day when it was safe to do so. [s. 6. (1) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #5: 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 :

1. The licensee has failed to ensure that residents #006 and #005 were not neglected by RPN #131.

Under O. Reg. 79/10, s. 5, for the purposes of the Act and Regulations, “neglect” means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

(A) A CIS report (CIS #0956-000018-19) was submitted to the Director on a specified date regarding improper/incompetent treatment and neglect of resident #006 by staff members. The home submitted the report after a family member of the resident notified the home that RPN #131 refused to assess and send the resident to hospital when the resident was in distress for specified reasons.

Review of the progress notes indicated that resident #006 had identified symptoms on a specified date, and that the symptoms worsened due to exacerbation of a specified condition that required specified treatments over the next two days. The records indicated that registered staff had not completed a

specified focused assessment on these days and the facility physician was not notified.

The home's Prevention of Abuse and Neglect policy (Policy #VII-G-10-10(a), last reviewed December 2018, defined neglect as the failure to provide the care and assistance required for the health, safety and/or well being of a resident. It included the action and/or inaction, or a pattern of inactions, that jeopardize the health and safety of residents.

The home completed an investigation into the incident. Review of the home's investigation notes indicated that RPN #131 did not complete specified assessments when the resident was exhibiting identified symptoms, and the physician at the home was not notified immediately when the resident had an exacerbation of their condition. On a specified date, the family member of the resident called RPN #131 to assess the resident because they noticed the resident experiencing specified symptoms. The investigation notes indicated that the RPN did not respond immediately and the family member took the resident to hospital themselves where they were admitted for an identified illness.

The home determined that RPN #131 had neglected the resident and they were disciplined.

(B) A CIS report (CIS #0956-000043-18) was submitted to the Director on a specified date regarding a medication administration incident and alleged improper/incompetent treatment of resident #005 by staff members resulting in a specified health condition and transfer to hospital.

Review of a physician's order effective on a specified date directed staff members to complete specified tests for resident #005 at specified times each day. The home's investigation notes indicated that RPN #131 did not complete the required test at an identified time on a specified date, as ordered. RPN #131 completed the test when resident #005 was found in a specified condition and sent to hospital.

The home conducted an investigation into the incident and interviewed RPN #131. During the interview, the RPN stated that they did not review the resident's plan of care prior to their shift, did not know the resident had a specified condition and required the specified test, and did not complete their daily assessment of the resident. Review of the disciplinary letter issued to RPN #131 indicated that the home determined the RPN's action was negligent, inappropriate and

unprofessional.

The DOC indicated during an interview that RPN #131 had been terminated from the home. They indicated that staff members at the home were expected to complete their daily assessments, provide treatment to residents as per physician orders, and to provide care as per the plan of care in a timely fashion. The DOC confirmed that RPN #131 neglected residents #005 and #006, as they failed to provide the care and assistance required for the health, safety and well being of the residents. [s. 19. (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 protect residents from abuse by anyone and ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #6: 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 has failed to ensure that staff used safe transferring and positioning devices or techniques when they assisted resident #002.

A CIS report (CIS #0956-000022-19) was submitted to the Director on a specified date where resident #002 alleged that they were treated roughly by staff on an earlier specified date when they were transferred to bed. The report indicated that

the resident was not properly secured to the specified transfer equipment, which resulted in the resident experiencing pain to an identified area of the body.

Review of the care plan indicated that on the date the transfer occurred, resident #002 was to be transferred by two staff using specified transfer equipment; it was revised on a later specified date and indicated that the resident should be transferred by two staff members using different transfer equipment.

Review of the progress notes indicated that on a specified date, resident #002 was referred to the PT by ADOC #107 for a transfer assessment due to a change in transfer ability. On a later specified date, RN #140 entered a note which indicated that the resident was not safe on the specified transfer equipment for identified reasons.

The PT assessments were reviewed in PCC. On a specified date, a transfer assessment was identified which indicated that PT #106 received a verbal referral from the DOC to assess resident #002's transfer status, as the resident was found to be unsafe using the transfer equipment that had previously been specified for the resident. The PT documented in the assessment that the resident was unable to safely transfer using that transfer method, and changed the resident's transfer status to a different method using different transfer equipment.

Review of the home's policy related to the specified transfer equipment, indicated that the specified equipment was only appropriate for residents who had the ability to participate in the transfer in a specified way, and that a different transfer method and equipment must be used if the resident was unable to participate as specified.

During an interview with resident #002, the resident recalled the transfer, but was unable to recall the specific date it occurred or the specific staff members involved. The resident indicated that they experienced pain in an identified area of their body when they were transferred into bed with the specified transfer equipment, and explained that they were not secured to the equipment appropriately.

PSW #128 was interviewed and indicated that they were present for the transfer of resident #002 on the specified date. The PSW indicated that they assisted PSW #124 to transfer the resident into bed using the specified transfer equipment. The PSW explained how the resident was transferred, and stated that

the resident was fully transferred into their bed even though they were not able to participate in the transfer as required for the transfer equipment being used. PSW #128 indicated that they heard the resident say "ouch" and noticed that resident #002 was upset, but was not aware that they experienced pain in a specified area of their body. The PSW acknowledged that the transfer was unsafe and that the resident should have been able to participate in the transfer in the specified way according to the home's policy.

Inspector #722 interviewed PT #106, who indicated that they received a referral on a specified date to assess resident #002's transfer status. The PT indicated that they assessed the resident prior to the transfer identified above, and did not change the resident's transfer status because they determined the resident was able to participate as required for the identified transfer method and equipment. They indicated that they notified staff that the resident could be transferred with the specified transfer equipment. The PT indicated that they assessed resident #002 again on a later specified date at the request of the DOC, and determined that the resident was unable to participate as needed in the transfer, and recommended a different transfer method and equipment. They stated that they notified the registered staff of the change and placed the appropriate transfer logo above the resident's bed. The PT indicated that registered staff were responsible for updating the resident's care plan, and they thought staff had already started using the new method for transferring the resident.

During the interview, PT #106 also indicated that the expectation was that if a resident was unable to transfer safely using the method identified in the care plan, staff should immediately stop the transfer and increase the level of transfer support. The PT indicated that staff were always able to go up a level for transferring, but they could not go down a level without a transfer assessment by the PT. The PT confirmed that when staff observed that resident #002 was not participating as required using the recommended transfer equipment, they should have safely stopped the transfer, notified registered staff, and used a different transfer method and equipment. The PT acknowledged that transferring a resident with the specified equipment, when the resident was not able to participate as required, was unsafe.

The DOC confirmed during an interview that the PSWs should have stopped the transfer of resident #002 when they identified that the resident was not participating in the transfer as required, registered staff should have been notified, and a higher level of support used for the transfer. The DOC acknowledged that

resident #002 was not transferred safely on the specified date, when they were unable to participate as required in the transfer using the specified transfer equipment. [s. 36.]

Additional Required Actions:

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

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001, who exhibited skin

breakdown, received immediate treatment and interventions to promote healing.

A CIS report (CIS #0956-000010-19) was submitted to the Director on a specified date, related to an allegation of neglect involving resident #001 that occurred on an earlier specified date, where it was alleged that resident #001 was not provided continence care as per their plan of care for a specified shift.

Review of the progress notes indicated that the resident was found by PSW #138 at the beginning of a specified shift on an identified date, shortly after shift change, in a specified condition that suggested that resident #001 had not been provided continence care. The DOC and RPN #137 were immediately notified and assisted the PSW to provide specified care to the resident. RPN #137 completed a head-to-toe assessment, and skin and wound assessment, and identified an alteration in the resident's skin integrity.

Inspector #722 reviewed the head-to-toe assessment that was completed by RPN #137 on the date the incident occurred, which indicated that resident #001 had altered skin integrity in specified areas of their body. A skin and wound assessment was also completed by RPN #137 on the same date and indicated that the resident had other specified signs of altered skin integrity on specified areas of their body. The skin and wound assessment indicated that the care plan and interventions were reviewed and updated, along with a referral to the wound care nurse and registered dietician.

The treatment orders were reviewed in both the electronic health record and resident #001's paper chart, which indicated specified treatment for one of the areas of altered skin integrity identified in the skin and wound assessment, which also indicated to monitor every shift and provide the required treatment only when needed. This order was created by RPN #137 two days after the incident occurred and the alterations in skin integrity were identified.

The electronic treatment administration record (eTAR) was reviewed and also indicated that the treatment order was initiated two days after the incident, and discontinued three days later. There were no entries in the eTAR related to the treatment of resident #001's altered skin integrity on the day the incident occurred, or the following day.

RPN #137 confirmed during an interview with Inspector #722 that they had assessed resident #001 on the day this incident occurred, and that they had

identified skin breakdown as specified above. RPN #137 indicated that they had little recollection of the incident, and confirmed that they must have initiated the specified skin and wound treatment as documented in the eTAR and treatment orders. RPN #137 indicated that they should have started treatment immediately, on the day the altered skin integrity was identified.

ADOC #107, the Would Care Lead, indicated during an interview that the home followed a specified skin and wound care protocol, and that registered staff determined the appropriate treatment based on this protocol for alterations in skin integrity where the skin was intact, without additional consultation. ADOC #107 described the treatment that would have been appropriate for resident #001 based on their skin and wound assessment at the time of the incident. ADOC #107 confirmed that, according to the protocol, the treatment for resident #001's identified alterations in skin integrity should have been initiated immediately and entered in the eTAR on the date the incident occurred.

The DOC indicated during an interview that the expectation was that when registered staff identified specified alterations in skin integrity, they should initiate treatment immediately to promote healing as per the home's skin and wound care protocol. The DOC confirmed that treatment for resident #001's altered skin integrity should have been initiated on the day it was identified by RPN #137. [s. 50. (2) (b) (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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

(A2)
1. The licensee has failed to ensure that strategies for residents who demonstrated responsive behaviours were developed and included in the plans of care for residents #003, #004, #008, and #012.

(A) A CIS report (CIS #0956-000018-18) was submitted to the Director related to a physical altercation between two residents. The report indicated that on an identified date, resident #007 sustained a specified minor injury due to a physical altercation with resident #008.

Review of the progress notes indicated that resident #008 was involved in multiple altercations with other residents prior to this incident.

Review of resident #008's care plan prior to this incident indicated that there were responsive behaviour interventions in place. However, after this critical incident, there were no interventions for responsive behaviours identified in the resident's care plan.

ADOC #107 confirmed during an interview that resident #008 had responsive behaviour interventions in their care plan prior to this incident, and that there were no responsive behaviour focus areas or interventions in the resident's care plan after the incident. They were unable to explain why responsive behaviour strategies were missing from the resident's care plan. The ADOC explained that

the home had a technical problem with the electronic heath record in June 2018, when they were transitioning to a new platform, and information from residents' care plans in PCC were not transferred appropriately. They suspected that the responsive behaviour focus area of resident #008's care plan must not have been transferred to the new system.

The DOC confirmed that there were no responsive behaviour interventions documented in resident #008's care plan after the specified date. The DOC indicated that front-line staff members rely on the care plan in PCC, which populated the Kardex that the PSWs accessed in their Point of Care (POC) tablet, to provide care for residents. They indicated that it was the expectation of the home that registered staff identify responsive behaviour interventions in the resident's care plan to protect other residents from abuse.

(B) A CIS report (CIS # 0956-000020-18) was submitted to the Director related to a physical altercation between residents #003 and #004 on a specified date. Neither resident sustained an injury during the altercation.

The progress notes for resident #003 were reviewed for a specified period, related to this incident, which described the physical altercation between the residents. The progress notes indicated that Dementia Observation Scale (DOS) monitoring was initiated for resident #003 for a specified period, and that the resident did not have any other behaviours during this period. There were no further progress notes identified that documented behavioural issues and/or interventions.

Resident #003's care plan was reviewed and there were no triggers identified and/or interventions in place related to responsive behaviours at the time of this incident. Resident #003 had specified responsive behaviour interventions in their care plan that were discontinued prior to this incident. Identified responsive behaviour interventions were added to resident #003's care plan at a later specified date; however, they were not related to interactions with co-residents. The resident was not receiving any medications associated with responsive behaviour management.

A RAI-MDS quarterly assessment that was initiated prior to this incident indicated in Section E: Mood and Behaviour Patterns, that the resident exhibited specified responsive behaviours towards co-residents. It also indicated that the resident had other responsive behaviours related to personal care.

Inspector #722 reviewed the High Risk binder for the home area where resident #003 resided, a tool used to identify residents on the unit with responsive behaviours, which indicated that resident #003 had specified responsive behaviours involving personal care. There was no indication in the binder that the resident had specified responsive behaviours that were directed at co-residents.

PSW #112 was interviewed and indicated that they routinely provided care to resident #003. The PSW described specific responsive behaviours exhibited by resident #003 and directed toward co-residents, which they described as occurring occasionally. The PSW identified some triggers and general behavioural interventions they used when resident #003 was exhibiting specified responsive behaviours, and indicated that they should be in the Kardex that the PSWs accessed through POC on their tablet. They acknowledged that there were no interventions in the care plan for resident #003 related to their responsive behaviours directed at co-residents.

RPN #115 indicated that they had provided care to resident #003, and described the resident as generally quiet. They stated that with specified triggers, the resident would exhibit certain responsive behaviours toward co-residents.

ADOC #104, the behaviour support lead, indicated during an interview that they were aware of the altercation between residents #003 and #004 on the specified date, and they were aware that resident #003 had a history of demonstrating certain responsive behaviours toward staff and co-residents, specifically involving an identified trigger. The ADOC was under the impression that these behaviours had subsided, as there was no documentation in the progress notes that the resident continued to exhibit responsive behaviours toward co-residents, and they thought that the negative interactions with co-residents had decreased for specified reasons. The ADOC acknowledged that they were aware that resident #003 occasionally had specified responsive behaviours in identified situations. They also indicated that direct care staff tended to normalize responsive behaviours and often failed to document them in the progress notes.

ADOC #104 indicated that responsive behaviour triggers and interventions should be identified in the resident's care plan, which was accessible to registered staff in PCC, and accessible to PSWs through POC on their tablets. The ADOC indicated that they were not aware that resident #003 had responsive behaviours that needed to be captured in their care plan. The ADOC was not aware that resident #003 continued to have specified responsive behaviours as indicated in the RAI-

MDS assessment prior to this incident and as described by PSW #112 and RPN #115. The ADOC also did not recognize that the specified behaviours they described above for resident #003 were responsive behaviours that required strategies and interventions.

The DOC indicated during an interview that they were not aware that resident #003 had any responsive behaviours, and then went on to describe specific responsive behaviours that they had observed in resident #003. They indicated that there was a trigger in the past for the resident's responsive behaviours, but that this trigger was no longer a concern for specified reasons. The DOC indicated that the expectation was that PSWs should report responsive behaviours to the registered staff, registered staff should notify the behavioural support lead in the home, the resident should be assessed, and responsive behaviour triggers and strategies included in the resident's care plan as appropriate. They indicated that the PSWs have often normalized responsive behaviours among residents and have not been reporting the behaviours to registered staff. The DOC indicated that triggers and interventions for responsive behaviours needed to be included in the care plan in PCC so that all staff could access the plan of care related to responsive behaviours for the resident.

Resident #003's behaviours impacted other residents and occurred frequently according to staff in the home and the RAI-MDS assessment detailed above. The information gathered during this inspection demonstrated that the licensee failed to develop and implement strategies for resident #003's responsive behaviours toward staff and co-residents for specified periods.

(C) A CIS report (CIS # 0956-000020-18) was submitted to the Director related to a physical altercation between residents #003 and #004 on a specified date. Neither resident sustained an injury during the altercation.

The progress notes for resident #004 were reviewed for a specified period related to this incident. A note by PT #106 on a specified date identified specific responsive behaviours related to personal care. A progress note entered on a later specified date described an altercation that involved resident #003 and indicated that DOS monitoring was initiated. Progress notes for a specified period indicated that DOS monitoring was ongoing, and a note on a specified date indicated that DOS monitoring was completed and no behaviours were identified. There were no further progress notes identified that documented behavioural issues and/or interventions for resident #004 during this period.

Resident #004's care plan was reviewed, and there were no identified triggers and/or interventions related to responsive behaviours in place at the time of the incident, or at the time of the inspection. Inspector #722 reviewed the history of revisions in the resident's care plan, and identified various interventions related to responsive behaviours involving staff, co-residents, and personal care. All of these interventions were discontinued in June 2018.

A RAI-MDS quarterly assessment was identified that was initiated prior to the responsive behaviour focus area being discontinued from resident #004's care plan. It indicated in Section E: Mood and Behaviour Patterns, that resident #004 exhibited specified behaviours toward self or others and involving personal care up to five times per week. The RAI-MDS assessment indicated that the resident had not exhibited any behavioural symptoms in the seven days prior to the assessment. There were similar findings in Section E of the RAI-MDS annual assessment for resident #004 that was completed on a later specified date, after the responsive behaviour interventions had been removed from resident #004's care plan in June 2018.

Inspector #722 reviewed the High Risk binder for the home area where resident #004 resided, a tool used to identify residents on the unit with responsive behaviours. Resident #004 was not identified on the list for their home area.

PSW #110 was interviewed and indicated that they routinely provided care to resident #004. The PSW indicated that the resident had responsive behaviours and proceeded to describe the resident's specific responsive behaviours toward staff and co-residents. PSW #110 also identified a number of triggers for resident #004's behaviours. They also described several interventions they used when the resident was demonstrating specified responsive behaviours. PSW #110 indicated that triggers and interventions for a resident's responsive behaviours should be in their Kardex in POC, and confirmed that they were unable to identify any interventions in the Kardex for resident #004.

RPN #111 was interviewed and indicated that they routinely provided care to resident #004. The RPN also indicated that resident #004 had identified responsive behaviours towards staff and co-residents. The RPN stated, "It's not that [the resident] is really having behaviours…," and proceeded to identify specific responsive behaviours they had observed involving resident #004. The RPN indicated that these behaviours occurred approximately once every two to

three weeks and identified various triggers for resident #004's responsive behaviours.

RPN #111 indicated that they knew what interventions to use for resident #004's responsive behaviours because they had worked with the resident for so long. They described the various interventions they used for specified responsive behaviours. The RPN reviewed resident #004's care plan and acknowledged that the triggers and interventions for their responsive behaviours were not identified and documented. The RPN further indicated that interventions were previously in place for the resident's responsive behaviours, but they had not been re-entered into the resident's care plan when the home switched from one version of the electronic health record to another in June 2018. The RPN explained that registered staff normally accessed interventions related to responsive behaviours in the resident's care plan, and PSWs through the Kardex in POC on their tablets.

ADOC #104, the behaviour support lead, was interviewed and indicated that they were aware that resident #004 could demonstrate specified responsive behaviours with staff and co-residents, and identified specific triggers for the behaviours. The ADOC indicated that the resident exhibited these behaviours up to once a week and acknowledged that the resident's responsive behaviours were likely not documented, as they were normalized by staff.

ADOC #104 indicated that triggers and interventions related to a resident's ongoing responsive behaviours should be identified and documented in the resident's care plan, which was where registered staff and PSWs were expected to access the interventions. The ADOC also indicated that residents with responsive behaviours were identified in the red High Risk binder on the unit where they reside. The ADOC confirmed that there were no entries in resident #004's care plan related to their responsive behaviours and explained that they were not carried over from the previous version of PCC when the home changed platforms in June 2018.

The DOC indicated during an interview that they were not aware that resident #004 had responsive behaviours, and that they were not familiar with the resident. The DOC indicated that the expectation was that PSWs should report responsive behaviours to the registered staff, registered staff should notify the behavioural support lead in the home, the resident should be assessed, and responsive behaviour triggers and strategies included in the resident's care plan as appropriate. The DOC indicated that the PSWs have often normalized responsive

behaviours among residents and have not been reporting the behaviours to registered staff. The DOC indicated that triggers and interventions for responsive behaviours needed to be included in the care plan in PCC so that all staff could access the plan of care related to responsive behaviours for the resident.

Resident #004's behaviours impacted other residents and were a relatively frequent (up to once a week) occurrence according to staff in the home. The information gathered during this inspection demonstrated that the licensee failed to have strategies in place for resident #004's responsive behaviours since June 2018, when the home changed platforms for their electronic health record.

(D) A CI report (CIS #0956-000019-18) was submitted to the Director for an incident where resident #012 had an altercation with resident #010, which caused resident #010 to sustain minor injuries.

Review of resident #012's care plan prior to the incident, and prior to the conversion to the new platform in PCC, indicated that the resident had specified responsive behaviours toward staff during care. Various interventions were identified in the resident's care plan (e.g., re-approach, safety checks, monitoring behaviours, medications, etc.). At the time of the inspection, there were no responsive behaviour interventions identified in resident #012's care plan; they had not been added after the conversion to the new platform in PCC.

Review of the home's Responsive Behaviour Management policy (Policy #VII-F-10.20), revised March 2018, indicated that for residents with responsive behaviours, the registered staff were expected to:
- Conduct and document an assessment of the resident experiencing responsive behaviours, which included complete behavioural assessments based on resident need, including but not limited to Dementia Observation System (DOS).
- Determine if the resident's responsive behaviour was endangering others; and strategize with other members of the interdisciplinary team to identify risk level, causes, and triggers.
- Complete an electronic Responsive Behaviour Referral to the internal BSO Lead/Designate when there is a new, worsening, or change in responsive behaviours

Resident #012's progress notes were reviewed, and there were no entries that indicated the DOS assessments were initiated after the altercation with resident #010. A referral to the home's behaviour support lead was also not located in the

progress notes or clinical assessments in PCC after the altercation.

PSW #118 indicated during an interview that they witnessed the incident; they described the altercation and confirmed that resident #012 caused the injury to resident #010 through their actions. The PSW stated that resident #012 tended to demonstrate specified responsive behaviours with staff during care, but they were not aware of any altercations that involved co-residents.

RPN #108 indicated during an interview that they responded to the incident and stated that when a resident-to-resident altercation occurred, registered staff were expected to initiate DOS monitoring for the aggressor. The RPN indicated that the DOS assessments would be reviewed by the nurse manager to identify if any interventions were needed for the resident. They confirmed that the DOS assessments were not done for resident #012 after this incident, and they should have been done.

ADOC #104, the behaviour support lead, stated during an interview that resident #012 had responsive behaviours involving both co-residents and staff during care, and identified behavioural triggers. They indicated that the resident had not previously demonstrated specified behaviours toward co-residents, and the altercation with resident #010 was a new behaviour. The ADOC stated that they would expect close monitoring of resident #012 after the incident, initiation of the DOS assessment tool, and a referral to the home's behaviour support lead. The ADOC indicated that none of these actions were taken in response to this incident, resident #012 was not assessed for their new responsive behaviour, and new strategies were not implemented to address the new behaviour.

The DOC stated in an interview that the staff had not taken action to monitor, assess or to identify strategies for resident #012 who had demonstrated responsive behaviours towards a co-resident.

The findings above indicated that the triggers and strategies for responsive behaviour management were not developed or included in the plans of care for residents #003, #004, #008, and #012. [s. 53. (4) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that for each resident demonstrating responsive behaviours, strategies are developed and implemented to respond to these behaviours, where possible, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

(A2)
The licensee has failed to ensure that drugs were stored in an area that was secure and locked.

On a specified date and time, Inspector #645 observed a medicated topical cream stored on a resident's bedside table. The topical cream was open and unlabelled, and the resident shared the room with another resident. On another specified date and time, the inspector also observed another treatment cream, prescribed to another resident, and stored in their room. On another specified date and time, the inspector observed another identified medicated cream, prescribed for another specified resident, stored on their bedside table.

RN #123 and RN #133 indicated in separate interviews that medicated/prescribed topical creams should be safely stored in the secure medication room located by the nursing station. They acknolwedged that the identified medicated topical creams were not stored securely.

ADOC #103 indicated during an interview with Inspector #645 that it was the home's expectation that all topical medications were safely stored in the locked medication room. The ADOC confirmed that leaving the medications on the residents' bedside table posed a risk to other residents. [s. 129. (1) (a)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee has failed to ensure that all staff participated in the implementation of the infection prevention and control program.

(A) On a specified date, during medication administration observation, Inspector #645 observed a specified resident room to be on droplet precautions. The room was observed to have a droplet precaution sign and Personal Protective Equipment (PPE) gowns and gloves placed by the entrance to the room. The precaution sign directed staff members to wear appropriate PPEs all the time when providing care to a specified resident in the room. On the same day, PSW #136 was observed entering the room without donning the appropriate PPE (gown and gloves). The PSW was observed providing care and transferring the resident in bed. The PSW was also observed leaving the room and entering another resident's room without washing their hands after providing care.

During an interview with PSW #136, they confirmed that they did not wear the appropriate PPE when they provided care to the identified resident. The PSW explained that staff were expected to wear appropriate PPEs when they provided care to residents on isolation precautions and wash their hands after providing care to residents to decrease the transmission of infections.

The ADOC indicated during an interview that staff were expected to wear appropriate PPE all the time when they provided care for residents who were on isolation precautions. They confirmed that PSW #136 did not appropriately implement the infection prevention and control program of the home when they failed to don the appropriate PPEs and wash their hands after they provided care to the identified resident.

(B) On a specified date and time during the inspection, two soiled wash basins were observed on top of the sink in the washroom of an identified resident room, which was shared by two residents. One of the wash basins was labelled with a resident's name and the other was unlabelled. Inside the labelled wash basin, Inspector #645 observed two unlabelled combs, two toothbrushes that belonged

to two residents stuck together, one denture cup labelled with a different resident name, unlabelled deodorant, and Cavilion peri-area protective cream that belonged to another resident in a different resident room. All of these items were stored together in the same wash basin labelled for a specified resident.

Review of the home's Personal Effects Guidelines policy, (Policy #VII-C-10.10 (B)), last reviewed April 2019, under the Infection Prevention and Control program, indicated that all personal items that are to be kept in a resident's room must be labelled and stored separately to prevent transmission of diseases. According to the policy, personal items included but were not limited to mouth washes, deodorants, ointments, and other cleaning materials.

PSW #137 confirmed during an interview that the toothbrushes that belonged to two residents in the room were stored together. The PSW indicated that they did not know to which resident the unlabelled combs and deodorant belonged. They indicated that the toothbrushes, wash basins and the combs should have been labelled and stored separately to avoid the risk of infection transmission. The PSW also indicated that the Cavilion peri-area cream was not to be shared among residents and they were not sure why it was stored in a specified resident room. The PSW also indicated that the denture cup belonged to a specified resident and it should not have been stored in the wash basin labelled for another resident.

ADOC #103 was interviewed and indicated that cleaning, labelling, storing, and disinfection practices were part of the infection prevention and control program which included, but was not limited to, cleaning and disinfecting personal care devices such as wash basins, toothbrushes, deodorants and other cleaning materials. They indicated that staff were expected to clean, label and store residents' belongings to minimize the risk of infection. They confirmed that the staff members did not participate in the implementation of the infection prevention and control program of the home. [s. 229. (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 all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that their written policy to promote zero tolerance of abuse and neglect of residents was complied with related to an allegation of neglect involving resident #001.

A CIS report (CIS #0956-000010-19) was submitted to the Director related to an allegation of neglect involving resident #001 that occurred on a specified date, where the resident was found early on a specified shift saturated in urine. It was alleged that PSW #129 had not provided continence care to the resident during the specified shift as required according to the resident's plan of care.

The incident report and progress notes were reviewed and indicated that staff discovered resident #001 at the beginning of the specified shift on an identified date saturated in urine. An assessment determined that the resident had specified alterations in skin integrity to identified areas of the body. The CIS report identified that PSW #139, RPN #137, and the DOC responded to this incident. PSW #129 was responsible for the resident's care during the previous shift.

Inspector #722 reviewed the home's investigation file for this allegation of neglect, which was provided by the Executive Director. The file included a copy of the original CIS report, and hand-written notes from a notebook, with a specified date. The notes identified resident #001's name, the date of the incident, the title "Fact

Finding", and those present at the meeting, including PSW #129, a union representative, the DOC, and ADOC #138. The notes detailed a discussion between the DOC and PSW #129, where the PSW was given an opportunity to describe the incident. There were no other notes, statements, or other documentation identified by Inspector #722 in the investigation file provided related to this incident.

The home's Prevention of Abuse & Neglect of a Resident policy (Policy #VII-G-10.00), current revision December 2018, indicated the following with respect to investigating allegations of abuse or neglect:
- The Executive Director or designate initiates the investigation by requesting that anyone aware of or involved in the situation write, sign, and date a statement accurately describing the event, reiterating anonymity and protection against retaliation.
- The alleged abuser is also asked to write, sign, and date a statement of the event.
- The Executive Director or designate interviews the resident, other residents, and/or persons who may have any knowledge of the situation. If possible, include a management witness during the interviews with all residents. The witness takes detailed notes of the conversations.

PSW #129 indicated in an interview with Inspector #722 that they were notified they were on leave with pay pending the investigation, they were interviewed by the DOC on a specified date with their union representative present, and they were provided a Non-Disciplinary Coaching Letter on a specified date. The PSW indicated that they were not asked, and did not provide, a written, signed and dated statement related to the incident.

Inspector #722 interviewed RPN #137, who indicated that they were working on the evening shift and in the unit where resident #001 resided when the resident was found saturated in urine. RPN #137 indicated that they assisted PSW #139 to clean up the resident and completed a head-to-toe assessment, where they identified specified alterations in skin integrity associated with excessive moisture. RPN #137 indicated that they never met with management about the incident and were never asked to provide a written statement.

The DOC indicated during an interview with Inspector #722 that ADOC #138, who was no longer employed by the home at the time of the interview, was delegated to complete the investigation, since resident #001 resided on the unit for which

ADOC #138 was responsible. The DOC verified that they participated in the meeting with PSW #129 as detailed above. They confirmed that if the resident, their SDM, or other staff members were interviewed during the investigation, that the ADOC should have taken notes, with a witness, and they should have been included in the investigation file. The DOC also confirmed that there was no written statement from the staff member alleged to have neglected resident #001. The DOC confirmed that the home's policy related to prevention of abuse and neglect was not complied with for the investigation of this incident of alleged neglect that involved resident #001. [s. 20. (1)]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that staff who had knowledge of an incident of resident-to-resident abuse, that resulted in harm to the resident, immediately reported it and the information upon which it was based to the Director.

A CIS report (CIS #0956-000018-18) was submitted to the Director on a specified date, related to an incident of resident-to-resident abuse that involved residents #007 and #008 and that occurred on the previous day.

Review of the CIS report and progress notes indicated that on a specified date, resident #007 sustained an identified injury during an altercation with resident #008 that required medical intervention.

The DOC and ADOC #107 both confirmed in separate interviews that this incident of resident-to-resident physical abuse was not reported immediately to the Director, and that it should have been reported on the day the incident occurred. [s. 24. (1)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001's substitute decision-maker (SDM) was notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation.

(A) A CIS report (CIS #0956-000010-19) was submitted to the Director related to an allegation of neglect involving resident #001 that occurred on a specified date, where resident #001 was found early on a specified shift saturated in urine. It was alleged that PSW #129 had not provided continence care to the resident during the previous shift as required according to the resident’s plan of care.

Review of the CIS report indicated that resident #001’s SDM had been notified of the incident when it occurred. The CIS report was not updated with information about the outcome of the investigation, and did not indicate that the SDM had been notified of the results of the investigation.

Inspector #722 reviewed the progress notes, which provided a description of the incident as well as actions taken by staff, and there were no notes identified after the incident that indicated that resident #001’s SDM had been notified of the results of the investigation.

The investigation file provided by the home was reviewed, and there was no documentation identified that indicated that the resident’s SDM had been notified that the investigation had been completed, or the results of the investigation.

Inspector #722 interviewed resident #001’s SDM, who did not recall being notified of this incident, that an investigation had been initiated, or the results of an investigation. The SDM indicated that they thought that they would have remembered being notified of such an incident.

The DOC indicated during an interview that ADOC #138 was delegated to investigate the incident and was no longer employed by the home. The DOC confirmed during the interview that the investigation was likely completed on a specified date, based on available documentation, and that the expectation was that ADOC #138 should have contacted resident #001’s SDM to notify them that the investigation was completed and of the findings. The DOC verified that they had not personally contacted resident #001 to discuss the results of the investigation.

(B) A CIS report (CIS #0956-000022-19) was submitted to the Director on a specified date, where resident #002 alleged that they were treated roughly by staff on a specified date, when they were transferred to bed. The latest amendment to the CIS report, on a specified date and time, indicated that the incident was under investigation and that long-term actions were to be determined at the outcome of

the investigation. There was no indication in the report that the resident's SDM had been notified of the results of the investigation, and there were no further amendments to the report.

Review of the investigation files provided by the home indicated that this incident of alleged abuse was investigated, including interviews with the resident, co-residents, and other staff involved or aware of the incident. There were no notes that indicated that the resident's SDM was notified of the results of the investigation.

Inspector #722 reviewed the progress notes, and was unable to identify any notes that indicated that resident #002's SDM had been contacted and informed that the investigation was completed and the results of the investigation.

ADOC #107 indicated during an interview that they were responsible for conducting the investigation into the allegation of abuse involving resident #002, and stated that the investigation into this allegation was completed on a specified date. ADOC #107 indicated that they did not notify the resident's SDM to inform them that the investigation was completed or of the results of the investigation.

The DOC indicated during an interview that they did not notify resident #002's SDM that the investigation was completed, or of the results of the investigation. They also indicated that the expectation was that the ADOC delegated to complete the investigation notify the resident (if applicable) and the resident's SDM that the investigation was completed and the results of the investigation. They indicated that when the SDM was notified of the results, that it should have been documented in the progress notes and/or in an amendment to the CIS report. [s. 97. (2)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 232. Every licensee of a long-term care home shall ensure that the records of the residents of the home are kept at the home. O. Reg. 79/10, s. 232.

Findings/Faits saillants :

1. The licensee has failed to ensure that records for resident #003 and #004, specifically related to the Dementia Observation System (DOS) tool, were kept at the home.

A CIS report (CIS #0956-000020-18) was submitted to the Director on a specified date, related to a physical altercation between residents #003 and #004.

Review of the progress notes indicated that the altercation occurred on a specified date, and that DOS monitoring was initiated for both residents after the incident. Entries were also identified in the progress notes for both residents which indicated that the DOS monitoring was completed on specified shifts.

Inspector #722 reviewed the clinical health records (electronic and hard-copy) for both residents and was unable to locate a DOS monitoring tool for either resident that was initiated for this incident. A risk management binder and a storage area for archived files were also searched by staff on the identified units, and the completed DOS tools for residents #003 and #004 were not located.

ADOC #104, the behaviour support lead in the home, indicated during an interview with Inspector #722 that the DOS tool should have been completed for residents #003 and #004 for five days after the altercation. They indicated that when the DOS tool was initiated, PSWs were expected to document the resident's activity (e.g., sleeping, awake/calm, noisy, restless/pacing, etc.) each hour during their shift. The tool was to be kept in a binder in the nursing station, so that registered staff could ensure it was completed. When completed, the ADOC indicated that the nursing staff should have summarized the findings and filed the completed DOS record in the residents' clinical records (hard-copy) stored on the unit. The ADOC stated that they had searched and were unable to locate the DOS records for residents #003 and #004 after the altercation; they indicated that they could not be sure that it was completed for either resident, except that it was documented in the progress notes.

During an interview with Inspector #722, the DOC confirmed the expectations related to DOS monitoring as described above by ADOC #104. The DOC verified that staff had searched for the records, and acknowledged that the completed DOS tools for residents #003 and #004 were missing and could not be located. [s. 232.]

Issued on this 8 th day of November, 2019 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

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 COREY GREEN (722) - (A2)
Inspection No. / No de l'inspection :	2019_616722_0018 (A2)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	005801-18, 008432-18, 015088-18, 016344-18, 016606-18, 026243-18, 000050-19, 002959-19, 004952-19, 013007-19, 014575-19 (A2)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Nov 08, 2019(A2)
Licensee / Titulaire de permis :	Vigour Limited Partnership on behalf of Vigour General Partner Inc. 302 Town Centre Blvd, Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Altamont Care Community 92 Island Road, SCARBOROUGH, ON, M1C-2P5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jane Smith

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

To Vigour Limited Partnership on behalf of Vigour General Partner Inc., 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)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.
4. A pain management program to identify pain in residents and manage pain.
O. Reg. 79/10, s. 48 (1).

Order / Ordre :

(A2)
The licensee must be compliant with O.Reg. 79/10, s. 48 (1).

Specifically, the licensee must develop, submit, and implement a written plan for achieving compliance under this order to ensure that the falls prevention and management program is implemented in the home.

Specifically, the plan must ensure that:

(a) The licensee's falls prevention program is adhered to, including residents' post fall assessments, falls risk assessments, and referrals to the appropriate interdisciplinary team member (e.g., physiotherapist) for assessment as specified in the program.

(b) When referrals are sent to interdisciplinary team members, that

assessments are completed within one day of receiving the referral, or on the next shift that they are working in the home.

(c) All residents at risk of falls in the home have interventions in place for falls prevention, as well as mobility and transfer status, that are documented in the residents' plan of care.

(d) The plan of care is revised when residents' care needs change to reflect falls risk, falls prevention interventions, post fall care, as well as changes in residents' mobility and transfer status, based on assessments by the interdisciplinary team.

(e) Training is provided to direct care staff, including but not limited to, personal support workers, registered staff, physiotherapist, physiotherapy assistants, and occupational therapist, on their responsibilities related to residents at risk for falls, specifically the requirements under the home's falls prevention and management program, as well as requirements for revisions to the plan of care.

The home shall retain all records related to staff training and make them available to the Inspector when requested, including the content of the training, dates that training occurred, and staff attendance records.

Please submit the written plan for achieving compliance for inspection 2018_616722_0018 to Corey Green, LTC Homes Inspector, MOHLTC, by email to torontosao.moh@ontario.ca by November 8, 2019. Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

(A2)
1. The licensee has failed to ensure that the falls prevention and management program, as detailed in the home's Falls Prevention policy, was implemented in the home for residents #009, #010, and #011.

Review of the home's Falls Prevention policy (Policy #VII-G-30.00), revised January 2015, indicated that registered staff were required to complete the Falls Risk Assessment in the electronic documentation system within 24 hours of admission or

re-admission, when triggered by the Resident Assessment Instrument - Minimum Data Set (RAI-MDS) assessments protocol, and with a significant change in the resident's status. Upon completion of the Falls Risk Assessment, registered staff were expected to update the resident's care plan with associated risk level and interventions.

The policy also indicated that when a fall occurred, the registered staff were expected to update the resident's care plan and complete a referral to the appropriate discipline, such as the physiotherapist (PT), occupational therapist (OT), or recreation staff. The policy indicated that the members of the interdisciplinary team were expected to complete their respective assessments, discuss the appropriate interventions with the multidisciplinary care team, and document all new interventions in the care plan. It also indicated that staff were to inform the registered nurse if an item (e.g., an assistive device) was introduced to a resident, and registered staff were expected to update the resident's care plan to include new interventions.

The evidence below will show that (i) care plans were not updated related to falls prevention interventions, mobility and transfers, (ii) falls risk assessments were not completed, and (iii) that PT did not consistently complete post fall assessments for residents #009, #010, and #011.

(A) A critical incident system (CIS) report (CIS #0956-000006-18) was submitted to the Director on March 21, 2018, for an injury where resident #009 was transferred to hospital on March 20, 2019, due to a fractured right hip that required surgery.

Review of the CIS report and progress notes indicated that resident #009 sustained a fall on February 24, 2018, was sent to hospital for assessment, returned on the same day with a diagnosis of gall stones, and was treated for pain with analgesics in the home. The resident sustained another fall on March 12, 2018, was assessed without injury, and remained in the home. An x-ray done in the home on March 20, 2018, showed that the resident had sustained a right hip fracture. The resident was admitted to hospital on March 22, 2018, had right hip surgery, and returned to the home on April 3, 2018.

The progress notes for resident #009 were reviewed and indicated the following related to resident care for falls prevention, mobility, and transfers:
- Resident #009 remained in bed from February 24, 2018, when they returned from

the hospital, until March 4, 2018.
- Various notes in March 2018 indicated that the resident began using a wheelchair for mobility in the home on March 4, 2018, and continued to use the wheelchair.
- March 7, 2018, registered staff sent a referral to the PT to assess the resident due to a decline in transfer status and ambulation.
- March 19, 2018, the PT assessed the resident, and gave instructions to leave the resident resting in bed until assessed by the physician.
- March 20, 2018, PT #106 assessed the resident for transfers and mobility, identified that the resident could not weight bear, and recommended a mechanical lift for transfers; the PT indicated that they changed the transfer logo above the resident's bed, and informed registered staff.
- March 22, 2018, resident was transferred to hospital, had right hip surgery, and returned to the home on April 3, 2018.
- April 3, 2018, PT indicated that they had difficulties assessing the resident due to cognitive issues but would attempt to get resident up using sit-to-stand lift four times per week to promote healing and weight bearing tolerance. PT #106 did not specify the resident's transfer status.

(i) Care Plan: Review of the health records for resident #009 indicated that the resident had an admission Falls Risk Assessment completed on September 1, 2017, which indicated that the resident was at moderate risk for falls. The admission care plan for resident #009 did not include any interventions related to falls prevention or mobility (i.e., ambulatory with a cane), and indicated the following for transfers: "Resident is able to hold onto staff waist, pivot, stand with assistance." It was not clear to the Inspector what assistance staff were expected to provide to the resident for transfers.

From admission in September 2017, until March 20, 2018, there were no revisions or additions to resident #009's care plan related to falls prevention, mobility (e.g., bedrest, wheelchair), or transfer status. There were no revisions to the resident's care plan after they fell on February 24, 2018; when registered staff identified a change in the resident's transfer status and ability to ambulate on March 7, 2018; or after the PT assessed the resident on March 20, 2018, and changed their transfer status to a mechanical lift.

On March 21, 2018, 25 days after resident #009's initial fall, the care plan was revised and indicated that the resident required a two-person transfer with a

mechanical lift for transfers and toileting. On April 12, 2018, the resident's care plan was updated to identify that the resident had sustained a right hip fracture and the following falls prevention intervention was added: "Monitor / evaluate / provide with / monitor use of adaptive devices PRN: (Specify: Fracture pan, Gait belt, Abduction pillow, Walker, Wheelchair, Elevated toilet seat.)." The DOC acknowledged during an interview that this falls prevention intervention was not individualized to the resident and did not specify the required adaptive devices.

RPN #128 indicated during an interview that they had provided care to resident #009 and witnessed their fall on March 12, 2018. The RPN indicated that after the fall on February 24, 2018, the resident was no longer ambulatory and was being transferred to a wheelchair for locomotion to the dining room for meals. They acknowledged that resident #009's care plan did not have any falls prevention interventions, or specify that the resident used a wheelchair for mobility when the resident fell on March 12, 2018.

PSW #117 indicated during an interview that they had worked with resident #009 and could not recall how the resident was being transferred in the time after the resident's falls and when the resident began to use their wheelchair. PSW #117 was aware that the resident required a mechanical lift for transfers.

(ii) Falls Risk Assessments: Review of the assessments in PointClickCare (PCC) indicated that resident #009 had a Falls Risk Assessment completed on September 1, 2017, that identified the resident as moderate risk for falls. There were no further Falls Risk Assessments completed until April 3, 2018, when the resident returned to the home from the hospital after hip surgery.

As per the falls prevention policy noted above, registered staff were required to complete the Falls Risk Assessment with a significant change in the resident's status. Specifically, there were no Falls Risk Assessments identified on the following dates:
- February 24, 2018: resident sustained a fall and remained in bed until March 4, 2018.
- March 4, 2018: staff began using a wheelchair for mobility in the home.
- March 7, 2018: resident was identified by registered staff to have a change in transfer ability and ambulation, referral was sent to PT.
- March 12, 2018: resident sustained a second fall from their wheelchair.

- March 20, 2018: resident's transfer status was changed to mechanical lift.

(iii) Physiotherapy Post Fall Assessments: Review of the progress notes indicated that a referral was not sent by registered staff to the PT after resident #009 fell on February 24, 2018. The notes indicated that the registered staff submitted another referral to the PT on March 12, 2018, after the resident sustained another fall.

Assessments were reviewed in PCC, and a PT assessment was not identified for resident #009 after the fall on February 24, 2018. A PT assessment was identified on March 16, 2018; four days after the referral for the fall on March 12, 2018, and nine days after a previous PT referral by registered staff on March 7, 2018.

RPN #128 stated during an interview that registered staff were expected to refer residents to the PT for assessment after every fall; the RPN acknowledged that a referral was not sent to the PT after resident #009 fell on February 24, 2019.

PT #106 indicated during an interview that they assessed residents after they sustained falls or had a change in their transfer status when they received referrals from registered staff. The PT stated that they had not received a referral after resident #009 fell on February 24, 2018, and confirmed that they did not assess the resident when they returned from the hospital. The PT acknowledged that they received a referral for resident #009 on March 7, 2018, and were not able to explain why they waited until March 16, 2018, to assess the resident. The PT indicated that they only worked in the home four days per week, and acknowledged that residents should be assessed when they are referred.

(B) A CIS report (CIS # 0956-000019-18) was submitted to the Director on June 24, 2018, when resident #010 sustained a fall and was transferred to hospital where they received treatment for a fractured finger.

Review of the CIS report and progress notes indicated that on June 24, 2018, resident #010 was involved in an altercation with resident #012, who pulled resident #010's cane and caused them to fall in the hallway. The resident was assessed, sustained a laceration above their right eye, and was sent to hospital for further assessment. Resident #010 was diagnosed with a fracture to the middle finger of their right hand and returned to the home on the same day with a splint.

(i) Care Plan: Resident #010's care plan was reviewed, including the revision history, from admission on June 22, 2018, to discharge on October 9, 2018. No falls prevention interventions were identified in the resident's care plan during this period, including after being identified as moderate risk for falls in the Falls Risk Assessment on September 13, 2018.

(ii) Falls Risk Assessment: Review of the health record for resident #010 indicated that they were admitted to the home on June 22, 2018. As per the falls prevention policy, registered staff were required to complete the Falls Risk Assessment within 24 hours of admission to the home.

Resident #010's assessments were reviewed in PCC, and there were no Falls Risk Assessments identified for the resident on admission. A Falls Risk Assessment was not completed for resident #010 until September 13, 2018, which identified the resident as moderate risk for falls.

(iii) Physiotherapy Post Fall Assessments: The progress notes and assessments were reviewed for resident #010's fall on June 24, 2018, and there was no referral to PT, or assessment by PT, identified for resident #010 after they fell.

RPN #108 confirmed during an interview that a referral was not sent to the PT after resident #010 fell. RPN #108 acknowledged that PT referrals were supposed to be sent for every resident fall, and that the registered staff would work with the PT to determine if any additional interventions for mobility, transfers, and falls prevention were needed for the resident.

PT #106 confirmed during an interview that they had not received a referral from the registered staff after resident #010 fell on June 24, 2018, and they did not assess the resident at that time. The PT indicated that they were notified of the fall and fracture by the Nurse Practitioner (NP) on July 16, 2018, and assessed the resident at that time.

(C) A CIS report (CIS #0956-000010-18) was submitted to the Director on April 17, 2018, for resident #011, who sustained a fall in their room on April 11, 2018, and another fall on April 16, 2018, that resulted in fractures.

Review of the progress notes indicated that on April 11, 2018, the resident sustained

a fall in their room, was assessed and no injuries were identified. On April 16, 2018, the resident had another fall, was assessed and found to have swelling to their left wrist and arm; the resident was not transferred to hospital. On April 17, 2018, the resident was transferred to hospital due to swelling and bruising, and was diagnosed with fractures of their left wrist and arm.

(i) Care Plan: Review of resident #011's care plan and assessments indicated that prior to the fall on April 11, 2018, the resident was identified as moderate risk for falls; however, their care plan did not include a falls prevention focus area. The following interventions were identified in other focus areas of resident #011's care plan prior to their fall: ensure that the resident wears proper footwear when ambulating, ensure that the resident was wearing their eyeglasses, and ensure that the floor of their room was free of clutter. The care plan prior to the fall did not identify the resident's mobility needs. Resident #011's care plan was revised on April 9, 2018, just prior to their first fall, from a sit-to-stand lift for transfers, to a two-person assist. There were no revisions or additions identified in resident #011's care plan related to their falls risk, falls prevention interventions, transfer status, or mobility after either of their falls in April 2018.

Review of the post fall huddle note indicated that staff brought the resident to the nursing station for close monitoring after they fell on April 11, 2018. The progress notes indicated that staff continued to monitor the resident at the nursing station from April 11 to 16, 2018. This intervention was not identified in the resident's care plan.

A PT assessment completed on April 26, 2018, was reviewed, and indicated that the resident needed constant monitoring as they were at high risk for falls due to self-transfers. In addition, the PT provided a chair alarm to the resident, and indicated that it was required as the resident continued to attempt to get out of their wheelchair. None of these interventions were added to the resident's care plan.

PSW #135 indicated during an interview that they had worked with resident #011 during and after their two falls in April 2018 and stated that the resident was provided a chair alarm after their fall. The PSW could not recall if there were any directions specified in the plan of care for transferring the resident after they fractured their left wrist and arm. No directions were identified when the care plan was reviewed by the inspector.

RPN #119 stated during an interview that the resident was provided a wheelchair alarm but was unsure if the alarm was put in place before or after the second fall on April 16, 2018. They also stated that if the PT had recommended any new falls prevention interventions, this would be communicated to the registered staff, who were responsible for updating the resident's care plan.

(ii) Physiotherapy Post Fall Assessments: Review of the progress notes for resident #011 indicated that the registered staff had not sent a referral to the PT using the PT 1:1 Referral form in PCC to assess the resident after their falls on April 11 and 16, 2018, where the second fall resulted in injuries.

The PT assessments in PCC were reviewed and indicated that PT #106 had assessed the resident on April 12, 2018, after the NP made a verbal request to the PT to assess the resident. There was no PT assessment documented after the fall on April 16, 2018. The resident was assessed by the PT on April 26, 2018, 10 days after their second fall, at the request of the NP.

RPN #119 indicated during an interview that a referral should have been sent to the PT by registered staff after resident #011's falls and confirmed that no referrals were submitted for either fall.

The DOC and ADOC #103, the Falls Prevention Lead in the home, stated in separate interviews that the plan of care for residents' transfer status, mobility, and falls prevention interventions should have been documented in their care plans in PCC. They indicated that registered staff were responsible for updating resident care plans, specifically when recommendations were made by the PT, and acknowledged that was not done as specified above for residents #009, #010, and #011.

They also stated that the Falls Risk Assessment should have been completed for residents #009 and #010 as per the home's policy, using the Falls Risk Assessment tool in PCC, and their risk identified in their care plan. They also indicated that the Falls Risk Assessment should have been completed when the residents' ambulation status changed, and that this was not done.

In separate interviews, they confirmed that according to their falls prevention program and policy, registered staff were expected to always refer residents to the PT after they sustained a fall, so that their transfer status, mobility, and falls risk

could be assessed. They indicated that the PT should have assessed residents #009, #010, and #011 when they received the referral, or the next shift they were in the home, for changes in their transfer status, mobility and risk for falls.

PT #106 indicated during an interview that when they determined from an assessment that a resident's transfer or mobility status had changed, they placed a transfer logo above the resident's bed and notified registered staff, who were responsible for updating the resident's care plan in PCC. They stated that they should have received a referral from registered staff after every resident fall, and that they were expected to assess the resident on the day the referral was received, or the next shift they were working in the home. PT #106 acknowledged that they did not assess residents #009, #010, and #011 after falls as specified above.

Both the DOC and ADOC confirmed that the home's Falls Prevention and Management Program was not implemented by various staff in the home, specifically related to updating resident care plans with falls prevention interventions, completing Falls Risk Assessments, and post fall PT assessments for residents #009, #010, and #011.

The severity of this issue was determined to be a level 2 as there was minimal harm to residents. The scope of the issue was a level 3 (widespread) as it related to three out of three residents reviewed. The home had a level 2 compliance history as there were previous non-compliances to different sub-sections. (646)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 21, 2020

Order # / Ordre no : 002 **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 :

(A2)
The licensee must be compliant with r. 131. (2) of the LTCHA.

Specifically, the licensee must ensure that:

(a) Registered staff members administer medications as prescribed by the prescriber.

(b) Specified tests are completed as per the physician order.

(c) Appropriate training/re-training is provided to staff members on the prevention of medication incidents, when they have administered medications to residents incorrectly.

Grounds / Motifs :

(A2)
1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

(A) A CIS report (CIS #0956-000043-18) was submitted to the Director on December 31, 2018, regarding a medication administration incident and alleged improper/incompetent treatment of resident #005 by staff members resulting in hypoglycemia and transfer to hospital.

Review of the medical records indicated that resident #005 was admitted to the home

on December 17, 2018, with the following medical diagnoses: diabetes mellitus (DM), atherosclerotic heart disease, chronic kidney disease, hyperlipidemia, stroke and hypertension. A review of the electronic medication administration record (eMAR) indicated that the resident required insulin therapy involving Lantus, Levemir, and Humulin R, to manage complicated DM.

Review of the Physician Orders in PCC indicated that the resident's insulin orders were changed multiple times within 10 days post admission.

On December 22, 23, and 24, 2018, the Physician Orders indicated that staff members were to check resident #005's blood sugar (BS) three times a day (TID), and to notify the physician if fasting BS was greater than 12.0 millimoles (mmol). Review of resident #005's clinical records indicated that on December 22, 2018, registered staff had not checked the resident's BS for the whole day. On December 23, 2018, resident's BS was 12.2 mmol at 1500 hours, and the physician was not notified. On December 24, 2018, the resident's BS was 12.2 mmol at 1600 hours, and the physician was not notified.

On December 28, 29, and 30, 2018, the Physician Orders indicated that insulin was to be held if resident #005's BS was below 10.0 mmol. Review of the home's investigation notes related to this incident, dated January 2, 2019, indicated the following:
- December 28, 2018, at 0717 hours, resident #005's BS result was 5.8 mmol. The eMAR indicated that 6 units of insulin was administered to the resident at 0730 hours and there was no documentation available that indicated the insulin was held as prescribed.
- December 29, 2018, at 0807 and 0927 hours, resident's BS was 2.3 mmol and 3.4 mmol, respectively. The eMAR indicated that 6 units of insulin was administered at 0730 hours. There was no documentation available that indicated the insulin was held as prescribed.
- December 30, 2018, at 0851 hours, resident #005's blood sugar (BS) result was 4.9 mmol. The eMAR indicated that 6 units of insulin was administered to the resident at 0730 hours and the insulin was not held as prescribed.

Review of the clinical records indicated that on December 31, 2018, at 0915 hours, resident #005 was found unresponsive. BS was checked, and it was 1.1 mmol. The resident had shallow breathing with periods of apnea and vital signs were unstable.

The resident was not arousable to painful stimuli, glucagon was ordered and given, and the resident was transferred to hospital with symptoms of hypoglycemia. A review of the clinical records indicated that there was no BS check completed at 0730 hours as prescribed.

Interview with RPN #122 revealed that resident #005's BS on December 28 and 30, 2018, was 5.8 mmol and 4.9 mmol, respectively. During the interview, RPN #122 confirmed that they administered insulin on both days and that they had made an error. They acknowledged that the physician order directed them to hold insulin if the BS was less than or equal to 10 mmol. They indicated that insulin is a high alert drug and, in the future, they would pay extra attention to the physician order prior to administering any medication. They acknowledged that it was the expectation of the home and the College of Nurses of Ontario (CNO) to administer medication safely. RPN #122 indicated that they received training on safe medication administration as a disciplinary action and had learned from the situation.

Interview with RPN #130 confirmed that on December 29, 2018, resident #005's BS at 0730 hours was 3.4 mmol and that they administered 6 units of insulin. They indicated that the physician order directed them to hold the insulin if the BS was less than or equal to 10 mmol. They confirmed that on that day they made a mistake and acknowledged the importance of checking the physician order prior to administering any medications. RPN #130 stated that the home provided them education regarding safe drug administration and hypoglycemia management.

ADOC #104 was interviewed and confirmed that resident #005 was hospitalized with symptoms of severe hypoglycemia following three insulin administration errors. The ADOC indicated that RPN #122, #130 and #131 did not follow the physician orders and administered insulin to resident #005 when their BS result was below 10 mmol. The ADOC also confirmed that on several occasions, registered staff did not check the resident's BS as prescribed. They indicated that insulin was a high alert drug and staff were always required to check and recheck the physician order prior to dispensing and administering the medication. They indicated that the staff members involved were disciplined, and appropriate training was provided.

(B) Review of the home's Quarterly Medication Review and Adverse Drug Reaction documentation indicated that there were medication administration incidents that involved residents #014, #015 and #016. The records indicated the following

incidents:

- On May 14, 2019, at 0530 hours, registered staff did not administer Loxapine 25 milligrams (mg) by mouth (PO) to resident #016 as prescribed. The physician order on May 7, 2019, directed staff members to administer the medication one hour before an outpatient appointment for electroconvulsive therapy. The resident was sent to hospital without receiving the prescribed dose.

- On May 03, 2019, at 2035 hours, the physician ordered the following: Kayexalate Powder (Sodium Polystyrene Sulfonate) 15 mg by mouth one time a day for two days. Resident #014 was given a third dose of Kayexalate Powder on day three. The incident report indicated that the medication was not given as prescribed.

- Resident #013 had the following order: Administer Tylenol Arthritis 650 mg, two tablets PO, every 12 hours for indicated diagnosis. On June 10, 2019, RPN #132 gave the resident a total of 3900 mg of Tylenol all at once, and was terminated immediately for this medication incident.

The DOC confirmed during an interview that it was the expectation of the home and the CNO that registered staff administer medications as prescribed by the prescriber. The DOC indicated that registered staff were always to check and recheck the physician's order prior to dispensing and administering medications. The DOC indicated that the staff members involved were disciplined, and appropriate training was provided to mitigate the risk of medication incidents.

The severity of this issue was determined to be a level 3 as there was actual harm to a resident. The scope of the issue was a level 2 (pattern) as it related to two of three residents reviewed. The home had a level 3 compliance history as there was a previous non-compliance to the same subsection: Voluntary Plan of Correction (VPC) issued February 26, 2019 (2018_414110_0013)

The LTCH has a history of five (5) other compliance orders in the last 36 months. (645)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Dec 20, 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:

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

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 8 th day of November, 2019 (A2)

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Amended by COREY GREEN (722) - (A2)

Service Area Office / Bureau régional de services : Central East Service Area Office