Ontario

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

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

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

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


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

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

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| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Nov 13, 2018 | 2018_524500_0013 | 018458-18 | Resident Quality Inspection |

## Licensee/Titulaire de permis

The Jewish Home for the Aged
3560 Bathurst Street TORONTO ON M6A 2E1

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

The Jewish Home for the Aged
3560 Bathurst Street NORTH YORK ON M6A 2E1

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

NITAL SHETH (500), BABITHA SHANMUGANANDAPALA (673), GORDANA KRSTEVSKA (600)

## Inspection Summary/Résumé de l'inspection

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

**This inspection was conducted on the following date(s): July 25, 26, 30, 31, August 1, 2, 3, 7, 9, 10, 13, 14, 15, 17, 20, 21, 23, off-site September 4, 2018.**

**The following intakes were completed concurrently in this Resident Quality Inspection (RQI):**
**Log # 008249-18, Critical Incident System (CIS) report #2824-000013-18, related to infection prevention and control (IPAC), Complaint Log# 007882-18, #018159-18, related to authorization for admission in the home, #018468-18 related to skin and wound care, and follow up Log #029536-17 related to communication system in the home.**

**During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant of the DOC, Admission, Health Record, and Privacy Persons, Director of IPAC Program, Food and Nutrition Services Manager, Environment Services Manager (ESS), unit managers, Pharmacist, Food Services Supervisor (FSS), registered nurses (RNs), registered practical nurses (RPNs), personal support workers (PSWs), dietary aide, President of the Residents' Council, and Family Council, residents, family members and Client Services Manager at the Toronto Central Local Health Integration Network (TC-LHIN).**

**During the course of the inspection the inspectors observed resident care areas, medication administration, meal service, and reviewed residents health care records, staffing schedules, and home's policies and procedures.**

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

**Admission and Discharge**
**Continence Care and Bowel Management**
**Dignity, Choice and Privacy**
**Dining Observation**
**Family Council**
**Hospitalization and Change in Condition**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Nutrition and Hydration**
**Personal Support Services**
**Residents' Council**
**Safe and Secure Home**
**Skin and Wound Care**

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

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

| REQUIREMENT/ EXIGENCE | TYPE OF ACTION/ GENRE DE MESURE | INSPECTION # / NO DE L'INSPECTION | INSPECTOR ID #/ NO DE L'INSPECTEUR |
|---|---|---|---|
| O.Reg 79/10 s. 17. (1) | CO #001 | 2017_420643_0021 | 500 |

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

**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal**

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

**s. 136. (2) The drug destruction and disposal policy must also provide for the following:**
**2. That any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs. O. Reg. 79/10, s. 136 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the home's drug destruction and disposal policy included that any controlled substance that is to be destroyed and disposed of is stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs.

During the completion of the mandatory medication inspection protocol as part of the Resident Quality Inspection (RQI), the inspector reviewed three medication incidents.

A review of Safety Event Reporting System (SERS) report indicated that on one of the units, Registered Practical Nurse (RPN) #151 had administered an identified medication to resident #046, instead of the prescribed medication, which did not result in any treatment required. The report stated that there was a change to the medication order 22 days prior to the date of the medication incident. A review of the Medication Management Group Meeting audio record provided by the home, indicated discussions around the current process in the home related to storage, destruction and disposal of narcotic and controlled substances.

A review of the home's policy titled "Destruction and Disposal of Narcotic and Controlled Substances", Policy 3.3.9, dated March 2018, did not include information on how, or where to store controlled substances that are to be destroyed and disposed of, including those that had been discontinued, until the destruction and disposal occurs.

In interviews, RPN #147, RPN #148, and Registered Nurse (RN) #136 stated that the process in the home for controlled substances that had been discontinued was for registered staff to place a yellow "direction change" sticker on the packaging of the medications and the medication count sheet, to indicate that they had been discontinued, then take them to the pharmacist and destroy them together as soon as possible. They further stated that as the pharmacist is not available 24/7, the controlled substances that had been discontinued were stored in the same double locked bin as controlled substances with current orders, and the information was endorsed to the oncoming staff until such time that the controlled substances could be disposed of with the pharmacist.

On an identified day, in the presence of RPN #148, as part of the mandatory medication observation, the inspector observed the contents of the controlled substances bin. A medication card belonging to resident #047, which contained an identified medication had a yellow sticker on the front to indicate that it had been discontinued, was observed

to have been stored in the same double locked bin of the medication cart, along with other current controlled medications available for administration.

In an interview, RPN #148 confirmed that the identified medication had been discontinued for resident #047, and that they were unsure of the expectation of how soon discontinued controlled substances were to be disposed of with the pharmacist.

A record review of resident #047's medication orders also indicated that there was a change in the medication order, made two days prior to the observation mentioned above.

In an interview, Director of Care (DOC) #106 acknowledged that the current practice of the home which involved storing discontinued controlled substances with controlled substances available for administration to residents posed an increased risk for medication incidents to take place, such as the medication incident involving resident #047. [s. 136. (2) 2.]

***Additional Required Actions:***

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

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights**

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

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**
**1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).**

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**
**11. Every resident has the right to,**
**i. participate fully in the development, implementation, review and revision of his or her plan of care,**
**ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,**
**iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and**
**iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the following rights of residents are fully respected and promoted: every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

The inspector conducted a dining room observation on an identified unit. The inspector identified that Personal Support Worker (PSW) #100 was assisting resident #041 and resident #020. The inspector observed both residents received a specified textured meal and PSW #100 observed mixing all three food items together and feeding the residents.

A review of resident #020 and #041's written plans of care did not indicate that the food

items were to be mixed together for the identified residents at mealtime.

A review of the home's policy entitled, 'Meal Service", revised July 10, 2018, indicated that residents will be treated and spoken to with dignity and respect during meal service. Food shall not be mixed together on the plate unless requested by the resident.

During an interview with PSW #100 they asked the inspector, "is there anything wrong" with mixing the food items together.

Interviews with PSWs #100, #103, #104, #114, #123, and #125, RPN #119, #124, and #126, RN #101, Food Services Supervisor (FSS), Food Service Manager (FSM), Unit Manager (UM) #133, and Executive Director (ED) confirmed that the food should not be mixed together before feeding the resident, and it is considered a dignity and respect issue. Staff should always maintain the resident's dignity and respect. [s. 3. (1) 1.]

2. The licensee has failed to ensure that the following rights of residents are fully respected and promoted: every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

The medication Inspection Protocol (IP) was completed as a mandatory task in this Resident Quality Inspection (RQI).

On an identified day, empty medication pouches containing residents' Personal Health Information (PHI) were observed in a garbage can along with other common waste. The pouches had not been altered in any way to ensure the confidentiality of the PHI including residents' names, prescribed medications, and date of birth.

A review of the home's policy titled "Confidentiality of Client Personal Information", Version 3.0, dated March 2018, page 9, stated that all parties should store all client medical records in confidence, and destroy them in a confidential manner according to law. Specifically, residents' names should be blacked out from the prescription label, and empty containers or devices should be disposed of according to the pharmacy and facility policy.

In interviews, RPN #124 from unit 4, RPN #148 from unit 5, and RPN #149 from unit 7 all

stated that the home's process was to dispose of medication pouches into the regular garbage bins. They all acknowledged that the medication pouches contained residents' PHI but were not aware of any specific policy related the disposal of the medication pouches.

In an interview, DOC #106 confirmed that the current practice throughout the home was to dispose of medication pouches into the regular garbage and acknowledged that this was not an appropriate way to dispose of these pouches as they contained residents' confidential PHI. [s. 3. (1) 11. 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 the following rights of residents are fully respected and promoted:***
***- every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity,***
***- every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act, to be implemented voluntarily.***

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**WN #3: 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,**
**(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).**
**(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).**

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

**Findings/Faits saillants :**

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

A complaint report was submitted to the Ministry of Health and Long-Term Care (MOHLTC), by the substitute decision maker (SDM) regarding care for resident #021. The concern was related to an impaired skin integrity on the resident's identified body area that the SDM was not aware of prior to the resident's hospitalization. The resident was transferred to hospital, where they deceased 10 days later.

An interview with the SDM indicated that on an identified day, resident #021 had been hospitalized due to a change in condition. The assessment in the hospital indicated that the resident had impaired skin integrity on the body area that the SDM was not aware of, and the SDM confirmed the staff from the home had not communicated to them about it.

Resident #021's clinical record review indicated that at the time of the hospitalization, the resident had impaired skin integrity on the specified body area. A patient notes record of resident #021, dated 82 days prior to the hospitalization, indicated that resident #021 had a newly identified impaired skin integrity on a specified body area. During this 82 days, the resident's impaired skin integrity progressed and worsened. Treatment was provided and resident was referred to other disciplines.

Interview with RPN #130 indicated that after they identified impaired skin integrity, they provided treatment to the resident, and documented in the progress notes their findings and actions. They referred the resident to the attending physician, dietitian and Occupational Therapist (OT). The RPN said they did not verbally tell the RN as they had documented in the progress notes. The RPN stated that they were thinking the RN will read the notes prior to writing the shift report so the information will be communicated to the upcoming shift.

Interview with RN #138 indicated that the initial stage of the resident's impaired skin integrity was not informed by the RPN and the RN did not enter the newly identified impaired skin integrity in the report to the upcoming shift. The RN also stated they do not read all the progress notes as there are 150 resident progress notes to be read which is a lot. The RN also stated that they enter high risk issues in the report communicated by the RPNs from each unit, and they read the notes only for those high risks issues and follow up accordingly.

Interview with RN #140 also stated that for the RN to read all progress notes would take lots of time that is to be focused on following up on the high risk issues. Unfortunately the RPN did not communicate the newly identified impaired skin integrity to the RN so the RN was not able to follow up with it. [s. 6. (4) (a)]

2. The licensee has failed to ensure that the resident, the SDM, if any, and the designate of the resident/SDM were given an opportunity to participate fully in the development and implementation of the plan of care.

A complaint report was submitted to the MOHLTC, by the SDM regarding care for resident #021. The concern was related to an impaired skin integrity on the resident's identified body area that the SDM was not aware of prior to the resident's hospitalization. The resident was transferred to hospital, where they deceased 10 days later.

An interview with the SDM indicated that on an identified day, resident #021 had been hospitalized due to a change in condition. The assessment in the hospital indicated that the resident had an impaired skin integrity on the body area that the SDM was not aware of, and the SDM confirmed the staff from the home had not communicated to them about it. The SDM submitted a picture of the resident's impaired skin integrity. The picture was taken while the team at the hospital was preparing the resident for treatment of the impaired skin integrity.

Resident #021's clinical record review indicated that at the time of the hospitalization the resident had two different types of identified impaired skin integrity on two identified body areas, in addition to a third impaired skin integrity. Further review of the resident progress notes indicated that the resident's third impaired skin integrity was monitored and followed by the attending physician as well as the specified care specialist from the hospital.

A review of resident #021's clinical record indicated that the impaired skin integrity was documented as newly identified impaired skin integrity by RPN #130. The RPN also documented that treatment was provided and the resident was referred to other disciplines. The note indicated the SDM was not notified.

An interview with the RPN confirmed that they had not notified the SDM then or after the treatment was provided. The RPN said that because they were part time staff they expected the full time staff would have notified the family. Interview with the full time registered staff indicated that they could not recall if they had talked to the SDM regarding the resident's newly identified impaired skin integrity.

Further review of the resident's progress notes indicated that the resident's impaired skin integrity were assessed by physician, OT during three months of period and treatments were provided. During this time, the resident's impaired skin integrity worsened.

A review of the "Patient Care Notes" 1.5 months later, indicated that the resident was transferred to the hospital due to a change in the condition, and showed no indication that the SDM had been notified or been given an opportunity to participate fully in the development and implementation of the plan of care about the resident's impaired skin integrity.

An interview with RPNs #130 and #140 indicated that they had not notified the SDM about resident #021 developing an impaired skin integrity on a specified body areas or when it started getting worse and medical and surgical intervention had been considered in plan of care.

In an interview, RN #137 acknowledged that they had not contacted the SDM regarding developing and worsening of the impaired skin integrity as they were not aware of that and communication to the SDM is the responsibility of the registered staff on the floor who provide care and treatment to the resident.

During an interview, the DOC acknowledged there was a problem of not communicating with one of the SDM, as the SDM had complained to the home regarding this concern. Further, the DOC said that the home had identified the weakness in regards to the home's identified care program as a whole, and the home is in the process of changing the policy and re-educating the staff, but unfortunately the home is not able to do anything about things that happened before, but will look into improving the program. [s. 6. (5)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that:***
***-staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other***
***-every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 44. Authorization for admission to a home**

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

**s. 44. (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,**
**(a) the home lacks the physical facilities necessary to meet the applicant's care requirements; 2007, c. 8, s. 44. (7).**
**(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or 2007, c. 8, s. 44. (7).**
**(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval. 2007, c. 8, s. 44. (7).**

**s. 44. (9) If the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out,**
**(a) the ground or grounds on which the licensee is withholding approval; 2007, c. 8, s. 44. (9).**
**(b) a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care; 2007, c. 8, s. 44. (9).**
**(c) an explanation of how the supporting facts justify the decision to withhold approval; and 2007, c. 8, s. 44. (9).**
**(d) contact information for the Director. 2007, c. 8, s. 44. (9).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless, (a) the home lacks the physical facilities necessary to meet the applicant's care requirements; (b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or (c) circumstances exist which are provided for in the regulations as being a ground for withholding approval. 2007, c. 8, s. 44 (7).

MOHLTC received a complaint indicating the home rejected a placement application for applicant #1. Applicant #1 had applied for a Transitional Behavioural Support Unit

(TBSU) bed at the home on an identified day, at which time it was accepted. Health reports were provided to the home on four and seven months later. When a bed became available nine months later, the home rejected the applicant's admission, because the applicant needed a one on one sitter for 16 hours daily.

Interview with UM #113 and the ED indicated that applicant #1 was rejected for a reason which is not provided in the legislation. [s. 44. (7)]

2. The licensee has failed to ensure that if the licensee withholds approval for admission, the licensee give to persons described in subsection (10) a written notice setting out, (a) the ground or grounds on which the licensee is withholding approval; (b) a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care; (c) an explanation of how the supporting facts justify the decision to withhold approval; and (d) contact information for the Director.

MOHLTC received a complaint indicating the home had completed an internal transfer of an applicant without Toronto Central Local Health Integration Network (TC-LHIN) approval and contravened the existing placement process.

A review of a refusal letter for applicant #2 indicated that the home had reviewed the placement application and was unable to accept this placement because the applicant did not have a specified primary diagnosis and therefore did not meet the eligibility criteria for TBSU.

Interview with UM #113 and the ED indicated that the application was rejected based on the eligibility criteria and confirmed that there was no detail about the grounds, and detail explanation was not provided in the letter to justify the home's decision to withhold the application. [s. 44. (9)]

***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 appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless, (a) the home lacks the physical facilities necessary to meet the applicant's care requirements; (b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or (c) circumstances exist which are provided for in the regulations as being a ground for withholding approval, and***
***- if the licensee withholds approval for admission, the licensee give to persons described in subsection (10) a written notice setting out, (a) the ground or grounds on which the licensee is withholding approval; (b) a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care; (c) an explanation of how the supporting facts justify the decision to withhold approval; and (d) contact information for the Director, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care**

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

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

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

**Findings/Faits saillants :**

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

A complaint report was submitted to the MOHLTC, by the SDM regarding care for resident #021. The concern was related to an impaired skin integrity on the resident's identified body area that the SDM was not aware of prior to the resident's hospitalization. The resident was transferred to hospital, where they deceased 10 days later.

An interview with the SDM indicated that on an identified day, resident #021 had been hospitalized due to a change in condition. The assessment in the hospital indicated that the resident had an impaired skin integrity on the body area that the SDM was not aware of, and the SDM confirmed the staff from the home had not communicated to them about

it.

Resident #021's clinical record review indicated that at the time of the hospitalization, the resident had an impaired skin integrity on the specified body area. A patient notes record of resident #021, dated 82 days prior to the hospitalization, indicated that resident #021 had a newly identified impaired skin integrity on a specified body area. During these 82 days, the resident's impaired skin integrity progressed and worsened. Treatment was provided and resident was referred to other disciplines.

Patient Notes record of resident #021 included a documentation note about the resident's impaired skin integrity, carried out by RPN #140 indicating that RPN identified an impaired skin integrity on an identified body area.

A review of the Meditech "Assessment Form" section failed to reveal that the identified impaired skin integrity assessment was carried out by RPN #140 when it was identified.

During the interview with RPN #140, the RPN confirmed that the expectation of registered staff is to carry out an assessment every time when staff identify an impaired skin integrity of the residents. The RPN was not able to explain why the assessment was not conducted for resident #021.

Patient notes record, included a note carried out by RPN #130 indicating about the resident's newly identified impaired skin integrity on a specified body area. Treatment was provided and resident was referred to other disciplines.

A review of the Meditech "Assessment Form" section failed to reveal that a skin assessment was carried out by RPN #130 on the above mentioned day or ever after, when the RPN identified the alteration of the resident skin.

During an interview the RPN stated the expectation was that the registered staff would carry out an assessment of each resident with identified altered skin integrity using the skin assessment form in Meditech. The RPN also said that they were documenting in the progress notes every time they changed the treatment but had missed to complete the skin assessment for a newly identified impaired skin integrity.

Review of the resident's skin assessment record under: "Skin Integrity Assessment Tool" which was confirmed through an interview with RN #139, the Skin and Wound Lead (SWCPL), indicated that registered staff had not carried out skin assessments for

resident #021's skin integrity from September 2017, until December 2017, when the RN #137 identified that the resident had an impaired skin integrity. RN #139's statement included that the staff had documented when they changed the resident's dressing however the resident was not assessed for skin integrity using a clinical tool specifically designed for skin and wound assessment.

An interview with DOC indicated that the home had identified a weakness in area of the identified care program from the RQI in December 2017 when the home was issued a Voluntary Plan of Correction (VPC) for non-compliance related to the skin and wound care program. The DOC also stated the home had created an action plan and are in progress of revising the policy for skin and wound program and educating the staff regarding the skin and wound assessment practice. [s. 50. (2) (b) (i)]

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

A complaint report was submitted to the MOHLTC, by the SDM regarding care for resident #021. The concern was related to an impaired skin integrity on the resident's identified body area that the SDM was not aware of prior to the resident's hospitalization. The resident was transferred to hospital, where they deceased 10 days later.

The assessment in the hospital indicated that the resident had impaired skin integrity on the body area that the SDM was not aware of, and the SDM confirmed the staff from the home had not communicated to them about it. The SDM submitted a picture of the resident's impaired skin integrity. The picture was taken while the team at the hospital was preparing the resident for treatment of the impaired skin integrity.

The home's policy, revised November 2014, under "Early Risk Assessment and Reassessment" state for patients with existing identified skin impairements, comprehensive assessment (including local wound assessment) will be performed initially, followed by a reassessment at a minimum of weekly to determine wound progress and effectiveness of treatment plan.

A review of Meditech "Patient notes" record indicated that the resident was admitted with an impaired skin integrity which was not healing. A review of the notes for the period of three months indicated the registered staff had not carried out an assessment for resident #021's impaired skin integrity until three days prior to hospitalization.

- A note carried out by RPN #140 indicated the RPN identified an impaired skin integrity on a specified area. Further review of the notes indicated the area was not assessed weekly by registered staff during a three month period.

- A note carried out by RPN #130 indicated that the RPN had identified a newly identified impaired skin integrity. Treatment provided and the resident was referred to other disciplines. Further review of the "Patient notes" record indicated on an identified day, RPN #140 documented that resident #021 had an impaired skin integrity with an identified symptom. Review of the notes also indicated that there was no weekly assessments completed by registered staff.

A review of the "Assessment Form" section in Meditech for the period of three to four months, indicated weekly wound assessments for the three identified impaired skin integrity were not carried out, and there was only one assessment conducted by RN #137.

The RPN #140 stated weekly wound assessments were not carried out for resident #021 once the resident was identified to have altered skin integrity.

A review of the Meditech "Wound Assessment Form" indicated there was no initial or weekly wound assessments completed for resident #021 in a three month period, and there was only one assessment completed for resident #021's impaired skin integrities.

- A review of the Meditech "Assessment Form" section failed to reveal that an assessment was carried out by RPN #130 on an identified day, when the RPN identified the alteration of the resident skin. The RPN stated that whenever they changed the resident's treatment they would document in the progress notes, however they confirmed that they did not carry out the weekly assessment.

Interview with RN #139, the lead of an identified program, and RN #137 unit manager, indicated it was the home's expectation when a resident was identified as having alteration of skin integrity that registered staff was to assess the site and carry out weekly skin assessment and document the assessment on Meditech. The RNs were provided with resident #021's assessment record dates and both acknowledged that from reviewing the assessment record, it showed the weekly wound assessments for resident #021 were not carried out. [s. 50. (2) (b) (iv)]

3. The licensee has failed to ensure that the resident who is dependent on staff for repositioning had been repositioned every two hours or more frequently as required depending on the resident's condition and tolerance of tissue load, and while asleep if clinically indicated.

A complaint report was submitted to the MOHLTC, by the substitute decision maker (SDM) regarding care for resident #021. The concern was related to an impaired skin integrity on the resident's identified body area that the SDM was not aware of prior to the resident's hospitalization. The resident was transferred to hospital, where they deceased 10 days later.

An interview with the SDM indicated that on an identified day, resident #021 had been hospitalized due to a change in condition. The assessment in the hospital indicated that the resident had an impaired skin integrity on the body area that the SDM was not aware of, and the SDM confirmed the staff from the home had not communicated to them about it. The SDM submitted a picture of the resident's impaired skin integrity. The picture was taken while the team at the hospital was preparing the resident for treatment of the impaired skin integrity due to infection.

Resident #021's clinical record review indicated that at the time of the hospitalization the resident had two different types of identified impaired skin integrity on two identified body area, in addition to a third area of impaired skin integrity. Further review of the resident progress notes indicated that the resident's impaired skin integrity was monitored and followed by the attending physician as well as the specified care specialist from the hospital. The resident needed total assistance for activities of daily living and they used a wheelchair for locomotion.

A review of resident #021's clinical record indicated that the newly identified impaired skin integrity was documented on an identified day, by RPN #130. The resident had been referred to the occupational therapist and assessed on a specified day. Recommendation to the nursing staff was to reposition the resident in a specified manner every two hours and possibility to provide therapeutic surface instead of regular mattress.

A review of the resident's written plan of care, indicated one of the interventions for skin care was the resident to be repositioned every two hours to promote healing and improve skin integrity.

A review of the Personal Support Workers' documentation record for turning and

repositioning for four consistent months, indicated that repositioning had not been scheduled in the PSWs' record as per plan of care every two hours. Furthermore, even the turning and repositioning was scheduled for every shift, the record indicated the staff had not carried out the repositioning of the resident.

In an interview conducted with PSW #141, the PSW stated that they had not turned and repositioned resident #021 as the resident had been in a wheelchair most of the time per the SDM request. The PSW acknowledged that the resident who needs total assistance for activities of daily living and who is at risk for impaired skin integrity need to be repositioned as often as possible to take off the load and to prevent impairment.

During an interview, RN #139 stated that the staff was expected to turn and reposition the residents who are at risk minimum every two hours if not contraindicated. Upon review of the PSW documentation in Meditech, the RN acknowledged that the staff had not carried out the intervention to turn and reposition the resident every two hours.

In an interview DOC acknowledged that the home had identified the skin care program had not been followed so the home had reviewed and revised the program and already started the education of the registered staff in regards to the skin and wound care program and need to comply with the program. [s. 50. (2) (d)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that:***
***-the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,***
***-the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated,***
***- the resident who is dependent on staff for repositioning has been repositioned every two hours or more frequently as required depending on the resident's condition and tolerance of tissue load, and while asleep if clinically indicated, to be implemented voluntarily.***

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**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs**

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

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that drugs were stored in an area or a medication cart that is secure and locked.

During the completion of the mandatory medication inspection protocol as part of the RQI, the inspector reviewed three medication incidents and completed observations.

A review of SERS report indicated that RPN #151 had administered an identified medication to resident #046, instead of the prescribed medication resulting in mild harm.

On August 2, 2018, between approximately 1200hrs to 1230hrs, the inspector visited different floors to complete observations related to the storage of controlled substances, and observed the following:

-a medication cart on an identified floor was left unlocked and unattended. There were no residents in the vicinity, and there were staff passing by. RPN #124 returned to the cart four minutes later and stated that they had left to address a resident concern.
-a medication cart on another floor was left unlocked and unattended. Two residents in wheelchairs were noted to be sitting in the vicinity; however, there was no staff around. RPN #149 returned to the cart three minutes later and stated that they had left to administer medications to a resident.

On August 2, 2018, at 1607hrs, the inspector visited a third home area to interview RPN #151, who was involved in the medication incident described in SERS report. The inspector observed the medication room on this unit to have been left unlocked, and the door left ajar, with no staff in the vicinity. A family member and resident passed by and stopped to ask the inspector where they could find the nurse, and shortly after the inspector provided an answer, RPN #151 returned to the medication room and was apologetic for having left the door open. In the presence of RPN #151, the medication cart inside the room was observed to have been left open, there was a bottle of alcohol on the counter, and all of the controlled substances from the narcotic bin had also been left out on the counter. RPN #151 confirmed these observations to the inspector.

In interviews, RPN #124, RPN #149, RPN #151, and DOC #106 all acknowledged that the medication cart should be locked and secured if it is being left unattended. RPN #151 and DOC #106 further acknowledged that the medication room should be locked, and controlled substances should be double locked, and not left in an open unlocked area as this would pose potential risk/harm. [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.***

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**WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions**

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

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that every medication incident involving a resident was documented and reported to the resident, the resident's substitute decision maker (SDM) if any, the attending physician and the pharmacy service provider.

During the completion of the mandatory medication inspection protocol as part of the RQI, the inspector reviewed three medication incidents.

A review of the home's policy titled Medication Incident Report, Policy 3.5.5, dated March 2018, stated that every medication incident involving a client shall be documented in the SERS, and reported to the client, client's SDM, if any, the Manager, the prescriber of the drug, and the pharmacy service provider.

In interviews, RN #136, UM #133, UM #145 and DOC #106 stated that if a medication

incident is identified, staff are to assess the resident, ensure their safety, notify the resident and/or SDM, physician, pharmacist, and UM, and complete a SERS report. In addition, documentation of who was notified of the medication incident is to be documented in the SERS report or the resident's progress notes.

A) A review of SERS report indicated that RPN #151 had administered an identified medication to resident #046, instead of the prescribed medication resulting in mild harm; however, no treatment was required. The report stated that the order had been changed 22 day prior to the incident. Further review of the SERS report, and resident #046's progress notes, did not indicate whether the resident, resident's SDM if any, the prescriber of the drug, and the pharmacy service provider were informed about this medication incident.

In an interview, RPN #151 stated that the medication incident involved resident #151 was their first medication incident, and that they had filed and submitted a report, but had not informed resident #151 of the medication incident, or anyone else. RPN #151 further stated they were not aware of the home's policy related to medication incidents.

In interview, UM #133 and DOC #106 acknowledged that there was no documentation in the SERS report nor resident #046's progress notes to indicate that resident #046, their SDM if any, the pharmacist and physician were informed about the medication incident related to resident #046.

B) A review of SERS report indicated that a staff member noted during narcotic count that a medication card did not contain the correct dose. The identified pouch was sealed, and had been circled with a pen by a staff member two days ago, and had been captured in the narcotic count. The report indicated the medication card would be returned to pharmacy for the error to be corrected, but did not confirm that this action had in fact been completed.

The SERS report did not indicate the name of the resident that the medications belonged to, or whether the resident, resident's SDM if any, the prescriber of the drug, and the pharmacy service provider were informed about this medication incident. Although UM #145 signed off that follow up had been completed for this incident on an identified day, it did not indicate the details of what the follow up encompassed.

In an interview, UM #145 stated that the UM's responsibility includes reviewing completed SERS reports to ensure that they have been filled out appropriately, and in

their entirety, and if required, they are responsible for filling in any missing information. UM #145 further stated that SERS report should include documentation of the name of the resident, and who was informed of the incident and acknowledged that these items were not documented in SERS report. UM #145 directed the inspector to RN #136 who was also notified of this incident as they could not identify the resident.

In an interview, RN #136 stated that the staff member who had discovered the incident had brought it to their attention and they had directed the staff member to complete a SERS report. After reviewing the report, RN #136 acknowledged that it did not contain required documentation including the resident's name, or the individuals who were required to be notified of the incident as per the home's policy. RN #136 then contacted RPN #152 via telephone, as RPN #152 was reportedly aware of this medication incident, and RPN #152 identified the resident as resident #045. RN #136 reviewed resident #045's progress notes in the presence of the inspector and acknowledged that there was no documentation related to the incident in the resident's progress notes either. RN #136 stated they had not contacted those required to be informed of the medication incident, and could not confirm whether the staff member who had brought the incident to their attention had done so either.

In an interview, DOC #106 acknowledged that documentation had not been completed in its entirety as per the home's policy as it did not include the resident's name, nor did it confirm that resident #046, their SDM if any, the prescriber of the drug, and the pharmacy service provider were informed about this medication incident. [s. 135. (1)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every medication incident involving a resident is documented and reported to the resident, the resident's substitute decision maker (SDM) if any, the attending physician and the pharmacy service provider, to be implemented voluntarily.***

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**WN #8: 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 :**

1. The licensee has failed to ensure that all staff participate in the implementation of the Infection Prevention and Control (IPAC) program.

The inspector conducted a dining room observation on an identified unit. The inspector identified that PSW #100 was assisting resident #041 and resident #020. The inspector observed both residents received an identified textured meal. PSW #100 was observed unorganized, feeding both residents by sitting in the middle of those two residents. PSW #100 placed both residents' plates too close to one another. The inspector observed the PSW protecting self from resident #020's identified behaviour using a towel. The inspector did not observe PSW #100 protecting resident #041's food from resident #020's identified behaviour to protect from a risk of cross contamination.

A review of resident #020's written plan of care indicated that the resident's eating ability was impaired and required total assistance with feeding, staff to observe facial expression during mealtimes to get ahead of their identified behavior.

Interview with PSW #100 confirmed that resident #020 has an identified behaviour at meal time.

Interviews with PSWs #100, #103, #104, #114, #123, and #125, RPN #119, #124, and #126, FSS, FSM, UM #133, and the ED confirmed that all staff members are expected to follow IPAC practices all the time and prevent any risk for cross contamination at the meal time. [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 (IPAC) program, to be implemented voluntarily.***

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**WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records**

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

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

**Findings/Faits saillants :**

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

A complaint report was submitted to the MOHLTC by a SDM about a concern regarding care for resident #021. The concern was related to an impaired skin integrity on the specified body area that the SDM was not aware of prior to the resident's hospitalization. The resident was transferred to hospital and deceased 10 days later.

As required by the Regulation (O. Reg. 79/10, s. 30 (1) 1.), in respect to interdisciplinary skin and wound care program required by the Regulation (O. Reg. 79/10, s. 48 (1) 2.) the Licensee shall ensure that there is a written description of the program that includes relevant policies, procedures and protocols.

The home's policy, with a revised date of November 2014, indicate the following:
- Under the framework of Early Risk Identification, section Early Risk Assessment and Reassessment for patient with existing skin impairment, a comprehensive assessment, (including local wound assessment) will be performed initially, followed by a reassessment at a minimum of weekly to determine wound progress and effectiveness of treatment plan.
- Under Procedure 2.0 A. section 2 stated: complete Braden scale for Predicting Score Risk within 24 hours of admission or readmission and at regular intervals according to Appendix A which for Apotex (meaning the home) stated minimum of weekly for the first 4 weeks of admission then as determined by subsequent risk assessment thereafter:
1. High to very high risk (Braden score 6-12) – monthly
2. No risk to Moderate Risk (score greater than 13) – Quarterly
3. Change in status – based on Risk score

Frequency of reassessment will be based on level of risk, change in resident's status and other clinical assessments.

Review of resident #021's clinical health record and interviews with RPN #139, and the Skin and Wound care Program Lead confirmed that during four months, Braden Scale and weekly skin and wound assessments were not completed for the resident's impaired skin integrity on the above mentioned identified body areas.

A review of clinical health records also indicated that the weekly wound assessments were not completed when the resident was identified with new impaired skin integrity. During three months of time, the resident's Braden Scale score increased from 13 to 14, which indicated that the resident's impaired skin integrity became worse.

Interviews with RN #137, #139, and the Skin and Wound care Program Lead confirmed that the weekly wound assessments were not completed and staff are required to complete these assessment as per the home's policy for the wounds identified in the above mentioned body area during identified three months.

Interview with RN #136 indicated that the resident's impaired skin integrity should have been assessed whenever treatment were changed and the assessments should have been documented in the resident's progress notes. The RN also indicated that weekly wound assessments were to be completed on a clinically appropriate tool, available in the home's electronic documentation system as per the home's policy.

An interview with DOC indicated that the home had identified a weakness in area of the

skin care program from the RQI in December 2017, when the home was issued a Voluntary Plan of Correction (VPC) for non-compliance in skin and wound care program. The DOC also stated the home had created an action plan and are in progress of revising the policy for skin and wound program and educating the staff regarding the skin and wound assessment practice. [s. 8. (1) (a),s. 8. (1) (b)]

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**WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services**

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

**s. 15. (2) Every licensee of a long-term care home shall ensure that,**
**(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).**
**(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).**
**(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the home, furnishings and equipment were kept clean and sanitary.

The inspector conducted a mandatory task of the RQI dining room observation on July 25, 2018, on the third floor RF unit, and observed a few walls soiled with dry food stains, including the wall attached to the servery, the wall underneath the windows, the wall behind the soiled utility cart, the wall below the switch board, and the wall below the menu board.

Interview with PSWs #103, #104, #114, #123, and #125, RPN #119, #124, and #126, RN #101, FSS, FSM, and UM #133 confirmed the above mentioned walls required cleaning.

The Enviornmental Service Supervisor (ESS) and the ED indicated in the interviews that the above mentioned walls required cleaning and identified that these walls were fabric walls and difficult to clean, however the home will work on a plan to address the issue. [s. 15. (2) (a)]

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**WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 42. Requirements for admission to home**
**The following are required in order for a person to be admitted as a resident of a long-term care home:**
**1. A placement co-ordinator must have determined that the person is eligible for long-term care home admission under section 43.**
**2. The placement co-ordinator for the geographic area where the home is located must have authorized the admission of the person to that specific home under section 44. 2007, c. 8, s. 42.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the requirements for admission to home was complied with: in order for a person to be admitted as a resident of a long-term care home: the placement coordinator for the geographic area where the home is located must have authorized the admission of the person to that specific home under section 44.

MOHLTC received a complaint, indicating the home had completed an internal transfer of an applicant without TC-LHIN approval and contravened the existing placement process. On an identified day, the TC-LHIN had matched applicant #2's application to a behavior support unit bed. Applicant #2 was waiting for the last nine months, to move to the home while occupying the hospital bed. Eleven days later, the home informed the TC-LHIN that the applicant on rank four on the wait list occupying Centralized Access to Senior Specialty Hospital Beds (CASS) bed was transferred to the home's behavioral unit in order to address the immediate need of transferring an identified resident from the behavior unit to the CASS bed due to escalated behavioral issues. There were some conversations with the TC-LHIN and the home for the bed match break however the placement coordinator from the TC-LHIN never authorized this admission.

Interview with Client Services Manager, Information & Referral and Health Records & Placement from Toronto Central Local Health Integration Network indicated that the TC-LHIN had never authorized admission for the resident who was occupying CASS bed who was on rank four on the wait list. Also, the TC-LHIN never authorized bed match break for applicant #2. The Client Services Manager, Information & Referral and Health Records & Placement confirmed that the home had made some arrangements with the internal transfers with different programs in the same organization.

Interview with UM #113 and the ED confirmed that the placement coordinator from the TC-LHIN did not authorize the admission for the applicant on the forth rank on wait list and allow the home to break the bed match for applicant #2. [s. 42. 2.]

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**WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management**

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

**s. 51. (2) Every licensee of a long-term care home shall ensure that,**
**(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that each resident who is incontinent received an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

Resident #007 was triggered for the continence care and bowel management due to the resident using a specific device from stage one of the RQI.

A review of resident #007's clinical record indicated that there was no assessment completed for the resident using a clinically appropriate tool.

A review of resident #007's Minimum Data Sheet (MDS) assessment indicated that the resident was continent for bladder and incontinent for bowel.

A review of resident #007's written plan of care indicated that the resident is continent for bladder and bowel.

Interview with PSW #125 indicated that the resident is continent for bladder and bowel.

Interview with RPN #126 indicated that the resident is continent for bowel and incontinent for bladder, and unable to provide information about the resident's continence assessment, however RPN #126 identified that the registered staff is responsible to complete the continence assessment but was not sure, how frequent the assessment should be completed. [s. 51. (2) (a)]

2. Resident #008 was triggered for the continence care and bowel management due to the resident using a specific device from stage one of the RQI.

A review of resident #008's clinical record indicated that there was no assessment completed for the resident using a clinically appropriate tool.

A review of resident #008's MDS assessment, indicated that the resident was incontinent for bladder and continent for bowel.

A review of resident #008's written plan of care indicated that the resident is continent for bladder and bowel.

Interview with PSW #127 indicated that the resident is incontinent for bladder and bowel.

Interview with RPN #128 indicated that the resident was incontinent for bowel and bladder, and indicated that the continence assessment is required on admission. RPNs are not responsible to complete any assessment tools, and RNs are responsible for that.

A review of the home's policy entitled, "Bladder Continence and Bowel Management Policy", dated June 2015, indicated that each client must be assessed for bladder and functioning within 7-14 days of admission, quarterly and any change in condition that affects continence level. Nursing staff to determine if three day bladder/bowel diary (Appendix A) is required, and appropriate for new client. After completing the nursing admission assessment, a more detailed continence assessment (Appendix B, Continence Assessment) can be completed based on the health care professional clinical judgment and client need for a more expanded assessment. Consideration for a more detailed continence assessment include but not limited to the following: incontinence/ new or sudden onset incontinence, chronic constipation, history of falls associated with toileting, client has goal of improving continence and reported urinary issues (frequency, urgency, etc.).

Interview with UM #133 confirmed that they could not find the continence assessment completed for resident #007 and #008, and RPNs or RNs are responsible to complete the continence assessment and it should be completed on admission, quarterly and when there is a significant change in the resident's status. [s. 51. (2) (a)]

**WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service**

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

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:**
**1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).**

**s. 73. (2) The licensee shall ensure that,**
**(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the home has a dining and snack service that included, at a minimum, the following elements: communication of the seven-day menus to residents.

The inspector completed a dining room observation on July 25, 2018, at 1200 hours. The dining room had a posting of daily menus, and the seven days menu was not posted.

Interview with Dietary Aide #102 indicated that the seven days menu should be posted however, sometimes residents would remove the menu and there is no space on the board to post the seven days menu.

Interviews with PSWs #103, #104, #114, #123, and #125, RPN #119, #124, and #126, RN #101, FSS, FSM, and UM #133 indicated that seven days menu should have been posted in the dining room to communicate the menu to the residents. [s. 73. (1) 1.]

2. The licensee has failed to ensure that no resident who requires assistance with eating or drinking was served a meal until someone was available to provide the assistance required by the resident.

The inspector conducted a dining room observation on July 25, 2018, at 1200 hours, on

the third floor RF unit. The inspector identified that resident #020 was served their meal without feeding assistance being available. PSW #100 was assisting resident #041 at the same table where resident #020 was sitting. At the same time, the inspector observed resident #042 was served food on the dining table without feeding assistance available.

A review of resident #020 and #042's written plan of care indicated that the residents required total feeding assistance.

During an interview, PSW #100 indicated that they have only two hands and can feed only one resident at a time and did not recognize resident #020 was served food, without assistance being available and that the food was getting cold. PSW #100 confirmed that food should not be served to the resident unless feeding assistance is available.

A review of the home's policy entitled, 'Meal Service", revised July 10, 2018, indicated that no resident who requires assistance with eating or drinking is served a meal unless a staff member is available to provide assistance required by the resident.

Interviews with PSWs #100, #103, #104, #114, #123, and #125, RPN #119, #124, and #126, RN #101, FSS, FSM, UM #133, and the ED confirmed that the food should not be served to the resident unless feeding assistance is available. [s. 73. (2) (b)]

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**Issued on this 26th day of November, 2018**

**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**

**Order(s) of the Inspector**

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

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

**Ordre(s) de l'inspecteur**

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

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

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

## Public Copy/Copie du public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | NITAL SHETH (500), BABITHA SHANMUGANANDAPALA (673), GORDANA KRSTEVSKA (600) |
| **Inspection No. / No de l'inspection :** | 2018_524500_0013 |
| **Log No. / No de registre :** | 018458-18 |
| **Type of Inspection / Genre d'inspection:** | Resident Quality Inspection |
| **Report Date(s) / Date(s) du Rapport :** | Nov 13, 2018 |
| **Licensee / Titulaire de permis :** | The Jewish Home for the Aged<br>3560 Bathurst Street, TORONTO, ON, M6A-2E1 |
| **LTC Home / Foyer de SLD :** | The Jewish Home for the Aged<br>3560 Bathurst Street, NORTH YORK, ON, M6A-2E1 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Derrick Bernardo |

Ontario

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

**Order(s) of the Inspector**

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

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

**Ordre(s) de l'inspecteur**

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

To The Jewish Home for the Aged, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

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

**Order(s) of the Inspector**

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

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

**Ordre(s) de l'inspecteur**

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

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**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. 136. (2) The drug destruction and disposal policy must also provide for the following:

1. That drugs that are to be destroyed and disposed of shall be stored safely and securely within the home, separate from drugs that are available for administration to a resident, until the destruction and disposal occurs.
2. That any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs.
3. That drugs are destroyed and disposed of in a safe and environmentally appropriate manner in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
4. That drugs that are to be destroyed are destroyed in accordance with subsection (3). O. Reg. 79/10, s. 136 (2).

**Order / Ordre :**

The licensee must be compliant with r.136 (2) 2 of the LTCHA.

The licensee must prepare, submit and implement a plan to ensure that the home's drug destruction and disposal policy must provide that any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance.

The plan must include, but is not limited to the following:
1. Conduct a review of the home's drug destruction and disposal policy and update it to include how and where to store controlled substances that have been discontinued, including those that are to be destroyed and/or disposed of.
2. a). Provision of education to all registered nursing staff related to the updated policy and where to access it, to ensure that staff understand their roles and responsibilities.
2. b). Provision of education to all registered nursing staff regarding medication administration practice including safe drug destruction. Maintain a documented record of what the education entailed, who provided the education, the dates the education was provided and the staff names who attended the education.
3. Development and implementation of quality improvement initiatives including but not limited to documented audits to ensure that the updated policy is implemented and complied with.
For the above, as well as for any other elements included in the plan, please include who will be responsible, as well as a timeline for achieving compliance, for each objective/goal listed in the plan.

Please submit the written plan to TorontoSAO.moh@ontario.ca by November 27, 2018.

**Grounds / Motifs :**

1. The licensee has failed to ensure that the home's drug destruction and disposal policy included that any controlled substance that is to be destroyed and disposed of is stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs.

During the completion of the mandatory medication inspection protocol as part of the Resident Quality Inspection (RQI), the inspector reviewed three medication

incidents.

A review of Safety Event Reporting System (SERS) report indicated that on one of the units, Registered Practical Nurse (RPN) #151 had administered an identified medication to resident #046, instead of the prescribed medication, which did not result in any treatment required. The report stated that there was a change to the medication order 22 days prior to the date of the medication incident. A review of the Medication Management Group Meeting audio record provided by the home, indicated discussions around the current process in the home related to storage, destruction and disposal of narcotic and controlled substances.

A review of the home's policy titled "Destruction and Disposal of Narcotic and Controlled Substances", Policy 3.3.9, dated March 2018, did not include information on how, or where to store controlled substances that are to be destroyed and disposed of, including those that had been discontinued, until the destruction and disposal occurs.

In interviews, RPN #147, RPN #148, and Registered Nurse (RN) #136 stated that the process in the home for controlled substances that had been discontinued was for registered staff to place a yellow "direction change" sticker on the packaging of the medications and the medication count sheet, to indicate that they had been discontinued, then take them to the pharmacist and destroy them together as soon as possible. They further stated that as the pharmacist is not available 24/7, the controlled substances that had been discontinued were stored in the same double locked bin as controlled substances with current orders, and the information was endorsed to the oncoming staff until such time that the controlled substances could be disposed of with the pharmacist.

On an identified day, in the presence of RPN #148, as part of the mandatory medication observation, the inspector observed the contents of the controlled substances bin. A medication card belonging to resident #047, which contained an identified medication had a yellow sticker on the front to indicate that it had been discontinued, was observed to have been stored in the same double locked bin of the medication cart, along with other current controlled medications available for administration.

In an interview, RPN #148 confirmed that the identified medication had been discontinued for resident #047, and that they were unsure of the expectation of how soon discontinued controlled substances were to be disposed of with the pharmacist.

A record review of resident #047's medication orders also indicated that there was a change in the medication order, made two days prior to the observation mentioned above.

In an interview, Director of Care (DOC) #106 acknowledged that the current practice of the home which involved storing discontinued controlled substances with controlled substances available for administration to residents posed an increased risk for medication incidents to take place, such as the medication incident involving resident #047. [s. 136. (2) 2.]

The severity of this issue was determined to be a level 2 as there was minimal harm and potential for actual harm to the residents. The scope of the issue was a level 2 as it related to two of three residents inspected and the home had a level 2 history. (673)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Jan 25, 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 13th day of November, 2018**

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

**Name of Inspector /**
**Nom de l'inspecteur :** Nital Sheth

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