Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 14, 2020	2019_715672_0020	018323-19	Complaint

Licensee/Titulaire de permis

Chartwell Master Care LP
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

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

Chartwell Ballycliffe Long Term Care Residence
70 Station Street AJAX ON L1S 1R9

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

JENNIFER BATTEN (672)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): December 6, 9, 10, 11, 13 and 16, 2019

The following intakes were inspected during this complaint inspection:

Log #018323-19, related to an anonymous complaint regarding resident #008's falls

PLEASE NOTE: A Voluntary Plan of Compliance related to LTCHA, 2007, r. 8. (1) (b), a Voluntary Plan of Compliance related to LTCHA, 2007, r. 53. (4) (b) and a Voluntary Plan of Compliance related to LTCHA, 2007, r. 229 (5) (b), identified in a concurrent Critical Incident System Inspection (inspection #2019_715672_0019, Log #016033-19, CIR #2658-000011-19 and Log #016412-19, CIR #2658-000012-19) were issued in this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), RAI-MDS Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), RN for Quality Control, Skin and Wound Care Champion, Physiotherapists (PT), Occupational Therapists (OT), Staffing Clerks, residents, family members, and visitors to the home.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Responsive Behaviours
Skin and Wound Care

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that care was provided to resident #008 as specified in the resident's plan of care.

An anonymous complaint was received by the Director, related to resident #008. The complaint indicated that resident #008 was frequently falling and staff were assisting the resident without assessing the resident and completing the required post fall assessments and documentation.

During review of resident #008's health care record, Inspector #672 reviewed the resident's written plan of care related to falls prevention and observed the resident was considered to be at risk for falling and had several interventions in place to prevent further falls.

Inspector #672 observed resident #008 several times during the inspection, and observed that on several identified dates and times, resident #008 did not have a specified number of falls prevention interventions in place, as per the written plan of care. Inspector #672 also observed resident #008's bedroom on several identified dates and times, and did not observe a specified number of interventions in place as indicated in the resident's written plan of care.

During separate interviews, PSWs #113, #116, #118, #122 and RPN #109 indicated resident #008 was known to not follow one of the specified falls prevention interventions. PSWs #113, #116, #118, #122 and RPN #109 further indicated resident #008 did not receive any increased monitoring in order for staff to assess if specified falls prevention interventions were in place, as per the written plan of care. PSWs #113, #116, #122 and RPN #109 indicated that resident #008 no longer utilized another of the specified falls prevention interventions, as the resident had not exhibited specified responsive behaviours "recently". PSWs #113, #116, #118, #122 and RPN #109 further indicated one of the specified falls prevention interventions were not present on resident #008's specified mobility aid as staff did not utilize the intervention, as staff found the intervention had not assisted the resident in an identified way. RPN #109 indicated a specified number of the falls prevention interventions should have been removed from resident #008's written plan of care.

During separate interviews, the RAI Coordinator and the DOC indicated the expectation in the home was for staff to provide care to the resident as indicated in the resident's plan of care. The RAI Coordinator further indicated if the direct care staff found that the interventions listed in the resident's plan of care were not effective for the resident, the staff were expected to report this to the registered staff, who were expected to revise the resident's plan of care.

During an interview, the Administrator indicated the expectation in the home was for staff to provide care to the resident as indicated in the resident's plan of care. The Administrator further indicated the expectation in the home was for each resident's plan of care to accurately reflect the resident's care needs, and if it did not, the direct care staff were expected to immediately come forward and report this to the registered staff, so that changes could be made to the plan of care. Once changes were made to a resident's plan of care, the registered staff were expected to share the changes with the direct care staff during shift report over the following several days, to ensure the relevant staff members were aware of the changes.

The licensee failed to ensure that care was provided to resident #008 as specified in the resident's plan of care related to specified falls prevention interventions. [s. 6. (7)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the internal "Resident Falls Prevention Program"

was complied with.

Inspector #672 reviewed the licensee's internal falls prevention policy, entitled "Resident Falls Prevention Program". The policy indicated specified interventions were expected to be in place for residents who were considered to be at high risk for falling.

Related to resident #008:

An anonymous complaint was received by the Director, related to resident #008. The complaint indicated that resident #008 was frequently falling and staff were assisting the resident without assessing the resident and completing the required post fall assessments and documentation.

During record review, Inspector #672 observed that resident #008 was at high risk for falls and had several interventions in place for falls prevention. During review of resident #008's progress notes from an identified period of time, Inspector #672 observed that resident #008 had sustained a specified number of falls during that time period.

Inspector #672 reviewed resident #008's written plan of care and observed the resident was identified to be at high risk for falling and had several interventions in place to assist in preventing falls. Review of resident #008's current MDS assessment showed that resident #008 had sustained previous falls during an identified time period.

Inspector #672 conducted several resident observations of resident #008's specified mobility aid and bedroom during an identified period of time and observed that resident #008 did not appear to have specified interventions in place, as per the internal "Resident Falls Prevention Program".

During an interview, RPN #109 indicated that the specified interventions had been implemented in the home "several months ago" but had not been implemented throughout the entire home. RPN #109 further indicated that registered staff were not used to implementing the specified interventions from the internal "Resident Falls Prevention Program" and believed it was the responsibility of the Quality Nurse RN (QN). RPN #109 observed resident #008's specified mobility aid and bedroom with Inspector #672 and indicated it did not appear the specified interventions had been implemented for resident #008.

To expand the scope of the inspection to determine if the specified interventions were

being implemented in the home for other residents who were at high risk for falls, Inspector #672 received the names of residents #005 and #007 from RPN #111 and PSW #118, who both indicated the residents were at high risk for falls.

Related to resident #005:

During review of resident #005's written plan of care, Inspector #672 observed that the resident was considered to be at high risk for falling and had several interventions in place to attempt to prevent falls from occurring. Inspector #672 then reviewed resident #005's Assessment section in PCC and reviewed the current Scott Fall Risk Screening tool, which indicated resident #005 was at high risk for falls.

On an identified date, Inspector #672 observed resident #005's specified mobility aid and bedroom, and did not observe the intervention from the "Resident Falls Prevention Program" implemented for the resident.

Related to resident #007:

During review of resident #007's written plan of care, Inspector #672 observed that the resident was considered to be at high risk for falling and had several interventions in place to attempt to prevent falls from occurring. Inspector #672 then reviewed resident #007's Assessment section in PCC and reviewed the current Scott Fall Risk Screening tool, which indicated resident #007 was at high risk for falls.

On an identified date, Inspector #672 observed resident #007's specified mobility aid and bedroom, and did not observe the intervention from the "Resident Falls Prevention Program" implemented for the resident.

During an interview, QN #106 indicated the licensee did utilize the fall prevention program in the home outlined in the "Resident Falls Prevention Program". QN #106 indicated the program had been implemented in the home within the year, but was unsure of the exact time period. QN #106 indicated they were aware that residents #005, #007 and #008 were at high risk for falling, were required to have the specified intervention implemented as per the instructions within the internal "Resident Falls Prevention Program" policy and would look into ensuring the residents received the specified intervention, as required.

During further resident observations on an identified date after the interview with QN

#106, Inspector #672 observed that residents #005, #007 and #008 did not have the specified intervention implemented, as per the directions in the “Resident Falls Prevention Program”.

During separate interviews, PSWs #113, #114, #116 and #118, RPNs #109, #110, #111 and #119 all indicated that residents #005, #007 and #008 were each at high risk for falling and should have the specified intervention implemented. RPNs #109, #110 and #111 further indicated they believed it was the responsibility of QN #106 to implement the specified intervention for residents who were considered to be at high risk for falling. RPN #119 indicated they believed the front line registered staff could also implement the specified intervention for residents who were considered to be at high risk for falling, along with QN #106.

During an interview, the DOC indicated the expectation in the home was for all staff to follow every internal policy and procedure, including the Falls Prevention policy. The DOC further indicated every resident in the home who were deemed to be at high risk for falling were expected to have the specified interventions from the “Resident Falls Prevention Program” implemented.

The licensee failed to ensure that the internal falls prevention policy, entitled “Resident Falls Prevention Program” was complied with, when residents assessed to be at high risk for falling did not have the specified interventions from the policy implemented. [s. 8. (1) (a),s. 8. (1) (b)]

2. NOTE: The following finding was identified during a concurrent Critical Incident System inspection in the home (Inspection#2019_715672_0019) and issued in this report.

The licensee failed to ensure that the internal policy entitled “Head Injury Routine” was complied with.

Inspector #672 reviewed the internal policy entitled “Head Injury Routine”, which stated any resident who may have sustained an injury to their head, with or without an observable injury, would have a head injury routine initiated. Once initiated, the head injury routine would continue for 48 hours unless it was ordered discontinued by the physician/nurse practitioner. The internal policy directed that after the initial neurovitals were obtained, head injury routine was to be performed every 30 minutes for two hours, every hour for the next four hours, then every four hours until 24 hours post fall had been

reached and then every eight hours until 48 hours post fall had been reached. Head injury routine involved assessing the resident's blood pressure, pulse, respirations, pupillary reactions, level of alertness and orientation as compared to the resident's normal level of alertness and orientation, and ability to move upper and lower limbs.

A Critical Incident Report was submitted to the Director related to an alleged incident of resident to resident abuse between residents #001 and #002. According to the CIR, resident #001 entered resident #002's bedroom and began to exhibit specified responsive behaviours and staff responded to the residents. Staff were able to redirect resident #001 from resident #002's bedroom and calm the resident down. As a result of the incident, resident #002 sustained identified injuries which required further assessment.

Inspector #672 reviewed resident #002's "Head Injury Flow Sheet" document which outlined the head injury routine documentation completed following the incident with resident #001. The instructions listed at the top of the assessment directed staff to complete the physical assessment of the resident every 30 minutes for two hours, every hour for four hours, every four hours until 24 hours post incident, then every eight hours until 48 hours post incident. Inspector #672 observed that the head injury assessment had not been completed for resident #002 as directed on the "Head Injury Flow Sheet" as follows:

- On an identified date and time, the blood pressure, pulse, respirations, pupil reaction and limb movement had not been assessed, as the resident was documented to be sleeping.

- On an identified date and two specified times, the entire assessment had not been completed, as the resident was documented to be at breakfast.

- On an identified date and two specified times, the entire assessment had not been completed, as the resident was documented to be at lunch.

- On an identified date and time, the entire assessment had not been completed, as it was left blank.

- On two identified dates and times, the entire assessment had not been completed, as per the directions for the assessment to be completed every eight hours until 48 hours post fall.

Related to Resident #001:

Review of resident #001's progress notes indicated resident #001 sustained an unwitnessed fall on an identified date and was placed on head injury routine.

Inspector #672 reviewed the "Head Injury Flow Sheet" document which outlined the head injury routine assessment completed following resident #001's fall. Inspector #672 observed that the head injury routine assessment had not been completed in full, as follows:

- On an identified date and time, the entire assessment had not been completed, as per the directions for the assessment to be completed every hour for four hours after the assessments which were to be completed every 30 minutes.

- On an identified date and two specified times, the entire assessment had not been completed, as the resident was documented to be sleeping.

- On an identified date and two specified times, the entire assessment had not been completed, as per the directions for the assessment to be completed every eight hours until 48 hours post fall.

- On an identified date and time, the entire assessment had not been completed, as it was left blank.

To expand the scope of the inspection to determine if "Head Injury Flow Sheet" documents were being completed in full for other residents in the home, Inspector #672 observed resident #004's health care record while conducting an inspection for another intake and observed the resident had recently been placed on head injury routine. Inspector #672 was also given the name of resident #007 from RPN #110, who indicated resident #007 had recently been assessed as per the head injury routine guidelines.

Related to resident #007:

During record review, Inspector #672 observed that resident #007 was at high risk for falls and had several interventions in place for falls prevention. During review of resident #007's progress notes from an identified time period, Inspector #672 observed that resident #007 had sustained a specified number of falls during that time which had

resulted in the resident being placed on head injury assessment.

Inspector #672 reviewed the “Head Injury Flow Sheet” documents which outlined the head injury routine assessments completed following each of the falls resident #007 sustained during an identified period of time. Inspector #672 observed that all of the head injury routine assessments had not been completed in full, as follows:

- On an identified date and two specified times, the entire assessment had not been completed, as it was left blank. At another identified time, the Coma Scale assessment had not been completed as it was documented the resident was sleeping, and at a later time, the blood pressure, pulse, respirations, pupil response and limb movement were not assessed, as each of the areas were left blank.

- On an identified date and two specified times, the entire assessment had not been completed, as it was left blank. At three identified times, the entire assessment had not been completed, as per the directions for the assessment to be completed every hour for four hours after the assessments which were to be completed every 30 minutes.

- On an identified date and two specified times, the entire assessment had not been completed, as per the directions for the assessment to be completed every eight hours until 48 hours post fall.

- On an identified date and two specified times, the entire assessment had not been completed, as the resident was documented to be sleeping. At another identified time, the entire assessment had not been completed, as it was left blank.

- On an identified date and time, the entire assessment had not been completed, as it was left blank.

- On an identified date and three specified times, the entire assessment had not been completed, as it was left blank.

- On an identified date and time, the entire assessment had not been completed, as the resident was documented to be sleeping.

- On an identified date and two specified times, the entire assessment had not been completed, as it was left blank.

- On an identified date and time, the Coma Scale assessment had not been completed as it was left blank.

- On an identified date and time, resident #007 sustained another fall, where head injury assessment was required. At two identified times, the entire assessment had not been completed, as the resident was documented to be sleeping. At another identified time, the entire assessment had not been completed, as it was left blank.

- On an identified date and time, the entire assessment had not been completed, as the resident was documented to be sleeping.

- On an identified date and time, the entire assessment had not been completed, as the resident was documented to be sleeping. At an identified time, the entire assessment had not been completed, as per the directions for the assessment to be completed every hour for four hours after the assessments which were to be completed every 30 minutes. At another identified time, the entire assessment had not been completed, as per the directions for the assessment to be completed every eight hours until 48 hours post fall.

Related to resident #008:

An anonymous complaint was received by the Director, related to resident #008. The complaint indicated that resident #008 was frequently falling and staff were assisting the resident without assessing the resident and completing the required post fall assessments and documentation.

During record review, Inspector #672 observed that resident #008 was at high risk for falls and had several interventions in place for falls prevention. During review of resident #008's progress notes from an identified period of time, Inspector #672 observed that resident #008 had sustained a specified number of falls during that time, some of which had resulted in the resident being placed on head injury assessment.

Inspector #672 reviewed the "Head Injury Flow Sheet" documents which outlined the head injury routine assessments completed for resident #008 during the specified period of time. Inspector #672 observed that each of the head injury routine assessments had not been completed in full, as follows:

- On an identified date and two specified times, the entire assessment had not been completed, as it was left blank. At an identified time, the entire assessment had not been

completed, as per the directions for the assessment to be completed every 30 minutes for two hours. At two identified times, the entire assessment had not been completed, as per the directions for the assessment to be completed every hour for four hours. On an identified date and time, the entire assessment had not been completed, as it was left blank, and at an identified time, the assessment had not been completed as it was documented the resident was sleeping.

- On an identified date and time, the blood pressure and pulse assessments had not been completed. At an identified time, the entire assessment had not been completed, as it was left blank. At two identified times, the entire assessment had not been completed, as per the directions for the assessment to be completed every hour for four hours. On an identified date and two specified times, the entire assessment had not been completed, as it was left blank. On an identified date and time, the entire assessment had not been completed, as it was left blank.

- On an identified date and time, the entire assessment had not been completed as per the directions for the assessment to be completed every hour for four hours. On an identified date and three specified times, the entire assessment had not been completed as per the directions for the assessment to be completed every hour for four hours.

- On an identified date and four specified times, the entire assessment had not been completed, as it was left blank. On an identified date and time, the entire assessment had not been completed as it was left blank. At an identified time, the entire assessment had not been completed as per the directions for the assessment to be completed every four hours until 24 hours post fall. At an identified time, the entire assessment had not been completed as per the directions for the assessment to be completed every eight hours until 48 hours post fall.

- On an identified date and time, the entire assessment had not been completed as per the directions for the assessment to be completed every hour for four hours. On an identified date and two specified times, the entire assessment had not been completed as per the directions for the assessment to be completed every four hours until 24 hours post fall. On an identified date and time, the entire assessment had not been completed as it was left blank.

- On an identified date and time, the blood pressure and pulse assessments had not been completed. At two identified times, the entire assessment had not been completed, as per the directions for the assessment to be completed every hour for four hours. On

an identified date and time, the entire assessment had not been completed, as it was left blank. On an identified date and three specified times, the entire assessment had not been completed as per the directions for the assessment to be completed every eight hours until 48 hours post fall.

- On an identified date and time, the Coma Scale assessment had not been completed as it was left blank. At an identified time, the entire assessment had not been completed, as per the directions for the assessment to be completed every 30 minutes for two hours.

- On an identified date and time, the entire assessment had not been completed, as per the directions for the assessment to be completed every 30 minutes for two hours. At two identified times, the entire assessment had not been completed as per the directions for the assessment to be completed every hour for four hours. At two identified times, the entire assessment had not been completed as per the directions for the assessment to be completed every four hours until 24 hours post fall. On an identified date and three specified times, the entire assessment had not been completed as per the directions for the assessment to be completed every four hours until 24 hours post fall. At an identified time, the entire assessment had not been completed as per the directions for the assessment to be completed every eight hours until 48 hours post fall. On an identified date and two specified times, the entire assessment had not been completed as per the directions for the assessment to be completed every eight hours until 48 hours post fall.

- On an identified date and time, the entire assessment had not been completed as it was documented the resident was in the dining room. At two identified times, the Coma Scale assessment had not been completed as it was left blank. On an identified date time, the entire assessment had not been completed as per the directions for the assessment to be completed every four hours until 24 hours post fall. At an identified time, the entire assessment had not been completed, as it was left blank.

- On an identified date and two specified times, the entire assessment had not been completed as per the directions for the assessment to be completed every hour for four hours. At two identified times, the entire assessment had not been completed as per the directions for the assessment to be completed every four hours until 24 hours post fall. On an identified date and two specified times, the entire assessment had not been completed as per the directions for the assessment to be completed every four hours until 24 hours post fall. At an identified time, the entire assessment had not been completed as it was documented the resident was sleeping.

- On an identified date and time, the blood pressure, pulse, respirations, pupil and limb movement assessments had not been completed. On an identified date and time, the entire assessment had not been completed as it was documented the resident was sleeping.

- On an identified date and time, the entire assessment had not been completed as per the directions for the assessment to be completed every hour for four hours. On an identified date and time, the entire assessment had not been completed as per the directions for the assessment to be completed every four hours until 24 hours post fall. At an identified time, the entire assessment had not been completed as per the directions for the assessment to be completed every eight hours until 48 hours post fall. On an identified date and time, the entire assessment had not been completed as it was documented the resident was sleeping.

- On an identified date and three specified times, the entire assessment had not been completed, as it was left blank. At an identified time, the entire assessment had not been completed as per the directions for the assessment to be completed every hour for four hours. On an identified date and time, the entire assessment had not been completed as it was documented the resident was resting. At an identified time, the entire assessment had not been completed as per the directions for the assessment to be completed every eight hours until 48 hours post fall.

Related to Resident #004:

During review of resident #004's health care record, Inspector #672 observed the resident was considered to be at high risk for falling and had several interventions in place in an attempt to prevent falls from occurring. On a specified date, resident #004 sustained an unwitnessed fall and was placed on head injury routine assessment. Inspector #672 reviewed the "Head Injury Flow Sheet" completed for the resident, and observed the head injury routine assessment had not been completed in full, as follows:

- On an identified date and three specified times, the entire assessment had not been completed, as it was left blank. At two identified times, the assessment had not been completed as it was documented the resident was sleeping. At two identified times, the assessment had not been completed as it was documented the resident was in the dining room. On an identified date and time, the entire assessment had not been completed as per the directions for the assessment to be completed every four hours

until 24 hours post fall. On an identified date and three specified times, the entire assessment had not been completed as per the directions for the assessment to be completed every eight hours until 48 hours post fall.

During separate interviews, RPNs #109, #110, #111 and #119 indicated the expectation in the home was for registered staff to complete the head injury routine assessments as per the directions listed on the “Head Injury Flow Sheet”.

During an interview, RPN #112 indicated it was an acceptable practice in the home for registered staff members to not complete all of the resident assessments directed on the head injury routine document, if the nurse felt the resident was not acting any different than their usual patterns. RPN #112 further indicated it was an acceptable practice for registered staff to document on the “Head Injury Flow Sheet” information such as ‘resident sleeping’ or ‘in dining room’ to explain why the assessments had not been completed as directed. RPN #112 indicated they had been completing head injury routine assessments the same way in the home “for years”, and further indicated “most nurses” in the home had the same practice.

During an interview, the RN Quality Nurse indicated the expectation in the home was for the registered staff to assess the resident according to the directions listed on the “Head Injury Flow Sheet” document and should not miss assessing a resident due to meals or the resident sleeping.

During an interview, the DOC indicated the expectation in the home was for staff to assess and complete head injury routine assessments according to the directions listed on the head injury routine document. The DOC further indicated being aware that some of the registered staff members were not completing the “Head Injury Flow Sheet” and assessing the residents as directed on the head injury routine document and were documenting reasons such as “sleeping” or “in dining room” for not completing the resident assessments. The DOC indicated they felt this was acceptable, if the registered staff member had previously assessed the resident’s condition and believed they were within the resident’s normal parameters, and discussed this with the physician or nurse practitioner, and received permission to skip assessments as per the directions on the “Head Injury Flow Sheet”.

The licensee failed to ensure that the internal policy entitled “Head Injury Routine” was complied with, when head injury routine assessments were not completed according to the policy for residents #001, #002, #004, #007 and #008. [s. 8. (1) (a),s. 8. (1) (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 the internal falls prevention policy, entitled "Resident Falls Prevention Program" and the "Head Injury Routine" policy are complied with, to be implemented voluntarily.

WN #3: 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 residents #004, #008, #009 and #010 were assessed weekly from a member of the registered nursing staff when each resident exhibited areas of altered skin integrity, specific to skin tears.

Inspector #672 reviewed the internal policy entitled "Wound Care Treatment" which indicated residents with skin tears would have the wounds categorized according to the International Skin Tear Advisory Panel and an appropriate assessment in Point Click

Care would be initiated. The record was to be completed weekly by Registered Staff and was used to document specific information regarding areas of skin alteration as well as the treatment and healing of the affected areas.

An anonymous complaint was received by the Director, related to resident #008. The complaint indicated that resident #008 was frequently falling and staff were assisting the resident without assessing the resident and completing the required post fall assessments and documentation.

During review of resident #008's progress notes from an identified period of time, Inspector #672 observed that resident #008 had sustained a specified number of falls during that time period. As a result of one of the falls, Inspector #672 observed resident #008 acquired identified injuries to specified body parts.

Review of resident #008's physician's orders and electronic Treatment Administration Records (eTARs) from a specified time period indicated the identified injuries to specified body parts were monitored by the registered nursing staff until the area healed.

Inspector #672 then reviewed the assessments section in Point Click Care (PCC) from resident #008's electronic health care record. Inspector #672 observed an "Initial Skin and Wound" assessment had been completed upon the initial injuries. There was no documentation to indicate the resident was assessed weekly during a specified period of time.

Inspector #672 then reviewed resident #008's progress notes from an identified time period, which indicated on three separate dates. resident #008 sustained four identified injuries.

Review of resident #008's eTARs did not indicate one of the injuries to resident #008's identified body part was receiving any treatment, nor when the area healed. Inspector #672 reviewed the assessments section in PCC from resident #008's electronic health care record. Inspector #672 observed an "Initial Skin and Wound" assessment had been completed on a specified date. There was no documentation to indicate the resident was assessed weekly during a specified period of time.

Review of resident #008's eTARs indicated the two injuries to resident #008's identified body parts began receiving treatment on a specified date, and healed on a later specified date. Inspector #672 reviewed the assessments section in PCC from resident #008's

electronic health care record. Inspector #672 observed an "Initial Skin and Wound" assessment had been completed upon the initial injuries but there was no documentation to indicate the resident was assessed weekly during a specified period of time.

Review of resident #008's eTARs indicated the identified injury was acquired to resident #008's specified body part and began receiving treatment on an identified date and healed on a later identified date. Review of the assessments section in PCC from resident #008's electronic health care record indicated an "Initial Skin and Wound" assessment had been completed upon the initial injury but there was no documentation to indicate the resident was assessed weekly during a specified period of time.

To expand the scope of the inspection related to residents being assessed weekly by a member of the registered nursing staff when residents exhibited areas of altered skin integrity, Inspector #672 noted while reviewing resident #004's health care record for another inspection intake that resident #004 experienced frequent areas of altered skin integrity. Inspector #672 also received the name of resident #009 from RPN #110 and the name of resident #010 from RPN #120. Both RPNs indicated each resident had recently presented with areas of altered skin integrity.

Related to resident #004:

During review of resident #004's health care record, Inspector #672 observed the resident sustained multiple areas of altered skin integrity as a result of attempts to self transfer and several falls. Inspector #672 reviewed resident #004's progress notes, completed skin assessments, and eTARs during an identified period of time.

Review of the assessments section in PCC from resident #004's electronic health care record indicated an "Initial Skin and Wound" assessment had been completed on an identified date regarding a specified area of altered skin integrity. The assessment stated nursing measures were initiated.

Inspector #672 reviewed resident #004's eTAR from an identified month, which indicated the following:

- Resident #004 had an identified area of altered skin integrity present, which had been ongoing prior to the beginning of the identified month. The area had a specified treatment order in place to be completed until it healed. The eTARs indicated the area healed on an identified date.

Inspector #672 reviewed resident #004's progress notes and skin assessments. There was no documentation to indicate the resident was assessed weekly during a specified period of time, related to the identified area of altered skin integrity.

Further review of the assessments section in PCC from resident #004's electronic health care record indicated an "Initial Skin and Wound" assessment had been completed on another identified date, regarding another area of altered skin integrity.

Inspector #672 reviewed resident #004's eTAR from a specified month, which indicated the following:

- There was no documentation to indicate a treatment was initiated for the area during the specified month the area was first observed.

Inspector #672 reviewed resident #004's eTAR from the following specified month, which indicated the following:

- On an identified date, the area of altered skin integrity had a specified treatment order in place to be completed until it healed. The eTARs indicated the area healed on an identified date. Inspector #672 reviewed resident #004's progress notes and skin assessments. Following the "Initial Skin and Wound" assessment completed on an identified date, there was no documentation to indicate the resident was assessed during a specified period of time.

- On an identified date, there was an area of altered skin integrity documented to resident #004's identified body part. The area had a specified treatment order in place to be completed until it healed. The eTARs indicated the area healed on an identified date. Inspector #672 reviewed resident #004's progress notes and skin assessments. There was no documentation to indicate the resident was assessed weekly during a specified period of time.

Review of the assessments section in PCC from resident #004's electronic health care record indicated an "Initial Skin and Wound" assessment had been completed on an identified date regarding two other areas of altered skin integrity documented to resident #004's identified body parts.

Inspector #672 reviewed resident #004's eTAR from an identified month, which indicated

the following:

- On an identified date, the area of altered skin integrity had a specified treatment order in place to be completed until it healed. The eTARs indicated the area healed on an identified date. Inspector #672 reviewed resident #004's progress notes and skin assessments. There was no documentation to indicate the resident was assessed weekly during a specified period of time.

Review of the assessments section in PCC from resident #004's electronic health care record indicated an "Initial Skin and Wound" assessment had been completed on an identified date regarding another area of altered skin integrity.

Inspector #672 reviewed resident #004's eTAR an identified month, which indicated the following:

- On an identified date, the area of altered skin integrity had a specified treatment order in place to be completed until it healed. The eTARs indicated the area healed on an identified date. Inspector #672 reviewed resident #004's progress notes and skin assessments. There was no documentation to indicate the resident was assessed weekly during a specified period of time.

Review of the assessments section in PCC from resident #004's electronic health care record indicated an "Initial Skin and Wound" assessment had been completed on an identified date regarding an area of altered skin integrity. There was a specified treatment order for the area in place.

Inspector #672 reviewed resident #004's eTAR from an identified month, which indicated the following:

- On an identified date, the area of altered skin integrity had a specified treatment order in place to be completed until it healed. The eTARs indicated the area healed on an identified date. Inspector #672 reviewed resident #004's progress notes and skin assessments. There was no documentation to indicate the resident was assessed during a specified period of time.

Related to resident #009:

During review of resident #009's health care record, Inspector #672 observed the

resident had several ongoing areas of altered skin integrity and had also sustained multiple injuries to the skin, including skin tears. Review of the assessments section in PCC from resident #009's electronic health care record indicated an "Initial Skin and Wound" assessment had been completed on an identified date which indicated resident #009 had an identified number of areas of altered skin integrity.

The eTAR indicated one of the areas of altered skin integrity healed on an identified date, but all of the other areas were ongoing. Inspector #672 reviewed resident #009's progress notes and skin assessments. Related to the area of altered skin integrity which had healed, there was no documentation to indicate the resident was assessed weekly during a specified period of time.

Review of the assessments section in PCC from resident #009's electronic health care record indicated an "Initial Skin and Wound" assessment had been completed on an identified date regarding another area of altered skin integrity.

Inspector #672 reviewed resident #009's eTAR from a specified month, which indicated the following:

- On an identified date, the area of altered skin integrity had a specified treatment order in place to be completed until it healed. The eTARs indicated the area had not healed by an identified date. Inspector #672 reviewed resident #009's progress notes and skin assessments. There was no documentation to indicate the resident was assessed weekly during a specified period of time.

Review of the assessments section in PCC from resident #009's electronic health care record indicated an "Initial Skin and Wound" assessment had been completed on an identified date, regarding a different area of altered skin integrity.

Inspector #672 reviewed resident #009's eTAR from a specified month, which indicated the following:

- On an identified date, the area of altered skin integrity had a specified treatment order in place to be completed until it healed. The eTARs indicated the area had not healed by an identified date. Inspector #672 reviewed resident #009's progress notes and skin assessments. There was no documentation to indicate the resident was assessed weekly during a specified period of time.

Review of the assessments section in PCC from resident #009's electronic health care record indicated an "Initial Skin and Wound" assessment had been completed on an identified date, regarding an identified number of new areas of altered skin integrity.

Inspector #672 reviewed resident #009's eTARs from a specified period of time, which indicated the following:

- There was no documentation to indicate a treatment was initiated for the areas in the month the areas were first observed.

- There was one entry into the following month's eTAR, which could have been related to the above areas of altered skin integrity, with instructions and a specified treatment order in place. Review of the identified month's eTAR indicated the areas had not healed as of an identified date and the specified treatment was being completed on a daily basis during the identified month. There was no documentation to indicate the resident was assessed weekly during a specified period of time.

Review of the assessments section in PCC from resident #009's electronic health care record indicated an "Initial Skin and Wound" assessment had been completed on an identified date, regarding a new area of altered skin integrity.

Inspector #672 reviewed resident #009's eTAR from a specified month, which indicated the following:

- On an identified date, the area of altered skin integrity had a specified treatment order in place to be completed until it healed. The eTARs indicated the area had not healed by an identified date. Inspector #672 reviewed resident #009's progress notes and skin assessments. There was no documentation to indicate the resident was assessed weekly during a specified period of time.

Related to resident #010:

During review of resident #010's health care record, Inspector #672 observed the resident had multiple areas of altered skin integrity, including skin tears.

Review of the assessments section in PCC from resident #010's electronic health care record indicated an "Initial Skin and Wound" assessment had been completed on an identified date, regarding an area of altered skin integrity.

Inspector #672 reviewed resident #010's eTAR from a specified month, which indicated the following:

- On an identified date, the area of altered skin integrity had a specified treatment order in place to be completed until it healed. The eTARs indicated the area had not healed by an identified date. Inspector #672 reviewed resident #010's progress notes and skin assessments. There was no documentation to indicate the resident was assessed weekly during a specified period of time.

Review of the assessments section in PCC from resident #010's electronic health care record indicated an "Initial Skin and Wound" assessment had been completed on an identified date, regarding another area of altered skin integrity.

Inspector #672 reviewed resident #010's eTAR from a specified month, which indicated the following:

- On an identified date, the area of altered skin integrity had a specified treatment order in place to be completed until it healed. The eTARs indicated the area had not healed by an identified date. Inspector #672 reviewed resident #010's progress notes and skin assessments. There was no documentation to indicate the resident was assessed weekly during a specified period of time.

Review of the assessments section in PCC from resident #010's electronic health care record indicated an "Initial Skin and Wound" assessment had been completed on an identified date, regarding two more areas of altered skin integrity.

Inspector #672 reviewed resident #010's eTAR from a specified month, which indicated the following:

- On an identified date, the area of altered skin integrity had a specified treatment order in place to be completed until it healed. The eTARs indicated the area had not healed by an identified date. Inspector #672 reviewed resident #010's progress notes and skin assessments. There was no documentation to indicate the resident was assessed weekly during a specified period of time.

Review of the assessments section in PCC from resident #010's electronic health care record indicated an "Initial Skin and Wound" assessment had been completed on an

identified date, regarding another area of altered skin integrity. The assessment did not indicate where the area of altered skin integrity was located.

Inspector #672 reviewed resident #010's eTAR from a specified month, which indicated the following:

- On an identified date, the area of altered skin integrity had a specified treatment order in place to be completed until it healed. The eTARs indicated the area had not healed by an identified date. Inspector #672 reviewed resident #010's progress notes and skin assessments. There was no documentation to indicate the resident was assessed weekly during a specified period of time.

During separate interviews, RPNs #109, #110, #119 and #120 all indicated the expectation in the home was for residents to receive weekly assessments from a member of the registered nursing staff when the resident had an exhibited area of altered skin integrity, which included abrasions and/or skin tears. RPNs #109 and #110 further indicated they were unaware if residents #008, #009 or #010 had received weekly assessments from a member of the registered nursing staff, and RPNs #119 and #120 indicated they were unaware if resident #004 had received weekly assessments from a member of the registered nursing staff. RPN #110 indicated they believed it was the responsibility of the skin and wound care champion in the home to complete and document weekly assessments of residents who exhibited areas of altered skin integrity, which included abrasions and/or skin tears.

During an interview, RN #121, the skin and wound care champion in the home indicated the expectation in the home was for residents to receive weekly assessments from a member of the registered nursing staff when they had an exhibited area of altered skin integrity, which included abrasions and/or skin tears. RN #121 further indicated it was the responsibility of the direct care RPNs to complete and document the weekly assessments of residents who exhibited areas of altered skin integrity. RN #121 indicated the expected practice in the home was for the RPN working on the resident home area to immediately enter the treatment order for the observed area of altered skin integrity into the eTAR, along with entering an order for the assessment of the resident to be completed weekly until the area had healed. The RPN was also expected to enter a focus with goals and interventions into the resident's written plan of care related to the area of altered skin integrity and the treatment order(s). The RPN working when the weekly assessment was due was then responsible for completing the assessment and documentation related to the resident's area of altered skin integrity. The resident

assessment was expected to include measurements of the wound; a description of the exudate from the area if any were present; a description of the wound edges and any other defining characteristics of the area of altered skin integrity; an assessment of the resident's pain level; the interventions in place related to the area of altered skin integrity and an indication of whether the care plan was reviewed and/or updated. RN #121 further indicated they were unaware if there was anyone in the home responsible for reviewing the documentation specific to residents with areas of altered skin integrity in an effort to ensure the residents were being assessed weekly and was unsure if residents #004, #008, #009 and #010 had received weekly assessments and documentation of the assessments from a member of the registered nursing staff related to their skin tears.

During separate interviews, the RAI-MDS Coordinator and the Administrator indicated the expectation in the home was for residents to receive weekly assessments from a member of the registered nursing staff when a resident exhibited an area of altered skin integrity, which included abrasions and/or skin tears.

The licensee failed to ensure that residents #004, #008, #009 and #010 were assessed weekly by a member of the registered nursing staff when each resident exhibited areas of altered skin integrity. [s. 50. (2) (b) (iv)]

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 residents with exhibited areas of altered skin integrity are assessed weekly from a member of the registered nursing staff, to be implemented voluntarily.

WN #4: 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 :

1. Please Note: The following finding was identified during a concurrent Critical Incident System inspection in the home (Inspection#2019_715672_0019) and issued in this report.

The licensee has failed to ensure that strategies were implemented to respond to resident #001's demonstrated responsive behaviours.

A Critical Incident Report was submitted to the Director related to an alleged incident of resident to resident abuse between residents #001 and #003. According to the CIR, resident #001 was sitting in the hallway, when the resident suddenly walked over and grabbed resident #003, causing an identified injury. The CIR further indicated resident #001 was supposed to have an identified nursing intervention in place at the time of the incident, but the intervention had not been implemented.

A second Critical Incident Report was submitted to the Director related to an alleged incident of resident to resident abuse between residents #001 and #002. According to the CIR, resident #001 entered resident #002's bedroom and began to exhibit specified responsive behaviours and staff responded to the residents. Staff were able to redirect resident #001 from resident #002's bedroom and calm the resident down. As a result of the incident, resident #002 sustained identified injuries which required further assessment.

Inspector #672 reviewed resident #001's written plan of care in place from a specified period of time, which stated resident #001 was expected to have an identified nursing

intervention in place at all times while the resident was awake.

During review of resident #001's physician's orders from a specified period of time, Inspector #672 observed resident #001 had an order from an identified date which stated resident #001 was to have an identified nursing intervention in place three times daily due to specified exhibited responsive behaviours.

Inspector #672 reviewed resident #001's electronic Medication Administration Record (eMAR) and electronic Treatment Administration Record (eTAR) from a specified period of time. The eMAR listed the physician's order which indicated resident #001 was to have an identified nursing intervention in place three times per day. The eMAR indicated the registered staff were to sign off at 0800, 1600 and 2300 hours to indicate that resident #001 had the identified nursing intervention in place for that shift. The eMAR indicated resident #001 did not have the identified nursing intervention implemented during a specified period of time on ten different occasions.

During review of resident #001's progress notes from a identified period of time, Inspector #672 observed that resident #001 had several observed incidents of exhibited responsive behaviours during that time period. The progress notes further indicated that most of the exhibited responsive behaviours occurred at specified times for identified reasons and on an identified date the DOC was notified of concerns from identified staff regarding resident #001's exhibited responsive behaviours and the need for the identified nursing intervention to be in place at all times.

During record review, Inspector #672 reviewed an internal document related to resident #001's identified nursing intervention, which was provided by the DOC. The internal document indicated that during an identified period of time, the identified nursing intervention was implemented on a specified number of shifts.

During an interview, RPN #110 indicated that resident #001 exhibited specified responsive behaviours which required an identified nursing intervention for specified reasons. RPN #110 further indicated that most of the specified exhibited responsive behaviours occurred at specified times for identified reasons. RPN #110 indicated that resident #001 had the identified nursing intervention in place during two of the three shifts. Lastly, RPN #110 indicated they recalled several days when the identified nursing intervention was not implemented for a specified reason. When the intervention was not implemented, the staff working those shifts attempted to keep "a closer eye" on resident #001, but did not recall resident #001 being placed on any type of formal increased

observation in order to monitor the resident's exhibited responsive behaviours.

During an interview, the DOC indicated that resident #001 had an identified nursing intervention in place throughout a specified month, due to identified exhibited responsive behaviours. The DOC further indicated being aware that there were "several days" during the specified month when the identified nursing intervention for resident #001 was not implemented for a specified reason. The DOC further indicated being unaware if any type of increased observation was implemented in order to monitor the resident's exhibited responsive behaviours and indicated a belief that the identified nursing intervention was only implemented during two of the three shifts. The DOC indicated the expectation in the home was for physician's orders and the interventions listed in each resident's written plan of care to be implemented as per the instructions listed, at all times.

The licensee failed to ensure a strategy was in place when an identified nursing intervention was implemented to respond to resident #001's demonstrated responsive behaviours. [s. 53. (4) (b)]

2. The licensee failed to ensure that staff documented the effectiveness of the resident's interventions for residents #004, #006 and #008.

An anonymous complaint was received by the Director, related to resident #008. The complaint indicated that resident #008 was frequently falling and staff were assisting the resident without assessing the resident and completing the required post fall assessments and documentation.

During review of resident #008's progress notes from a specified period of time, Inspector #672 observed that as a falls prevention intervention, resident #008 was placed on an identified assessment.

Inspector #672 reviewed the identified assessment documentation forms from an identified period of time and observed the identified assessment was broken down into half an hour increments for staff to document. Inspector #672 observed resident #008's identified assessment documentation forms during an identified period of time and observed the forms had not been completed in full on an identified number of different times.

To expand the scope of the inspection to determine if the identified assessment

documentation forms were being completed in full for other residents in the home, Inspector #672 observed resident #004's health care record while conducting an inspection for another intake and observed resident #004 had recently been placed on an identified assessment. Inspector #672 also received the name of resident #006 from RPN #111, who indicated the resident had also recently been placed on an identified assessment.

Related to Resident #004:

During review of resident #004's progress notes and written plan of care from an identified period of time, Inspector #672 observed that resident #004 had been placed on an identified assessment several times for identified reasons. Inspector #672 observed the identified assessment was broken down into half an hour increments for staff to document. Inspector #672 observed resident #008's identified assessment documentation forms during an identified period of time and observed the forms had not been completed in full on an identified number of different times.

Related to resident #006:

Inspector #672 reviewed resident #006's written plan of care, which indicated resident #006 had several exhibited responsive behaviours, with interventions in place. Review of resident #006's progress notes from an identified period of time indicated that resident #006 had been receiving ongoing identified assessment. Inspector #672 then reviewed resident #006's entire health care record and observed resident #006 had received identified assessment during several identified periods of time. Inspector #672 observed the identified assessment was broken down into half an hour increments for staff to document. Inspector #672 observed resident #008's identified assessment documentation forms during an identified period of time and observed the forms had not been completed in full on an identified number of different times.

During separate interviews, PSWs #113, #114, #115, #116, #117 and #118 all indicated the expectation in the home was for the PSW staff to complete the identified assessment and documentation of the resident's actions and exhibited responsive behaviours every half an hour, as per the directions listed on the assessment. The PSW staff were then to provide the assessment forms to the registered staff at the end of each shift for review and possible discussion if the resident had exhibited unexpected responsive behaviours during that shift.

During separate interviews, RPNs #109, #110, #111 #112 and #119 and the RN Quality Nurse indicated the expectation in the home was for the PSW staff to complete the assessment of the resident's actions and exhibited responsive behaviours every half an hour, as per the directions listed on the assessment. The registered staff were then expected to review each assessment form at the end of the shift to ensure it had been completed in full, discuss any unexpected findings with the PSW staff and then document in the progress notes regarding the resident's exhibited behaviours for that shift.

During an interview, the DOC indicated residents were periodically placed on an identified assessment within the home for differing reasons, such as assessing the effectiveness of medication regimes or interventions listed in the resident's written plan of care. The DOC further indicated that when a resident was placed on an identified assessment, the expectation in the home was for the PSW staff to complete the assessment of the resident's actions and exhibited responsive behaviours every half an hour, as per the directions listed on the assessment form. The registered staff were then expected to review each assessment form at the end of each shift to ensure the document had been completed in full, discuss any unexpected findings with the PSW staff and then document in the resident's progress notes regarding the resident's exhibited behaviours for that shift. The DOC reviewed the assessment forms for residents #004, #006 and #008 and indicated the staff had not completed the documentation according to the expectations in the home, as the instructions on the assessment forms had not been followed.

The licensee failed to ensure that staff documented the effectiveness of the resident's interventions, when identified assessment forms for residents #004, #006 and #008 were not completed in full. [s. 53. (4) (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 strategies are implemented to respond to responsive behaviours including assessment, reassessment, and interventions and resident's responses to interventions are documented, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Please Note: The following finding was identified during a concurrent Critical Incident System inspection in the home (Inspection#2019_715672_0019) and issued in this report.

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

A Critical Incident Report was submitted to the Director related to an alleged incident of resident to resident abuse between residents #001 and #002. According to the CIR, resident #001 entered resident #002's bedroom and began to exhibit specified responsive behaviours and staff responded to the residents. Staff were able to redirect resident #001 from resident #002's bedroom and calm the resident down. As a result of the incident, resident #002 sustained identified injuries which required further assessment.

During review of resident #001's health care record, Inspector #672 observed resident #001 had been involved in several other alleged incidents of resident to resident abuse, and had been exhibiting identified responsive behaviours. Due to resident #001 exhibiting identified responsive behaviours, the physician ordered a specified test to assess for an indicated type of infection. On an identified date, resident #001 began to receive treatment for an identified infection.

Review of resident #001's physician's orders indicated the resident received an order for an identified medication on a specified date.

Inspector #672 reviewed resident #001's progress notes from an identified period of time, and observed there was no documentation on an identified number of shifts regarding

the resident's infection symptoms or vital signs.

During separate interviews, RPNs #109, #110, #111, #112, #119 and #120 all indicated the expectation in the home was for registered staff to document on the resident once per shift while the resident was receiving a medication. The documentation was to include an acknowledgement that the resident was receiving a medication, what symptoms the resident was exhibiting, how the resident presented during that shift, and any vital signs which may have been obtained.

During review of resident #002's progress notes related to the alleged incident between residents #001 and #002, Inspector #672 observed resident #002 had also received a medication on an identified date.

Related to resident #002:

During review of resident #002's progress notes from an identified period of time, Inspector #672 observed the resident had received an identified medication twice during that time frame. On an identified date, resident #002 was observed to have an identified infection which they received an identified medication for.

Review of resident #002's physician's orders indicated the resident received two orders for an identified medication on a specified date.

Inspector #672 reviewed resident #002's progress notes from an identified period of time, and observed there was no documentation on an identified number of shifts regarding the resident's infection symptoms or vital signs.

During further review of resident #002's progress notes, Inspector #672 observed resident #002 began to complain of identified symptoms of an infection on an identified date. Identified tests were completed which indicated the resident did have an identified infection, therefore specified medications were initiated.

Review of resident #002's physician's orders indicated the resident received an order for an identified medication on a specified date.

Inspector #672 reviewed resident #002's progress notes from an identified period of time, and observed there was no documentation on an identified number of shifts regarding the resident's infection symptoms or vital signs.

Related to resident #003:

A Critical Incident Report was submitted to the Director related to an alleged incident of resident to resident abuse between residents #001 and #003 that resulted in injury. The CIR further indicated resident #001 was supposed to have an identified nursing intervention in place at the time of the incident, but the intervention had not been implemented.

During review of resident #003's progress notes related to the alleged incident between residents #001 and #003, Inspector #672 observed resident #003 received an identified medication related to the identified injury obtained during the incident, as it had become infected.

Review of resident #003's physician's orders indicated the resident received an order for an identified medication on a specified date.

Inspector #672 reviewed resident #003's progress notes from an identified period of time, and observed there was no documentation on an identified number of shifts regarding the resident's infection symptoms or vital signs.

Related to resident #009:

Inspector #672 reviewed resident #009's progress notes from an identified period of time, and observed the resident received an identified medication.

Review of resident #009's electronic health care record indicated that on an identified date, resident #009 was observed to have a specified infection and had an identified medication initiated.

Review of resident #009's physician's orders indicated the resident received an order for an identified medication on a specified date.

Inspector #672 reviewed resident #009's progress notes from an identified period of time, and observed there was no documentation on an identified number of shifts regarding the resident's infection symptoms or vital signs.

Inspector #672 expanded the scope of the inspection to include two more residents from

the complaint inspection who had recently received an identified type of medication within the home, to assess if staff had recorded symptoms of infection in the residents, as required. Inspector #672 was informed by registered staff that residents #005 and #007 had recently received an identified medication.

Related to resident #005:

Inspector #672 reviewed resident #005's progress notes from an identified period of time, and observed the resident received an identified medication.

Review of resident #005's electronic health care record indicated that on an identified date, resident #005 was observed to have a specified infection and had an identified medication initiated.

Review of resident #005's physician's orders indicated the resident received an order for an identified medication on a specified date.

Inspector #672 reviewed resident #005's progress notes from an identified period of time, and observed there was no documentation on an identified number of shifts regarding the resident's infection symptoms or vital signs.

Related to resident #007:

Inspector #672 reviewed resident #007's progress notes from an identified period of time, and observed the resident received an identified medication.

Review of resident #007's electronic health care record indicated that on an identified date, resident #007 was observed to have a specified infection and had an identified medication initiated.

Review of resident #007's physician's orders indicated the resident received an order for an identified medication on a specified date.

Inspector #672 reviewed resident #007's progress notes from an identified period of time, and observed there was no documentation on an identified number of shifts regarding the resident's infection symptoms or vital signs.

During separate interviews, the RAI-MDS Coordinator, the RN for Quality and the DOC

indicated the expectation in the home was for registered staff to document on the resident once per shift while the resident was receiving an identified type of medication. The documentation was to include an acknowledgement that the resident was on an identified medication, what symptoms the resident was exhibiting, how the resident presented during that shift, and any vital signs which may have been obtained. The DOC further indicated this expectation included when a resident received an identified topical medication therapy.

The licensee failed to ensure that staff on every shift recorded symptoms of infection in residents #001, #002, #003, #005, #007 and #009 as required, when each resident received an identified medication. [s. 229. (5) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that on every shift symptoms of infection are recorded, to be implemented voluntarily.

Issued on this 16th day of January, 2020

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

Original report signed by the inspector.