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
Mar 25, 2019	2018_725522_0017 (A1)	006606-18, 010096-18, 016935-18, 017672-18, 029559-18, 030018-18	Critical Incident System

Licensee/Titulaire de permis

Caressant-Care Nursing and Retirement Homes Limited
264 Norwich Avenue WOODSTOCK ON N4S 3V9

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

Caressant Care on Bonnie Place
15 Bonnie Place St Thomas ON N5R 5T8

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

Amended by JULIE LAMPMAN (522) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The licensee requested an extension to the compliance due date for CO #003 related to housekeeping and CO #004 related to the administration of drugs, to May 31, 2019.

Issued on this 25th day of March, 2019 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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Ministère de la Santé et des Soins de longue durée

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

Amended by JULIE LAMPMAN (522) - (A1)

Amended Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 7, 8, 9, 13, 14,15,16, 19, and 20, 2018.

During this inspection, the following Critical Incidents (CIS) were inspected:

CIS #2730-000015-18 related to a resident incident;

CIS #2730-000014-18 related to a medication incident;

CIS #2730-000008-18 related to a resident incident.

The following Follow-ups were completed during this inspection:

Follow-up Log #029559-18 to compliance order #001 from Resident Quality Inspection #2018_606563_0005 related to the home's organized program for housekeeping;

Follow-up Log #010096-18 to compliance order #002 from Resident Quality Inspection #2018_606563_0005 related to the administration of medication.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Nursing, the Food Services Manager, the Resident Care Coordinator, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Housekeepers, a Ward Clerk, residents and family members.

The inspector(s) also reviewed relevant policies and procedures, medication incident reports, and clinical records for identified residents. The administration of medication and the general cleanliness and condition of the home was observed.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Falls Prevention
Hospitalization and Change in Condition
Medication

During the course of the original inspection, Non-Compliances were issued.
6 WN(s)
1 VPC(s)
4 CO(s)
1 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 the care set out in the plan of care was provided to the resident as specified in the plan.

A Critical Incident Systems (CIS) report was submitted by the home to the Ministry of Health and Long-Term Care regarding a resident incident.

The CIS report indicated that an identified resident had a fall.

Review of the identified resident's most recent plan of care noted specific interventions for the identified resident.

In an interview, the Personal Support Worker stated that they had not followed the identified resident's specific interventions.

In an interview, the Registered Nurse (RN) stated they responded to the identified resident's fall. The RN stated specific interventions were not in place for the resident at the time of their fall.

In an interview, the Director of Care stated staff should have followed the identified resident's plan of care.

The licensee had failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan. [s. 6. (7)]

Additional Required Actions:

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

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

A Critical Incident Systems (CIS) report was submitted by the home to the Ministry of Health and Long-Term Care regarding a resident incident.

The CIS report indicated that an identified resident had a fall.

Review of the home's policy "Safety Plan – Resident Part C - Post Fall Management" with a review date of May 2018, noted the following: "Upon discovery of a fall, Code Care is called. The interdisciplinary team will: a) Initiate Head Injury Routine and assess the resident's level of consciousness and any potential injury associated with the fall as required."

Review of the home's policy "Head Injury Routine" with a review date of July 2016, noted the following:
"Immediately after a resident sustains a trauma to the head of an unwitnessed fall, the Registered Nurse in charge is to assess the resident, using the Glascow

Coma Scale and do a complete set of vital signs." Using the Glascow Coma Scale as a documentation tool and vital signs, assess the resident for 72 hours with the following frequency: "Every half hour for the first two hours following the injury, every hour for the next four hours, every four hours for the next eight hours, every shift for the remainder of the 72 hour monitoring."

Review of the identified resident's Glascow Coma Scale (GCS) noted not all of the assessments were documented.

In an interview, the Registered Nurse (RN) stated they completed the GCS for the identified resident after their fall. The RN was unable to explain why all of the GCS was not documented. The RN stated they did not complete the GCS for the identified resident at a specific time as required, as the resident was sleeping and the RN did not want to bother the resident.

In a telephone interview, another RN stated when they started their shift they noticed that the previous entry on the GCS was noted as "sleeping" and that this was unsatisfactory when completing post falls vitals on a resident.

In an interview, the Director of Care stated registered staff should have followed the home's policy and completed all sections of the GCS and roused the identified resident while they were sleeping to complete the GCS.

The licensee has failed to ensure that where the Act or Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee was required to ensure that the policy was complied with. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee has failed to ensure that where the Act or Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee was required to ensure that the policy was in compliance with and was implemented in accordance with applicable requirements under the Act.

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

O. Reg. 79/10, s. 135(1) states, "Every licensee of a long-term care home shall

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

A review of four of the home's medication incidents noted no documentation to support that the Medical Director of the home had been notified of the medication incidents.

Review of Medical Pharmacies policy 9-1 "Medication Incident Reporting" revised June 2018, noted no reference to notification of the Medical Director of medication incidents.

In an interview, the Director of Care reviewed the home's policy with the inspector and confirmed the home's policy did not indicate that the Medical Director was to be notified of medication incidents.

The licensee has failed to ensure that the home's medication management system policies were in compliance with the Act and Regulation. [s. 8. (1) (a)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures that had been developed as part of the organized program of housekeeping were implemented for cleaning floors, furnishings, and wall surfaces for resident bedrooms and common areas.

On May 4, 2018, during the Resident Quality Inspection (RQI), #2018_606563_0005, Compliance Order (CO) #001 was issued and ordered the licensee to take action to achieve compliance by ensuring that procedures were developed and implemented as part of the organized program of housekeeping for cleaning floors, furnishings, and wall surfaces for resident bedroom and common areas. This order was to be complied by June 8, 2018.

CO #001 stated, "The licensee must be compliant with Ontario Regulation s. 87 (2)(a).
Specifically the licensee must:
a) Ensure that their written policy titled "Cleaning Guidelines - Thorough Cleaning" is fully implemented.
b) Ensure that there is a documented schedule for the "Thorough Cleaning" of the home, furnishings and equipment, including flooring and baseboards in resident rooms, bathrooms and common areas and that this schedule is fully implemented. The completion of the cleaning tasks outlined in the "Thorough Cleaning" schedule must be documented.
c) Ensure a monitoring process is developed and implemented, including the staff responsible for monitoring, to ensure that the home, furnishings and equipment are kept clean and sanitary. This monitoring process must be documented."

Observations of resident bedrooms on a specific date, found that 17 out of 22 (77

per cent) of the rooms were not kept clean. Resident bedrooms were observed to have dust and debris along the perimeters of the room, under beds and closets as well as in bathrooms.

The Chapel, Main lounge, B and C Wing lounges, all dining rooms and hallways were also noted as not clean.

Review of the number of Personal Protective Equipment (PPE) carts outside of resident rooms noted that 6 out of 10 PPE carts had stains, dirt and debris on them and on the floor around the carts.

In an interview, an identified housekeeper stated dining rooms were cleaned everyday right after breakfast. The housekeeper stated cleaning of all dining rooms took place at 0920, 1315, and 1815 hours, after residents had completed their meals. The housekeeper stated there was a schedule of when common areas were cleaned and a schedule for thorough cleans. The housekeeper stated usually two to three rooms had a thorough clean per week.

In an interview, another housekeeper stated they were responsible to clean resident rooms, which included cleaning behind all the doors and that they tried to dust five or six resident rooms a day. The housekeeper stated hallways were cleaned every morning. The housekeeper stated they were responsible for a specific wing and three rooms in another hall and stated they felt this was a lot for one person. The housekeeper stated a deep clean of a resident's room consisted of steam cleaning edges and scraping edges of the room, washing the walls, dusting, and cleaning the resident's bed. The housekeeper stated two to three rooms get deep cleaned every other week. The housekeeper stated when a common area on the daily rotation was cleaned the housekeeper would do a high and low dust, scrape edges, sweep, and mop the area.

Observations of resident bedrooms found that 17 out of 22 (77 per cent) of the rooms were not kept clean. Resident bedrooms were observed to have dust and debris along the perimeters of the room, under beds and closets as well as in bathrooms.

The Chapel, Main lounge, B and C Wing lounges, all dining rooms and hallways were also noted as not clean.

Review of the number of Personal Protective Equipment (PPE) carts outside of

resident rooms noted that 6 out of 10 PPE carts had stains, dirt and debris on them and on the floor around the carts.

Follow up observations were made of residents' rooms, dining rooms and common areas including hallways, identified as areas of concern from the previous day. Several resident rooms, dining rooms, common areas and PPE carts remained unclean.

Review of the home's policy "Cleaning Guidelines - Thorough Cleaning" with a review date of August 2017, noted the following:
"All areas of the facility must be thoroughly cleaned as per schedule." This policy included the following procedure: "Thorough cleaning: all daily cleaning items; stripping, re-waxing floors (if required) and buffing as per schedule; pull out furniture to clean behind; cleaning of inside windows; washing walls, ceilings (where possible); carbolizing of unit, including doors, closets, chest of drawers; removal of laundering of window curtains and privacy curtains (semi-annually or as per schedule); thorough dusting high and low; includes washroom area as well when cleaning resident's room."

Review of the home's policy "Cleaning Guidelines-Residents Rooms" with a review date of August 2017, noted the following:

"The residents' room shall be thoroughly cleaned and monitored for safety hazards daily." This policy included the following procedure:
"Order of cleaning/ method of cleaning:
1. Put toilet bowl cleaner in toilet to sit
2. Gather garbage
3. Light dust beginning with the high areas first using green microfiber cloth wardrobes tops, pictures, clocks, etc. Window sills, bedside table(s), headboard, dresser(s), TV, etc.
4. Clean windows (inside) using green microfiber cloth folded
5. Dry mop floor
6. Wet mop floor (ensure wet floor sign is displayed)
Washroom
1. Dust top of light fixture using disinfectant dampened red microfiber cloth
2. Clean mirror (glass cleaner) using microfiber cloth folded (re dampen as required)
3. Clean vanity, soap dispenser, towel holder, taps sink (disinfectant cleaner)
4. Clean toilet tank and work your way down to the outside of the bowel using

disinfectant
dampened red microfiber cloth
5. Clean toilet seat top and bottom (disinfectant cleaner) using red microfiber cloth folded
6. Remove all microfiber cloths, cleaners and secure on cart
7. Clean toilet bowl using toilet bowl brush
8. Wet mop bathroom floor
NOTE: Some chemicals require time to be effective and minimize cleaning effort."

Review of the home's policy "Cleaning Guidelines-Common/General Areas" with a review date of August 2017, noted the following:

"LOUNGES:
1. Clean furniture with disinfectant as directed
2. Remove dishes and food stuffs, if any
3. Dry and wet mop floors or vacuum (depending on type of flooring)
4. Clean floors as per schedule and buff/vacuum as per schedule
5. Ensure walls are clean and unmarked
6. Arrange furniture in a pleasant manner (a standard layout should be used and after any
activity or function returned to that layout).
7. Remove excess newspapers which accumulate
NURSES STATION:
1. Dry, wet mop floors as per routine
2. Clean and disinfect the telephone
3. Clean nurses' station desk/counter tops

HALLWAYS:
1. Dry and/or damp mop or use Auto Scrubber to clean hallways daily.
2. Use safe working habits when washing floors by:
• setting out caution signs
• watching residents and offering guidance
• waiting until one side is dry before starting on the other
3. Buff hallways as per routine
4. Clean mats at entrance with vacuum

DINING ROOMS:
1. Clean the dining area twice daily. (where applicable after supper)
2. Sweep and wet mop the floor after breakfast and lunch

3. As scheduled, the dining room is cleaned and buffed
4. Ensure all walls areas are clean. There must be no evidence of food staining on walls
5. Ensure all furniture is clean
6. Close doors and leave lights on when leaving dining room"

In an interview, the Executive Director (ED) stated they were the lead for the housekeeping program. Review of the home's Action Plan for compliance order #001 related to s. 87(2) with the ED noted that an additional eight hours of housekeeping had been added biweekly. This shift was to focus on dusting lounges, main resident areas, baseboards, hallways, buffing and additional cleaning as assigned by the ED. The Action Plan noted that the Administrator would complete daily walk throughs and biweekly audits of cleaning. Housekeeping staff were to complete daily shift routines and submit to the Administrator monthly. The Administrator would track deep cleaning of all resident rooms, hallways and other resident common areas to ensure they were all completed on a regular rotation.

The ED stated that daily cleaning of a resident's room and bathroom included cleaning the garbage, floors, bathrooms, light dusting, and a check of baseboards, registers and window ledges to ensure they were not dusty. The ED stated they had asked housekeeping staff if residents had falls mats to clean the falls mat and to pick up the fall mat and clean underneath it. Mats may not be cleaned every day but housekeeping staff needed to keep an eye on them every day. The ED stated toilets including raised toilet seats should be cleaned every day. The ED stated resident furniture should be dusted and polished daily and housekeeping staff should check behind resident's beds and dressers. The ED stated if housekeepers noticed PPE carts were dirty they should wipe them down and clean them on an as needed basis.

The ED stated dining rooms were cleaned after every meal. The ED stated housekeeping staff cleaned the floors, walls, doors, windows and dusted and the dietary staff cleaned the tables and chairs.

The ED stated that they kept a tracking list of "thorough cleans" in a binder with the dates the clean was completed. The ED stated they were responsible for monitoring the cleaning. The ED stated they looked at the room before, after and during the thorough clean and audited the room and then they signed off that the room was completed.

The ED stated that a deep clean was when the furniture was removed and floors stripped and a thorough clean was when the room was buffed. The ED stated that completion and monitoring of the thorough cleans were documented in the Deep Clean Tracker. The ED stated that a room would be stripped once per year and then buffed once per year. Therefore, the room would have a thorough clean every six months. The ED stated they looked at the last time the room was stripped, if it had been six months that would be the next room to have a thorough clean.

Review of the 2018 Deep Clean Tracking sheet for C Wing with the ED noted that five out of 21 rooms (24 per cent) and common areas had not had a thorough clean within six months. The ED acknowledged that one room had not had any cleaning in 2018, one had not been cleaned within six months and the remaining three rooms had been documented on a different tracking sheet and had not been carried over on to the 2018 Deep Clean Tracking sheet.

Review of the 2018 Deep Clean Tracking sheet for B Wing with the ED noted 30 of 31 rooms (97 per cent) and common areas had not had not had a thorough clean within a six month period in 2018.

There was no documentation on the 2018 Deep Clean Tracking sheet to support that any of the dining rooms and hallways had been cleaned in 2018. The ED acknowledged that the dining rooms and hallways had not been completed to date.

Inspector #522 requested to see the schedule of thorough cleans from June 2018 to December 2018. The ED stated they did not have a schedule for "Thorough Cleans" and currently they had been assigning the rooms at the time the shift was scheduled.

Review of C Wing Housekeeping Routine sheets for a specific month with the ED, noted the following:
- The C Wing lounge was not documented as having been cleaned one out of nine scheduled times (11 per cent).
- The C Wing Nurses Station was not documented as having been cleaned two out of four scheduled times (50 per cent).
- Daily housekeeping tasks were not documented as having been completed four out of 31 days (13 per cent).

Review of B Wing Housekeeping Routine sheets for a specific month with the ED, noted the following:
- The Main Lounge was not documented as having been cleaned three out of 14 scheduled times (21 per cent).
- The B Wing Nurses Station was not documented as having been cleaned three out of four scheduled times (75 per cent).
- Daily housekeeping tasks were not documented as having been completed three out of 31 days (10 per cent).

The ED stated the housekeeper worked alone on one of the dates, so they would only have done garbages and spot mopped. On another date, the ED had asked the housekeepers to complete focused cleaning in C Wing and the expectation would be that the housekeepers should have completed their normal duties also. The ED stated on the other dates in the month, the housekeepers were not working short and the housekeepers should have documented completion of their work.

Inspectors #522 and #740 toured home areas with the ED.

The ED acknowledged the areas of concern identified by inspectors. The ED acknowledged that all areas that inspectors had identified should have been cleaned as part of the housekeeper's daily tasks. The ED stated that hand sanitizers were dripping on the floors causing the finish to come off and they had asked maintenance to order trays for underneath the hand sanitizer to catch the liquid sanitizer. The ED acknowledged that some of the dirt was ground into the floors especially at the edges and that stripping the floors would take it out.

Observations of resident bedrooms found that 11 out of 22 (50 per cent) of the rooms had still not been cleaned thoroughly. The Chapel, Main lounge, B and C Wing lounge, all dining rooms and hallways and resident PPE carts were also noted to still have dirt, debris and cobwebs.

In an interview, the ED gave Inspector #522 documentation of the "thorough cleans" completed from June 2018 to present. The ED acknowledged that they did not have all the documentation of the completion of the cleaning tasks from the "thorough cleans" that had occurred from June 2018 to present.

Based on observations, interviews and record review it was found that there were

areas of the home that were not kept clean. It was identified that there was no schedule in place at the time of the inspection for the thorough cleaning of resident rooms and common areas. There were several rooms that had not had a thorough clean completed within a six month time period. It was also identified that the procedures that had been developed as part of the organized program of housekeeping for cleaning resident rooms and common areas were not fully implemented.

The licensee has failed to ensure that the procedures that had been developed as part of the organized program of housekeeping were implemented for cleaning floors, furnishings, and wall surfaces for resident bedroom and common areas. [s. 87. (2) (a)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended: CO# 003

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug was administered to a resident in the home unless the drug had been prescribed for the resident.

The home submitted a Critical Incident Systems (CIS) report to the Ministry of Health and Long-Term Care, related to a medication incident whereby an identified resident was given another resident's medication.

Review of the CIS report and medication incident report noted that a Registered Practical Nurse (RPN) gave an identified resident the wrong medication. The RPN gave the identified resident medication that belonged to another resident. The RPN asked the identified resident if they were a different resident and the identified resident stated "yes". There were no ill effects to the resident.

In an interview, the Director of Care verified that the identified resident had been administered medications that had not been prescribed for the resident.

The licensee has failed to ensure that no drug was administered to a resident in the home unless the drug had been prescribed for the resident. [s. 131. (1)]

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

On May 4, 2018, during the Resident Quality Inspection (RQI), #2018_606563_0005, Compliance Order (CO) #002 was issued and ordered the licensee to take action to achieve compliance by ensuring that time specific drugs were administered to residents in accordance with the directions for use specified by the prescriber. This order was to be complied on June 8, 2018.

During the inspection, medication incidents were reviewed from June 8, 2018 to November 13, 2018, and noted the following medication incidents:

A) Review of a specific medication incident noted that an identified resident did not receive their medication as prescribed.

In an interview, the Registered Practical Nurse (RPN) stated that they had signed off in the identified resident's electronic Medication Administration Record that the resident had been administered the specific medication but had forgotten to remove the medication from the resident's blister pack.

B) Review of another medication incident noted that an identified resident did not receive their medication as prescribed. The medication incident report noted that the RPN went to give the resident their specific medication and found that the specific medication was not available in the facility.

In an interview, the Registered Nurse stated that the RPN informed them that they could not find the identified resident's specific medication. The RN stated the identified resident was the only resident on the specific medication so they were unable to borrow the medication from another resident. The RN stated they called Medical Pharmacies and asked them to deliver the medication as soon as possible. The RN stated that due to the length of time it took for the medication to be delivered the identified resident missed their dose as prescribed.

C) Review of another medication incident noted that an identified resident was not administered their medication as prescribed. The medication incident report noted that the resident's medication was given 48 hours earlier that prescribed.

In an interview, the RN stated they had discovered the medication incident with a RPN during their medication count.

In an interview, the Director of Care acknowledged that the identified residents did not receive their medication as prescribed.

The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended: CO# 004

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

WN #5: 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 and every adverse drug reaction was documented, together with a record of the immediate actions taken to assess and maintain the resident's health.

A) Review of a specific medication incident report noted that an identified resident

did not receive their medication as prescribed. The medication incident report noted that the Registered Practical Nurse (RPN) went to give the resident their specific medication and found that the specific medication was not available in the facility.

The medication incident report noted the identified resident was to be monitored. Review of the identified resident's electronic health record in Point Click Care (PCC) noted no documentation related to the monitoring of the resident after the resident did not receive their medication as prescribed.

In an interview, the Registered Nurse (RN) reviewed the resident's electronic health record in PCC with the inspector and verified there was no documentation related to the medication incident. The RN stated that staff would have monitored the resident and this should have been documented in the resident's progress notes.

In an interview, the Director of Care stated that registered staff should have documented the monitoring of the identified resident when the resident did not receive their medication as prescribed.

B) Review of another medication incident report noted that an identified resident was not administered their medication as prescribed. The medication incident report noted that the resident's medication was given 48 hours earlier that prescribed.

In an interview, the RN stated they had discovered the medication incident with a RPN. The RN reviewed the identified resident's electronic progress notes in PCC with the inspector. The RN confirmed that there was no documentation of monitoring the identified resident after the medication incident.

In an interview, the Director of Care stated that registered staff should have documented the monitoring of the identified resident when the resident had their medication administered earlier than prescribed.

The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was documented, together with a record of the immediate actions taken to assess and maintain the resident's health. [s. 135. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every medication incident involving a resident and every adverse drug reaction is documented, together with a record of the immediate actions taken to assess and maintain the resident's health, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may occur shall immediately report the suspicion and the information upon which it was based to the Director: Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The home submitted a Critical Incident Systems (CIS) report to the Ministry of Health and Long-Term Care, related to improper/incompetent treatment of a resident that resulted in harm or risk to a resident. The incident had occurred the previous day.

Review of the CIS report and the corresponding medication incident report noted that a Registered Practical Nurse (RPN) gave an identified resident the wrong medication. The RPN gave the identified resident medication that belonged to another resident. The oncall doctor was notified and the identified resident's vitals were monitored every two hours overnight and every shift for 24 hours. The identified resident was drowsy throughout the next day.

In an interview, the Director of Care stated that the MOHLTC should have been notified immediately regarding of the incompetent treatment of the identified resident that had resulted in a risk of harm to the resident.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may occur shall immediately report the suspicion and the information upon which it was based to the Director: Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. [s. 24. (1)]

Issued on this 25th day of March, 2019 (A1)

[redacted]

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by JULIE LAMPMAN (522) - (A1)
Inspection No. / No de l'inspection :	2018_725522_0017 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	006606-18, 010096-18, 016935-18, 017672-18, 029559-18, 030018-18 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Mar 25, 2019(A1)
Licensee / Titulaire de permis :	Caressant-Care Nursing and Retirement Homes Limited 264 Norwich Avenue, WOODSTOCK, ON, N4S-3V9
LTC Home / Foyer de SLD :	Caressant Care on Bonnie Place 15 Bonnie Place, St Thomas, ON, N5R-5T8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Justyna Zmuda

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

To Caressant-Care Nursing and Retirement Homes Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee must be compliant with s. 6. (7) of the LTCHA.

Specifically, the licensee must ensure that the care set out in a resident's plan of care is provided to the resident as specified in the plan.

Grounds / Motifs :

1. The licensee had failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A Critical Incident Systems (CIS) report was submitted by the home to the Ministry of Health and Long-Term Care regarding a resident incident.

The CIS report indicated that an identified resident had a fall.

Review of the identified resident's most recent plan of care noted specific interventions for the identified resident.

In an interview, the Personal Support Worker stated that they had not followed the identified resident's specific interventions.

In an interview, the Registered Nurse (RN) stated they responded to the identified resident's fall. The RN stated specific interventions were not in place for the resident at the time of their fall.

In an interview, the Director of Care stated staff should have followed the identified resident's plan of care.

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

The severity of this issue was determined to be a level 3 as there was actual harm to the resident. The scope of the issue was a level 1 as it was isolated. The home had a level 3 history of noncompliance with this section of the LTCHA, that included a Voluntary Plan of Correction (VPC) issued May 4, 2018 (2018_606563_0005), a VPC issued April 28, 2017 (2017_263524_0005), a VPC issued March 3, 2016 (2016_254610_0005), and a VPC issued March 18, 2016 (2016_260521_0004). (522)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 29, 2019

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with r. 8. (1)(b) of Ontario Regulation 79/10.

Specifically, the licensee must ensure that the home's "Head Injury Routine" policy is complied with.

Grounds / Motifs :

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

A Critical Incident Systems (CIS) report was submitted by the home to the Ministry of Health and Long-Term Care regarding a resident incident.

The CIS report indicated that an identified resident had a fall.

Review of the home's policy "Safety Plan – Resident Part C - Post Fall Management" with a review date of May 2018, noted the following: "Upon discovery of a fall, Code Care is called. The interdisciplinary team will: a) Initiate Head Injury Routine and assess the resident's level of consciousness and any potential injury associated with the fall as required."

Review of the home's policy "Head Injury Routine" with a review date of July 2016, noted the following:
"Immediately after a resident sustains a trauma to the head of an unwitnessed fall, the Registered Nurse in charge is to assess the resident, using the Glascow Coma Scale and do a complete set of vital signs." Using the Glascow Coma Scale as a documentation tool and vital signs, assess the resident for 72 hours with the following frequency: "Every half hour for the first two hours following the injury, every hour for the next four hours, every four hours for the next eight hours, every shift for the remainder of the 72 hour monitoring."

Review of the identified resident's Glascow Coma Scale (GCS) noted not all of the assessments were documented.

In an interview, the Registered Nurse (RN) stated they completed the GCS for the identified resident after their fall. The RN was unable to explain why all of the GCS was not documented. The RN stated they did not complete the GCS for the identified resident at a specific time as required, as the resident was sleeping and the RN did not want to bother the resident.

In a telephone interview, another RN stated when they started their shift they noticed that the previous entry on the GCS was noted as "sleeping" and that this was unsatisfactory when completing post falls vitals on a resident.

In an interview, the Director of Care stated registered staff should have followed the home's policy and completed all sections of the GCS and roused the identified resident while they were sleeping to complete the GCS.

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

The severity of this issue was determined to be a level 3 as there was actual harm to the resident. The scope of the issue was a level 1 as it was isolated. The home had a level 3 history of noncompliance with this section of Ontario Regulation 79/10, that included a Voluntary Plan of Correction (VPC) issued May 4, 2018 (2018_606563_0005), a VPC issued March 3, 2016 (2016_254610_0005), and a VPC issued March 18, 2016 (2016_260521_0004). (522)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Mar 29, 2019

Order # / Ordre no : 003

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

Linked to Existing Order / Lien vers ordre existant: 2018_606563_0005, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,

(a) cleaning of the home, including,

(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and

(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces;

(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:

(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,

(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and

(iii) contact surfaces;

(c) removal and safe disposal of dry and wet garbage; and

(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Order / Ordre :

The licensee must be compliant with Ontario Regulation 79/10 s. 87. (2)(a).

Specifically the licensee must:
a) Ensure that their written policies titled "Cleaning Guidelines - Thorough Cleaning", "Cleaning Guidelines-Residents Rooms" and "Cleaning Guidelines-Common/General Areas" are fully implemented.
b) Ensure that there is a documented schedule for the "Thorough Cleaning" of the home, furnishings and equipment, including flooring and baseboards in resident rooms, bathrooms and common areas and that this schedule is fully implemented. The completion of the cleaning tasks outlined in the "Thorough Cleaning" schedule must be documented.
c) Ensure the monitoring of the thorough cleans is documented.
d) All housekeeping staff will receive education on the home's policies "Cleaning Guidelines - Thorough Cleaning", "Cleaning Guidelines-Residents Rooms" and "Cleaning Guidelines-Common/General Areas". This education must be documented.

Grounds / Motifs :

1. The licensee has failed to ensure that procedures that had been developed as part of the organized program of housekeeping were implemented for cleaning floors, furnishings, and wall surfaces for resident bedrooms and common areas.

On May 4, 2018, during the Resident Quality Inspection (RQI), #2018_606563_0005, Compliance Order (CO) #001 was issued and ordered the licensee to take action to achieve compliance by ensuring that procedures were developed and implemented as part of the organized program of housekeeping for cleaning floors, furnishings, and wall surfaces for resident bedroom and common areas. This order was to be complied by June 8, 2018.

CO #001 stated, "The licensee must be compliant with Ontario Regulation s. 87 (2) (a).
Specifically the licensee must:
a) Ensure that their written policy titled "Cleaning Guidelines - Thorough Cleaning" is fully implemented.
b) Ensure that there is a documented schedule for the "Thorough Cleaning" of the home, furnishings and equipment, including flooring and baseboards in resident rooms, bathrooms and common areas and that this schedule is fully implemented.

The completion of the cleaning tasks outlined in the "Thorough Cleaning" schedule must be documented.
c) Ensure a monitoring process is developed and implemented, including the staff responsible for monitoring, to ensure that the home, furnishings and equipment are kept clean and sanitary. This monitoring process must be documented."

Observations of resident bedrooms on a specific date, found that 17 out of 22 (77 per cent) of the rooms were not kept clean. Resident bedrooms were observed to have dust and debris along the perimeters of the room, under beds and closets as well as in bathrooms.

The Chapel, Main lounge, B and C Wing lounges, all dining rooms and hallways were also noted as not clean.

Review of the number of Personal Protective Equipment (PPE) carts outside of resident rooms noted that 6 out of 10 PPE carts had stains, dirt and debris on them and on the floor around the carts.

In an interview, an identified housekeeper stated dining rooms were cleaned everyday right after breakfast. The housekeeper stated cleaning of all dining rooms took place at 0920, 1315, and 1815 hours, after residents had completed their meals. The housekeeper stated there was a schedule of when common areas were cleaned and a schedule for thorough cleans. The housekeeper stated usually two to three rooms had a thorough clean per week.

In an interview, another housekeeper stated they were responsible to clean resident rooms, which included cleaning behind all the doors and that they tried to dust five or six resident rooms a day. The housekeeper stated hallways were cleaned every morning. The housekeeper stated they were responsible for a specific wing and three rooms in another hall and stated they felt this was a lot for one person. The housekeeper stated a deep clean of a resident's room consisted of steam cleaning edges and scraping edges of the room, washing the walls, dusting, and cleaning the resident's bed. The housekeeper stated two to three rooms get deep cleaned every other week. The housekeeper stated when a common area on the daily rotation was cleaned the housekeeper would do a high and low dust, scrape edges, sweep, and mop the area.

Observations of resident bedrooms found that 17 out of 22 (77 per cent) of the rooms were not kept clean. Resident bedrooms were observed to have dust and debris along the perimeters of the room, under beds and closets as well as in bathrooms.

The Chapel, Main lounge, B and C Wing lounges, all dining rooms and hallways were also noted as not clean.

Review of the number of Personal Protective Equipment (PPE) carts outside of resident rooms noted that 6 out of 10 PPE carts had stains, dirt and debris on them and on the floor around the carts.

Follow up observations were made of residents' rooms, dining rooms and common areas including hallways, identified as areas of concern from the previous day. Several resident rooms, dining rooms, common areas and PPE carts remained unclean.

Review of the home's policy "Cleaning Guidelines - Thorough Cleaning" with a review date of August 2017, noted the following:
"All areas of the facility must be thoroughly cleaned as per schedule." This policy included the following procedure: "Thorough cleaning: all daily cleaning items; stripping, re-waxing floors (if required) and buffing as per schedule; pull out furniture to clean behind; cleaning of inside windows; washing walls, ceilings (where possible); carbolizing of unit, including doors, closets, chest of drawers; removal of laundering of window curtains and privacy curtains (semi-annually or as per schedule); thorough dusting high and low; includes washroom area as well when cleaning resident's room."

Review of the home's policy "Cleaning Guidelines-Residents Rooms" with a review date of August 2017, noted the following:

"The residents' room shall be thoroughly cleaned and monitored for safety hazards daily." This policy included the following procedure:
"Order of cleaning/ method of cleaning:
1. Put toilet bowl cleaner in toilet to sit
2. Gather garbage
3. Light dust beginning with the high areas first using green microfiber cloth wardrobes tops, pictures, clocks, etc. Window sills, bedside table(s), headboard,

dresser(s), TV, etc.
4. Clean windows (inside) using green microfiber cloth folded
5. Dry mop floor
6. Wet mop floor (ensure wet floor sign is displayed)
Washroom
1. Dust top of light fixture using disinfectant dampened red microfiber cloth
2. Clean mirror (glass cleaner) using microfiber cloth folded (re dampen as required)
3. Clean vanity, soap dispenser, towel holder, taps sink (disinfectant cleaner)
4. Clean toilet tank and work your way down to the outside of the bowel using disinfectant
dampened red microfiber cloth
5. Clean toilet seat top and bottom (disinfectant cleaner) using red microfiber cloth folded
6. Remove all microfiber cloths, cleaners and secure on cart
7. Clean toilet bowl using toilet bowl brush
8. Wet mop bathroom floor
NOTE: Some chemicals require time to be effective and minimize cleaning effort."

Review of the home's policy "Cleaning Guidelines-Common/General Areas" with a review date of August 2017, noted the following:

"LOUNGES:
1. Clean furniture with disinfectant as directed
2. Remove dishes and food stuffs, if any
3. Dry and wet mop floors or vacuum (depending on type of flooring)
4. Clean floors as per schedule and buff/vacuum as per schedule
5. Ensure walls are clean and unmarked
6. Arrange furniture in a pleasant manner (a standard layout should be used and after any
activity or function returned to that layout).
7. Remove excess newspapers which accumulate
NURSES STATION:
1. Dry, wet mop floors as per routine
2. Clean and disinfect the telephone
3. Clean nurses' station desk/counter tops

HALLWAYS:

1. Dry and/or damp mop or use Auto Scrubber to clean hallways daily.
2. Use safe working habits when washing floors by:
• setting out caution signs
• watching residents and offering guidance
• waiting until one side is dry before starting on the other
3. Buff hallways as per routine
4. Clean mats at entrance with vacuum

DINING ROOMS:
1. Clean the dining area twice daily. (where applicable after supper)
2. Sweep and wet mop the floor after breakfast and lunch
3. As scheduled, the dining room is cleaned and buffed
4. Ensure all walls areas are clean. There must be no evidence of food staining on walls
5. Ensure all furniture is clean
6. Close doors and leave lights on when leaving dining room"

In an interview, the Executive Director (ED) stated they were the lead for the housekeeping program. Review of the home's Action Plan for compliance order #001 related to s. 87(2) with the ED noted that an additional eight hours of housekeeping had been added biweekly. This shift was to focus on dusting lounges, main resident areas, baseboards, hallways, buffing and additional cleaning as assigned by the ED. The Action Plan noted that the Administrator would complete daily walk throughs and biweekly audits of cleaning. Housekeeping staff were to complete daily shift routines and submit to the Administrator monthly. The Administrator would track deep cleaning of all resident rooms, hallways and other resident common areas to ensure they were all completed on a regular rotation.

The ED stated that daily cleaning of a resident's room and bathroom included cleaning the garbage, floors, bathrooms, light dusting, and a check of baseboards, registers and window ledges to ensure they were not dusty. The ED stated they had asked housekeeping staff if residents had falls mats to clean the falls mat and to pick up the fall mat and clean underneath it. Mats may not be cleaned every day but housekeeping staff needed to keep an eye on them every day. The ED stated toilets including raised toilet seats should be cleaned every day. The ED stated resident furniture should be dusted and polished daily and housekeeping staff should check behind resident's beds and dressers. The ED stated if housekeepers noticed PPE

carts were dirty they should wipe them down and clean them on an as needed basis.

The ED stated dining rooms were cleaned after every meal. The ED stated housekeeping staff cleaned the floors, walls, doors, windows and dusted and the dietary staff cleaned the tables and chairs.

The ED stated that they kept a tracking list of "thorough cleans" in a binder with the dates the clean was completed. The ED stated they were responsible for monitoring the cleaning. The ED stated they looked at the room before, after and during the thorough clean and audited the room and then they signed off that the room was completed.

The ED stated that a deep clean was when the furniture was removed and floors stripped and a thorough clean was when the room was buffed. The ED stated that completion and monitoring of the thorough cleans were documented in the Deep Clean Tracker. The ED stated that a room would be stripped once per year and then buffed once per year. Therefore, the room would have a thorough clean every six months. The ED stated they looked at the last time the room was stripped, if it had been six months that would be the next room to have a thorough clean.

Review of the 2018 Deep Clean Tracking sheet for C Wing with the ED noted that five out of 21 rooms (24 per cent) and common areas had not had a thorough clean within six months. The ED acknowledged that one room had not had any cleaning in 2018, one had not been cleaned within six months and the remaining three rooms had been documented on a different tracking sheet and had not been carried over on to the 2018 Deep Clean Tracking sheet.

Review of the 2018 Deep Clean Tracking sheet for B Wing with the ED noted 30 of 31 rooms (97 per cent) and common areas had not had not had a thorough clean within a six month period in 2018.

There was no documentation on the 2018 Deep Clean Tracking sheet to support that any of the dining rooms and hallways had been cleaned in 2018. The ED acknowledged that the dining rooms and hallways had not been completed to date.

Inspector #522 requested to see the schedule of thorough cleans from June 2018 to December 2018. The ED stated they did not have a schedule for "Thorough Cleans"

and currently they had been assigning the rooms at the time the shift was scheduled.

Review of C Wing Housekeeping Routine sheets for a specific month with the ED, noted the following:
- The C Wing lounge was not documented as having been cleaned one out of nine scheduled times (11 per cent).
- The C Wing Nurses Station was not documented as having been cleaned two out of four scheduled times (50 per cent).
- Daily housekeeping tasks were not documented as having been completed four out of 31 days (13 per cent).

Review of B Wing Housekeeping Routine sheets for a specific month with the ED, noted the following:
- The Main Lounge was not documented as having been cleaned three out of 14 scheduled times (21 per cent).
- The B Wing Nurses Station was not documented as having been cleaned three out of four scheduled times (75 per cent).
- Daily housekeeping tasks were not documented as having been completed three out of 31 days (10 per cent).

The ED stated the housekeeper worked alone on one of the dates, so they would only have done garbages and spot mopped. On another date, the ED had asked the housekeepers to complete focused cleaning in C Wing and the expectation would be that the housekeepers should have completed their normal duties also. The ED stated on the other dates in the month, the housekeepers were not working short and the housekeepers should have documented completion of their work.

Inspectors #522 and #740 toured home areas with the ED.

The ED acknowledged the areas of concern identified by inspectors. The ED acknowledged that all areas that inspectors had identified should have been cleaned as part of the housekeeper's daily tasks. The ED stated that hand sanitizers were dripping on the floors causing the finish to come off and they had asked maintenance to order trays for underneath the hand sanitizer to catch the liquid sanitizer. The ED acknowledged that some of the dirt was ground into the floors especially at the edges and that stripping the floors would take it out.

Observations of resident bedrooms found that 11 out of 22 (50 per cent) of the rooms had still not been cleaned thoroughly. The Chapel, Main lounge, B and C Wing lounge, all dining rooms and hallways and resident PPE carts were also noted to still have dirt, debris and cobwebs.

In an interview, the ED gave Inspector #522 documentation of the "thorough cleans" completed from June 2018 to present. The ED acknowledged that they did not have all the documentation of the completion of the cleaning tasks from the "thorough cleans" that had occurred from June 2018 to present.

Based on observations, interviews and record review it was found that there were areas of the home that were not kept clean. It was identified that there was no schedule in place at the time of the inspection for the thorough cleaning of resident rooms and common areas. There were several rooms that had not had a thorough clean completed within a six month time period. It was also identified that the procedures that had been developed as part of the organized program of housekeeping for cleaning resident rooms and common areas were not fully implemented.

The licensee has failed to ensure that the procedures that had been developed as part of the organized program of housekeeping were implemented for cleaning floors, furnishings, and wall surfaces for resident bedroom and common areas.

The severity of this issue was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of the issue was a level 3 as it was widespread. The home had a level 5 history of noncompliance, with multiple noncompliance with at least one related order to this section of Ontario Regulation 79/10, that included: A Compliance Order issued May 4, 2018 (2018_606563_0005), a Voluntary Plan of Correction (VPC) issued April 28, 2017 (2017_263524_0005), and a VPC issued March 18, 2016 (2016_260521_0004). (522)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 31, 2019(A1)

Order # / Ordre no : 004

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

Linked to Existing Order / Lien vers ordre existant: 2018_606563_0005, CO #002;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with r. 131. (2) of Ontario Regulation 79/10.

Specifically, the licensee shall ensure that identified residents and all other residents are administered drugs in accordance with the directions for use specified by the prescriber.

Grounds / Motifs :

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

On May 4, 2018, during the Resident Quality Inspection (RQI), #2018_606563_0005, Compliance Order (CO) #002 was issued and ordered the licensee to take action to achieve compliance by ensuring that time specific drugs were administered to residents in accordance with the directions for use specified by the prescriber. This order was to be complied on June 8, 2018.

During the inspection, medication incidents were reviewed from June 8, 2018 to November 13, 2018, and noted the following medication incidents:

A) Review of a specific medication incident noted that an identified resident did not receive their medication as prescribed.

In an interview, the Registered Practical Nurse (RPN) stated that they had signed off

in the identified resident's electronic Medication Administration Record that the resident had been administered the specific medication but had forgotten to remove the medication from the resident's blister pack.

B) Review of another medication incident noted that an identified resident did not receive their medication as prescribed. The medication incident report noted that the RPN went to give the resident their specific medication and found that the specific medication was not available in the facility.

In an interview, the Registered Nurse stated that the RPN informed them that they could not find the identified resident's specific medication. The RN stated the identified resident was the only resident on the specific medication so they were unable to borrow the medication from another resident. The RN stated they called Medical Pharmacies and asked them to deliver the medication as soon as possible. The RN stated that due to the length of time it took for the medication to be delivered the identified resident missed their dose as prescribed.

C) Review of another medication incident noted that an identified resident was not administered their medication as prescribed. The medication incident report noted that the resident's medication was given 48 hours earlier that prescribed.

In an interview, the RN stated they had discovered the medication incident with a RPN during their medication count.

In an interview, the Director of Care acknowledged that the identified residents did not receive their medication as prescribed.

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

The severity of this issue was determined to be a level 2 as there was minimal harm or potential for actual harm to the resident. The scope of the issue was a level 3 as it was widespread involving three out of three residents. The home had a level 5 history of noncompliance, with multiple noncompliance with at least one related order to this section of Ontario Regulation 79/10, that included a Compliance Order (CO) issued May 4, 2018 (2018_606563_0005), a CO issued April 28, 2017 (2017_263524_0005), and a Voluntary Plan of Correction issued March 18, 2016

(2016_260521_0004).
(522)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 31, 2019(A1)

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:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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 25th day of March, 2019 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by JULIE LAMPMAN (522) - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

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Service Area Office / Bureau régional de services : London Service Area Office