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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 22, 2018	2018_643111_0006	005760-18	Resident Quality Inspection

Licensee/Titulaire de permis

The Royale Development GP Corporation as general partner of The Royale Development LP
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

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

Case Manor Care Community
28 Boyd Street P.O. Box 670 BOBCAYGEON ON K0M 1A0

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

LYNDA BROWN (111), KELLY BURNS (554)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): March 26 to 29, April 3 to 5, 2018 and April 6, 2018 (off-site)

The following complaints were completed concurrently during this inspection:
-Log # 007790-17 related to care concerns.
-Log # 022518-17 related to staffing and meals.
-Log # 026123-17 related to bed refusal.
-Log # 001004-18 related to alleged staff to resident abuse.

The following critical incidents were completed concurrently during this inspection:
-Log # 021601-17 (CIR) related to fall with injury.
-Log # 024410-17 (CIR) related to staff to resident abuse.

A follow-up inspection (log # 001399-18) was also completed concurrently during this inspection related to 24/7 RN coverage.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Care (DOC), Associate Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Restorative Care Coordinator (RCC), Office Manager, Program Assistant (PA), Dietary Manager (DM), Registered Dietitian (RD), Housekeeping Aides, Community Care Access Centre (CCAC) Placement Coordinator, residents, families, Resident Council President, Family Council Chairperson, Physiotherapist (PT) and Respiratory Therapist (RT).

During the course of the inspection, the inspector(s) reviewed health care records of current and deceased residents, reviewed staffing schedules, reviewed resident council meeting minutes, reviewed medication incidents, observation medication administration and storage, toured the home and reviewed the following licensee policies: Responsive Behaviours, Restraint Implementation Protocols, Monitoring of Resident Weights, Behaviour Management, Falls Prevention, Skin and Wound Care Management Protocol, Complaints Management Program, Medication Incidents Reporting and Adverse Drug Reactions and Drug Allergies.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **13 WN(s)**
- **9 VPC(s)**
- **1 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 LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

The licensee has failed to ensure that at least one registered nurse who is an employee

of the licensee and a member of the regular nursing staff is on duty and present at all times unless there is an allowable exception to this requirement.

Related to Log # 001399-18:

The licensee was issued a compliance order #001, for LTCHA, 2007, S.O. s. 8(3) during inspection #2017_623626_0016, which was served on a specified December 8, 2017 with a compliance date of February 28, 2018. The licensee was also to complete a corrective action plan to ensure compliance.

The licensee was ordered to ensure:
1. At least one Registered Nurse (RN), who is both an employee of the licensee and a member of the regular nursing staff of the home, was on duty and present in the home at all times.
2. Provide documented evidence to demonstrate that a backup RN staffing plan had been implemented, in accordance with the legislative requirements under O.Reg. 79/10, s.45.
3. Provide documented evidence to demonstrate recruitment and retention had been completed for any planned and/or extended leave.
4. Provide documented evidence that the Corporate Office had been notified of any RN staffing concerns.

Review of the licensee's corrective action plan indicated all vacant RN positions were filled. The staffing contingency plan was reviewed/updated to include backup to ensure that an RN was on duty at all times and updated the casual RN availability.

The licensee failed to ensure steps #1 and #2 of the order were met.

Case Manor Care Community has a licensed bed capacity of 96 beds.

In an interview with the Director of Care (DOC) on a specified date, by Inspector #111, indicated awareness of only one shift where there was no RN present in the home since a specified date in 2018, but the DOC was unaware of the specific date. A request was made for the actual worked RN staffing schedule but it was not provided at that time.

In an interview with the Executive Director (ED) the following day, by Inspector #111, the inspector requested a copy of the actual worked Registered Nursing (RN) staffing schedule for a one month period in 2018 and an 'electronic RN staffing schedule' was

provided. The schedule indicated there were no dates identified with no RN coverage in the home. The ED indicated no awareness of any shifts when the home did not have an RN on-site since the compliance date. The ED also indicated there were no RN vacancies. The ED indicated the electronic RN staffing schedule would indicate any call-ins or shifts that were to be replaced.

In an interview with the DOC eight days later, indicated no awareness of any gaps in RN staffing schedule since the compliance date and provided the Inspector with a 'daily RN roster' that would indicate any last minute changes or call-ins and who the shifts were replaced with.

In an interview with RN #113 on a specified date, by Inspector #111, indicated there were specified dates (during a specified month) when there was no RN on-site, after the compliance date. The RN indicated the RNs work on a specified unit and administered medications to residents. The RN indicated on specified date, the RN staffing schedule noted the RN had worked during a specified eight hour period but confirmed only working on-site for a three hour period. The RN indicated two days after that specified date, the RN staffing schedules indicated the RN had worked during a specified eight hour period but confirmed working a different eight hour period on the same date (the following shift). The RN also indicated they had not worked on site on a third specified date as identified on the RN schedule.

In an interview with RN #124 on a specified date, by Inspector #111, indicated during a specified date (post compliance date),had worked a 12 hour shift, despite the RN schedule indicating the RN worked an eight hour shift. The RN indicated she did not work on a second specified date despite the RN staffing schedule indicating the RN was working. The RN indicated was on-call on a third specified date (working off-site) for a three hour period and then worked on-site for a 12 hour period, despite the RN schedule indicating RN #128 worked for the first three hour period (that RN #124 was on-call).

In an interview with RN #128 on a specified date, by Inspector #111, confirmed the RN did not work on two specified dates, after the compliance date, despite both the RN staffing schedules indicating the RN had worked on those dates and times. The RN also indicated on a third specified date, the RN worked the shift after the shift that was identified on the RN schedule.

In an interview with RPN #115 on a specified date, by Inspector #111, confirmed there was no RN on-site on a specified date and shift (post compliance date), despite the RN

schedule indicating RN #128 was working.

A request was made to the DOC for a Medication Administration Record (MAR) for a specified unit during a specified month(post compliance date). Review of the MAR provided had the name of the resident removed. A request for the unaltered MAR was made but not provided. The MAR indicated:
- on a specified date, RPN #129 signed for medications at a specified time (despite the RN schedule indicating RN #113 was working).
- on a specified date, RPN #129 signed for medications at a specified time (despite the RN schedule indicating RN #128 was working).
- on a specified date, RPN #100 signed for medications at a specified time (despite the RN schedule indicating the RN #128 was working).
- on a specified date, RPN #130 signed for medications at a specified time(despite the RN schedule indicating RN #113 was working).
- on a specified date, RPN #115 signed for medications at a specified time (despite the RN schedule indicating RN #128 was working).

Review of the electronic and daily roster RN staffing schedule (post compliance date) indicated there was an RN who was a member of the regular nursing staff of the home, on duty and present in the home at all times during that time period. However, there were inconsistencies noted between the two RN staffing schedules that were provided, the eMAR provided by the DOC and from staff interviews to support an RN was on site for five specified dates and times.

The licensee failed to demonstrate due to several inconsistencies, that a registered nurse who was both an employee of the licensee and a member of the regular nursing staff, was on duty and present in the home and documented evidence to demonstrate that a backup RN staffing plan had been implemented.

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 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. (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).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

The licensee failed to ensure that there is a written plan of care for each resident that sets out, the planned care for the resident; the goals the care is intended to achieve; and clear directions to staff and others who provide direct care to the resident #024, specific to use of a drug.

Related to Intake #007790-17:

RPN #115 and RN #113 indicated, to Inspector #554 on a specified date, that resident #024 required the use of a drug continuously. RPN #115 and RN #113 indicated that registered nursing staff delegate the application of a continuous drug to PSW's.

The clinical health care record was reviewed for resident #024 for a six month period. Documentation in the clinical health record identified that resident #024 was administered the drug for a specified diagnosis.

A Physician's Order, on a specified date, indicated that resident #024 was prescribed the identified drug at specified intervals.

The written care plan, during the specified six month period in 2017, identified the use of the drug. The written care plan reviewed failed to identify the goals the care was intended to achieve, and clear directions to staff and others who provided direct care to resident #024.

PSW #126 and #127 indicated, to Inspector #554 on a specified date, that PSW's apply the specified drug on a continuous basis to residents. PSW #126 and #127 indicated that PSW's would determine the rate to be used for a specified drug, for the identified resident, in the electronic health record. Both PSW's indicated that the written care plan is a means used by the licensee to tell the PSW's what care to provide to each resident.

RN #113 indicated the written care plan for the identified six month period did not identify goals of care, and did not provide clear directions to staff and others providing direct care to resident #024 related to application and use of the drug. RN #113 indicated that the written care plan only indicated that the resident had the drug.

The licensee failed to ensure that the written plan of care for resident #024 sets out, the planned care for the resident, the goals the care is intended to achieve, and clear directions to staff and others who provide direct care to the resident #024, specific to use of a drug [s. 6. (1)](554)

2. The licensee failed to ensure that the Substitute Decision Maker (SDM) for resident #024 was given the opportunity to participate fully in the development and implementation of the plan of care.

Related to Intake #007790-17:

Resident #024's SDM indicated, to Inspector #554 on a specified date that they were not notified of resident #024 having a skin related issue until a specified date in 2017. Substitute Decision Maker indicated that they were first notified on a specified date in 2017 of resident's wound to a specified area during a visit with resident #024. Substitute Decision Maker indicated being told by Registered Nurse #114 that resident #024 had the wound for approximately two weeks based on documentation in the health record.

The clinical health record, for resident #024, was reviewed for a specified one month

period:
- On a specified date, RN #118 documented, in a progress note, that day staff reported that resident #024's had an identified skin impairment to a specified area. RN documented actions taken including the appearance of the skin impairment and the application of a dressing. There was no indication that SDM for resident #024 was notified.
- Thirteen days later, RN #114 documented being called to resident #024's room to reassess a dressing to a specified area. RN documented that SDM was present in resident's room on this date.

RN #113 indicated, to Inspector #554 on a specified date, that registered nursing staff are to notify resident's SDM promptly of any changes to resident's health condition, which would include altered skin integrity. RN #113 indicated that notification of SDM would be captured in resident's health record, specifically in progress notes, under 'family communications'. RN #113 indicated recall of resident #024's SDM concern regarding the altered skin integrity, and indicated that the SDM, for resident #024, was not notified of the altered skin integrity until SDM's visit to the long-term care home (thirteen days later).

RN #118 was unavailable for an interview during this inspection.

The Associate Director of Care (ADOC) and the DOC indicated, to Inspector #554 on two specified dates, that the SDM was to be notified as soon as possible of any changes in resident's health condition, which included changes in a resident's skin integrity.

Registered Nurse #118 failed to ensure that the SDM for resident #024 was given the opportunity to participate fully in the development and implementation of the plan of care. [s. 6. (5)](554)

3. The licensee failed to ensure that the plan of care, for resident #021, was revised when the care set out in the plan of care had not been effective, and that different approaches had been considered in the revision of the plan of care, specific to falls prevention and management.

Related to Intake #021601-17:

The DOC submitted a Critical Incident Report (CIR) to the Director, on a specified date, specific to an incident that caused injury to a resident for which the resident was taken to

hospital and which resulted in a significant change in resident's health status. The incident occurred on a specified date and submitted and involved resident #021.

The clinical health record, for resident #021, was reviewed for a nine month period. Resident #021 was cognitively impaired and was known to be at risk for falls. Fall incidents are documented as occurring on seven specified dates in 2017. Of the seven documented falls, five resulted in injury, and four of the seven incidents required resident #024 to be transferred to hospital for assessment and treatment. Resident #021 is no longer a resident in the long-term care home.

RPN #115, the Physiotherapist(PT), ADOC and Restorative Care Coordinator (RCC) all indicated, to Inspector #554 on two separate dates, that resident #021 was at risk for falls, due to identified risk factors. RPN #115 and the Physiotherapist indicated resident #21 was forgetful and would leave the mobility aid behind in identified areas, or would push the mobility device away when encouraged to use it.

The plan of care documents the following specific to falls incidents and interventions:

Written Care Plan (in place at time of falls):
- Risk for falls: specified multiple risk factors. Goals of care, identify that resident #021 will be free of falls. There were a list of specified interventions included.
- Toileting Program: staff to assist resident #021 according to assessed needs, during specified times.
- Mobility: one staff to assist with ambulation and walk to and from dining room for all meals.

A review of the plan of care for resident #021 indicated that the plan of care was not revised when the care set out in the plan of care had not been effective, and that different approaches had been considered in the revision of the plan of care, specific to falls prevention and management.

RPN #115, the PT, ADOC and RCC all indicated that there had been no new interventions and/or approaches considered in the plan of care for resident #021, specific to falls prevention and management. RPN #115, PT and the RCC identified that the identified intervention, encourage resident #021 to use mobility aid remained ineffective.

The licensee failed to ensure that the plan of care, for resident #021, was revised when the care set out in the plan of care had not been effective, and that different approaches

had been considered in the revision of the plan of care, specific to falls prevention and management, specifically during specified dates when resident fell and sustained injury. (554)

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 the written plan of care for each resident sets out clear directions for staff and other who provide care to the resident, and the planned are for the resident related to use of a drug, the SDM is given an opportunity to participate in the development and implementation of the plan of care, and when the plan of care is not effective related to falls prevention management, that different approaches are considered in the revision, to be implemented voluntarily.

WN #3: 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 :

The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, specific to skin and wound care management.

Under O. Reg. 79/10, s. 48 (1) - Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the

home, specifically (2) a skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.

Under O. Reg. 79/10, s. 50 (1) - The skin and wound care program must, at a minimum, provide for the following: the provision of routine skin care to maintain skin integrity and prevent wounds; strategies to promote resident comfort and mobility and promote the prevention of infection, including the monitoring of residents; strategies to transfer and position residents to reduce and prevent skin breakdown and reduce and relieve pressure, including the use of equipment, supplies, devices and positioning aids; and treatments and interventions, including physiotherapy and nutrition care.

The licensee's policy, 'Skin and Wound Care Management' (#VII-G-10.80) states that each resident will have a skin assessment and where indicated, a treatment plan for maintenance of skin integrity and wound management. The Skin and Wound Care Management policy directs the following:

Registered Nursing Staff will:

- With a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, conduct a skin assessment; provide immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection as required; refer to the Registered Dietitian for assessment; updated the plan of care including Treatment Administration Record (eTAR), and care plan as appropriate; initiate electronic weekly skin assessment.
- Document in the individualized plan of care any skin care measures to: identify level of risk, promote healing, optimize nutrient intake, and prevent deterioration and infection.
- Utilize the wound management treatment plan and monthly wound care tracking sheet for all residents requiring wound care management.
- Transfer the information from the weekly skin surveillance / electronic assessment documentation to the resident's record.

Related to Intake #007790-17:

On a specified date in 2017, resident #024 was identified as exhibiting altered skin integrity.

Registered Nurse (RN) #118 documents in a progress note on a specified date, that the

resident had altered skin integrity to a specified area had altered skin integrity. RN #118 indicates that a specified treatment was applied to the area. RN #118 indicated in the documentation that resident #024 complained of pain when the specified area was touched. RN #118 indicated, in the progress note, that the wound would be monitored.

The clinical health record, for resident #024, was reviewed over a one month period. The review of the resident's clinical health record failed to provide evidence to support that the licensee's Skin and Wound Care Management policy was complied with specifically:

Assessments:
- Resident #024 was identified as having altered skin integrity on a specified date. The next assessment of resident's wound is documented as occurring thirteen days following the initial assessment date.

Referral to Registered Dietitian (RD):
- A referral to RD was not initiated until approximately three weeks after the altered skin integrity was noted.

Plan of Care:
- The electronic treatment record (eTAR) was not initiated on the day the altered skin integrity was noted, to identify that resident #024 had altered skin integrity and did not reflect treatment measures in place. The eTAR was not initiated until thirteen days later.
- The written care plan to identify that resident had altered skin integrity, specifically the wound to a specified area, goals of care and interventions to promote comfort and wound healing until thirteen days later.

Registered Nurse #113 indicated, to Inspector #554 on a specified date, that when a resident is identified as exhibiting altered skin integrity the following measures are to be implemented, a new wound tracking sheet is placed into the yellow skin and wound care binder (located in each nursing station), the eTAR is to be implemented identifying the wound and treatment measures in place, initial skin and wound care assessment (in Point of Care (PCC), under assessments tab), complete a dietary referral (in PCC), written care plan is to be updated indicating resident has a skin issue, interventions added to written care plan, that the Substitute Decision Maker for resident is to be called and notification charted in resident's progress notes and the Physician is to be notified via the physician communication book. Registered Nurse #113 indicated that the health record for resident #024 failed to identify that the indicated steps had been initiated until thirteen days later.

Registered Nurse #118 was unavailable for an interview during this inspection.

Associate Director of Care and the Director of Care indicated, to Inspector #554 on two separate dates, that according to the above documented review of resident #024's health record, RN #118 failed to follow procedures outlined in the Skin and Wound Care Management policy.

The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, specific to skin and wound care management for resident #024. [s. 8. (1) (a),s. 8. (1) (b)] (554)

2. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, specific to Falls Prevention and Management Program.

Under O. Reg. 79/10, s. 48 (1) - Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home, specifically, a falls prevention and management program to reduce the incidence of falls and the risk of injury.

Under O. Reg. 79/10, s. 49 (1) - The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids.

The licensee's policy, 'Falls Prevention' (#VII-G-30.00) indicated that each home will have a falls prevention and management program in place to reduce the incidence of falls and the risk of injury to residents. The program will be monitored by the home's Resident Safety Coordinator or Falls Committee.

The policy 'Falls Prevention' directs the following:

The Director of Care or Designate will:
- Lead and coordinate the implementation of the Fall Prevention and Management Program, utilizing the falls tools and assessments.
- Determine a communication process by which residents at moderate or high risk for falls are easily identified to the entire care team.

- Review all falls incidents, and identify action plans to address trends.

Registered Nursing Staff will:
- Complete the Falls Risk Assessment in the electronic documentation system at the following times, within 24 hours of admission or re-admission; as triggered by MDS Resident Assessment Protocol; and with a significant change.
- Upon completion of the detailed Fall Risk Assessment, update the care plan with associated risk level and interventions.
- Monitor preventative interventions and evaluate effectiveness on an ongoing basis and with the quarterly review.

Related to Intake #021601-17:

The Director of Care submitted a Critical Incident Report (CIR) to the Director on a specified date, specific to an incident that caused injury to a resident for which the resident was taken to hospital and which resulted in a significant change in resident's health status. The incident occurred on a specified date and involved resident #021.

The clinical health record, for resident #021, was reviewed for a nine month period. The review indicated that resident #021 was cognitively impaired and at risk for falls. The clinical health record indicated that resident #021 had several falls during that nine month period, with a number of those falls resulting in injury, and a specified number of the falls required resident #021 to be transferred to hospital for assessment and treatment. Resident #021 is no longer a resident in the long-term care home.

RPN #115, ADOC and the DOC indicated, to Inspector #554 on two separate dates, that a Fall Risk Assessment is to be completed when a resident is admitted to the long-term care home, upon readmission from hospital, when a resident has two or more falls per month, or has one fall consistently monthly, or when a resident has a significant change in their health status. RPN #115 and the DOC indicated that a Fall Risk Assessment should have been completed for resident #021 based on the number of falls resident had, and the significant change in resident #021's health status, especially following the fall, in which resident sustained an injury to a specified area.

DOC indicated that resident #021 should have been identified as being at high falls risk, noting the number of falls resident had, and should have had interventions in place associated with risk level.

The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with related to Falls Prevention and Management Program, specifically completion of Fall Risk Assessment, updates of resident's care plan, associated risk level and interventions, for resident #021. [s. 8. (1) (b)](554)

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 the following licensee policies: skin and wound care management and the falls prevention and management is complied with, to be implemented voluntarily.

WN #4: 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 :

The licensee has failed to ensure that the person who had reasonable grounds to suspect that any of the following had occurred, immediately reported the suspicion and the information upon which it was based to the Director: 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

Related to log # 024410-17:

A critical incident report (CIR) was submitted to the Director on a specified date for a witnessed incident of staff to resident emotional abuse that occurred on a specified date and time towards resident #025. The CIR indicated the ED initiated the investigation and the CIR was completed by the DOC.

Interview with the ED and DOC on a specified date, by Inspector #111, both confirmed the Director was notified when the CIR was submitted, seven days later.

The licensee failed to ensure that a witnessed staff to resident emotional abuse, was immediately reported to the Director [s.24(1)] (554)

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a 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 reported the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 30. Protection from certain restraining

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff. 2007, c. 8, s. 30. (1).
2. Restrained, in any way, as a disciplinary measure. 2007, c. 8, s. 30. (1).
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

s. 30. (5) The use of barriers, locks or other devices or controls at entrances and exits to the home or the grounds of the home is not a restraining of a resident unless the resident is prevented from leaving. 2007, c. 8, s. 30. (5).

Findings/Faits saillants :

The licensee has failed to ensure that residents were not restrained by the use of barriers, locks or other devices or controls (except under the common law duty described in section 36) from: leaving a room or any part of the home, including the grounds of the home or; from entering part of the home generally accessible to other residents.

During the initial tour of the home, Inspector #554 noted the home had three floors, with each floor containing resident home areas. The inspector noted that a swipe card was required to enter or exit all three resident home areas.

Interview with resident #003, on a specified date by Inspector #554, indicated when asked by inspector #554 "if you wanted to go off this floor to another floor, are you able to?" and the resident responded, "couldn't - it's like a prison here, can't leave". The resident was asked if they had a swipe card to exit the unit and indicated "no". The resident indicated they could only leave the unit to go to another unit if escorted by

The resident stated that not being able to leave the unit alone was "like a prison here - but learn to live with it".

Review of resident #003 health care record by Inspector #554, indicated the resident was admitted on a specified date in 2017 with a CPS score of level 2/6. Review of the written plan of care indicated the resident was independent with use of a cane. The plan also indicated the resident had no responsive behaviours related to wandering, exit seeking and any history of elopement. There were no physician or Nurse Practitioner (NP) orders, assessments, or consents in place related to use of the environmental restraint or reasons for the restraint.

Interview with resident #012, on a specified date by Inspector #111, indicated the resident previously had a swipe card to exit the unit and then had the swipe card taken away. The resident indicated it was because when the resident was leaving the unit, another resident left the unit at the same time. The resident stated "I got in trouble for letting someone off the unit" while attempting to leave the unit to participate in an independent activity. The resident also stated "now I have to find staff to let me off the unit and I can’t always find anyone" preventing the resident from participating in the activity. The resident stated the swipe card was never returned and stated "I want it back so I can go upstairs when I feel like it".

There was no documented evidence in the health care record of resident #012, to indicated the resident or the resident’s SDM provided consent for an environmental restraint. There was no physician or NP order for an environmental restraint and no assessments or written plan of care indicating the use of environmental restraint and reason for its use.

Interview with RPN #105 and PSW #106, on specified date by Inspector #111, indicated there were currently no residents on the specified unit that had swipe cards. PSW #106 indicated resident #012 was the only resident who had a swipe card but it was removed.

Interview with the Restorative Care Coordinator (RCC) on a specified date, by Inspector #111, indicated the RCC was responsible for tracking all the physical restraints in the home. The RCC indicated the resident use of swipe cards were not tracked by the RCC but by the Office Manager.

Interview with the Office Manager on a specified date, by Inspector #111, indicated all swipe cards provided to any residents were tracked and provided the Inspector with the

list of residents with swipe cards.

Review of the resident list with swipe cards provided by the Office Manager indicated 7 out of 96 residents were given a swipe card to enter or exit the resident home areas.

Interview with the ED on a specified date, by Inspector #111, indicated all the resident home areas were locked, including the elevator to access the second and third floor and required the use of a swipe card to enter or exit the resident home areas. The ED indicated this was put in place due to previous non-compliance related to home not being secure. The ED was unable to provide details related to same when inquired. The Inspector noted that the previous non-compliance was related to the front door of the home not being secured and/or alarmed. The ED indicated all residents were assessed for safety and if no risk was determined, they were given a swipe card to enter or exit the units. The ED was unable to indicate how many residents from each floor had a swipe. The ED indicated that residents with CPS score of 0-2 would be able to receive a swipe care that would allow those residents the ability to leave the units.

The licensee was restraining residents by the use of locks or other devices or controls which prevented residents from leaving a part of the home, including the grounds of the home or; from entering part of the home generally accessible to other residents. On the first floor, residents without the swipe card, are restrained by use of lock(s). Residents on second and third floor, are restrained by use of the elevator controls which also require the use of a swipe card. The home indicated that only residents assessed with CPS score of 0-2 would be able to receive a swipe card. The inspector verified that only 7 out of 96 residents were provided a swipe card despite several other residents having CPS scores between 0-2. Resident #012 had a CPS score of 0 and was not provided a swipe card. Therefore, most of the residents were being restrained by use of lock(s) regardless of a CPS score. In addition, there was demonstrated concern/negative impact towards the identified restrained residents. [s. 30. (1) 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 no residents are restrained with use of barriers, locks or other devices or controls, or from leaving any part of the home, including the grounds of the home, or from entering a part of the home that is generally accessible to other residents, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee failed to ensure that resident #024 who was exhibiting altered skin integrity was reassessed at least weekly be a member of the registered nursing staff.

Related to Intake #007790-17:

The clinical health record, for resident #024, was reviewed for a one month period:
- On an identified date, Registered Nurse (RN) #118 documented, in a progress note,

that day staff reported that resident #024's had an area of altered skin integrity. The RN documented actions taken including the appearance of the wound, its measurements and amount of exudate, and application of a dressing.The RN indicated that the area would be monitored.
- Thirteen days later, RN #114 documented an assessment of resident #024 altered skin integrity, including actions taken, assessments, measurements, application of dressing and notification of resident's physician.

There was no documentation supporting that a weekly assessment, by registered nursing staff, was completed for resident #024, following the initial date of the assessment until thirteen days later.

Registered Nurse #113 indicated, to Inspector #554 on a specified date, that resident's exhibiting altered skin integrity are assessed at minimum of weekly by registered nursing staff. RN #113 indicated that skin assessments, by registered nursing staff, are documented in the electronic health record, for each resident, under the assessments tab. RN #113 indicated that this assessment is identified as a 'skin and wound assessment'. RN #113 further indicated that the skin and wound assessment would be linked to a progress note in the resident's health record. RN #113 confirmed that resident #024's altered skin integrity to a specified area was documented as being assessed upon initial notification and the next assessment was thirteen days later.

The Director of Care indicated, to Inspector #554 on a specified date, that any resident exhibiting altered skin integrity were to have a weekly skin assessment completed using the 'skin and wound care assessment' template located in Point Click Care (the licensee's electronic health record) under the assessments tab. Director of Care provided confirmation that there was no weekly skin and wound care assessment between specified dates.

The licensee failed to ensure that resident #024 who was exhibiting altered skin integrity, was reassessed at least weekly be a member of the registered nursing staff during the above identified dates. [s. 50. (2) (b) (iv)] (554)

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 residents with altered skin integrity as reassessed at least weekly by a member of the registered nursing staff, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee has failed to ensure the behavioural triggers had been identified for the resident demonstrating responsive behaviours (where possible), and that strategies had been developed and implemented to respond to the resident demonstrating responsive behaviours, where possible.

Review of the RAI-MDS (on a specified date) indicated the resident demonstrated specified responsive behaviours and the behaviours had deteriorated. The summary indicated the onset of symptoms correlated with the start of new medication.

Review of the current written plan of care for resident #001 indicated the resident was cognitively impaired and demonstrated responsive behaviours related to specified diagnoses. Interventions included specified strategies. The written plan of care did not

indicate who the responsive behaviour was directed towards, what the specific behaviours included and did not identify triggers or any other interventions to manage the specific responsive behaviours.

Review of the health care record for resident #001 indicated the resident was admitted on a specified date and the resident was to be monitored for a specified responsive behaviour. The resident was admitted with a physician order for a specified medication at bedtime for an identified responsive behaviour and was also started on a second specified medication at bedtime, three months later.

Review of the progress notes for a six month period for resident #001 indicated the resident demonstrated a number of incidents of responsive behaviours which began a month after admission and continued to escalate. The progress notes indicated specified responsive behaviours were directed towards resident #029 and occasionally towards resident #004, #010, #015, #018, #028 and other unidentified residents. The progress notes identified specified triggers when the responsive behaviours were occurring.

Review of the health care record of resident #029 indicated the resident was cognitively impaired and demonstrated specified responsive behaviours.

Review of the progress notes of resident #001 and #029 indicated the responsive behaviours occurred on specified dates and a specified number of the incidents were directed towards resident #029.

Interview with resident #001 on a specified date by Inspector #111, indicated the resident was cognitively impaired. The resident's spouse was with the resident at the time. The resident wandered independently around the unit in a mobility aide.

Review of the white Behavioural Supports Ontario (BSO) board in the nursing station indicated resident #001 demonstrated specified responsive behaviours and interventions.

Interview with RPN #122, on a specified date by Inspector #111, indicated they were the designated BSO for a three month period (during the period resident #001 demonstrated the responsive behaviours) but was no longer the BSO staff member. The RPN indicated the role included: a daily review of the 24 hour progress notes to determine any residents demonstrating responsive behaviours, talking to staff on the floor to gather more information, determine if any heightened monitoring was needed, if any medication

changes were needed, update the BSO binders on each unit (which contained the written care plan) and updated the BSO identification board (on each unit). The RPN indicated resident #001 demonstrated specified responsive behaviours, especially towards resident #029. The RPN indicated resident #029 was cognitively impaired and demonstrated specified responsive behaviour which was a trigger for resident #001. The RPN indicated resident #001 was easily redirected. The RPN confirmed resident #001 was not identified in the BSO binder but was identified on the BSO whiteboard. The RPN indicated awareness of one incident of resident to resident physical abuse by resident #001 towards resident #029 in a specified area. The RPN indicated no other assessments were completed or referrals related to resident #001 responsive behaviours. The RPN indicated no awareness that resident #001 had ongoing responsive behaviours involving resident #029. The RPN indicated there was currently no BSO program currently in place.

The responsive behaviours were not clearly identified on the written plan of care (type of responsive behaviour or whom it was directed towards. The behavioural triggers for resident #001 (especially resident #029 and a specified area) were not identified in the written plan of care. The strategies that were used to reduce the incidents of responsive behaviours were not identified where possible, to manage the resident's responsive behaviours and several of the residents involved in the altercations were not able to be identified. There were no other additional strategies considered, when the identified strategies were not effective.

The licensee has failed to ensure the behavioural triggers had been identified for the resident demonstrating responsive behaviours (where possible), and that strategies had been developed and implemented to respond to the resident demonstrating responsive behaviours, where possible.[s.53(4)](111)

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 residents demonstrating responsive behaviours, have the behavioural triggers identified where possible and strategies are developed and implemented to respond to the residents that are demonstrating responsive behaviours, where possible, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

The licensee has failed to ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month,
2. A change of 7.5 per cent of body weight, or more, over three months.

Review of the health care record for resident #004 indicated the resident was admitted on a specified date in 2017. The resident had a specified weight loss in one quarter since admission. The current written plan of care indicated the resident was a high nutritional risk.

Interview with PSW #106 by Inspector #111, on a specified date, indicated resident #004 was independent with feeding and only consumes approximately 50 per cent of meals and drinks poorly.

Interview with RPN #105 by Inspector #111, on a specified date, indicated any residents who have a significant weight loss from previous month, should be re-weighed to ensure accuracy and then complete a referral to the RD related to the weight loss. The RPN indicated no awareness of resident #004 having a specified weight loss since admission and confirmed no referral was completed to the RD.

Interview with RD by Inspector #111, on a specified date, indicated they had just started working in the home (approximately six weeks) and is in the home approximately two days per week. The RD indicated all new admission residents, any high risk residents, and any residents with a dietary referral related to dietary concerns or weight loss are reviewed by the RD. The RD indicated when a resident has a significant weight loss, they will talk to the resident and the staff regarding possible interventions. The RD indicated no awareness of resident #004 significant weight loss since admission and had not received any dietary referrals from nursing staff regarding weight loss. The RD confirmed the resident was a high nutritional risk.

Resident #004 was a high nutritional risk and had a weight change of 5 to 7.5 per cent of body weight over a three month period. There was no indication the resident was assessed using an interdisciplinary approach and that actions were taken and the outcomes were evaluated. [s.69](111)

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 residents with weight changes of 5 per cent over one month or seven point five per cent or more over three months, are assessed using an interdisciplinary approach and actions are taken, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

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

Findings/Faits saillants :

The licensee has failed to ensure that the resident's SDM and any other person specified by the resident, were immediately notified upon becoming aware of a witnessed incident of abuse or neglect of the resident that: resulted in a physical injury or pain to the resident, or caused distress to the resident that could potentially be detrimental to the resident' s health or well-being and the resident and resident's SDM were notified of the

results of the alleged abuse or neglect investigation immediately upon the completion.

Related to log # 024410-17:

Two critical incident reports were submitted to the Director for staff to resident verbal/emotional abuse involving PSW #103 towards two different residents, that occurred on the same day and time:
-a critical incident report (CIR) was submitted to the Director on a specified date for a witnessed staff to resident verbal/emotional abuse incident. The CIR indicated at a specified time, PSW #103 was witnessed being emotionally abusive towards to resident #027 which left the resident visibly upset. The CIR indicated the investigation was completed six days later, determined the incident was founded and the PSW received disciplinary action as a result. The CIR did not indicate the SDM was notified of the outcome of the investigation.
-the second critical incident report (CIR) was submitted to the Director six days later, for a witnessed staff to resident verbal abuse. The CIR indicated on a specified date and time, PSW #104 and PA #110 reported witnessing PSW #103 being verbally abusive towards resident #025. The CIR indicated the investigation was completed six days later, determined the incident was founded and the PSW received disciplinary action as a result. The CIR indicated the resident was notified of the incident but did not indicate the resident was notified of the outcome of the investigation.
-both CIRs were completed by the DOC.

Review of the health care record of resident #025 indicated the resident was cognitively impaired. The progress notes indicated the resident's SDM was notified of the staff to resident verbal abuse incident the day after the incident occurred. There was no documented evidence the resident and/or SDM were notified of the outcome of the investigation.

Review of the health care record for resident #027 had no documented evidence of the incident or to indicate when the resident was notified of the staff to resident verbal abuse or the outcome of the investigation.

Interview with resident #027 by Inspector #111, on a specified date, had no awareness of the staff to resident verbal abuse incident that occurred and denied recalling anyone speaking to the resident regarding the outcome of the investigation.

Interview with the DOC on a specified date, by Inspector #111, confirmed resident #025

was cognitively impaired and the SDM of resident was not made aware of the witnessed incident of staff to resident emotional abuse towards resident #025 until the day after the incident occurred. The DOC indicated resident #027 was spoken to regarding the incident on the day of the incident and notified of the outcome of the investigation two days later (despite the investigation not being concluded until six days later). The DOC confirmed there was no documented evidence that this occurred.

The licensee failed to ensure the SDM of resident #025 was immediately notified of a witnessed staff to resident emotional abuse incident. There was no documented evidence to indicate the licensee notified the SDM immediately upon the conclusion of the investigation of the outcome. There was no documented evidence the licensee notified resident #027 of the outcome of the investigation into the staff to resident verbal abuse. [s.97(1)(2)] (111)

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 the resident and or the resident's SDM are notified of any alleged, suspected or witnessed incidents of abuse or neglect that results in physical injury, pain or distress to the resident that could potentially be detrimental to the residents health or well-being and the resident and or SDM are notified of the results of the licensee's investigation immediately upon the completion, to be implemented voluntarily.

WN #10: 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).

Findings/Faits saillants :

The licensee failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

Related to Intake #007790-17:

Substitute Decision Maker for resident #024, indicated to Inspector #554 on a specified date, that the resident required the use of a drug treatment twenty-four hours a day.

The clinical health care record was reviewed for resident #024 for specified dates. The clinical health record identified that registered nursing staff administered the drug treatment to resident #024, at a specified dose, continuously.

A review of the Physician's Orders during that same specified dates, including a Medication Chart Review Report failed to support that resident #024 had been prescribed the drug treatment.

Resident #024 was no longer in the long-term care home.

RPN #115 and RN #113 indicated, to Inspector #554 on a specified date, that resident #024 required the use of the drug treatment twenty-four hours a day. RN #113 indicated that the specified treatment was considered a drug, and indicated that all drugs prescribed for a resident must be ordered by a physician.

RN #113 reviewed Physician Orders, specific to resident #024, during the specified period and confirmed that the drug treatment had not been prescribed for resident #024. RN #113 indicated that the original order for the drug treatment (dated six months earlier) had not been carried over onto the Medication Chart Review Report and there was no order in place at that time for the drug treatment as a result.

The Director of Care confirmed with Inspector #554 on a specified date, that the specified treatment was considered a drug, and further confirmed that all drugs administered to a resident require a physician's order.

The licensee failed to ensure that a specified drug, was prescribed for resident #024 during its administration to the resident during a two month period.[s.131(1)] (554)

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 no drug is used or administered (specifically oxygen) to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

The licensee has failed to ensure that the registered dietitian who is a member of the staff of the home: (a) completed a nutritional assessment for the resident on admission and whenever there was a significant change in the resident's health condition.

During stage one of the Resident Quality Inspection (RQI), resident #004 health care record and staff interview indicated weight loss with no plan.

Review of the health care record for resident #004 indicated the resident was admitted on a specified date. The resident weighed a specified weight on admission. Three months after admission, the resident had a significant weight loss. The initial nutritional assessment for resident #004 indicated the assessment was started on the day of admission but the assessment was left incomplete. The assessment indicated the resident was a nutritional risk and the resident was below the recommended range for age and desired weight range. The Registered Dietitian (RD) indicated unable to observe the resident due to outbreak. There was no documented evidence the initial nutritional assessment was ever completed.

Interview with RPN #105 by Inspector #111, on a specified date, indicated no awareness of resident #004 having weight loss since admission and confirmed no referral was completed to the RD.

Interview with RD by Inspector #111, on a specified date, indicated was new in the position (after the resident's admission) and was in the home two days a week. The RD indicated all new admission residents, any high risk residents, and any residents with a dietary referral for concerns with weight loss are assessed and reviewed by the RD. The RD indicated no awareness that the initial nutritional assessment was incomplete for resident #004 by the previous RD and was not aware the resident had sustained a significant weight loss since admission.

The RD who was in place at the time of the residents admission failed to ensure an admission nutritional assessment was completed for resident #004.[s.26(4)] (111)

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee failed to ensure when the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out, (b) a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care; (c) an explanation of how the supporting facts justify the decision to withhold approval.

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

Related to log # 026123-17:

A complaint was received from the Community Care Access Centre (CCAC) indicating an applicant for a long term care bed was refused admission based on a specified reason.

Review of the applicant's refusal letter for admission on a specified date, submitted by the licensee to the applicant, indicated the applicant was refused based on the nursing staff lacking the expertise necessary to meet the care requirements and the home lacked

the physical facility necessary to meet the care requirements of the applicant. The explanation provided by the licensee indicated the resident had a specified diagnosis, participated in a specified activity, the bed available was on the third floor and required staff to escort the resident and the home did not have the staff to escort the resident. The refusal letter was completed by the DOC.

Review of the CCAC information provided to the licensee (on a specified date) indicated the resident participated in an outdoor activity daily, family stated the resident was able to perform activity safely and had no concerns around the applicants activity and applicant was uncertain if going to continue the activity when going into Long Term Care.

Interview with the DOC by Inspector #111, indicated she could not recall specific details related to the applicants admission refusal letter as it was "sent a long time ago". The DOC was unable to indicate what level of nursing expertise was required to meet the resident's care requirements for a specified diagnosis and/or the outdoor activity. The DOC indicated the home lacked the physical facility necessary to meet the applicant's needs related to the outdoor activity because the home did not support the outdoor activity. The DOC was notified that applicant's who participated in the specified outdoor activity were not grounds for refusal. The ED later provided detailed information related to the applicants refusal for admission.

Interview with CCAC Placement Coordinator (CCAC-PC) by Inspector #111, indicated the home informed them that the applicant was refused because the applicant's outdoor activity. The CCAC-PC indicated the resident was able to independently participate in the outdoor activity and was willing to terminate the outdoor activity. The CCAC-PC indicated the home was informed that applicant's who participated in the outdoor activity were not grounds for bed refusals but the home refused the applicant anyway.

Review of the licensee's information provided by the ED indicated the applicants decision making was minimally impaired, participated in the outdoor activity daily and did not require staff assistance to go outside.

The documented evidence provided by the licensee did not support how the home lacked the physical facilities necessary to meet the applicant's care requirements or how the staff of the home lacked the nursing expertise necessary to meet the applicant's care requirements.[s.44(9)(c)] (111)

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

Related to log # 024410-17:

A critical incident report (CIR) was submitted to the Director on a specified date for a witnessed incident of staff to resident emotional abuse that occurred. The CIR indicated the incident occurred on a specified date and time towards resident #025 by PSW #103. The CIR did not indicate the police were notified. The CIR referenced a second critical incident report (CIR) that involved the same staff member.

Review of the second critical incident report (CIR) indicated on the same day as the first CIR, at a specified time, there was a witnessed staff to resident verbal/emotional abuse incident towards resident #027 by PSW #103. The CIR did not indicate the police were notified.

Interview with the ED and DOC by Inspector #111, indicated there were two separate incidents of staff to resident abuse that occurred on the same day, during a specified time towards resident #025 and #027. The ED indicated PSW #103 was involved in both incidents. The ED initiated an investigation. Both the ED and DOC confirmed the investigation determined the allegations were founded and the PSW received disciplinary action as a result. Both the ED and the DOC confirmed the police were not contacted regarding either incident.

The licensee did not immediately notify the police of two witnessed incidents of staff to resident verbal/emotional abuse and despite the investigation concluding the incidents were founded and disciplinary action taken with the staff member involved.[s.98] (111)

Issued on this 22nd day of June, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

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) :	LYNDA BROWN (111), KELLY BURNS (554)
Inspection No. / No de l'inspection :	2018_643111_0006
Log No. / No de registre :	005760-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	May 22, 2018
Licensee / Titulaire de permis :	The Royale Development GP Corporation as general partner of The Royale Development LP 302 Town Centre Blvd., Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Case Manor Care Community 28 Boyd Street, P.O. Box 670, BOBCAYGEON, ON, K0M-1A0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Monica Cara

To The Royale Development GP Corporation as general partner of The Royale Development LP, 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)

Linked to Existing Order / Lien vers ordre existant: 2017_623626_0016, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

The licensee shall be compliant with LTCHA, 2007, S.O. s. 8(3).

Specifically, the licensee shall ensure they:
1. Provide documented evidence to demonstrate the actual worked RN staffing schedule (which includes changes to the schedule for after business hours call-ins and any RN's identified as on-call) to clearly demonstrate that at least one Registered Nurse (RN), who is both an employee of the licensee and a member of the regular nursing staff of the home, is on duty and present in the home at all times.
2. Provide documented evidence to demonstrate that a backup RN staffing plan has been implemented, specifically when any agency RN staff are contacted for RN staff replacement, in accordance with the legislative requirements under O.Reg. 79/10, s.45.

Grounds / Motifs :

1. The licensee has failed to ensure that at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff is on duty and present at all times unless there is an allowable exception to this requirement.

Related to Log # 001399-18:

The licensee was issued a compliance order #001, for LTCHA, 2007, S.O. s.

8(3) during inspection #2017_623626_0016, which was served on a specified December 8, 2017 with a compliance date of February 28, 2018. The licensee was also to complete a corrective action plan to ensure compliance.

The licensee was ordered to ensure:
1. At least one Registered Nurse (RN), who is both an employee of the licensee and a member of the regular nursing staff of the home, was on duty and present in the home at all times.
2. Provide documented evidence to demonstrate that a backup RN staffing plan had been implemented, in accordance with the legislative requirements under O.Reg. 79/10, s.45.
3. Provide documented evidence to demonstrate recruitment and retention had been completed for any planned and/or extended leave.
4. Provide documented evidence that the Corporate Office had been notified of any RN staffing concerns.

Review of the licensee's corrective action plan indicated all vacant RN positions were filled. The staffing contingency plan was reviewed/updated to include backup to ensure that an RN was on duty at all times and updated the casual RN availability.

The licensee failed to ensure steps #1 and #2 of the order were met.

Case Manor Care Community has a licensed bed capacity of 96 beds.

In an interview with the Director of Care (DOC) on a specified date, by Inspector #111, indicated awareness of only one shift where there was no RN present in the home since a specified date in 2018, but the DOC was unaware of the specific date. A request was made for the actual worked RN staffing schedule but it was not provided at that time.

In an interview with the Executive Director (ED) the following day, by Inspector #111, the inspector requested a copy of the actual worked Registered Nursing (RN) staffing schedule for a one month period in 2018 and an 'electronic RN staffing schedule' was provided. The schedule indicated there were no dates identified with no RN coverage in the home. The ED indicated no awareness of any shifts when the home did not have an RN on-site since the compliance date. The ED also indicated there were no RN vacancies. The ED indicated the electronic RN staffing schedule would indicate any call-ins or shifts that were to

be replaced.

In an interview with the DOC eight days later, indicated no awareness of any gaps in RN staffing schedule since the compliance date and provided the Inspector with a 'daily RN roster' that would indicate any last minute changes or call-ins and who the shifts were replaced with.

In an interview with RN #113 on a specified date, by Inspector #111, indicated there were specified dates (during a specified month) when there was no RN on-site, after the compliance date. The RN indicated the RNs work on a specified unit and administered medications to residents. The RN indicated on specified date, the RN staffing schedule noted the RN had worked during a specified eight hour period but confirmed only working on-site for a three hour period. The RN indicated two days after that specified date, the RN staffing schedules indicated the RN had worked during a specified eight hour period but confirmed working a different eight hour period on the same date (the following shift). The RN also indicated they had not worked on site on a third specified date as identified on the RN schedule.

In an interview with RN #124 on a specified date, by Inspector #111, indicated during a specified date (post compliance date),had worked a 12 hour shift, despite the RN schedule indicating the RN worked an eight hour shift. The RN indicated she did not work on a second specified date despite the RN staffing schedule indicating the RN was working. The RN indicated was on-call on a third specified date (working off-site) for a three hour period and then worked on-site for a 12 hour period, despite the RN schedule indicating RN #128 worked for the first three hour period (that RN #124 was on-call).

In an interview with RN #128 on a specified date, by Inspector #111, confirmed the RN did not work on two specified dates, after the compliance date, despite both the RN staffing schedules indicating the RN had worked on those dates and times. The RN also indicated on a third specified date, the RN worked the shift after the shift that was identified on the RN schedule.

In an interview with RPN #115 on a specified date, by Inspector #111, confirmed there was no RN on-site on a specified date and shift (post compliance date), despite the RN schedule indicating RN #128 was working.

A request was made to the DOC for a Medication Administration Record (MAR)

for a specified unit during a specified month(post compliance date). Review of the MAR provided had the name of the resident removed. A request for the unaltered MAR was made but not provided. The MAR indicated:
- on a specified date, RPN #129 signed for medications at a specified time (despite the RN schedule indicating RN #113 was working).
- on a specified date, RPN #129 signed for medications at a specified time (despite the RN schedule indicating RN #128 was working).
- on a specified date, RPN #100 signed for medications at a specified time (despite the RN schedule indicating the RN #128 was working).
- on a specified date, RPN #130 signed for medications at a specified time (despite the RN schedule indicating RN #113 was working).
- on a specified date, RPN #115 signed for medications at a specified time (despite the RN schedule indicating RN #128 was working).

Review of the electronic and daily roster RN staffing schedule (post compliance date) indicated there was an RN who was a member of the regular nursing staff of the home, on duty and present in the home at all times during that time period. However, there were inconsistencies noted between the two RN staffing schedules that were provided, the eMAR provided by the DOC and from staff interviews to support an RN was on site for five specified dates and times.

The licensee failed to demonstrate due to several inconsistencies, that a registered nurse who was both an employee of the licensee and a member of the regular nursing staff, was on duty and present in the home and documented evidence to demonstrate that a backup RN staffing plan had been implemented.

The severity of this issue was a level 2 as there was potential for actual harm to the residents. The absence of an RN who is familiar with residents that reside in the Long-Term Care Home, potentially poses a risk to resident safety and affects every resident in the Home. The scope was level 3 as the compliance history indicated there was related non-compliance that included:Compliance order (CO) made under s. 8(3) of the LTCHA, during the RQI Inspection September 18, 2017 (#2017_623626_0016) with a compliance date of February 28, 2018. (111)

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : May 31, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

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

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this (these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
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 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)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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 22nd day of May, 2018

Signature of Inspector /
Signature de l'inspecteur :

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

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Name of Inspector / Nom de l'inspecteur : LYNDA BROWN

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