Ontario

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

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

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

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

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

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

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## Amended Public Copy/Copie modifiée du public

| Report Date(s)/ Date(s) du Rapport | Inspection No/ No de l'inspection | Log #/ No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Dec 13, 2019 | 2019_818502_0022 (A3) | 013130-19, 015486-19, 015534-19, 016969-19, 017642-19, 017913-19, 018104-19, 018242-19, 018420-19 | Critical Incident System |

### Licensee/Titulaire de permis

City of Ottawa
Community and Social Services, Long Term Care Branch 200 Island Lodge Road
OTTAWA ON K1N 5M2

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

Centre d'Accueil Champlain
275 Perrier Street VANIER ON K1L 5C6

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

Amended by JULIENNE NGONLOGA (502) - (A3)

### Amended Inspection Summary/Résumé de l'inspection modifié

**The Licensee order of the inspection report #2019_818502_0022 had been amended to extend the compliance due date to December 31, 2019 for CO #002.**

**The Public order of the inspection report #2019_818502_0022 had been amended to extend the compliance due date to December 31, 2019 for CO #002, and to remove the Personal Health Information (PHI).**

**Issued on this 13th day of December, 2019 (A3)**

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

**Original report signed by the inspector.**

Ontario

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

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

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

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


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

Amended by JULIENNE NGONLOGA (502) - (A3)

### Amended Inspection Summary/Résumé de l'inspection

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

**This inspection was conducted on the following date(s): September 19, 20, 23, 24, 25, 26, 30, October 1, 2, and 3, 2019, and offsite October 7, 2019.**

**During the course of the inspection, the following Critical Incident System (CIS) report were inspected during:**

**- CIS #M511-000034-19 (log #013130-19), CIS #M511-000042-19 (log #015534-19), CIS #M511-000047-19 (log #017642-19) and CIS #M511-000053-19 (log #018420-19), related to prevention of abuse and neglect.**

**- CIS #M511-000041-19 (log #015486-19) and CIS # M511-000051-19 (log #018242-19) related to fall with injury.**

**- CIS #M511-000049-19 (log #017913-19) related to injury with unknown cause.**

**- CIS #M511-000050-19 (log #018104-19) and CIS #M511-000046-19 (log #016969-19) related to missing narcotic.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Program Manager of Personal Care (PMPC), the Program Manager of Resident Care (PMRC), Pharmacist, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Physiotherapist (PT), Rehabilitation Assistant (RA), Resident Assessment Instrument-Minimum Date Set (RAI-MDS) Coordinator, Quality Assurance (QA) Nurse, residents and family members of the residents.**

**During the course of this inspection, the inspectors observed resident care, observed staff and resident interactions, interviewed staff and substitute Decision Maker (SDM) and reviewed the residents' health care records, staff schedules, the licensee investigation notes and relevant policies and procedures.**

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

**Dignity, Choice and Privacy**
**Falls Prevention**
**Medication**
**Prevention of Abuse, Neglect and Retaliation**
**Responsive Behaviours**

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

**12 WN(s)**
**7 VPC(s)**
**2 CO(s)**
**0 DR(s)**
**0 WAO(s)**

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

**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations**
**Every licensee of a long-term care home shall ensure that,**
**(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and**
**(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that procedures and interventions were developed and implemented to assist residents and staff who are at risk of harm as a result of resident #006's responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

Critical Incident System reports (CIS) were received by the Ministry of Long-Term Care (MLTC) related to alleged resident-to-resident abuse.

Record review of resident #006's electronic documentation records and CIS indicated that for a period of seven months resident #006 exhibited identified responsive behaviours on 18 occasions toward co-residents and staff.

A review the home's quarterly Resident Assessment Instrument-Minimum Data Set (RAI-MDS) indicated that resident #006 was assessed to be severely cognitively impaired, with a specified diagnosis.

Review of the psychiatry progress reports indicated specified triggers, outlined specified treatment and on two occasions directed staff to allow resident #006 to sleep late and provide all cares upon their awakening with the goal to increase comfort and reduce specified symptoms. The note directed home to have a signage in the resident room with the above recommendation.

This recommendation was not being followed as registered staff documented on multiple occasions for a period of three months, that resident #006 refused to wake up when staff attempted to provide care, and a sign with the above recommendation was not observed in resident #006's room. Resident #006 had 18 altercations with co-residents and staff some resulting in injury were noted during the same period.

Review of resident #006's plan of care outlined specified interventions that include administer medication as prescribed.

On multiple occasions registered staff documented that resident #006 refused their medications, and they verified during interviews that medications were not administered as prescribed at an identified time. They also documented that the attending physician was notified after each incident, but alternate time and method to administer the medication were not considered at the time of this inspection. Further review of the plan of care did not identify different approaches to address resident #006's behaviours and triggers mentioned above.

In separate interviews, PSWs #119, #132, RPN #133, RNs #106 and #123 indicated that resident #006 was unpredictable, displayed specified responsive, and the triggers were identified. They indicated that staff monitored and removed resident #006 from situation when they displayed the responsive behaviour, but staff cannot always control the resident as they ambulate independently on short distances in the unit. The staff did not identify specific interventions to manage the behaviour and reduce the triggers identified above.

In separate interviews, PMRC #100 and PMPC #124 indicated that resident #006 displays responsible behaviours as described above. The attending physician constantly reviewed resident #006's medication as recommended by the external psycho-geriatric team.

PMPC #124 indicated that the home cannot provide 1:1 permanently to resident #006.

PMRC #100 indicated that they oversee the Behaviour Support Ontario (BSO) program in the home, but each floor has a PSW as a BSO lead. However, each BSO lead assumes the role once a week on Thursdays and cannot leave their regular PSW assignment the rest of the week to assist the multidisciplinary team members in assessing and developing different strategies within the home's BSO

program.

From the record review, observation and staff interviews, staff were aware of resident #006's triggers and identified responsive behaviours. After an altercation with a co-resident that result in injury, close monitoring was initiated for an identified period, the resident was also moved to another floor. However, the resident continued to have harmful interactions with staff and co-residents. Therefore, the home failed to ensure that procedures and interventions were developed and implemented to assist residents #007 and #016, and staff who have been harmed and failed to minimize the risk of potentially harmful interactions between resident #006 and co-residents. [s. 55. (a)] (502)

***Additional Required Actions:***

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

**(A1)**
**The following order(s) have been amended: CO# 001**

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

**s. 6. (9) The licensee shall ensure that the following are documented:**
**1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).**
**2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).**
**3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).**

**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 :**

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

The MLTC received a CIS related to resident #008's fall which resulted in injury.

On an identified date and time, resident #008 had a fall in an identified care unit and complained of pain. As the pain worsened the next day, the resident was transferred to the hospital for further assessment, they resident had a specified procedure as a result of the injury.

Review of resident #008's MDS assessment indicated that the resident had memory deficit with a cognitive performance scale (CPS) score of five out of six.

Review of resident #008's progress notes indicated that on three different days the resident had fallen, and the wheelchair's brakes were not engaged.

Review of resident #008's plans of care for an identified period directs staff to ensure that the breaks were engaged when sitting in the wheelchair.

In an interview, PSW #121 stated that resident #008 required assistance to engage the brakes on the wheelchair, but removed them independently. The resident was often getting up from the wheelchair and could have a fall without staff knowledge.

In an interview, RPN #122 stated that resident #008 was able to engage and remove the brakes from the wheelchair.

In an interview, RN #123 stated that the resident was unable to understand to engage the brakes when standing or sitting from the wheelchair. RN #123 stated they were not allowed to engage the brakes on the resident's wheelchair because it was a restraint.

In an interview with the PMPC #124, stated that the brakes on the wheelchair was not engaged at the time of the fall incidents, therefore the licensee failed to ensure that the care was provided to the resident as specified in the plan.[s. 6. (7)] (211)

2. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

Two CIS were received by the MLTC related to resident-to-resident abuse.

A review of the first CIS indicated that on an identified date and time, resident #006 displayed an identified responsive behaviour toward resident #007.

A review of the second CIS indicated that on an identified date and time, resident #006 displayed an identified responsive behaviour toward, resulting in injury on resident #006.

Review of resident #006's Dementia Observation System (DOS) documentation record initiated as a result of the incident mentioned above indicated that the DOS documentation was not completed on 20 occasions during day, evening and night shifts.

In separate interviews, RNs #116 and #123 indicated that DOS documentation was initiated after the incident identified above. The RN acknowledged that staff did not complete the daily tracking form.

In an interview, RN #115 and PMPC #124 verified that the DOS documentation was not completed on the dates and shifts identified above. [s. 6. (9) 1.] (502)

3. A review of the resident's progress notes indicated that on an identified date and time, resident #002 was observed in resident #003's room displaying inappropriate behaviour toward resident #003.

Review of current resident #002's MDS, indicated that the resident had severely cognitive impairment and displayed specified responsive behaviour.

Review of resident #002's DOS documentation record for an identified period indicated that the DOS documentation was not completed on 14 occasions during day, evening and night shifts.

In an interview, PMPC #124 verified the DOS documentation was not completed consistently on each shift. [s. 6. (9) 1.] (502)

4. Review of current resident #008's MDS assessment indicated that the resident had memory deficit with a CPS score of five out of six. They also had severely cognitive impairment and never makes decisions.

Review of the resident's progress notes indicated that on an identified date, resident #008 had a fall which resulted in injury and was transferred to the hospital. DOS was initiated for pain and behaviour upon their return from hospital.

Review of resident #008's DOS documentation record initiated as a result of the incident of fall mentioned above indicated that the DOS documentation was not completed on 14 occasions during day, evening and night shifts.

In an interview with Inspector #211, PMRC #100 verified the DOS documentation was not completed consistently on each shift. [s. 6. (9) 1.] (502)

5. Review of resident #008's physician's order with a specified date, indicated to apply an identified strategy as the resident was at high risk for falls and it was included in the resident's written plan of care on that date.

Review of resident #008's Medication Administration Record (MAR) for an identified period disclosed that the strategy mentioned above was documented as implemented on three occasions.

In an interview, the technician of rehabilitation stated that the strategy mentioned above was in place a month prior to the physician order.

In an interview, the PMRC stated when the strategy is implemented, an identified form is initiated. The PMRC indicated that the identified form mentioned above was not in the resident's health care records, they were unable to demonstrate that there was documentation completed related to the strategy.

The licensee has failed to ensure that the provision of the care set out in the plan of care related to the monitoring of resident #008's PASD was documented. [s. 6. (9) 1.] (502)

6. The licensee has failed to ensure that if resident #009's was being reassessed and the plan of care was being revised because care set out in the plan has not been effective, different approaches were considered in the revision of the plan of care.

A CIS was received by the MLTC related to a fall of resident #009 resulting in an identified injury.

A review of the CIS indicated that on an identified date and time, resident #009 had a fall in an identified care unit and complained of pain. the resident was transferred to the hospital for further assessment, they resident had a specified treatment as a result of the injury.

A review of resident #009's progress notes indicated the following:
- On an identified date, resident #009's treatment plan was changed to specified care due to worsen of specified symptoms and the resident's drugs regime had also changed.
- a month later, the resident weight bearing capability changed. but remained continent of bladder and bowel, therefore required assistance of one staff for pivot transfer.
- on an identified date staff documented that each night resident #009 was sleepy and went to the washroom three to four times, and to the kitchenet two to three times. The resident required close monitoring as they were at high risk of fall.
- on an identified date, the attending physician documented that the resident had an impaired vision but further assessment to rule out specified injury was not done due to resident's specified symptom, and the resident would not want

specified treatment as their level of care was do not resuscitate (DNR).
- On six occasions the staff documented that resident required supervision to prevent a fall and injury
- During a period of 40,days, the resident sustained three fall in an identified care area and the last one resulted in specified injury.

A review of resident #009's annual RAI-MDS assessment at the time of the fall indicated that the resident had a short-term memory deficit with a CPS score of one out of six.

Review of resident #009's written plan of care for an identified period, indicated specified diagnoses and outlined the fall prevention interventions that were implemented.

Further review of resident #009's written plan of care did not identify specific interventions for the risk of falls identified above after the first fall, second fall and the third fall.

In separated interviews, RN #106, #110 and #115 indicated that resident #009's plan of care was revised after each incident of fall, but the interventions to prevent reoccurrence remained the same.

RN #115 stated that resident #009 was cognitive and was able to tell staff what they needed. However, they may not always remember to call for assistance. RN #106 indicated that they were satisfied with the interventions in place. All RNs acknowledged that those interventions did not address the risks of falls identified above.

In an interview, PMPC #124 verified that the plan of care did not include interventions to address specific risks of falls mentioned above.

From the record review and staff interviews, resident #009 had significant change in condition when the specific symptom worsened, specified care was initiated, and they had four falls during identified shifts. The risks of falls during that shifts was identified. However, the interventions to reduce those risks of fall and prevent reoccurrence remained the same after each fall. Therefore, the licensee failed to consider different approaches during the revision of the plan of care after each fall, when the interventions has not been effective. [s. 6. (11) (b)] (502)

***Additional Required Actions:***

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

**(A3)**
**The following order(s) have been amended: CO# 002**

***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 care set out in the plan of care is provided to the resident as specified in the plan, and***
***- if resident #010's was being reassessed and the plan of care was being revised because care set out in the plan has not been effective, different approaches were considered in the revision of the plan of care, to be implemented voluntarily.***

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**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 :**

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

In accordance with O. Reg. 79/10, s. 49 (1), the licensee was required to ensure that 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.

Specifically, staff did not comply with the licensee's Assessment Policy #315.08 revised on June 2019, and Assessment Head Injury policy #315.11 revised in September 2018, which were part of the licensee's falls prevention and management program.

Review of the licensee's Assessment Policy indicated that in the event of any unwitnessed fall, registered staff will always assess and document for head injury and monitor neuro vital signs.

Review of the licensee's Assessment Head Injury policy indicated that head injury assessment and neuro-checks shall be completed using neurological assessment tool (Form 315.11.a). The policy directs registered staff to monitor neurological status by completing the tool according to the following schedule:
- hourly for 4 hours, then if stable,
- every 4 hours for 24 hours, then if stable, and
- every shift for two days.

A CIS was received by the MLTC related to a fall of resident #010 resulting in a specified injury.

A review of the CIS indicated that on an identified date and time, resident #010 had a fall and complained of pain. The next day, the resident was diagnosed with an identified injury and had specified procedure.

A review of resident #010's progress notes indicated the resident had three unwitnessed falls for an identified period.
A review of Head Injury Routine (HIR) form for the period identified above, indicated that registered staff-initiated head injury assessment and neuro-checks post falls identified above. Further review indicated that the head injury

assessment and neuro-checks were not completed on 11 occasions.

A review of the resident care plan did not identify head injury assessment and neuro- checks for the dated mentioned above.

In an interview, RN #115 indicated that registered staff were expected to complete head injury assessment and neuro-checks after unwitnessed fall. They verified that the head injury assessment and neuro-checks were not completed on the date and time mentioned above.

Interview with PMPC verified that registered staff did not complete the HIR as per schedule outlined in the policy. [s. 8. (1) (a),s. 8. (1) (b)] (502)

2. In accordance with O. Reg. 114. (2) the licensee was required to ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt and administration of all drugs used in the home.

Specifically, the registered nursing staff did not comply with the licensee's policy MediSystems Pharmacy titled Leave of Absence (LoA) #MEDI-CL-ONT-026, dated October 1, 2018, which is part of the home's Medication Management Systems.

Review of the licensee's MediSystems Pharmacy titled Leave of Absence policy indicated the that MediSystem forms or home forms can be utilized to document Leave of Absence instructions as well as Listing of Medications given to the resident or person responsible.

Review of the Program Manager-Resident Care's email sent to all Registered Nurses and Registered Practical Nurses on an identified date indicated when a resident goes for a leave of absent (LOA) for more than one day and the resident is to receive narcotic medications, make a photocopy of the resident's narcotic card and give the narcotic card to the resident. Attach the photocopy of the narcotic card to the narcotic form. At each narcotic count, you need to indicate that the resident is on a LOA.

RPN #101 indicated that after the missing narcotic incident for resident #001, they were directed to give the whole narcotic card to the resident during their leave of

absence. They were instructed to photocopy the quantity left on the resident's narcotic sheet before giving the narcotic card to the resident, and document on the resident's narcotic sheet that the resident left with the narcotic card. They were also directed to document and sign on the resident's narcotic sheet on day, evening and night shifts that the resident did not return from their leave. Upon the resident's return, the registered nursing staff were directed to count and document on the resident's narcotic sheet the amount of narcotic medication left on the narcotic card to ensure the narcotic form and the amount returned on the narcotic card were the same.

In an interview, PMPC #124 stated that RPN #101 did not follow the policy MediSystem "Leave of Absence" related to resident #001's leaving the home with narcotic medication. [s. 8. (1) (b)](211)

3. In accordance with O. Reg. 114. (1) the licensee was required to develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcome for the residents.

Specifically, staff did not comply with the licensee's policy "Medication: Administration" #345.03 dated September 2018, which is part of the home's Medication Management Systems.

Review of the licensee's Medication: Administration policy indicated:
-Medications are poured into medication cups at time of administrating meds.
-Medication in the pouch is verified with the medication administration record (MAR)s before crushing the contents or removing from the pouch.
-Narcotics or controlled substances forms are updated as the shift proceeds and counted between two nurses during the shift to shift report.

On an identified date, the MLTC received CIS related to a medication incident that occurred on the same day.

Review of the incident indicated that on an identified date and time during the narcotic count at the change of shift, the registered nursing staff discovered that one tablet of an identified medication was missing for resident #004.

In an interview, RPN #102 stated they did not document immediately on the resident's Narcotic and Controlled Drug Administration Record form, the amount of narcotic left on the resident's narcotic card on the identified date and time. RPN

#102 indicated that they tried to find the missing narcotic but were not able to, as the tablet are small. RPN #102 acknowledged that they did not follow the procedure related to the administration of a narcotic.

In an interview, PMPC #124 stated that RPN #102 discovered that the identified medication was missing from resident #004's narcotic card on the identified date at the change of shift, when two nurses compared the amount of narcotic left on the narcotic card and the Narcotic and Controlled Drug Administration Record. The PMPC stated that RPN #102 confirmed not documenting immediately on the narcotic form the amount of narcotic medication left on the narcotic card. Therefore, the licensee has failed to comply with the home's Medication Administration policy as the Narcotics or Controlled Substances forms were not updated as the shift proceeds. [s. 8. (1) (b)] (211)

4. In accordance with Long-Term Act, 2007, c. 8, 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.

Specifically, the registered nursing staff did not comply with the licensee's policy #725.01 titled "Plan of Care Planning" dated February 2018, indicating the updated PSW Kardex will be printed and placed in the binder containing the PSW flow sheets and will be posted in the resident's room in a discrete location, for easy access for all staff upon consent of the resident or resident's substitute decision-maker.

On an identified date, inspector #211 observed resident #010's Kardex placed in the unlocked cupboard in a bathroom.

In an interview with the Program Manager-Resident Care, stated that they were unable to locate resident's consent signed by the resident's substitute decision-maker permitting the nursing staff to post the resident's Kardex in the bathroom.

The licensee has failed to ensure their policy titled "Plan of Care Planning" was complied, when resident #010's Kardex was posted in the resident's room without the resident or the SDM's consent. [s. 8. (1) (b)] (502)

5. The licensee has a policy titled "Assessment: Head Injury" #315.11, revised

September 2018 required staff to conduct a head injury routine (HIR) with a resident with actual or suspected head injury for a period of 72-hours from the time of the injury, using the appended neurological assessment tool (Form 315.11a). The policy indicated to monitor neurological status by completing the tool according to the following schedule:
-hourly for 4 hours, then if stable,
-every 4 hours x 24 hours, then if stable,
-every shift x 2 days.

Review of resident #008's progress notes indicated that the resident was found sitting on the floor in front of a chair on an identified date.

The neurological assessment tool (Form 315.11a) for an identified date indicated that the vital signs and the neurological signs were not taken on two occasions because the resident was sleeping.

The licensee has failed to ensure that their policy "Assessment: Head Injury" put in place was complied with when the registered nursing staff didn't follow their neurological assessment monitoring on the date and time identified above because resident #008 was sleeping. [s. 8. (1) (b)] (502)

***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 where the Act or Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy and procedure, the policy and procedure were complied with, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect**

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

**s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that resident #015 was not neglected by PSW #126.

Section 2(1) of Ontario Regulation 79/10 defines neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, including inaction or a pattern of inaction that jeopardizes the health or safety of one or more residents".

The MLTC received a CIS report related to neglect of resident #012 by a PSW.

A review of the CIS report and the home's investigation notes indicated that on an identified date and time resident #015's was in their pyjamas. The home's video footage summary indicated that the resident was transferred by staff of an identified shift without providing specified care. Staff of the next shift wheeled the resident in the dining room for two identified meal services without providing the specified care. Although resident #015's SDM requested that PSW #126 provide the specified care before the second meal service, the PSW provided the specified care nine hours later.

In an interview, PSW #126 indicated that resident #015's routine starts with staff of an identified shift, and the next shift provide specified care. The PSW stated that at the beginning of their shift, the resident was sitting on the wheelchair and covered with a blanket, they got busy and forgot to attend to the resident. The PSW stated that their workload had increase on that day due to unexpected events in the unit, but they did not inform the charge nurse or request assistance from other staff to care for their assigned residents. The acknowledged that they did not provide care to resident #015 as stated above.

In an interview, RN #131 acknowledge that not providing care to the resident was neglect

In an interview, DOC stated that PSW #126 had forgotten to provide care to resident #015. They stated that although it was not intentional, the resident was neglected by staff as specified care was not provided.

On the day of the incident staff of an identified shift transferred resident #015 toward the end of their shift and did not communicate the care needed to staff of the next shift. Those staff did not provide the specified care until nine hours after they were transferred to the wheelchair. The RPN did not act when the resident's SDM requested that the specified care be provided to the resident. This pattern of inaction resulted in resident being left to attend meal service with wet continence care product, therefore the licensee failed to protect resident #015 from neglect by staff. [s. 19. (1)] (502)

***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 are protected from neglect by the licensee or staff, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements**

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

**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 any actions taken with respect to a

resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The MLTC received a CIS related to resident #008's fall which resulted in injury.

On an identified date and time, resident #008 had a fall, they were transferred next day to the hospital for further assessment, they resident had a specified procedure as a result of the injury.
Review of the resident's progress notes for an identified period indicated that the resident had 13 falls. The progress notes also indicated to apply a belt to the resident's wheelchair since the resident was a high risk for fall.

Further review of the progress notes indicated that the resident was at high risk for fall. The resident was presently using a wheelchair and was in the evaluation process for a belt. The resident was not in the physiotherapy program as they wered6 unable to follow instructions.

Review of resident #008's plans of care for an identified period indicated the resident was in the process to be assessed for the application of a belt on the wheelchair. The resident's plans of care indicated to ensure that the brakes were engaged when sitting in the wheelchair.

In an interview, PSW #121 stated that the resident was getting up often from the wheelchair and could have had an unwitnessed fall as staff provided minimal supervision. BSO indicated that the resident was unable to put the brakes on the wheelchair but was able to remove them.

In an interview, RPN #122 stated that resident #008's walking ability became unstable in the last 30 days and was at risk for fall. The resident was not staying seated in the wheelchair. RPN #122 revealed that restraining the resident was not their first solution since the resident was able to walk. The falls were occurring when resident #008 was trying to pick up something from the floor or when trying to sit down, but not enough to put a belt on the wheelchair. It was observed that the resident was able to put on and take off the brakes on the wheelchair. RPN #122 stated that there was contradiction of opinion between the staff related to restraining the resident in the wheelchair.

In an interview, RN #123 stated that the resident was at high risk for fall. The resident was always leaning forward to pick up something that was not there. The

resident frequently removed their shoes. There was time when the resident was more at risk for fall due to weakness and unstable gait. The resident was uncooperative and was refusing to sit in the wheelchair. The resident was unable to understand to apply the brakes from the wheelchair when standing or sitting in the wheelchair. The resident never had a belt on the wheelchair.

In an interview, the Program Manager-Personal Care, stated that the resident would have refused the application of the belt when sitting in the wheelchair. The Program Manager-Personal care stated not being aware why the belt was not applied since the resident's progress notes indicated that the resident was in the process of having a belt installed.

In an interview with the Program Manager-Resident Care, stated that the registered nursing staff reported that an application of a seat belt on resident #008 's wheelchair would have increased the specified behaviour and put the resident at risk to fall with the wheelchair while still being attached with the wheelchair's seat belt. However, the Program Manager-Resident Care recognized that there was a lack of communication and collaboration between the staff for an identified period, when it was suggested to apply a belt on the resident's wheelchair. Their documentations did not indicate if assessment for the seat belt was completed thereafter. [s. 30. (2)] (211)

***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 actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.***

**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 125. Monitored dosage system**

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

**s. 125. (2) The monitored dosage system must promote the ease and accuracy of the administration of drugs to residents and support monitoring and drug verification activities. O. Reg. 79/10, s. 125 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the monitored dosage system must promote the ease and accuracy of the administration of drugs to residents and support monitoring and drug verification activities.

The MLTC received a CIS report from the licensee related to missing narcotic. Review of the CIS report indicated that on an identified date, RPN #101 gave specified medication to resident #001 prior to a leave of absence (LOA).

Review of resident #001's Narcotic and Controlled Drug Administration Record sheet dated indicated to administer the specified medication twice a day (BID) and was completed each shift while the resident was on LOA. It indicated eight the first day and two when the resident returned. The resident returned with one capsule of the specified medication for a total of three.

Review of the licensee's policy titled "medication: Counting Guidelines for Narcotic/Controlled Substances" #345.04 dated September 2018, indicated that both nurses must validate that the narcotic numbers identifying the medication are the same on the medication card and the narcotic count form.

Review of the home's investigation notes indicated that RPN #101 could not recall if seven or eight capsules of the specified medication was given to resident #001's for the LOA. Furthermore, RPN #101 admitted not viewing the number the medication left on the resident's narcotic card during the count.

In an interview, PMRC #100 stated that RPN #101 did write seven capsules of narcotic on resident #001's Narcotic and Controlled Drug Administration Record sheet and then corrected it by transposing the number eight over the number seven.

In an interview, PMPC #142 stated that the registered nursing staff are responsible for their practice standard and should follow the Medication Best Practice Guideline when administrating, dispensing and counting the narcotic's inventory on the Narcotic and Controlled Substance Administration Record sheet.

The licensee has failed to ensure that the specified medication was counted properly to promote the ease and accuracy of the administration of drugs given to resident #001's prior to the leave of absence. It also failed to support the monitoring and drug verification activities, because the registered nursing staff changed the count by transposing a different number over the previous count on the Narcotic and Controlled Drug Administration Record sheet. [s. 125. (2)] (502)

***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 monitored dosage system must promote the ease and accuracy of the administration of drugs to residents and support monitoring and drug verification activities, to be implemented voluntarily.***

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**WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 126. Every licensee of a long-term care home shall ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. O. Reg. 79/10, s. 126.**

**Findings/Faits saillants :**

1. The licensee failed to ensure that drugs remain in the original labeled container or package provided by the pharmacy service or the Government of Ontario until administered to a resident or destroyed.

In an interview, RPN #101 stated that on an identified date, each non-narcotics pouch for resident's LOA were opened to include the specified medication corresponding to the time the narcotics were prescribed to be administered. Afterward, the pouches were closed with an adhesive tape and were given to the resident for the LOA.

In an interview, the Administrator stated that the registered nursing staff did not follow the MediSystem Pharmacy's policy titled "Leave of Absence (LOA)" which is part of the home's Medication Management Systems. The Administrator stated that this policy indicated that the entire resident's narcotic card can be given to the resident during their LOA even if they didn't need all the narcotics on the card.

The licensee failed to ensure that the specified medications were left inside the resident's original labeled narcotic card provided by the pharmacy service as instructed in the LOA's policy until administered to the resident. [s. 126.] (502)

***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 remain in the original labeled container or package provided by the pharmacy service or the Government of Ontario until administered to a resident or destroyed, to be implemented voluntarily.***

**WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 128. Every licensee of a long-term care home shall ensure that a policy is developed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director, to govern the sending of a drug that has been prescribed for a resident with him or her when he or she leaves the home on a temporary basis or is discharged. O. Reg. 79/10, s. 128.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that a policy was developed and approved by the Director of Nursing and Personal Care and the pharmacy provider and, where appropriate, the Medical Director, to govern the sending of a drug that has been prescribed for a resident with him or her when he or she leaves the home on a temporary basis.

On an identified date PMRC stated that the licensee was using the MediSystem Pharmacy's policy titled "Leave of Absence (LOA)" #MEDI-CL-ONT-026, dated October 1, 2018, related to the procedure how to send controlled substances with a resident for a temporary leave basis.

On an identified date, PMRC sent an email to registered nursing staff stating that when a resident, who receives narcotics goes for a LOA more than one day, staff should make a photocopy of the narcotic card before giving the narcotic card to the resident. The photocopy of the narcotics card is attached to the narcotic counting sheet and at each count indicate LOA. When the resident returned from the LOA, the narcotics card is retrieved and immediately make the count.

In an interview, the pharmacist stated when a resident leaves the home for several days with the controlled substance card, the registered nursing staff must take a photocopy of the narcotics card prior and after the resident's LOA. Then, they needed to staple the photocopy of the narcotic card with the corresponding Narcotic and Controlled Substance Administration Record. Two nurses must make the count and compared the controlled substances on the "Narcotic and Controlled Substance Administration Record and the resident's narcotics cards before and after the resident's LOA. The pharmacist indicated that it was the responsibility of the licensee what steps and procedure should be taken by the registered nursing staff when sending a resident to a LOA with the controlled substance card.

The licensee failed to demonstrate that a policy was developed and approved by the Director of Nursing and Personal Care and the pharmacy provider, to govern the sending of a drug that has been prescribed when a resident leaves the home on a temporary basis. [s. 128.] (502)

***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 policy was developed and approved by the Director of Nursing and Personal Care and the pharmacy provider and, where appropriate, the Medical Director, to govern the sending of a drug that has been prescribed for a resident with him or her when he or she leaves the home on a temporary basis, to be implemented voluntarily.***

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**WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights**

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

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the right of the resident to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

On an identified date, Inspector #211 observed resident #005's plan of care posted inside the closet located in a shared bathroom. The closet's door was not locked and the personal health information (PHI) including the diagnosis and the date of birth were exposed.

In an interview with PSW #109, confirmed that resident #005's plan of care with the resident's PHI was posted in the unlocked closet in a shared bathroom.

In an interview, RN #110 stated that the resident's PHI including diagnosis were protected with a dark marker before being posted in the residents' room or bathrooms. The RN acknowledged that resident #005's PHI was not protected. Therefore, the licensee has not fully respected and promoted resident #005's right to have their PHI kept confidential accordance with that Act. [s. 3. (1) 11. iv.] (211)

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**WN #10: 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 immediately investigate an incident of missing controlled substance when resident #001 went for a leave of absence.

Review of the home's investigation indicated that RN #106 made PMPC, PMRC and the Administrator aware that a specified medicament count for resident #001 was incorrect on an identified date and time, as RPN #105 changed the number of the remaining medication. The missing controlled substance was reported to RN #106 by RPN #105 two days after becoming aware of the missing controlled substance as they waited until the resident returned from the LOA.

Review of the licensee's policy tiltled "Medication: Counting Guideline for Narcotic/Controlled Substance" #345.04, dated September 2018 indicated: The counts must be consistent between what medications are and what the count form indicates. If there is discrepancy, the nurses shall start an investigation and update the PMRC/delegate.

In an interview, PMRC stated that when the PMPC misunderstood the email when the came to work the next day.

Consequently, the investigation of the missing/unaccounted controlled substance did not start until four days after the licensee became aware of the missing controlled substance. [s. 23. (1) (a) (iii)] (211)

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**WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents**

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

**s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):**
**3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).**

**s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):**
**4. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.**

**Findings/Faits saillants :**

1. The licensee has failed to inform the Director no later than one business day after the occurrence of the missing controlled substance on an identified date for resident #001.

Review of the home's investigation indicated that on an identified date, RN #106 brought to the attention of PMPC, PMRC and the Administrator that identified medication count for resident #001 was incorrect in the past two days. RN #106 was informed by RPN #105 of the controlled substance discrepancy he same day it was reported.

In an interview with PMRC #100 stated that RN #106 was informed of the above-mentioned missing medication two days after it was noted. They confirmed that the incident was reported to the Director five days after the licensee became aware of the missing controlled substance. [s. 107. (3) 3.] (211)

2. The licensee has failed to inform the Director no later than one business day after resident #010 had a fall with injury that resulted in a significant change in resident #010's health condition and for which the resident was taken to a hospital specified treatment.

A CIS was received by the MLTC related to a fall of resident #010 resulting in

specified injury.

A review of the CIS indicated that on identified date and time, resident #010 was found on the floor in their room and they were complaining of specified pain. The attending physician directed staff to transfer the resident to hospital for further assessment. The resident was diagnosed with a specified injury and received specified treatment on identified date which resulted in complication.

Review of resident #010's progress notes indicated that on an identified date the resident's Substitute Decision Maker (SDM) called and told the home that the resident underwent specified treatment.
Further review of the CIS indicated that the incident mentioned above was reported to the Director three business day after the home became aware of the significant change in resident's health condition.

In an interview, PMRC #100 verified that they did not report the incident to the Director within one business, they acknowledged that it was a late reporting of three business day. [s. 107. (3) 4.] (502)

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**WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records**
**Every licensee of a long-term care home shall ensure that,**
**(a) a written record is created and maintained for each resident of the home; and**
**(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that a written record maintained for resident #010.

On an identified date, inspector #211 observed resident #009's plan of care placed in the unlocked cupboard in a bathroom. Resident #009's personal information from the plan of care was blackened.

Review of the licensee's policy #725.01 titled Plan of Care Planning dated February 2018, indicating the updated PSW Kardex will be printed and placed in the binder containing the PSW flow sheets and will be posted in the resident's room in a discrete location, for easy access for all staff upon consent of the resident or resident's substitute decision-maker (SDM).

In an interview, the Program Manager-Resident Care stated that they were unable to locate resident's consent signed by the resident's SDM. Therefore, the licensee, did not maintain a record created for resident #010 in the home. [s. 231. (a)] (211)

**Issued on this 13th day of December, 2019 (A3)**

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

**Original report signed by the inspector.**

Ontario

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

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

## Order(s) of the Inspector

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

## Ordre(s) de l'inspecteur

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

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

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

## Amended Public Copy/Copie modifiée du public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | Amended by JULIENNE NGONLOGA (502) - (A3) |
| **Inspection No. / No de l'inspection :** | 2019_818502_0022 (A3) |
| **Appeal/Dir# / Appel/Dir#:** | |
| **Log No. / No de registre :** | 013130-19, 015486-19, 015534-19, 016969-19, 017642-19, 017913-19, 018104-19, 018242-19, 018420-19 (A3) |
| **Type of Inspection / Genre d'inspection :** | Critical Incident System |
| **Report Date(s) / Date(s) du Rapport :** | Dec 13, 2019(A3) |
| **Licensee / Titulaire de permis :** | City of Ottawa<br>Community and Social Services, Long Term Care Branch, 200 Island Lodge Road, OTTAWA, ON, K1N-5M2 |
| **LTC Home / Foyer de SLD :** | Centre d'Accueil Champlain<br>275 Perrier Street, VANIER, ON, K1L-5C6 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Jacqueline Roy |

Ontario

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

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

## Order(s) of the Inspector

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

## Ordre(s) de l’inspecteur

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

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To City of Ottawa, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

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

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

## Order(s) of the Inspector

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

## Ordre(s) de l'inspecteur

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

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**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. 55. Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

**Order / Ordre :**

The licensee must be compliant with s. 55 (a) of Ontario Regulation 79/10.

Specifically, the licensee shall ensure procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of resident #006's responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents by completing the following:

1. Review the home's internal behavioral support program to ensure all members of the multidisciplinary team who care for residents with responsive behaviours participate in the program.

2. Ensure interventions for residents' displaying responsive behaviours are assessed for effectiveness by registered nursing staff and the home's BSO team in-between visits from the external psycho-geriatric outreach team.

3. Ensure registered nursing staff understand when and how to seek assistance from the internal BSO team and/or the external psycho-geriatric outreach team.

**Grounds / Motifs :**

1. The licensee has failed to ensure that procedures and interventions were developed and implemented to assist residents and staff who are at risk of harm as a result of resident #006's responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

Critical Incident System reports (CIS) were received by the Ministry of Long-Term Care (MLTC) related to alleged resident-to-resident abuse.

Record review of resident #006's electronic documentation records and CIS indicated that for a period of seven months resident #006 exhibited identified responsive behaviours on 18 occasions toward co-residents and staff.

A review the home's quarterly Resident Assessment Instrument-Minimum Data Set (RAI-MDS) indicated that resident #006 was assessed to be severely cognitively impaired, with a specified diagnosis.

Review of the psychiatry progress reports indicated specified triggers, outlined specified treatment and on two occasions directed staff to allow resident #006 to sleep late and provide all cares upon their awakening with the goal to increase comfort and reduce specified symptoms. The note directed home to have a signage in the resident room with the above recommendation.

This recommendation was not being followed as registered staff documented on multiple occasions for a period of three months, that resident #006 refused to wake up when staff attempted to provide care, and a sign with the above recommendation was not observed in resident #006's room. Resident #006 had 18 altercations with co-residents and staff some resulting in injury were noted during the same period.

Review of resident #006's plan of care outlined specified interventions that include administer medication as prescribed.

On multiple occasions registered staff documented that resident #006 refused their medications, and they verified during interviews that medications were not administered as prescribed at an identified time. They also documented that the attending physician was notified after each incident, but alternate time and method to administer the medication were not considered at the time of this inspection. Further review of the plan of care did not identify different approaches to address resident #006's behaviours and triggers mentioned above.

In separate interviews, PSWs #119, #132, RPN #133, RNs #106 and #123 indicated that resident #006 was unpredictable, displayed specified responsive, and the triggers were identified. They indicated that staff monitored and removed resident #006 from situation when they displayed the responsive behaviour, but staff cannot always control the resident as they ambulate independently on short distances in the unit. The staff did not identify specific interventions to manage the behaviour and reduce the triggers identified above.

In separate interviews, PMRC #100 and PMPC #124 indicated that resident #006 displays responsible behaviours as described above. The attending physician constantly reviewed resident #006's medication as recommended by the external psycho-geriatric team.

PMPC #124 indicated that the home cannot provide 1:1 permanently to resident

#006.

PMRC #100 indicated that they oversee the Behaviour Support Ontario (BSO) program in the home, but each floor has a PSW as a BSO lead. However, each BSO lead assumes the role once a week on Thursdays and cannot leave their regular PSW assignment the rest of the week to assist the multidisciplinary team members in assessing and developing different strategies within the home's BSO program.

From the record review, observation and staff interviews, staff were aware of resident #006's triggers and identified responsive behaviours. After an altercation with a co-resident that result in injury, close monitoring was initiated for an identified period, the resident was also moved to another floor. However, the resident continued to have harmful interactions with staff and co-residents. Therefore, the home failed to ensure that procedures and interventions were developed and implemented to assist residents #007 and #016, and staff who have been harmed and failed to minimize the risk of potentially harmful interactions between resident #006 and co-residents

The severity of this issue was determined to be a level 3 as there was actual harm to the residents. The scope of the issue was a level 1 as one out of three residents reviewed was affected. The home had a level 3 history as they had previous noncompliance to the same subsection of the LTCHA.

Due to the severity, scope, and history, a compliance order is warranted. (502)

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

## Order(s) of the Inspector

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

## Ordre(s) de l'inspecteur

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

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**Order # / Ordre no :** 002

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

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 6. (9) The licensee shall ensure that the following are documented:

1. The provision of the care set out in the plan of care.
2. The outcomes of the care set out in the plan of care.
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

**Order / Ordre :**

The licensee shall complied with s. 6 (9) of the LTCHA, 2007.

Specifically the licensee shall ensure that:
1. A Dementia Observation System Record is documented, consistently for residents #006, #002, #008 and any other resident in the home.

2. The Dementia Observation System Records for residents #006, #002, #008 and any other resident in the home contain documented evidence to support the identification of triggers, and the development of strategies to minimize the residents' responsive behaviour.

**Grounds / Motifs :**

(A3)
1. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

Two CIS were received by the MLTC related to resident-to-resident abuse.
A review of the first CIS indicated that on an identified date and time, resident #006 displayed an identified responsive behaviour toward resident #007.

A review of the second CIS indicated that on an identified date and time, resident #006 displayed an identified responsive behaviour toward resident #016, resulting in injury on resident #006.

Review of resident #006's Dementia Observation System (DOS) documentation record initiated as a result of the incident mentioned above indicated that the DOS documentation was not completed on 20 occasions during day, evening and night shifts.

In separate interviews, RNs #116 and #123 indicated that DOS documentation was initiated after the incident identified above. The RN acknowledged that staff did not complete the daily tracking form.

In an interview, RN #115 and PMPC #124 verified that the DOS documentation was not completed on the dates and shifts identified above.
(502)

(A3)
2. A review of the resident's progress notes indicated that on an identified date and time, resident #002 was observed in resident #003's room displaying inappropriate behaviour toward resident #003.

Review of current resident #002's MDS, indicated that the resident had severely cognitive impairment and displayed specified responsive behaviour.

Review of resident #002's DOS documentation record for an identified period indicated that the DOS documentation was not completed on 14 occasions during day, evening and night shifts.

In an interview, PMPC #124 verified the DOS documentation was not completed consistently on each shift.
(502)

(A3)
3. Review of current resident #008's MDS assessment indicated that the resident had memory deficit with a CPS score of five out of six. They also had severely cognitive impairment and never makes decisions.

Review of the resident's progress notes indicated that on an identified date, resident #008 had a fall which resulted in injury and was transferred to the hospital. The DOS documentation was initiated for pain and behaviour upon their return from hospital.

Review of resident #008's DOS documentation record initiated as a result of the incident of fall mentioned above indicated that the DOS documentation was not completed on 14 occasions during day, evening and night shifts.

The severity of this issue was determined to be a level 3 as there was actual risk to the residents. The scope of the issue was a level 1 as one out of three residents reviewed was affected. The home had a level 3 history as they had previous noncompliance to the same subsection of the LTCHA.

Due to the severity, scope, and history, a compliance order is warranted. (502)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Dec 31, 2019(A3)

Ontario

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

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

## Order(s) of the Inspector

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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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## 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:

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

Health Services Appeal and Review Board and the Director

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

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

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

## RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

**Issued on this 13th day of December, 2019 (A3)**

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

**Name of Inspector /**
**Nom de l'inspecteur :** Amended by JULIENNE NGONLOGA (502) - (A3)

Ontario

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