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 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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 5, 2017	2017_484646_0006	008125-16, 029711-16, 030834-16, 000622-17, 006720-17	Complaint

Licensee/Titulaire de permis

Downsview Long Term Care Centre Limited
3595 Keele Street NORTH YORK ON M3J 1M7

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

Downsview Long Term Care Centre
3595 Keele Street NORTH YORK ON M3J 1M7

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

IVY LAM (646), VERON ASH (535)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 8, 9, 10, 11, 12, 15,16, 17,18,19, 22, 23, 24, 25, 26, and 29, 2017.

The following Complaint inspections were conducted:

Related to Skin and Wound Care: 029711-16
Related to Pain: 030834-16
Related to Hospitalization and Change in Condition: 008125-16
Related to Prevention of Abuse, Neglect and Retaliation: 000622-17
Related to Food Quality, Nutrition and Hydration, Continence Care and Bowel Management, and Reporting and Complaints: 006720-17.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), primary physician, senior accountant, clinical coordinators, Resident Assessment Instrument (RAI) coordinator, Nurse Managers (NM), Physiotherapist (PT), Registered Dietitian (RD), Environmental Services Manager (ESM), educational coordinator, Social Worker (SW), resident family resource worker, Ontario Disability Support Program (ODSP) Manager, ODSP Caseworker, registered nursing staff, recreation assistant, Foot Care Nurse, Personal Support Workers (PSWs), dietary aide, housekeeping staff, receptionist, residents, and Substitute Decision Makers (SDMs).

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

14 WN(s)
8 VPC(s)
2 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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,
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds receive immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection.

Complaint #029711-16 was received by the Ministry of Health and Long-Term Care (MOHLTC) on an identified date regarding resident #003 which identified concerns related to immediate treatment and interventions to prevent infection.

The progress notes revealed that from June to August 2016, resident #003 experienced an ongoing identified change in status for an identified number of days. However, the change in status was temporarily controlled with the administration of an identified

medication. Furthermore, on an identified date, a registered nurse from the agency, who completed the dressing change to an identified part of the resident's body contacted the physician to discuss the status of the impaired skin integrity on an identified part of the resident's body, which was assessed as the source of the change in status. The progress notes indicated that as a result of that discussion, the resident was transferred to an acute care hospital.

During an interview, registered staff Registered Nurse (RN) #124 and RN #101 stated that in retrospect, because of the change in status, the Nurse Led Outreach Team (NLOT) or the physician should have been contacted sooner to further assess the resident's need for possible medication or transfer to hospital at an earlier date.

A review of the hospital admission notes from an identified date revealed that the resident had significant infection in the identified part of the body; and the hospital physician informed the family that the resident would require an identified surgery as a result of the infection.

During an interview, the Assistant Director of Care (ADOC) stated that the resident should have been transferred to hospital sooner or external resources should have been activated to support treatment and intervention.

The scope of the non-compliance is isolated to resident #003. The severity is actual harm.

A review of the home's compliance history revealed previous non-compliance related to the Long- Term Care Homes Act, O.Reg. c. 8, s. 50 (2). The non-compliance was as follows:
- Inspection #2015_108110_0002 -- complaint inspection, CO issued. [s. 50. (2) (b) (ii)]

2. The licensee has failed to ensure equipment, supplies, devices and positioning aids were readily available as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing.

A complaint (#030834-16) was received by the MOHLTC on an identified date regarding availability of equipment for resident #004.

Record review revealed that the resident was admitted to the home on an identified date, and was assessed by the physiotherapist (PT) on the same day. The progress notes

revealed that the resident was not admitted to the home with an identified assistive mobility device; however the family requested a loaner while the decision was being made to purchase a new assistive mobility device. During an interview, the PT stated that he/she requested a specific assistive mobility device from the home's vendor on September 2016; however, the resident remained in bed until the end of September when a loaner device became available; then on October 2016, resident #004 personal assistive mobility device arrived. He/she confirmed that the assistive device was delayed; and that it took one month to receive the assistive device in order to be able to transfer the resident out of bed and outside the room for meals and activities.

Record review revealed that in October 2016, the resident developed an identified area of impaired skin integrity on an identified part of his/her body.

During an interview, the PT stated that the home does not have the specific identified assistive mobility device on site and that the expectation was that it would take approximately two week for a loaner assistive device to be delivered to the home; however, he/she confirmed that this assistive device order was delayed by the vendor. [s. 50. (2) (c)]

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. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff that provide direct care to residents were provided training related to continence care and bowel management on either an

annual basis, or based on the staff's assessed training needs.

For the purposes of paragraph 6 of subsection 76 (7) of the Act, the licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations: continence care and bowel management.

The MOHLTC received a complaint (#006720-17) related to the home's assessment and provision of continence care.

Interviews with personal support worker (PSW) #138, RN #137 and #140 revealed that they could not recall training on the continence care and bowel management program in the past year.

Interviews with the Education Coordinator and ADOC revealed that under the previous Director of Care (DOC), education on continence care and bowel management was provided for staff every other year, not on an annual basis. The ADOC revealed that education on continence care and bowel management was not provided to staff in 2016. [s. 221. (2) 1.]

2. The licensee has failed to ensure that all staff who provide direct care to residents receive the training provided in pain management, staff must receive annual training in all the areas required under subsection 76 (7) of the Act.

For the purposes of paragraph 6 of subsection 76 (7) of the Act, the licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations: pain management, including pain recognition of specific and non-specific signs of pain.

Record review revealed that the education and training records related to the pain management program was not available for 2016. During interviews, the Education Coordinator and the ADOC confirmed that the pain management program training for 2016 was not completed because the Education Coordinator was informed by the previous DOC that the training for this program was not required annually.

The scope of the non-compliance is widespread. The severity is minimum risk.

A review of the home's compliance history revealed previous non-compliance related to the Long- Term Care Homes Act, O.Reg. c. 8, s. 221, was issued. The Noncompliance was as follows:
- Inspection #2014_321501_0021 – compliance order (CO) was issued. [s. 221. (2) 1.]

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

s. 6. (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 the plan of care set out clear directions to staff and others who provided direct care to the resident.

A complaint was received by the MOHLTC on an identified date, regarding the plan of care for resident #005.

Record review revealed that resident #005 was assessed using home's Resident Assessment Instrument (RAI) and was at an identified level of ability to make his/her own personal care decisions.

During an interview, the primary PSW #129 stated that the resident was very particular in that he/she wanted his/her room environment and in the provision of an identified area of care.

According to the PSW, the request would have been considered reasonable.

The PSW also stated that he/she informed the registered staff about the resident's request; however, the information was not included in the resident's written plan of care. A review of the resident's written plan of care revealed a hand-written statement which stated that day which the resident preferred to have his/her identified care, but did not include specific detail on how the resident preferred the identified care. Moreover, the written care plan did not include information related to the resident's preference for his/her room environment.

During an interview, the ADOC stated that the expectation was that registered staff update the resident's written care plan with pertinent information so that the plan of care set out clear directions to staff and other who provide direct care to the resident. [s. 6. (1) (c)]

2. A complaint was received by the MOHLTC an identified date regarding the plan of care for resident #003.

A review of the resident's written plan of care revealed that the care plan was not updated to include the identification of an identified medical condition and the associated signage and personal protective equipment (PPE) was not available. During an interview, RN #101 confirmed that the identified medical condition was not communicated to staff and that PPEs should have been made and the information should have been updated in the resident's written plan of care.

During an interview, the ADOC stated that the expectation was for registered staff

members to keep the written care plan updated with pertinent information to ensure clear directions were provided to staff and others who provided direct care to the resident. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide care to the resident.

Complaint #029711-16 was received by the MOHLTC on an identified date regarding concerns with care and treatment related to resident #003.

During an interview, PSW #148 stated that when providing care for resident with an identified nutrition intervention, he/she handle the equipment for the identified nutrition intervention. The PSW also stated that he/she repeated the procedure multiple times while providing care for residents. During an interview, RN #124 confirmed that he/she taught the PSWs how to work with the equipment for the identified nutrition intervention. However, he/she also stated that PSWs should not be handling the equipment for the identified nutrition intervention.

During an interview, the ADOC stated that PSWs should not be handling residents' equipment for the identified nutrition intervention and that the expectation was for PSWs and registered staff to work together to ensure that registered staff members handle the equipment for the identified nutrition intervention as appropriate while PSWs provide care. The ADOC also confirmed that the resident's plan of care did not set out clear directions to staff and others who provide care to the resident. [s. 6. (1) (c)]

4. Complaint #030834-16 was received by the MOHLTC on an identified date regarding the plan of care for resident #004.

During an interview, PSW #148 stated that when providing care for resident with an identified nutrition intervention, he/she handle the equipment for the identified nutrition intervention. The PSW also stated that he/she repeated the procedure multiple times while providing care for residents. During an interview, RN #124 confirmed that he/she taught the PSWs how to work with the equipment for the identified nutrition intervention. However, he/she also stated that PSWs should not be handling the equipment for the identified nutrition intervention.

During an interview, the ADOC stated that PSWs should not be handling residents' equipment for the identified nutrition intervention and that the expectation was for PSWs

and registered staff to work together to ensure that registered staff members handle the equipment for the identified nutrition intervention as appropriate while PSWs provide care. The ADOC also confirmed that the resident's plan of care did not set out clear directions to staff and others who provide care to the resident. [s. 6. (1) (c)]

5. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complement each other.

Complaint #029711-16 was received by the MOHLTC on an identified date regarding resident #003 identifying issues related to altered areas of skin integrity and interventions used to promote healing.

Record review revealed that resident #003 was admitted to the home on an identified date, and his/her plan of care showed that the resident was to be transferred to acute care hospital as needed. He/she was assessed using the home's Resident Assessment Instrument (RAI) to be at an identified ability to make decisions, to understand others, and required an identified level of staff assistance for activities of daily living. On an identified date, the progress notes revealed that the resident was assessed by a Speech-Language Pathologist (SLP) and made an identified recommendation related to the resident's oral intake. Resident #003 was admitted to the home with an identified nutrition treatment in place. The nurse consultation notes revealed that the resident had an initial skin assessment completed in October 2015, with an identified number of identified altered level of skin integrity at identified parts of the resident #003's body. The progress notes and physician order revealed that the Registered Dietitian (RD) #100 wrote multiple orders for an identified nutrition intervention to support healing.

A review of the resident's Medication Administration Records (MAR) and the Physician Three Month Medication Reviews dated from November 2015 to July 2016, the following orders were observed related to the resident's prescribed the identified nutrition intervention. In October 2015 the RD wrote an order to start the identified nutrition intervention at an identified and frequency; from November 2016 to July 2016, the frequency of the identified nutrition intervention was increased; and in July 2016 the order for the identified nutrition intervention was further increased. The resident's written care plan indicated the recommendation made by the SLP. However, a physician order was not written related to the recommendation in order to alert the pharmacy of the resident's status.

During an interview, RD #100 acknowledged that he/she did not specify the route of administration for the identified nutrition intervention when these orders were written. During an interview, the ADOC stated that the pharmacy system defaulted to an identified route of administration unless a specific alternate route was entered by the pharmacist or pharmacy technician. The MARs and Three Month Medication Reviews also revealed that both documents were signed by at least two registered staff and the primary physician providing care for resident #003 from November 2015 to July 2016. During an interview, RN #100 and RPN #124 confirmed that he/she signed the document but did not observe that the identified nutrition intervention was ordered to be administered by the default route rather than the alternate route for resident #003.

During an interview, Registered Practical Nurse (RPN) #136 stated that he/she would have administered the identified nutrition intervention to the resident by the default route as noted on the MAR because he/she had cared for other residents in the past that required the identified nutrition treatment , but was also allowed to have special nutrition interventions by the identified default route. The staff also stated that the resident did not include the SLP recommendation displayed on the resident's MAR to alert registered staff.

During an interview, the primary physician stated that he/she could not recall writing the order; but that an order should have been written for this resident. During an interview, RN #124 stated that he/she believed with a high percentage of certainty that whenever agency nurses or other registered staff from other units float into the unit to work with the resident, they would have administered the identified nutrition intervention by the identified default route to the resident as ordered and signed on the MAR. The staff also stated that since physician order Three Month Medication Reviews were signed by the physician and two registered staff from the home unit; those nurses would have considered the document to be accurate and credible.

Record review revealed that the resident was transferred to hospital at least three times for acute care treatment related to an identified diagnosis on multiple identified dates. During an interview, the resident's substitute decision-maker (SDM) stated that the resident was sent to hospital at least twice in the past related to the identified diagnosis.

During an interview, the home's ADOC reviewed the MARs and Three Month Medication Reviews and confirmed that the pharmacy entries were written to be administered by the identified default route. The ADOC also stated that the expectation was for registered

staff to double check physician and RD orders for accuracy and completeness related to residents' care and treatment. During an interview, RD #100 stated that going forward he/she would write the route to be administered to prevent such future incidents. [s. 6. (4) (b)]

6. The licensee has failed to ensure that the resident, the SDM, and the designate of the resident/SDM were provided the opportunity to participate fully in the development and implementation of the plan of care.

A complaint (#030834-16) was received by the MOHLTC on an identified date regarding participation in the plan of care for resident #004.

Record review revealed that resident #004's developed an altered area of skin integrity on an identified area of the resident's body, which was discovered by the registered staff on an identified date. The records also showed that RN #105 completed the skin assessment and sent a referral to the RD, nurse and the physician; however, there was no documentation that the resident's Substitute Decision Maker (SDM) was informed. During an interview, RPN #103 stated that he/she could not recall if the family was contacted and informed about the altered area of skin integrity; but that if they were called it would have been documented.

During an interview, the ADOC stated that the expectation was for the registered staff to notify the family whenever there was a change in the resident's condition and to share information and ensure the family's participation in the plan of care. [s. 6. (5)]

7. A complaint (#029711-16) was received by the MOHLTC on an identified date regarding concerns with care and treatment related to resident #003.

Record review revealed that resident #003 was assessed by the home's RAI to be able to make decisions, and that the resident had multiple identified altered level of skin integrity at identified parts of his/her body.

During an interview, the SDM stated that he/she was aware that the resident had altered areas of skin integrity on identified areas of his/her body as witnessed during his/her visits to the home, and that these areas were covered with identified care interventions. However, the SDM stated that he/she was shocked to learn the state of the resident's altered areas of skin integrity on one identified area of resident #003's body from the agency registered staff prior to the resident transfer to hospital on an identified date and

from the hospital physician regarding the status of the resident's altered area of skin integirty. The SDM also stated that the home should have informed him/her sooner about the true status of the resident's altered area of skin integrity.

During an interview, RN #101 stated that he/she had offered to show the altered areas of skin integrity to the SDM multiple times, but that the SDM declined to observe the area. The registered staff also confirmed that he/she did not document these interactions with the SDM nor the SDM refusals to observe the altered areas of skin integrity; and the staff does not recall discussing the status of the altered areas of skin integrity with the SDM. During an interview, the primary physician stated that he/she believed the SDM did not know how bad the altered areas of skin integrity have become.

During an interview, the ADOC stated that in retrospect, the home should have had a discussion with the SDM related to the resident's health status. [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:
1) the plan of care set out clear directions to staff and other who provide direct care to the resident,
2) staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments were integrated, consistent with and complement each other,
3) the resident, the SDM, and the designate of the resident/SDM been provided the opportunity to participate fully in the development and implementation of the plan of care, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated: abuse of a resident by anyone.

The MOHLTC received a complaint on an identified date regarding multiple care concerns for resident #001, including alleged abuse of resident #001 by resident #007.

Review of the progress notes for residents #001 and #007 revealed that on an identified date, a PSW reported to RPN #120 that the PSW found resident #007 inappropriately touching resident #001 in resident #001's room. The progress notes further revealed that RPN #120 had notified the ADOC, DOC, and the physician regarding the incident.

Interview with RPN #120 revealed that he/she could not recall who the PSW was who had reported the incident to him/her, but had documented the information provided by the PSW in the progress notes, and reported the incident to the management as evidenced by his/her progress notes.

Interview with the ADOC revealed that he/she was not aware of the incident at the time. Interview with the DOC revealed that he/she was made aware of the incident by reading RPN #120's documentation at the time.

Both the ADOC and DOC revealed that no investigation was done regarding the reported alleged abuse incident that occurred between residents #001 and #007 in November 2016. [s. 23. (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 every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated: abuse of a resident by anyone, to be implemented voluntarily.

WN #5: 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 any person who had reasonable grounds to suspect abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm, immediately report the suspicion and the information upon which it was based to the Director.

A complaint (#008125-16) was received by the MOHLTC on an identified date regarding the care and treatment provided related to resident #005.

Record review revealed that on an identified date, resident #005's family wrote a letter of complaint addressed to the DOC alleging that the resident was treated in a rough manner by two staff members on the unit. During an interview, the ADOC and current DOC confirmed that the alleged abuse was not reported to the Director. [s. 24. (1)]

2. A complaint (#029711-16) was received by the MOHLTC on an identified date regarding the care and treatment provided to resident #003.

Record review revealed that on an identified date, resident #003's SDM wrote a letter of complaint addressed to the Management of the home alleging that the resident was mistreated by the home. During an interview, the ADOC and current DOC confirmed that the alleged mistreatment of the resident was not reported to the Director. [s. 24. (1)]

3. The MOHLTC received a complaint (#000622-17) on an identified date regarding multiple care concerns for resident #001, including alleged abuse of resident #001 by resident #007.

A) Review of the progress notes for residents #001 and #007 revealed that on an identified date, RN #124 documented inappropriate touching of a resident based on PSW #111's report of having observed resident #007 and resident #001 in an identified interaction in resident #001's room.

Review of resident #001's MDS and written plan of care at the time of the incident revealed that the resident required an identified level of assistance for dressing, related to the resident's identified diagnoses.

Interview with PSW #111 revealed that at the time of the incident, he/she had observed resident #001 seated near the door with an area of his/her body inadvertently exposed. Resident #007 was observed to be engaged in inappropriate behaviour while facing resident #001. PSW #111 revealed that he/she could not recall seeing any touching of resident #001 by resident #007.

Interview with RN #124 revealed that he/she had documented 'inappropriate touching' in the progress notes based on the information provided by PSW #111. RN #124 further revealed that he/she had informed the management and SDMs of residents #001 and #007 of the incident on an identified date.

Interview with the ADOC revealed that the incident was investigated, and the home was not able to substantiate that any resident abuse had occurred. The ADOC further revealed that this incident was not reported to the MOHLTC when they had reasonable grounds to suspect abuse of a resident had occurred.

B) Review of the progress notes for residents #001 and #007 revealed that on another identified date, a PSW reported to RPN #120 that the PSW found resident #007 touch resident #001 with an identified part of his/her body, in resident #001's room. The progress notes further revealed that RPN #120 had notified the ADOC, DOC, and the physician regarding the incident.

Interview with RPN #120 revealed that he/she could not recall who the PSW was who had reported the incident to him/her, but had documented the information provided by the PSW in the progress notes, and reported the incident to the management as per his/her

progress note documentation.

Interview with the ADOC revealed that he/she was not aware of the incident at the time. The ADOC further revealed that it is the home's expectation for staff to notify the management team (administrator, DOC, ADOC, or clinical coordinators) of any incidents that required immediately reporting, and it would be the management team who would report the incident to the MOHLTC.

Interview with the DOC revealed that he/she was made aware of the incident by reading RPN #120's documentation at the time. The DOC further revealed that he/she did not report the identified incident to the MOHLTC.

The ADOC confirmed that both incidents involving residents #001 and #007 on the two identified dates were not reported to the Director. [s. 24. (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 any person who has reasonable grounds to suspect abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm, immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #6: 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. (1) The continence care and bowel management program must, at a minimum, provide for the following:
5. Annual evaluation of residents' satisfaction with the range of continence care products in consultation with residents, substitute decision-makers and direct care staff, with the evaluation being taken into account by the licensee when making purchasing decisions, including when vendor contracts are negotiated or renegotiated. O. Reg. 79/10, s. 51 (1).

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).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the annual evaluation of residents' satisfaction with the range of continence care products in consultation with residents, substitute decision-makers and direct care staff was conducted, with the evaluation being taken into account by the licensee when making purchasing decisions, including when vendor contracts are negotiated or renegotiated.

The MOHLTC received a complaint (#006720-17) related to the home's assessment and provision of continence care.

Interview with the ADOC revealed that the annual evaluation of satisfaction for the continence care and bowel management program was not conducted with residents, SDMs and direct care staff in 2016. [s. 51. (1) 5.]

2. The licensee has failed to ensure that 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 was conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

The MOHLTC received a complaint (#006720-17) related to the home's assessment and provision of continence care.

Review of resident #002's admission MDS assessment, PCC continence assessment and the New Admission HCA checklist revealed that he/she was at an identified level of continence, and did not require incontinence products.

Review of resident #002's observation flow sheet monitoring form revealed that resident #002's continence level progressively changed over a period of identified dates.

Review of the resident's progress notes revealed that resident #002 was provided with identified incontinence products on identified dates.

Interview with PSW #117 revealed that resident #002's continence level was different from that indicated in the MDS assessment, PCC continence assessment and the New Admission HCA checklist, at admission.

Interviews with RPN #120 and #132 revealed that, as evidenced by resident #002's flowsheet on an identified month, the resident's continence level changed over a period of time, but he/she was not informed by the PSWs regarding the resident's change, and no TENA New Admission and Product Change assessment form was completed for the resident.

RPN #132 revealed that a second continence assessment should have been completed for the resident when a change of status was indicated, and this assessment was not done for resident #002.

Interview with RN #112 revealed that he/she recalled that resident #002 was provided with the identified incontinence product, and the RN had documented in the progress notes about the resident's change of incontinence product, but he/she could not recall if a TENA New Admission and Product Change assessment form was completed for resident

#002.

Interview with the ADOC revealed that if a resident experienced a change in continence level, it was the home's expectation for staff to assess the resident and complete the PCC continence assessment and the TENA New Admission and Product Change assessment form.

The ADOC further revealed that these assessments were not completed for resident #002. [s. 51. (2) (a)]

3. The licensee has failed to ensure that there was a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes.

Review of the home's TENA management system - New Admission and Product change form, and the New Admission HCA checklist revealed that the listed products included pads and briefs, but pull-ups were not listed on either of the forms.

Review of the PCC Initial Admission Assessment revealed that the only option related to pull-ups was 'used own pull-up,' and there was no option on the form to select for the home to provide pull- ups for the resident.

Interviews with the following PSWs and registered staff revealed that the staff were not aware that pull-ups were available for residents in the home.

Interviews PSW #138, 142,143, 144, 145, RPN #132, and RN #137 revealed that the home only provides briefs, pads, and liners of various sizes, and pull-ups were provided by the family if residents were to continue to wear pull-ups in the home.

Interviews with RPN #132 and RN #137 further revealed that on admission, the staff would complete the TENA assessment form, which does not list pull-ups as an available product, and inform family members that the home does not currently provide pull-ups. The registered staff further revealed that the family could choose to provide pull-ups on their own, or use the other incontinence products available in the home.

Interview with RN #140 revealed that pull-ups are occasionally available, depending on the stock in the home, and a request is submitted to the home's continence champion before pull-ups could be provided. RN #140 further revealed that the request may take

up to 48 hours, and another incontinence product may be used until the pull-up was available.

Interview with the ADOC, who acted as the continence lead, revealed that it is the home’s expectation for staff to fill out the TENA Admission New Admission and Product Change for new residents, or if residents required a change of incontinence products. The ADOC further revealed that pull-ups are available in the home, and are kept in an identified area in the home.

The ADOC further revealed that pull-ups were not listed on the TENA New Admission form, and there was no option to select that the home will provide residents with pull-ups on the PointClickCare (PCC) Initial Admission Assessment.

The ADOC further revealed that because staff do not see pull-ups on the continence care product forms, they may not be aware of the range of continence care products available in the home. [s. 51. (2) (f)]

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:
1) the annual evaluation of residents' satisfaction with the range of continence care products in consultation with residents, substitute decision-makers and direct care staff is conducted, with the evaluation being taken into account by the licensee when making purchasing decisions, including when vendor contracts are negotiated or renegotiated,
2) 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,
3) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A complaint (#030834-16) was received by the MOHLTC on an identified date regarding

concerns with pain control related to resident #004.

Record review revealed that resident #004 had an identified altered area of skin integrity on an identified area of his/her body; RN #105 documented the skin assessment; however a pain assessment was not completed. During an interview, registered staff RN #104 confirmed that pain assessments were not completed although the resident was receiving an identified medication for pain and discomfort related to the altered area of skin integirty. The staff further stated that a pain assessment should have been completed using the pain assessment tool to ensure that the resident's pain was being controlled.

During an interview, the ADOC confirmed that the resident did not have a pain assessment completed using the home's clinical assessment tool; and that the expectation was for the registered staff to complete a pain assessment when the resident's status changes to warrant the administration of the identified class of medication. [s. 52. (2)]

2. A complaint (#008125-16) was received by the MOHLTC on an identified date regarding pain assessment and management related to resident #005.

Record review revealed that the resident was administered an identified medication 'as required' for complaint of pain on an identified part of the body related to an old injury.

The records also revealed that the resident did not have a pain assessment completed using the clinically indicated tool until an identified date, at the quarterly interval; although the resident was being administered pain medication regularly. During an interview, RN #101 confirmed the same information and stated that the resident should have had regular pain assessments completed so that the medication could be adjusted if needed.

During an interview, the ADOC stated that the expectation was for registered staff to complete a pain assessment using the appropriate pain assessment tool if the resident was receiving pain medication to assess the effectiveness of the medication. [s. 52. (2)]

3. A complaint (#029711-16) was received by the MOHLTC on an identified date regarding concerns with pain control related to resident #003.

Record review revealed that resident #003 had multiple identified altered areas of skin integrity at identified parts of his/her body; registered staff on various shifts documented

that the resident displayed signs of pain, and after the identified class of medication was administered the effects documented would vary. During an interview, RN #101 confirmed that pain assessments were not completed as required for the resident. The staff further stated that pain assessment should have been completed at least weekly and with change in status because the resident was receiving the identified class of medication for pain.

During an interview and after reviewing the resident's records, the ADOC confirmed that the resident did not have a pain assessment completed using the home’s clinical assessment tool; and that pain assessments should have been completed frequently so that identified class of medication was administered to reduce or resolve the resident's pain. [s. 52. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident is assessed using a clinically appropriate pain assessment instrument specifically designed for the purpose, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee has failed to ensure that that an analysis of every incident of abuse or neglect of a resident at the home was undertaken promptly after the licensee becomes aware of it.

The MOHLTC received a complaint on an identified date regarding multiple care concerns for resident #001, including two incidents alleged abuse of resident #001 by resident #007, on multiple identified dates.

Interview with the ADOC and DOC revealed that it was the previous DOC who was responsible for conducting analyses of abuse and neglect incidents. The ADOC and DOC revealed that the home did not conduct analyses of abuse and neglect incidents in 2016, and no analysis was done for the incidents involving residents #001 and #007. [s. 99. (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 that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A complaint (#029711-16) was received by the MOHLTC on an identified date regarding concerns with pain control related to resident #003.

Record review revealed that resident #003 had multiple identified altered areas of skin integrity at identified parts of his/her body. The records also showed that the physician successively changed the resident class of medication for pain control from one identified medication to a second identified medication, then to a third identified medication at an identified dose at an identified schedule, then updated the third identified medication to 'as required' (PRN) for breakthrough pain. Record review showed that the resident's signs of pain commenced in June 2016, and that the order for the third identified medication order was written in June 2016.

Record review revealed that during an identified period between June to August 2016, the scheduled third identified medication dosages were administered to the resident consistently. The progress notes revealed that between scheduled doses, the resident continued to display signs and symptoms of pain and discomfort almost on a daily basis and during all shifts; however, the identified third medication 'as required' (PRN) was administered to the resident as follows: between identified dates in June 2016, one PRN dose was administered; between the month of July 2016, 13 PRN doses were administered; and between identified dates in August 2016, when the resident was transferred to hospital, there were zero PRN dose of the third identified medication administered for pain control.

During an interview, RPN #146 stated that the PRN third identified medication should have been administered more frequently to control the resident's pain; and also confirmed by reviewing the Narcotic and Controlled Substance Administration Record that the PRN medication was not administered as ordered by the physician to control the resident's breakthrough pain. The registered staff further stated that some registered staff have expressed concerns related to addiction with the use of the identified third medication. During an interview, the ADOC stated that the identified PRN class of medication should have been administered to control the resident's breakthrough pain; and confirmed that registered staff did not administered the PRN third identified medication to the resident as specified by the physician. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs were administered to the resident in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).

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 the infection prevention and control program was evaluated and updated at least annually in accordance with evidence-based practice and, if there were none, in accordance with prevailing practice.

Record review revealed that there was no evaluation of the infection prevention and control program in 2016. During separate interviews with the home Education Coordinator #149 and the ADOC and Infections Prevention and Control (IPAC) Lead #101, both confirmed that the evaluation of the IPAC program in 2016 was not completed. [s. 229. (2) (d)]

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

A complaint (#029711-16) was received by the MOHLTC on an identified date regarding the plan of care related to resident #003.

Record review revealed that resident #003 had multiple identified altered areas of skin integrity at identified parts of his/her body. The record also revealed that on an identified date, the physician documented the result of a lab report which showed that the resident was positive for an identified medical condition. Registered staff #101 confirmed during an interview that the resident was not placed on contact precautions; and that he/she should have been placed on contact precautions with signage posted on the door of the resident's room, and PPE available for staff to use while providing care for the resident.

During an interview, the ADOC stated that the resident should have been placed on contact precautions with appropriate PPEs available for staff to use while providing care to the resident. [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:
1) the infection prevention and control program is evaluated and updated at least annually in accordance with evidence-based practice and, if there were none, in accordance with prevailing practice, and
2) staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a copy of any written complaints that have been received concerning the care of a resident or the operation of the home was forwarded to the director.

A complaint (#008125-16) was received by the MOHLTC on an identified date regarding the care and treatment provided related to resident #005.

Record review revealed that on an identified date, resident #005's family wrote a letter of complaint addressed to the DOC alleging that the resident was handled roughly by a registered staff and PSW on the unit. During an interview, the ADOC and current DOC confirmed that a copy of the letter was not forwarded to the Director. [s. 22. (1)]

2. A complaint (#029711-16) was received by the MOHLTC on an identified date regarding the level of care and treatment provided related to resident #003.

Record review revealed that on another identified date, resident #003's SDM wrote a letter of complaint addressed to the Management of the home regarding the level of care provided to the resident. During an interview, the ADOC and current DOC confirmed that a copy of the written complaint letter was not forwarded to the Director. [s. 22. (1)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the skin and wound, pain management, and infection prevention and control programs have a written description of the program that included its goals and objectives; relevant policies, procedures, protocols; methods to reduce risk; methods to monitor outcomes; and protocol for referral of resident to specialized resources when required.

A complaint (#029711-16) was received by the MOHLTC on an identified date regarding the care and treatments provided for resident #003.

A review of the records provided by the home's Education Coordinator revealed that the home does not have a written description of the skin and wound, pain management and infection prevention and control programs. During interviews, the ADOC and DOC both confirmed that the home does not have written descriptions for the skin and wound, pain management and infection prevention and control programs at this time. [s. 30. (1) 1.]

2. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessment, reassessments, interventions and the resident's responses to interventions were documented.

A complaint (#029711-16) was received by the MOHLTC on an identified date regarding documentation of personal care service provided to resident #003.

Record review revealed that resident #003 started receiving on-site specialist services in the home on an identified date. On that date, specialist #110 documented an identified service for resident #003. Subsequently, the next identified number of visits, including the final visit on an identified date had the same wording documented in the electronic documentation system (PCC) but with an identified intervention added to the last identified number of documented visits.

During an interview, specialist #110 informed the inspector that he/she usually document changes in condition related to residents on his/her work sheet and also in PCC. The nurse also stated that while providing treatments for residents, if there were issues identified with residents' identified part of the body, he/she would go to the registered staff on the unit and discuss the issue; but if there are no issues identified, he/she would not see or interact with the nurse during the visit. The specialist also stated that he/she had the option to discuss issues with his/her boss; and the boss would call and discuss individual resident's issues with the resident's SDM.

During the interview, the specialist recalled the resident presented with some signs of a change in medical status. During the interview, the specialist confirmed that he/she did not document accurately in the resident's electronic records.

The specialist stated that the service for resident #003 should have been reassessed to determine whether to continue or discontinue the service given the condition of the resident.

During an interview, the ADOC stated that he/she was very concerned that there was no

documentation related to the resident's identified altered areas of skin integrity on the identified parts of the resident's body by the specialist because the identified altered areas of skin integrity were first assessed and documented in at an identified date, and also confirmed that staff or management in the home does not currently communicate with the specialist or the consulting service regarding the residents' assessment, reassessment or response to the services being provided. [s. 30. (2)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

s. 101. (3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and O. Reg. 79/10, s. 101 (3).
(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was investigated, resolved where possible, and a response provided within 10 business days of receipt of the complaint; and where the complaint alleges harm or risk of harm to one or more residents, an investigation was commenced immediately.

A complaint (#008125-16) was received by the MOHLTC on an identified date regarding the care and treatment provided related to resident #005.

Record review revealed that on an identified date, resident #005's family member wrote a letter of complaint addressed to the DOC alleging that the resident was handled roughly by two staff on the unit. During an interview, the Social Worker (SW) stated that the resident also informed him/her about the incident; and that he/she immediately reported the incident to the DOC on an identified date. The records also revealed that the DOC conducted an investigation as evidenced by direct care staff interviews on a subsequent identified date; however, there was no documentation of a response to the complainant. During an interview, the complainant confirmed that he/she did not receive a verbal or written response from the DOC. During interviews, the ADOC and current DOC confirmed that the home did not provide a response to the complainant related to complaint letter given to the home on the identified date. [s. 101. (1) 1.]

2. The licensee has failed to ensure that a documented record was kept in the home that included the nature of each verbal or written complaint; the date the complaint was received; the type of action taken to resolve the complaint, including the date of the action, time frames for action to be taken and any follow-up action required; the final resolution, if any; every date on which any response was provided to the complainant and a description of the response; and any response made by the complainant.

A complaint (#008125-16) was received by the MOHLTC an identified date regarding the care and treatment provided related to resident #005.

Record review revealed that on an identified date, resident #005's family wrote a letter of complaint addressed to the DOC alleging that the resident was handled roughly by a registered staff and PSW on the unit. The records also revealed that the complaint was not entered in the home's complaint log. During an interview, the SW, who oversees the complaint program, confirmed that the written complaint was not documented in the home's complaint log and therefore details were not available as listed above. [s. 101. (2)]

3. A complaint (#029711-16) was received by the MOHLTC on an identified date regarding the level of care and treatment provided related to resident #003.

Record review revealed that on an identified date, resident #003's SDM wrote a letter of

complaint addressed to the Management of the home regarding the level of care provided by the home. Record review revealed that the complaint was not entered in the home's complaint log. During an interview, the SW who supported the complaint program confirmed that the complaint was not documented in the home's complaint log and therefore details were not available as listed above. [s. 101. (2)]

4. The licensee has failed to ensure that the documented record is reviewed and analyzed for trends at least quarterly.

The MOHLTC received multiple complaints (#006720-17 and #000622-17) related to the home's handling of complaints.

Review of the Downsview LTCC complaints policy (policy number COM-001, effective date October 2016), revealed that the home's internal complaint procedure was that the social worker and the facility Administrator would review and analyze complaints at least three times per year to look for trends as well as to ensure that there is continuity and consistency.

Review of the home's complaint records binder revealed that in 2016, review and analyses of complaints were conducted three times a year (January to April, May to August, and September to December). In 2017, the first review and analyses of complaints summary was done for January to April 2017.

Interview with the SW revealed that the home currently reviews and analyses the complaints received three times a year, and revealed that the home's complaints policy states that the review and analysis is to be done at least three times a year.

Interview with the ADOC revealed that the complains should have been reviewed and analyzed for trends quarterly, and the home's policy on review and trend analysis should be revised from at least three times a year to quarterly, to reflect the MOHLTC regulations. [s. 101. (3)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 233. Retention of resident records

Specifically failed to comply with the following:

s. 233. (2) A record kept under subsection (1) must be kept at the home for at least the first year after the resident is discharged from the home. O. Reg. 79/10, s. 233 (2).

Findings/Faits saillants :

1. There licensee has failed to ensure that a record kept under subsection (1) must be kept at the home for at least the first year after the resident is discharged from the home.

Subsection (1): Every licensee of a long-term care home shall ensure that the record of every former resident of the home is retained by the licensee for at least 10 years after the resident is discharged from the home.

The MOHLTC received a complaint (#006720-17) related to the home's assessment and provision of continence care. Review of resident #006's admission records revealed that the resident did not have a TENA New Admission and Product Change assessment form completed.

Review of resident #006's health records did not reveal a completed TENA New Admission and Product Change assessment form for his/her admission. Review of resident #006's admission progress note on PCC revealed that resident #006 required an incontinent product, to be provided by his/her family.

Interview with ADOC revealed that the home could not locate the record of the TENA New Admission and Product Change assessment form for resident #006, who was discharged from the home in 2017. [s. 233. (2)]

2. The MOHLTC received a complaint (#006720-17) related to the home's assessment and provision of continence care.

Review of resident #002's health records did not reveal a completed TENA New Admission and Product Change assessment form for his/her admission, or at any other time when his/her continence level changed.

Interview with ADOC revealed that the home was not able to find a TENA New Admission and Product Change assessment form for resident #002, who was discharged from the home in 2017. [s. 233. (2)]

Issued on this 6th day of July, 2017

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

Ministére 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) :	IVY LAM (646), VERON ASH (535)
Inspection No. / No de l'inspection :	2017_484646_0006
Log No. / Registre no:	008125-16, 029711-16, 030834-16, 000622-17, 006720-17
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jul 5, 2017
Licensee / Titulaire de permis :	Downsview Long Term Care Centre Limited 3595 Keele Street, NORTH YORK, ON, M3J-1M7
LTC Home / Foyer de SLD :	Downsview Long Term Care Centre 3595 Keele Street, NORTH YORK, ON, M3J-1M7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Christiana Burns

To Downsview Long Term Care Centre 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 :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(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;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(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).

Order / Ordre :

The licensee shall ensure that:
1. An interdisciplinary collaborative component is incorporated in the following home's policies: a) skin and wound, and b) pain management policies,
2. All direct care staff are trained in these policies, and
3. There is ongoing quality monitoring of this process in place,

to ensure there is interdisciplinary collaboration in the assessment and implementation of residents' care and treatment.

Grounds / Motifs :

1. The licensee has failed to ensure that resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds receive immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection.

Complaint #029711-16 was received by the Ministry of Health and Long-Term Care (MOHLTC) on an identified date regarding resident #003 which identified concerns related to immediate treatment and interventions to prevent infection.

The progress notes revealed that from June to August 2016, resident #003 experienced an ongoing identified change in status for an identified number of days. However, the change in status was temporarily controlled with the administration of an identified medication. Furthermore, on an identified date, a registered nurse from the agency, who completed the dressing change to an identified part of the resident's body contacted the physician to discuss the status of the impaired skin integrity on an identified part of the resident's body, which was assessed as the source of the change in status. The progress notes indicated that as a result of that discussion, the resident was transferred to an acute care hospital.

During an interview, registered staff Registered Nurse (RN) #124 and RN #101 stated that in retrospect, because of the change in status, the Nurse Led Outreach Team (NLOT) or the physician should have been contacted sooner to further assess the resident's need for possible medication or transfer to hospital at an earlier date.

A review of the hospital admission notes from an identified date revealed that the resident had significant infection in the identified part of the body; and the hospital physician informed the family that the resident would require an

identified surgery as a result of the infection.

During an interview, the Assistant Director of Care (ADOC) stated that the resident should have been transferred to hospital sooner or external resources should have been activated to support treatment and intervention.

The scope of the non-compliance is isolated to resident #003. The severity is actual harm.

A review of the home's compliance history revealed previous non-compliance related to the Long- Term Care Homes Act, O.Reg. c. 8, s. 50 (2). The non-compliance was as follows:
- Inspection #2015_108110_0002 -- complaint inspection, CO issued. [s. 50. (2) (b) (ii)] (535)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 10, 2017

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:

1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act.
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

Order / Ordre :

The licensee shall prepare, submit, and implement a plan that ensures that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is in compliance with, and is implemented in accordance with all applicable requirements under the Act; and is complied with.

The plan shall include, but is not limited to:

1) The revision of the home's continence care, and pain policies to ensure that they are in compliance with, and are implemented in accordance with all applicable requirements under the LTCHA, 2007.

2) The completion of education for all applicable management and front-line staff related to the home's continence care, and pain policies.

3) Continence care: Ensure continence care assessment forms include available products in the home, and that direct care staff are aware of the revised forms and products availability.

4) Continence care: Ensure the training of front-line staff to be aware of the range of continence care products, including pull-ups, available in the home, and how staff should access the appropriate continence care products.

5) Pain management: The training of front-line staff in pain management, including recognition of specific and non-specific signs of pain, and to ensure staff are aware of when to complete pain assessment for any resident.

6) The development of quality management activities, including monitoring and evaluation, to ensure the home's continence care and pain management policies; and the process/protocol for internal and external referrals related to residents' pain control resources are complied with by all staff.

7) Ensuring nursing related policies are made accessible to all nursing units for reference by registered and direct care staff.

The plan shall be submitted by Wednesday, July 19, 2017, via email to: ivy.lam@ontario.ca.

Grounds / Motifs :

1. The licensee has failed to ensure that all staff that provide direct care to

residents were provided training related to continence care and bowel management on either an annual basis, or based on the staff's assessed training needs.

For the purposes of paragraph 6 of subsection 76 (7) of the Act, the licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations: continence care and bowel management.

The MOHLTC received a complaint (#006720-17) related to the home's assessment and provision of continence care.

Interviews with personal support worker (PSW) #138, RN #137 and #140 revealed that they could not recall training on the continence care and bowel management program in the past year.

Interviews with the Education Coordinator and ADOC revealed that under the previous Director of Care (DOC), education on continence care and bowel management was provided for staff every other year, not on an annual basis. The ADOC revealed that education on continence care and bowel management was not provided to staff in 2016. (646)

2. The licensee has failed to ensure that all staff who provide direct care to residents receive the training provided in pain management, staff must receive annual training in all the areas required under subsection 76 (7) of the Act.

For the purposes of paragraph 6 of subsection 76 (7) of the Act, the licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations: pain management, including pain recognition of specific and non-specific signs of pain.

Record review revealed that the education and training records related to the pain management program was not available for 2016. During interviews, the Education Coordinator and the ADOC confirmed that the pain management program training for 2016 was not completed because the Education Coordinator was informed by the previous DOC that the training for this program

was not required annually.

The scope of the non-compliance is widespread. The severity is minimum risk. A review of the home's compliance history revealed previous non-compliance related to the Long- Term Care Homes Act, O.Reg. c. 8, s. 221, was issued. The Noncompliance was as follows:
- Inspection #2014_321501_0021 – compliance order (CO) was issued. (646)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 10, 2017

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 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 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
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 5th day of July, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Ivy Lam

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