Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 29, 2020	2020_556168_0013	010431-20, 010644-20, 010811-20, 010843-20, 011094-20, 011507-20, 012138-20, 012142-20, 012158-20, 012159-20, 012200-20	Complaint

Licensee/Titulaire de permis

Vigour Limited Partnership on behalf of Vigour General Partner Inc.
302 Town Centre Blvd Suite 300 MARKHAM ON L3R 0E8

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

Camilla Care Community
2250 Hurontario Street MISSISSAUGA ON L5B 1M8

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

LISA VINK (168), GILLIAN HUNTER (130), HELENE DESABRAIS (615), SHERRI COOK (633)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 2, 3, 4, 5, 8, 9, 10, 11, 12, 15, 16, 17, 18, 19, 22, 23, 24, 25, 26, 29, 30, 2020 and July 2, 3, 7, 8, 9, 10, 13, 14, 15, 16, 17, 20, 21, 22, 23, 30, 31, 2020 and August 4, 5, 6, 7, 10, 11 and 12, 2020.

This inspection included both on and off site inspection activities.

This inspection was completed to inspect upon the following intake logs:
012138-20 - for Critical Incident System (CIS) report number 2472-000011-20, related to prevention of abuse and neglect;
012142-20 - for CIS report number 2472-000012-20, related to prevention of abuse and neglect;
010811-20 - for CIS report number 2472-000005-20, related to prevention of abuse and neglect;
010431-20 - for CIS report number 2472-000004-20, related to falls prevention and management;
012200-20 - for CIS report number 2472-000017-20, related to reports regarding critical incidents and infection prevention and control program;
012158-20 - for CIS report number 2472-000015-20, related to reports regarding critical incidents and infection prevention and control program;
012159-20 - for CIS report number 2472-000016-20, related to reports regarding critical incidents and infection prevention and control program;
010843-20 - related to the Residents' Bill of Rights and skin and wound care;
011507-20 - related to prevention of abuse and neglect;
010644-20 - related to the Residents' Bill of Rights and falls prevention and management; and
011094-20 - related to plan of care.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), acting Executive Director (aED), Behavioural Supports Ontario/Communications lead, Director of Care (DOC), assistant Directors of Care (ADOC), Office Manager, Nutritional Consultant, Scheduling Coordinator, Physiotherapist (PT), Environmental Services Supervisor (ESS), laundry aide, Resident and Family Experience Coordinator, recreation staff, housekeeping staff, Personal Support Workers (PSW), Care Support Assistants (CSA), Registered Nurses (RN), Registered Practical Nurses (RPN), residents and family members; and hospital partner staff including: a Physician, Nurse Practitioner (NP), the Vice President of Patient Care Services, a Coodinator, Project Director of Patient Care Services, a Director, Nurse Continence Adviser, a scheduler, Personal Care Attendants (PCA); and a Tena Director and Point Click Care Customer Support Representative.

During the course of the inspection, the inspectors observed the provision of care, services and supplies; reviewed records including but not limited to relevant training records, policies and procedures, meeting minutes, line listings, logs, clinical health records, schedules and investigative notes.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Infection Prevention and Control
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing
Training and Orientation

During the course of this inspection, Non-Compliances were issued.
- **17 WN(s)**
- **9 VPC(s)**
- **4 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	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(b) that the interdisciplinary team that co-ordinates and implements the program meets at least quarterly; O. Reg. 79/10, s. 229 (2).

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Infection Prevention and Control interdisciplinary team met at least quarterly.

The following non-compliance was identified during the inspection for complaint intake #011507-20 and supporting CIS intake #010811-20 both related to prevention of abuse and neglect and supporting CIS intakes #012158-20, #012159-20 and #012200-20 each related to reports regarding critical incidents and infection prevention and control program.

The home's policy, Infection Prevention and Control Committee, IX-A-10.20, current revision April 2016, identified that "there will be an established interdisciplinary Infection Prevention and Control Committee in the care community and this committee shall report to the Professional Advisory Committee".
Interview with former ADOC #133, confirmed that in 2019 they were the Infection Prevention and Control lead. They confirmed that it was the expectation that meetings were held on a quarterly basis and that they maintained their own meeting minutes.
A review of the Infection Prevention and Control Committee meeting minutes identified that meetings for 2019, were held on three dates in 2019.
The aED was not able to provide meeting minutes to support that meetings were held on a quarterly basis as required for 2019.

The Infection Prevention and Control interdisciplinary team did not meet at least

quarterly. [s. 229. (2) (b)]

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

The following non-compliance was identified during the inspection for complaint intake #011507-20 and supporting CIS intake #010811-20 both related to prevention of abuse and neglect and supporting CIS intakes #012158-20, #012159-20 and #012200-20 each related to reports regarding critical incidents and infection prevention and control program.

The home's policy, LTC Infection Prevention and Control, IX-F-10-00, April 2019, identified "In the event that documented surveillance of resident signs and symptoms suggests that a potential outbreak may be in progress, immediate measures must be implemented to reduce the transmission of disease. The Infection Control Practitioner (ICP), in consultation with the Medical Director or the local Public Health Unit (PHU), will review surveillance data and confirm that an outbreak is occurring".
i. The nurse would: Implement initial infection control measures as appropriate according to signs and symptoms presented, including isolation of affected resident(s) and use of additional precautions. Do not wait for confirmation of the organism; review status of all residents in resident home area/neighborhood, ensuring line listing is fully completed; communicate with ICP and ensure team members follow all recommendations made; notify attending physician and obtain any orders; and ensure any new cases are reported to ICP as soon as possible.
ii. The Infection Control Practitioner or designate would: review the line listing and identify if the definition of an outbreak was met; communicate suspected outbreak to all resident home areas/neighborhoods; communicate suspected outbreak to all Department Managers and Medical Director; and notify the local Public Health Unit (PHU) of suspected outbreak and identify any testing or special measures to be implemented.

A. A review of clinical records identified that during three months in 2019/2020, there were clusters of residents exhibiting respiratory symptoms throughout the home which suggested potential outbreaks.
This information was confirmed by Peel Regional Public Health in July 2020.

B. A further review of clinical records, Infection Prevention and Control (IPAC) meeting minutes, quarterly Professional Advisory Council (PAC) meeting minutes, daily Leadership Meeting minutes, monthly Leadership Meeting minutes, IPAC risk

assessments and staff interviews, identified:
i. Immediate measures to reduce the transmission of disease, such as isolating residents, implementing appropriate precautions, including signage, and testing to identify causative organism, were not consistently implemented.
ii. Line listings were not fully completed. Documentation recorded in progress notes identified that residents exhibiting symptoms of respiratory illness were not consistently added to the surveillance lists.
Residents added to the surveillance list were not added in chronological order, suggesting they were not added on a daily basis and when symptoms were first identified.
iii. The ICP was not immediately notified of all new cases.
iv. The ICP did not review and analyze the surveillance data on a daily basis, communicate suspected outbreaks to all resident home areas, communicate suspected outbreaks to all Department Managers and Medical Director, or consult with the local PHU and confirm that an outbreak was occurring.
v. During the COVID-19 outbreak, symptomatic COVID-19 positive residents and COVID-19 negative residents and staff assigned to their care, were not consistently co-horted.
vi. Excessive use of personal protective equipment (PPE), for example double masking and black plastic bags were worn by staff, as identified through the IPAC assessment conducted in April 2020.
vii. It was identified that staff were initially observed to be wearing garbage bags over their clothing and on their feet as PPE, and continued to wear gloves while they washed their hands instead of changing gloves.

It was confirmed through record reviews, meeting minute reviews, IPAC assessments and interview with aED, DOC and ADOC #133 that not all staff participated in the implementation of the infection prevention and control program. [s. 229. (4)]

3. The licensee has failed to ensure that staff monitored symptoms of infection in residents on every shift in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

The following non-compliance was identified during the inspection for complaint intake #011507-20 and supporting CIS intake #010811-20 both related to prevention of abuse and neglect and supporting CIS intakes #012158-20, #012159-20 and #012200-20 each related to reports regarding critical incidents and infection prevention and control program.

Recommendations for the Control of Respiratory Infection Outbreaks in Long Term Care Homes, by the Ministry of Health and Long-Term Care (MOHLTC) (March 2018), indicated under 2.2.3, Methods of Data Collection for Surveillance: "Daily surveillance is the most effective way to detect respiratory infections. Residents with respiratory and other symptoms should be noted on the daily surveillance form (refer to Appendix 3 - Sample Respiratory Outbreak Line Listing Form). This form should be easy to use and include patient identification and location, date of onset, a checklist of relevant signs and symptoms, including fever, diagnostic tests and results when available. The completed form should be forwarded to the Infection Control Practitioner (ICP) on a daily basis and any suspected outbreak should be reported immediately to the ICP".

A review of the Infection Control Surveillance Records, line listings created and provided for each resident home area for three months in 2019/2020, identified that surveillance lists had been completed on a monthly basis and not on a daily basis as required.
Not all residents were monitored every shift until their symptoms resolved, symptomatic residents had not been added to the surveillance list in chronological order and/or when symptoms were first identified.
A review of progress notes, identified that not all residents, specifically residents #018, #032, #033, #035, #036, #038, #039, #042 and #044, were line listed or monitored when symptoms were noted or added to surveillance lists.

This information was confirmed by the aED.

Staff did not monitor symptoms of infection in residents on every shift. [s. 229. (5) (a)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 Infection Prevention and Control interdisciplinary team meet at least quarterly and that staff monitor symptoms of infection in residents on every shift in accordance with evidence-based practices and if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure policies included in the required Continuous Quality Improvement system were complied with.

In accordance with LTCHA s. 84 the licensee was required to have a quality improvement and utilization review system and in accordance with O. Reg. 79/10, s. 228 the licensee was required to ensure that there was a written description of the system that included its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.

The following non-compliance was identified during the inspection for complaint intake #011094-20 related to plan of care, for resident #023.

The home's policy, Resident Incident Reporting, XXIII-D-10.00, current revision June 2019, identified that "all incidents involving residents will be reported through the Risk Management module in the electronic documentation platform for the following incidents" including "injury of unknown cause", that the nurse will "initiate and complete documentation of the incident in the Risk Management module and complete the User Defined Assessment as part of the incident", and that the Director of Care or designate will "review the Risk Management dashboard for new incidents and conduct an investigation and document investigation findings as required".

The clinical record included documentation that resident #023 reported pain and another symptom on a date in April 2020. The physician was notified and an analgesic and a diagnostic test was ordered.
The test was completed two days later and confirmed an injury.
Later that day the resident was transported to the hospital for treatment as confirmed by RN #126.
A review of the Risk Management module did not include a report of the injury of unknown cause.

Interview with the DOC, by Inspector #130, confirmed that they did not complete an investigation into the injury.
Interview with ADOC #135 confirmed that although they were aware of the injury and did ask two staff about what had happened, they did not initiate or complete an investigation.
Interviews conducted included one with staff member #163 who "recalled" a incident on the Thursday before the injuries were identified; however, details regarding the incident/shift were not confirmed.
An interview with the substitute decision maker (SDM) identified that five days prior to the first documented entry regarding the identified pain, they were notified by phone by a staff member, that the resident had an incident two days prior and had pain. According to the SDM phone calls prior to the date that pain was first documented, indicated that the resident experienced pain.
In June 2020, the resident's SDM contacted the home regarding concerns, which included what was the cause of the injury to the resident, at which time an investigation was initiated.

The Resident Incident Reporting policy was not complied with. [s. 8. (1) (b)]

2. The licensee has failed to ensure procedures included in the required Nursing and

Personal Support Services program were complied with.

In accordance with LTCHA, s. 8 (1) the licensee was required to have an organized program of nursing services to meet the assessed needs of the residents.

The home's procedure, Progress Notes - Documentation Tips, VII-J-10.02(b), current revision May 2019, identified that staff were to "document for yourself: what you did or what you observed".

i. The following non-compliance was identified during an inspection for complaint intake #011094-20, related to plan of care, for resident #023.
A review of the progress notes by RPN #127, identified that resident #023 presented with pain and another symptom on a date in April 2020. The resident was assessed, the physician was contacted, orders were received and the SDM notified of the change in the resident's condition.
Interview with RPN #127 identified that they did not contact the physician nor the SDM on the identified shift, and that this was completed by the charge RN #125.
Interview with RN #125 confirmed that they worked on the identified shift with RPN #127, worked as a team and that they contacted the physician and the SDM; however, did not document their actions, as this was completed by the RPN.
There were no progress notes documented by RN #125; however, the Digital Prescriber's Orders included the telephone order written by the RN.

ii. The following non-compliance was identified during an inspection for complaint intake #010644-20 related to falls prevention and management and the Residents' Bill of Rights and CIS intake #010431-20 regarding falls prevention and management for resident #010.
According to the clinical record resident #010 experienced an undesired assessment value and were later found in a location and had passed away.
RPN #109, although not assigned as the primary RPN for the resident, worked on the shift and participated in their care.
A review of the progress notes on the identified date included one entry by RPN #109, when they contacted the physician due to the assessment value and orders were received and processed.
Interview with RPN #109 identified that they checked on and assessed the resident related to the assessment value, followed up with the PSW staff regarding the resident's status, assessed the resident after they were found, including an assessment of vital signs and contacted the physician after the resident had passed away.

Following a review of the clinical record RPN #109 confirmed that they did not complete additional documentation as they felt that RPN #119, who was responsible for the care of the resident would complete this task.

The procedure, Progress Notes - Documentation Tips was not complied with. [s. 8. (1) (b)]

3. The licensee has failed to ensure that any procedure in the required Nursing and Personal Support Services program were complied with.

In accordance with LTCHA s. 8 (1) the licensee shall ensure that there was an organized program of nursing services for the home to meet the assessed needs of the residents.

The following non-compliance was identified during an inspection for complaint intake #010644-20 related to falls prevention and management and the Residents' Bill of Rights and CIS intake #010431-20 regarding falls prevention and management for resident #010.

The home's procedure, Access to Electronic Resident Records, VII-A-10.20, current revision February 2020, identified that "team members with access to electronic resident records will not allow others to document in electronic resident record under their name/log in".

The clinical record of resident #010 was in part reviewed.
RN #108, disclosed to the home that they documented in the clinical record of resident #010, using the log in of RPN #119, with the knowledge of the RPN; specifically that the RN assisted the RPN to "finish the report".
Interview with RPN #119, confirmed that on the identified date they had allowed RN #108 to document on their behalf in the clinical record of the resident.

The procedure, Access to Electronic Resident Records was not complied with. [s. 8. (1) (b)]

4. The licensee has failed to ensure that any procedures in the required Nursing and Personal Support Services program was complied with.

In accordance with LTCHA s. 8 (1) the licensee was to ensure that there was an organized program of nursing services for the home to meet the assessed needs of the

residents.

The following non-compliance was identified during an inspection for complaint intake #010644-20 related to falls prevention and management and the Residents' Bill of Rights and CIS intake #010431-20 regarding falls prevention and management for resident #010.

A. The home's procedures, for management of a specified diagnosis, procedures number VIII-C-10.30, current revision May 2019 and number VII-C-10.30(b), dated May 2019, were reviewed.
The documents identified detailed directions for staff to follow under specific situations, including interventions, reassessment, notification, referrals and documentation.

i. A review of the clinical record identified that on a specified date resident #010, had an assessment value at an undesired level and other observations were recorded. RPN #109 recorded that the resident was given an intervention.
When rechecked, approximately one hour later, the assessment value was noted be be improved, their intake was recorded and there was a note that the physician was notified. Orders were received to hold medication and to contact the physician the next day with an assessment value.
Interview with RPN #109 confirmed that on the identified shift, they did not follow the procedures when they provided the intervention, which was not consistent with the procedure and that they did not have an order for the intervention. They did not repeat the test at the frequency identified in the procedure. They confirmed that they did not notify the SDM nor did they send a referral to report the incident. To their recall they rechecked the assessment value, when they administered medications later in the shift; however, failed to document this assessment.

The procedure was not complied with.

B. The home's procedure, for management of a specified diagnosis, procedure number VIII-C-10.20, current revision May 2019, provided staff direction if identified assessment values were abnormally high or low compared to resident's usual values, which included when to repeat the procedure, additional actions to take and documentation requirements.

i. According to the clinical record on a day in May 2020, resident #010 had an elevated assessment value, an intervention was provided and their intake was recorded.

Progress notes by RPN #118 identified that almost three hours later, the assessment value remained elevated and after an additional 15 minutes the value was noted to be even higher. The physician was called and prescribed a medication which was administered.
Interview with RPN #118 identified that in their opinion the assessment value was considered high. To their recall they did repeat the testing procedure on the resident; although failed to document the results which they had communicated to the oncoming staff verbally at shift report. They confirmed that they did not take additional action as noted in the procedure. To their recollection they did monitor the resident due to the change in status; however, did not document their assessment findings.
ii. According to the clinical record three days later, the resident refused a meal and only took fluids. Documentation by RPN #118 identified an elevated assessment value. Medication was administered as prescribed, the resident was not in distress, was alert and responsive and their intake was monitored.
Interview with RPN #118 identified what, in their opinion, was the "range" for the resident's assessment value and that the resident had a number of changes to their medication orders.
A review of the electronic Medication Administration Record (eMAR), for May 2020, identified that resident's value range, during the time of the assessment, was below the range identified by the RPN.
RPN #118 recalled direction that they provided to PSW staff regarding the resident and confirmed that they did not repeat the testing procedure nor other aspects of the procedure.

iii. According to the clinical record later that day, the oncoming shift RPN #109 made the decision to withhold a prescribed intervention, due to the elevated assessment value noted previously. The RPN noted their assessment findings of the resident. An assessment of vital signs identified an elevated assessment value and a temperature of 38.1 degrees Celsius. Scheduled acetaminophen was administered. The physician was called and orders were received for medications, which were given. Later during the shift the resident was afrebile and sleeping.
Interview with RPN #109 confirmed that in their opinion the identified assessment value was considered high. They identified that they may have repeated the testing procedure; however, failed to document the results, along with other monitoring they completed, and confirmed that they did not follow other direction as noted in the procedure.
iv. The following day, according to the clinical record, the resident had an elevated assessment value, a numeric value, as recorded by RPN #119, on an identified form. The same value was also recorded as "high" by RPN #109, approximately 40 minutes

later in the progress notes. The physician was called and prescribed a medication which was administered by RPN #119.
Interview with RPN #119 identified that in their opinion the assessment value was considered high. To their recall they identified that they did repeat the testing procedure, assessed the resident's value a total of three times, which remained elevated; although, failed to document the results, as well as the monitoring completed and other assessment findings. They confirmed that they did not carry out the remainder of the procedure. The physician was not contacted again until the resident had passed away later in the shift. The resident's plan was not revised.

The procedures were not complied with. [s. 8. (1) (b)]

5. The licensee has failed to ensure that procedures included in the required Nursing and Personal Support Services Program were complied with.

In accordance with LTCHA s. 8 (1) the licensee was required to have an organized program of nursing services for the home to meet the assessed needs of the residents.

The following non-compliance was identified during an inspection for complaint intake #010644-20 related to falls prevention and management and the Residents' Bill of Rights and CIS intake #010431-20 regarding falls prevention and management for resident #010.

The home's Procedure Upon Resident Death, VIII-B-10.80, current revision May 2019, identified that "if the death is a Coroner's Case, instruct team members not to move the body or move anything in the room, or remove any tubes until after the Coroner has provided authorization to do so".
According to a progress note written by RN #108, resident #010 was found in a location without vital signs. The resident was then transferred into bed with a mechanical lift by staff. RPN #109 contacted the attending physician regarding the resident's death, who provided direction to contact the Coroner.
RN #108 was interviewed by the home and confirmed that the body was not to be moved, as the resident's death was a Coroner's case.
This was confirmed during the internal investigation completed by the home with RPN #109.

The Procedure Upon Resident Death was not complied with when the resident's body was moved prior to consultation or authorization with the Coroner. [s. 8. (1) (b)]

6. The licensee has failed to ensure that the procedures in the required Medication Management System were complied with.

The following non-compliance was identified during complaint inspection #011094-20 related to plan of care, for resident #023.

In accordance with O. Reg. 79/10, s. 114 (1) the licensee was required to have an interdisciplinary medication management system that provided for safe medication management and in accordance with O. Reg. 79/10, s. 114 (2), the licensee was required to ensure that written policies and protocols were developed to ensure the accurate acquisition, dispensing, receipt, storage, administration and destruction and disposal of all drugs used in the home.

i. The home's procedure, from Medical Pharmacies, Prescriber's Medication Review, 8-5, revised March 2018, identified that the staff were to complete a "precheck prior to Prescriber Review which included to check orders on the Medication Review against the prescriber's orders in the resident's chart, going back to the date on which the MAR sheets were last checked against the prescriber's orders; and update the Medication Review form by making all changes necessary to reflect all current prescriber's orders"; and for processing the Medication Review form staff were to "review each individual order and process discontinued or changed orders".

Resident #023 had a Physician Medication Review signed by the physician on a date in March 2020, which was processed by nursing staff.
This review included as needed orders for acetaminophen.
The order for as needed acetaminophen tablets was for 325 mg, two tablets by mouth every four hours for fever over 38 degrees Celsius (°C), and a maximum of two doses/24 hour period.
The order for as needed acetaminophen suppository was 650 mg to insert rectally every four hours for fever over 38 °C and a maximum of two doses/24 hour period.
A review of the March and April 2020, eMAR included direction for: acetaminophen 325 mg, two tablets by mouth every four hours as needed for fever, maximum of four doses/24 hour period and for acetaminophen suppository 650 mg to be inserted rectally every four hours as needed for fever, maximum of four doses/24 hour period.
Interview with ADOC #136, following a review of the Physician Medication Review and March 2020 eMAR confirmed that the review was not processed according to the procedure when the acetaminophen orders for as needed acetaminophen tablets and

suppository were recorded, at the frequency of four doses in a 24 hour period.

ii. The home's procedure, from Medical Pharmacies, Ordering and Receiving Medication, 4-2-1, revised September 2019, identified for processing prescriber's orders, that the nurse shall "process all new, changed, or discontinued orders as per nursing policy and procedures" and "ensure order is accurately transcribed to the MAR".

According to the Digital Prescriber's Orders for resident #023, RN #126 received a telephone order from the physician for an analgesic to be given immediately and then before or at time of transfer to hospital.
A review of the eMAR did not include documentation of the telephone order received as confirmed by ADOC #135 following a review of the clinical record.

The procedures, in the Medication Management System were not complied with. [s. 8. (1) (b)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 required procedures and protocols are complied with, to be implemented voluntarily.

WN #3: 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 all residents, including resident #023 were not neglected by the licensee or staff.

O. Reg. 79/10 s. 5 identified neglect as the failure to provide a resident with the treatment, care services or assistance required for health, safety or well-being and included inaction or a pattern of inaction that jeopardized the health, safety or well being of one or more residents.

A. The following non-compliance was identified during the inspection for complaint intake #011507-20 and supporting CIS intake #010811-20 both related to prevention of abuse and neglect and supporting CIS intakes #012158-20, #012159-20 and #012200-20 each related to reports regarding critical incidents and infection prevention and control program.

As a part of the provincial response to the COVID-19 pandemic in long-term care homes, a hospital partner signed a Voluntary Management Contract (VMC) to act as temporary manager of Camilla Care Community, in May 2020. Prior to the implementation of the VMC, the hospital partner provided expertise and support to Camilla Care Community which started in April 2020.
In April 2020, the home had its first laboratory confirmed case of COVID-19 and an outbreak was declared in the home by Peel Public Health unit.
Later that month the hospital partner received a letter from the Sienna President and Chief Executive Officer which requested staffing support, citing significant staffing shortages.
A Critical Incident System (CIS) report, submitted in May 2020, indicated that nine days prior, hospital partner manager #132 was informed by email that a staff member, who worked at Camilla Care Community witnessed instances of alleged staff to resident abuse, and unsafe practices that impacted the safety of the residents.
According to an Initial Report of the Temporary Manager, dated in June 2020, for a time period between April 2020 and June 2020, the hospital partner assessment team witnessed a number of concerns related to infection prevention and control. COVID-19 positive residents and COVID-19 negative residents shared the same rooms, lack of signage and/or inaccurate signage to clearly show which residents were COVID-19 positive versus negative; that staff did not know which precautions were required when they cared for the residents. Not all Camilla Care Community nursing staff were aware of how and when to swab residents for COVID-19 testing. Staff were not proficient in the use of personal protective equipment (PPE) which included how to safely put on and take off (don and doff) equipment, the required frequency to change PPE throughout a shift, or the need to change PPE when they moved from a COVID-19 positive resident to a COVID-19 negative resident. PPE (i.e. masks, gloves, gowns etc.) was not

consistently/properly used by all staff; some staff did not wear masks while others wore double masks. Staff were seen caring for COVID-19 positive residents, then went to the nursing station without removal of PPE. Staff were initially observed with garbage bags over their clothing and on their feet as PPE, and kept gloves on while they washed their hands instead of changing their gloves.

During this inspection, a review of clinical records identified that during three months in 2019/2020, there were clusters of residents, who exhibited respiratory symptoms throughout the home, which suggested potential outbreaks.
This information was confirmed by Peel Public Health in July 2020, during the course of the inspection.
A further review of clinical records, Infection Prevention and Control (IPAC) meeting minutes, quarterly Professional Advisory Council (PAC) meeting minutes, daily Leadership Meeting minutes, monthly Leadership Meeting minutes, IPAC risk assessments and staff interviews, identified:
i. Immediate measures to reduce the transmission of disease, such as the isolation of residents, the implementation of appropriate precautions which included signage and testing to identify causative organism, were not consistently implemented.
ii. Line listings were not fully completed. Documentation recorded in progress notes identified that residents who exhibited symptoms of respiratory illness were not consistently added to the surveillance lists. Residents who were added to the surveillance list were not added in chronological order, which suggested that they were not added on a daily basis and when symptoms were first identified.
iii. The Infection Control Practitioner (ICP) was not immediately notified of all new cases.

iv. The ICP did not review and analyze the surveillance data on a daily basis; communicate suspected outbreaks to all resident home areas, Department Managers or the Medical Director; or consult with the local Public Health Unit (PHU) to confirm that an outbreak was occurring.
v. During the COVID-19 outbreak, symptomatic COVID-19 positive residents and COVID-19 negative residents and staff assigned to their care, were not consistently co-horted.
vi. Excessive use of PPE, ie, double masking and black plastic bags being worn, was identified through IPAC assessment completed on a date in April 2020.
vii. A review of the "Infection Control Surveillance Record(s)" for each resident home area, for three months in 2019/2020, identified that surveillance lists had been completed on a monthly basis and not on a daily basis as required. Not all residents were monitored every shift until their symptoms resolved, symptomatic residents had not been

added to the surveillance list in chronological order and/or when symptoms were first identified. A review of progress notes, identified that not all residents with respiratory symptoms were included in the surveillance lists during the identified months.
viii. Registered staff reported critical staffing shortages in nursing and dietary departments prior to the redeployment of hospital partner staff.

The licensee's pattern of inaction related to infection prevention and control and outbreak management jeopardized the health, safety or well-being of one or more residents. (#130)

B. The following non-compliance was identified during an inspection for complaint intake #011094-20 related to plan of care, for resident #023.
According to the clinical record resident #023 had identified diagnoses. They presented with pain and another symptom on a date in April 2020, and two days later was transferred to the hospital with an injury, treated and re-admitted to the home eight days later.
A recent Minimum Data Set (MDS) assessment identified their cognitive, transfer, toileting and mobility status.
They had their temperature monitored and was screened for COVID-19 symptoms consistently at least twice a day since a date in April 2020, according to the records.
Their electronic Medication Administration Records (eMAR) for April 2020, noted that they had a routine order for acetaminophen 325 milligrams (mg), two tablets, four times a day at 0900, 1300, 1800 and 2100 hours, which was consistently signed as administered as prescribed. Staff documented the resident's pain level four times a day with the administration of the routine acetaminophen.
Additionally, they had an order for acetaminophen 325 mg, two tablets, every four hours, as needed, for a fever over 38 degrees Celsius (°C) and not to exceed 3200 mg daily from all sources.

A review of a twelve day time period in April 2020, was conducted including review of progress notes, selected Daily Active Screening records, assessments, temperature summary records and the eMAR, along with interviews with staff and the substitute decision makers (SDMs) which identified the following:

On a date in April 2020, in the morning the resident was documented to have an elevated temperature. There was no documentation of a reassessment until later in the evening, when it was identified that their temperature was reduced.

The next day, in the morning, the resident presented with an elevated temperature which was treated with an additional dose of acetaminophen with effect, according to the record. As recorded by ADOC #135, the resident had interventions put in place and a test completed. They were documented to have an elevated temperature in the evening and later that shift it was reduced. According to the eMAR they were administered 3250 mg of acetaminophen in the 24 hour time period.

The following day, an additional dose of acetaminophen was administered in the morning, for an elevated temperature with effect. The physician documented that the resident had symptoms and a test result was pending. According to the eMAR they were administered 3250 mg of acetaminophen in the 24 hour time period.

The following day, there was no documentation in the progress notes; however, temperature readings were recorded within normal limits.
There was no evidence that the resident reported pain according to the pain levels recorded on the eMAR or in the Point of Care (POC) follow up question report. The records did not include that there was a change in the resident's abilities or level of care provided. There were no assessments for an incident recorded under Assessments in Point Click Care (PCC).

The following day, the progress notes identified the resident to have an elevated temperature in the morning which improved later on the day shift. During the afternoon shift, an assessment of the resident was documented, including intake and symptoms. They were afebrile later in the shift. There was no evidence that the resident reported pain according to the pain levels recorded on the eMAR or in the POC follow up question report. The records did not include that there was a change in the resident's abilities, level of care provided or reports of any pain.

The following day, in the morning an additional dose of acetaminophen was administered for an elevated temperature with effect. The test results were received. Interventions were in place with treatment to include acetaminophen, they were to be monitored and tracked as documented by the DOC. In the evening, according to the progress notes they presented with an elevated temperature which was treated with routinely ordered acetaminophen with effect. According to the eMAR they were administered 3250 mg of acetaminophen in the 24 hour time period.
There was no evidence that the resident reported pain according to the pain levels recorded on the eMAR or in the POC follow up question report. The records did not include that there was a change in the resident's abilities, level of care provided or

reports of any pain.
According to the SDM, they spoke with a staff member regarding the resident. During this conversation they were notified that two days prior, an incident occurred, the resident had complaints of pain and they were informed of the test result. The SDM identified to the Inspector, that this conversation was the first communication that they had regarding the resident being tested, an incident or symptoms displayed.

The following day, in the morning the resident had an elevated temperature which was treated with an additional dose of acetaminophen. Their temperature later on the day shift remained elevated. A note prior to lunch identified that they presented with an elevated temperature, observations were noted, an intervention was provided for comfort and staff continued to monitor. The resident had an elevated temperature during the evening shift. According to the eMAR they were administered 3250 mg of acetaminophen in the 24 hour time period. There was no evidence that the resident reported pain according to the pain levels recorded on the eMAR, or in the POC follow up question report. The records did not include that there was a change in the resident's abilities, level of care provided or reports of any pain.

The following day, in the morning an additional dose of acetaminophen was administered for an elevated temperature with effect. According to the documentation by ADOC #135, the SDM was notified of the resident's test result. Their temperature in the afternoon was improved. Later that shift, an additional dose of acetaminophen was administered for an elevated temperature with effect and no other symptoms were noted. According to the eMAR they were administered 3900 mg of acetaminophen in the 24 hour time period. There was no evidence that the resident reported pain, according to the pain levels recorded on the eMAR or in the POC follow up question report. The records did not include that there was a change in the resident's abilities, level of care provided or reports of any pain.
According to the SDM they spoke with RN #108 during the evening who reported that the resident experienced pain, analgesic was given and the SDM was encouraged to contact the home the following day.

The following day, an additional dose of acetaminophen was administered in the morning for an elevated temperature with effect. Later that shift the resident was assessed and assessment finding were documented. The following shift they were reassessed, with assessment finding recorded along with documentation of their food and fluid intake. According to the eMAR they were administered 3250 mg of acetaminophen in the 24 hour time period. There was no evidence that the resident reported pain, according to

the pain levels recorded on the eMAR or in the POC follow up question report. The records did not include that there was a change in the resident's abilities, level of care provided or reports of any pain.
According to the SDM they spoke with RN #126 who reported that the home did not have a physician onsite, they were attempting to get a diagnostic test ordered and they had administered acetaminophen to the resident.

The following day, in the morning, an additional dose of acetaminophen was administered for an elevated temperature with effect. A progress note from the physician included the status of the resident and that a medication was prescribed. RPN #127 documented that the resident presented with symptoms, other than pain. The SDM was contacted regarding the resident's condition and interventions. There was no evidence in the clinical record that there was a discussion related to pain during this call with the SDM, which was confirmed by RPN #129. According to the eMAR they were administered 3250 mg of acetaminophen in the 24 hour time period. There was no evidence that the resident reported pain according to the pain levels recorded on the eMAR or in the POC follow up question report. The records did not include that there was a change in the resident's abilities, level of care provided or reports of any pain.
According to the SDM they spoke with, who they believe to be RN #126, who communicated that the home suspected that the resident had an injury, they continued to receive acetaminophen and the plan was to have a diagnostic test completed in three days.

The following day, the resident was identified to be afebrile. A progress note, prior to noon, by RPN #127 identified that in the morning the resident was in a lot of pain especially when a specific area was touched, another symptom was noted and care was provided with the help of staff. The physician was informed and ordered a diagnostic test and an analgesic to be given every four hours as needed. The SDM was informed of the resident's condition and interventions.
There was no record that the analgesic was administered during the day shift after the order was received, which was confirmed by RPN #127, who administered the routine dosage of acetaminophen twice on the shift.
A note was recorded at 1500 hours which identified the resident had a pain assessment completed by RPN #127; however, the staff reported that this assessment was completed earlier in the day. The pain intensity was described, the description of pain was included and observations of the resident were noted.
During the evening, the resident was administered the analgesic by RPN #177, with an initial pain level score of two, suggestive of mild pain. The record noted that the resident

was moaning when talking at times and that staff would continue to monitor. RPN #177 had no recall of the location of the resident's pain when interviewed, nor did they recall if they assessed the area of suspected injury; however, recalled that the resident was in bed and required additional assistance by staff.
Later on the night shift, RN #125 noted the medication was effective. There was no additional documentation regarding the resident's pain, level of assistance required or an assessment of the suspected area of injury. RN #125 identified that they were not aware of reports of pain on their shift and for that reason there were no concerns recorded.
The resident was administered the analgesic the following morning, by RPN #127, according to the progress notes for facial grimacing and a pain level score of zero, suggestive of no pain. The medication was noted to be effective, with a pain level score of two, a score level higher than the initial assessment. Interview with RPN #127 identified that to their recall they did reassess the resident, they remained in bed during the shift and required additional assistance by staff; however, they failed to document their actions and assessment. They identified that the resident was in some pain with care, which was believed to be in the suggested location; however, if it was of concern they would have contacted the physician for additional analgesic or to arrange transport to hospital.
During the evening, RPN #177 administered the analgesic with effect. The progress notes identified that the resident appeared to be in pain and they would be monitored. RPN #177 had no recall of the location of the resident's pain when interviewed, nor did they recall if they assessed the resident for the suspected injury; however, recalled that the resident was in bed and required additional assistance by staff.

There was no documented assessments, the following day in the progress notes. The clinical record included a diagnostic test report, with the same day, which noted an injury. The progress notes included one entry an "Order - Administration Note" which noted that a medication was not administered at 1400 hours as the resident was transferred to the hospital by RN #126. A review of the Digital Prescriber's Orders identified that a phone order was received from the physician on the identified date, to transfer the resident to the hospital and for an analgesic to be given immediately and then before/at time of transfer to hospital.
In the Clinical Indicator section of the document it was written that the resident was in pain, noted the injury and that medication was given from the emergency drug box. Interview with RN #126 confirmed that they, following a review of the clinical record, were not aware of what was the cause of the injury to the resident, and that if the resident was involved in an incident, they would have required staff assistance. During the interview RN #126 stated that they recalled that they contacted the physician and transported the

resident to the hospital. In their opinion the resident was in more pain than previously identified and due to the activity of transport to the hospital, they requested additional analgesic. It was indicated that they contacted the SDM regarding the transfer. RN #126 confirmed that they did not document their assessments, nor actions taken; however, completed all necessary activities. A review of the Emergency Starter Box Ordering Form identified that the medication was signed out for use by the resident.

The resident was transferred to the hospital.

The Ambulance Call Report dated that same day, noted that long-term care home staff reported an incident and a time frame when it occurred, that there was no assessment by medical doctor, that a diagnostic procedure was attempted but patient did not tolerate, the observations and assessment findings of long-term, care home staff, along with the administration of the analgesic.
The resident was admitted to the hospital for the injury and was treated four days later.

The resident was neglected by the licensee or staff when:
i. The SDM was not given the opportunity to participate fully in the plan of care when they were not consulted to consent for testing and were not notified of the test results when immediately known to the home. Additionally, the SDM reported challenges with communicating with staff at the home during this time period, to discuss changes in the resident's needs.
ii. The physician was not contacted for direction when the resident required additional acetaminophen to manage their temperature and the dose administered exceeded the maximum dose in a 24 hour time period, on eight occasions.
iii. A physician's note, included the presence of an assessment finding which was not previously documented.
iv. As needed pain medication was not administered when first ordered, during the day shift despite the pain assessment which identified that the resident experienced pain.
v. Documentation from the time that pain was first recorded until transported to hospital, did not include assessments of the resident's change in condition related to the injury, any change in care needs and the resident's response; with the exception of the effectiveness of the as needed analgesic, which was administered three times.
vi. Interview with the DOC and ADOC #135 confirmed that the cause of the injury was not investigated for a causative agent. There was no documentation related to an incident or some type of event when first known to the SDM, or during the time frame documented on the Ambulance Call Report.

Resident #023 was neglected. [s. 19. (1)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

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

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug was used by or administered to resident #007 in the home unless the drug had been prescribed for the resident.

The following non-compliance was identified during an inspection for complaint intake #011507-20 and supporting CIS intake #012142-20, both for prevention of abuse and neglect.

i. A review of the home's Medical Directives - Preprinted Admission and PRN Orders did not include orders for the administration of a specific treatment.
RN #188 stated that a physician's order was needed prior to the administration of a specific treatment to a resident.
A review of resident #007's progress notes included that they received the treatment prior to it being prescribed.

A progress note identified that the resident was received with an identified assessment finding, with the treatment in place.
A physician’s order the following day, indicated that the treatment was ordered, with specified instructions for comfort, as needed.

ii. A review of the physician's notes on a specified date in April 2020, for resident #007 indicated a change in their resident's condition, proposed changes to the plan of care, a risk factor related to nutrition and a suspected outcome.
Later that day, the progress notes included a Pharmacy Consultation Introduction/Review of Symptoms. This noted included, in part, that the resident had a change in status related to nutrition and a plan for oral medications.
Progress notes and the physician's order indicated that the physician assessed the resident and orders were received.
Staff did not follow the orders when they administered oral medications on the three occasions from the time that the order was received until the resident passed away.
During interviews, the aED, RN #124 and RN #188 confirmed that the medications should not have been administered based on the order in place.

Drugs were used by or administered to resident #007 which were not prescribed. [s. 131. (1)]

2. The licensee has failed to ensure a drug was administered to resident #010 in accordance with the directions for use specified by the prescriber.

The following non-compliance was identified during an inspection for complaint intake #010644-20 related to falls prevention and management and the Residents' Bill of Rights and CIS intake #010431-20 regarding falls prevention and management for resident #010.

According to the electronic Medication Administration Record (eMAR) resident #010 had a current physician's order for a medication to be administered in the evening with supper at 1800 hours.
The eMAR included "High Alert" direction to not give the medication if less than 50 per cent (%) of supper was consumed.
Point of Care (POC) task documentation, for the question, "Eating - how much I consumed" required staff to record the percentage that the resident consumed during the meal.
The documentation identified that on four days in May 2020, the resident consumed 0-25

% of their supper meal.
A review of the eMAR for May 2020, identified that on three of the identified dates in May 2020, the evening dosage of the medication was administered by RPN #116.
Following a review of the clinical record, RPN #116 confirmed that the medication was administered; however, not in accordance with the directions for use as indicated on the eMAR, on the three dates, when it was given despite the intake consumed at the supper meal.

A drug was not administered to resident #010 in accordance with the directions for use as specified. [s. 131. (2)]

3. The licensee has failed to ensure that acetaminophen was administered to resident #023 in accordance with the directions for use specified by the prescriber.

The following non-compliance was identified during an inspection for complaint intake #011094-20 related to plan of care, for resident #023.

According to the eMAR resident #023 had orders for routine and as needed acetaminophen. A time frame of nine days in April 2020 was reviewed.
The orders from the Physician Medication Review, signed in March 2020, were for:
-acetaminophen 325 milligrams (mg), two tablets, by mouth four times a day and also an as needed (PRN);
-acetaminophen suppository 650 mg, every four hours as needed, for fever over 38 degrees Celsius (°C), maximum of two doses/24 hour period and directions "do not exceed 3200 mg daily from all sources";
-acetaminophen tablets, 325 mg, give two tablets, by mouth every four hours, as needed, for fever over 38 °C, maximum of two doses/24 hour period and directions "do not exceed 3200 mg daily from all sources";
-acetaminophen suppository 650 mg, every four hours, as needed for pain, maximum of four doses/24 hour period and directions "do not exceed 3200 mg daily from all sources"; and
-acetaminophen tablets 325 mg, give two tablets, by mouth every four hours, as needed for pain, maximum of four doses/24 hour period and directions "do not exceed 3200 mg daily from all sources".

A review of the progress notes and eMAR identified that the resident was administered their routine dosage of acetaminophen 325 mg, two tablets, four times a day at 0900, 1300, 1800 and 2100 hours consistently which was a total for 2600 mg of

acetaminophen in a 24 hour period.

i. On a date in April 2020, the resident presented with an elevated temperature and was administered as needed acetaminophen 325 mg, two tablets, with effect.
The resident was administered an additional 650 mg of acetaminophen, for a total of 3250 mg of acetaminophen in the 24 hour time period.
ii. The following day, the resident presented with an elevated temperature and was administered as needed acetaminophen 325 mg, two tablets, with effect.
The resident was administered an additional 650 mg of acetaminophen, for a total of 3250 mg of acetaminophen in the 24 hour time period.
iii. The following day, the resident presented with an elevated temperature and was administered as needed acetaminophen 325 mg, two tablets, with effect.
The resident was administered an additional 650 mg of acetaminophen, for a total of 3250 mg of acetaminophen in the 24 hour time period.
iv. The following day, the resident presented with an elevated temperature and was administered as needed acetaminophen 325 mg, two tablets.
The resident was administered an additional 650 mg of acetaminophen, for a total of 3250 mg of acetaminophen in the 24 hour time period.
v. The following day, the resident presented with an elevated temperature at 0556 hours and again at 1949 hours and was administered as needed acetaminophen 325 mg, two tablets, on each occasion, both with effect.
The resident was administered an additional 1300 mg of acetaminophen, for a total of 3900 mg of acetaminophen in the 24 hour time period.
vi. The following day, the resident presented with an elevated temperature and was administered as needed acetaminophen 325 mg, two tablets, with effect.
The resident was administered an additional 650 mg of acetaminophen, for a total of 3250 mg of acetaminophen in the 24 hour time period.
vii. The following day, the resident presented with an elevated temperature and was administered as needed acetaminophen 325 mg, two tablets, with effect.
The resident was administered an additional 650 mg of acetaminophen, for a total of 3250 mg of acetaminophen in the 24 hour time period.

Interview with ADOC #135, following a review of the prescriber's orders and eMAR confirmed that the resident exceeded their optimal dose of acetaminophen on the identified dates, and that it was the expectation that staff followed up with the physician regarding the concern.

The medication was not given in accordance with the prescriber's directions. [s. 131. (2)]

4. The licensee has failed to ensure that a medication was administered to resident #022 in accordance with the directions for use specified by the prescriber.

The following non-compliance was identified during an inspection for complaint intake #010843-20 related to skin and wound care and the Residents' Bill of Rights.

A review of the current physician's order for resident #022, included an order for a topical prescription treatment cream to be administered twice a day.
The electronic Treatment Administration Record (eTAR) included for the administration of the cream to be applied twice a day at 1000 hours and 2000 hours.
The eTARs from April 2020 to June 2020, did not include signatures for the application of the treatment on 23 occasions.
The resident informed Inspector #615 that they no longer used the prescribed cream, that the physician advised them to apply an over the counter cream, and that it was better for them.
RN #141 stated that the prescription treatment cream should be applied every morning; however, resident #022 had been applying an over the counter cream for a couple of weeks and staff would record a "check" as applied on the eTAR when it was provided to the resident.

Drugs were not administered to the resident in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

5. The licensee has failed to ensure that resident #022 administered a drug to themselves unless the administration had been approved by the prescriber in consultation with the resident.

The following non-compliance was identified during an inspection for complaint intake #010843-20 related to skin and wound care and the Residents' Bill of Rights.

A review of the home's policy, Self-Administration of Medications, 5-5, dated February 2017, identified that "self-administration of medications by a resident is permitted when specifically approved by the prescriber who, with input from the health team, determines that the resident is capable of self-administering his/her own medications in a self-care plan".

A review of the current physician's order for resident #022 identified a topical prescription

treatment cream to be administered twice a day.
There was no physician's order for the resident to self administer the medication.
During an interview resident #022 stated that they self applied creams.
RN #141, RPN #143 and PSW #107 each stated that the resident applied creams on their own. When asked which creams the resident applied, the staff stated, all creams, including the prescribed cream.
RN #126 stated that registered staff applied all prescribed creams and that no residents were to self apply the treatments. RN #126 added that if a resident was independent, they had a choice to apply the cream themselves, but the physician would prescribe for self-administration and follow the procedure.

The resident administered a drug to themselves which was not approved by the prescriber in consultation with the resident. [s. 131. (5)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 by or administered to a resident in the home unless the drug has been prescribed for the resident and that a resident does not administer a drug to themselves unless the administration has been approved by the prescriber in consultation with the resident, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure resident #011 and #020's right to be treated with courtesy, respect and dignity were fully respected and promoted.

i. The following non-compliance was identified during an inspection for complaint intake #011507-20 and supporting CIS intake #012138-20 both for the prevention of abuse and neglect.
Resident #020 was identified in their recent Minimum Data Set (MDS) assessment to have a cognitive performance score (CPS) which suggested a level of cognition.
On a date in June 2020, staff #105 reported to Inspector #168, that PSW #120 was aggressive with the resident during the provision of care on a date in May 2020.
Interview with PSW #120 confirmed that they performed an activity, while staff #105 provided care to the resident, who demonstrated responsive behaviours; however, not with force, but to calm the resident and that they explained what they were doing.
Interview with staff #105 confirmed that they completed the resident's care, while the activity was being performed by PSW #120, and although no injury was noted, the resident experienced pain and was not listened to.
There was no documentation of the incident in the clinical record nor an assessment of the resident following the interaction.
A review of the care plan in place in June 2020, did not include that the resident displayed the identified behaviour nor interventions to manage the behaviour.
Neither staff member was provided training on the home's policies and procedures on the Prevention of Abuse and Neglect or Responsive Behaviours, as confirmed by ADOC #136 and hospital partner manager #140. (#168)

ii. The following non-compliance was identified during an inspection for complaint intake #011507-20 and supporting CIS intake #010811-20, both related to prevention of abuse and neglect.
Resident #011 had a CPS which suggested a level of cognition.
On a date in May 2020, staff #105 witnessed PSW #111 talk to resident #011 inappropriately while they assisted in the provision of care.
The resident was interviewed by the ED, fourteen days after the incident, and expressed no concerns with the staff who provided the care.
The resident was interviewed by the NP, fifteen days after the incident, and had no recall of the incident.
The Inspector interviewed the resident in June 2020, during which time the resident expressed they were satisfied with the staff who provided care and had no complaints.

PSW #111 was interviewed regarding the allegation. The PSW acknowledged on the identified shift they were unfamiliar with the resident's behaviours and worked below the desired staffing complement. They admitted that they spoke to the resident inappropriately.

The residents were not treated with courtesy, respect and dignity. [s. 3. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are treated with courtesy, respect and dignity, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

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

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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to residents #015, #019 and #020 related to their continence care needs.

The following non-compliance was identified during an inspection for complaint intake #011507-20 and supporting CIS intake #010811-20 both related to prevention of abuse and neglect.

The home's procedure, Continence Program - Promoting Continence, VII-D-10.10, current revision April 2019, identified that “all care team members will adhere to each resident's individualized plan of care, which will include the following: scheduled times for checking, changing and toileting residents and a resident specific toileting regimen for the continent or potentially continent resident".

i. Resident #015 was identified in their current care plan with a specific continence status and required assistance with care; however, it did not include an individualized plan, with scheduled times to be checked and changed, as verified by RN #124, following a review of the plan.

ii. Resident #019 was identified in their current kardex report to require staff assistance with meeting their continence care needs and that they had a specific continence status. RN #124 verified, following a review of the document, that it did not include an individualized plan, with scheduled times to be checked, changed and toileted, or a specific toileting regimen.

iii. Resident #020 was identified in their most recent Bladder and Bowel Continence Assessment with a specific continence status and an intervention to support this need. Interview with PSW #149 confirmed the resident's continence status and the intervention. A review of the current care plan identified the continence level of the resident; however, did not include an individualized plan, with scheduled times to be checked, changed and toileted, or a specific toileting regimen.

Interview with the aED confirmed the expectation that the plans of care included the frequency of residents to be checked, changed and/or toileted according to the procedure.

The plans of care did not provide clear direction to staff regarding continence care needs. [s. 6. (1) (c)]

2. The licensee has failed to ensure that there was a written plan of care for resident #007 that set out clear directions to staff and others who provided direct care.

The following non-compliance was identified during an inspection for complaint intake #011507-20 and CIS intake #012142-20 both related to the prevention of abuse and neglect.

A review of the physician's orders in Point Click Care (PCC), for resident #007 identified their diet orders, which was consistent with the direction in the care plan used by staff until April 2020.
A review of the physician notes on a specified date in April 2020, identified a concern, that the resident had a change in nutritional status and they would be started on a treatment.
Later that day, the progress notes included a Pharmacy Consultation Introduction/Review of Symptoms. This noted included, in part, that the resident had a change in status related to nutrition and a plan for oral medications.
Additionally the progress notes indicated that the physician assessed the resident and orders were received.
Between the date of the physician's order and until five days later actions of staff did not adhere to the specific physician's orders related to the change in nutritional status.
RN #124 was interviewed and following a review of the progress notes and care plan, confirmed that the plan of care was was not clear regarding the physician's orders related to the interventions for the nutritional status change.

The licensee failed to ensure that there was a written plan of care for resident #007 that set out clear directions to staff and others who provided direct care to the resident. [s. 6. (1) (c)]

3. The licensee has failed to ensure that staff and others involved in different aspects of care collaborated with each other in the assessment of the resident #010 so that their assessments were integrated, consistent with and complemented each other, related to assessment findings when there was a change in status.

The following non-compliance was identified during an inspection for complaint intake #010644-20 related to falls prevention and management and the Residents' Bill of Rights and CIS intake #010431-20 regarding falls prevention and management for resident #010.

i. On a date in May 2020, the resident experienced an acute medical event.
RPN #109's progress notes indicated an assessment value which was "high".
According to another form recorded by RPN #119, the assessment value was recorded as a numerical value.
Interview with RPN #109 confirmed that they did not assess the resident with a diagnostic tool and documented the value as communicated to them by RPN #119.
There was a discrepancy of approximately 40 minutes between the reported times of the assessment value between RPN #109 and RPN #119 for the same value.
Interview with RPN #119 identified that the diagnostic tool utilized to determine the assessment value displayed a code, not a numerical value, which in their opinion meant the value was greater than a specific number.
A review of the diagnostic tool user guide identified that the identified code meant a specified test result, which was not consistent with the opinion of RPN #119.
RPN #119 confirmed that they were not aware of the specific numeric value of the assessment, as the tool did not display a number, only the code; however, since they were required to document a numeric value, the chosen number was recorded.

ii. Later that day, the resident was found to have had passed away.
A review of a progress note with the transcriber noted as RPN #119, identified that at a specified time the resident's level of consciousness at the time of the assessment was comatose.
A review of a progress note with the transcriber noted as RN #108, identified that at around the same time the resident was not breathing and no pulse.
A review of a progress note, a late entry written, three days later, by RN #108, identified that they pronounced the resident's death after finding out that resident was breathing and with no heart rate.
RPN #119 confirmed that the resident was deceased on the identified date and was not comatose despite the documentation.

The assessments were not consistent and did not complement each other when there was a change in the resident's condition. [s. 6. (4) (a)]

4. The licensee has failed to ensure that resident #023 and their substitute decision maker (SDM) were provided the opportunity to participate fully in the development and implementation of the plan of care.

The following non-compliance was identified during an inspection for complaint intake

#011094-20 related to plan of care, for resident #023.

Resident #023 was identified in their recent Minimum Data Set (MDS) assessment with a cognitive status and an ability for daily decision making.
A progress note identified that resident #023 had a testing procedure completed by ADOC #135.
A lab report, with a final report date two days later and faxed date four days after the test, noted the test results.
Discussion with the SDM identified that on day four, after testing, they contacted the home at which time they were informed of the resident's status, of the testing completed and the test results. The test results were known to the home two days prior, according to the staff member, who reported the test result.
A progress note, dated on the faxed date, identified the resident's test results as recorded by the DOC.
Documentation recorded on day six, after the test was completed, by ADOC #135 identified that the SDM was informed of the test results.
A review of the clinical record did not include consent for the testing.
Interview with the ADOC confirmed that they did not communicate with the family for consent for testing, as it was not documented.

The resident nor SDM were provided the opportunity to participate fully in the development and implementation of the plan of care. [s. 6. (5)]

5. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #021 as specified in the plan.

The following non-compliance was identified during an inspection for complaint intake #011507-20 and supporting CIS intake #010811-20 both related to the prevention of abuse and neglect.

A review of resident #021's care plan included a current falls intervention.
Observations of the resident on three dates in June 2020, identified that the intervention was not in place.
PSW #145 confirmed to Inspector #130, that the intervention was not in place on a date in June 2020.
Interview with RPN #129, the same day, confirmed to Inspector #130, that the resident required the intervention.

Care was not provided to resident #021 in accordance with the plan of care. [s. 6. (7)]

6. The licensee has failed to ensure that the care set out in the plan of care related to responsive behaviours, for resident #012 was provided to the resident as specified in the plan.

The following non-compliance was identified during an inspection for complaint intake #011507-20 and supporting CIS intake #010811-20 both related to the prevention of abuse and neglect.

According to the plan of care resident #012 had a specific cognitive performance score (CPS) score which indicated a cognitive status; they required assistance of staff for some activities of daily living; and had a history of responsive behaviours.
The care plan to manage the behaviours directed staff to use an approach, if the resident demonstrated an emotion, validate them and assist with the task under a specific situation.
During an interview PSW #110 confirmed that on a date in May 2020, they with staff #104 assisted the resident with care.
Both staff confirmed in interviews, that the resident exhibited a behaviour.
Staff #104 stated that they performed an action while PSW #110 completed the care.
Neither staff used the approach when the resident demonstrated the emotion.

Care was not provided to resident #012 as specified in their plan of care with respect to management of responsive behaviours. [s. 6. (7)]

7. The licensee has failed to ensure that staff and others who provided direct care to residents were kept aware of the contents of the plans of care and given convenient and immediate access to them.

The following non-compliance was identified during an inspection for complaint intake #011507-20 and supporting CIS intake #012138-20 both related to the prevention of abuse and neglect.

The home utilized a computerized software program identified as Point Click Care (PCC) to maintain resident records, including the care plan.
Interview with ADOC #135 confirmed that staff were directed to refer to the kardex (in PCC) for direction related to resident care needs.
Interview with ADOC #136 confirmed the home did not utilize logos, other visual

communication methods nor did they print off a copy of the care plan or kardex to direct staff. Direct care staff were to refer to the kardex for the care needs of the residents.
Interview with the aED confirmed that staff, not directly hired by Camilla Care Community did not have access to PCC on or around a date in May 2020.

PSW #120 and staff #105, were assigned to provide care to residents, including resident #021, during an identified shift in May 2020.
Interview with PSW #120 identified that they were not able to comment on the contents of resident #021's care plan, related to a specific care need, on the identified shift, as they were not assigned to work with a staff member from Camilla Care Community.

Interview with the aED confirmed that when the staff did not have access to PCC, they did not have access to residents' care plans.
It was noted that on and around the identified date, direct care staff, not directly hired by the home, were to work with regular Camilla Care Community staff and did not have their own assignment, which was why they did not have independent access to PCC.

After a date in June 2020, training was provided to specific staff, not directly hired by the home, who were then granted access to PCC. On a date in July 2020, the decision was made that additional staff, not directly hired by the home would also be provided access.

Not all staff, who provided direct care to residents, were aware of the contents of the plans of care, nor had convenient and immediate access. [s. 6. (8)]

8. The licensee has failed to ensure that resident #023 had their plan of care reviewed and revised when their care needs changed.

The following non-compliance was identified during an inspection for complaint intake #011094-20 related to the plan of care, for resident #023.

According to the clinical record, on a date in April 2020, resident #023 displayed symptoms which included pain.
The resident was assessed and transferred to the hospital two days later and returned to the home eight days later, after treatment, with a diagnosis and was on routine analgesic.

i. The PT assessed the resident the day after they returned from the hospital. Based on this assessment RPN #127 recorded a progress note, that the PT provided directions for

safety, care needs and a level of assistance for an activity of daily living. The note identified that interventions would be relayed at shift report.
A review of the care plan did not include a direction as indicated by the PT when reviewed in June 2020.
Specific safety interventions were not included in the plan of care until five days after the initial assessment was completed, as confirmed by RPN #127 following a review of the plan.
ii. The resident presented with pain and had analgesic ordered prior to transport to hospital and on readmission.
A review of the care plan did not include a focus statement related to pain.
RPN #127 confirmed the expectation that pain would be included in the care plan based on the interventions in place.

The plan of care was not revised with the changes in care needs. [s. 6. (10) (b)]

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 plan of care sets out clear directions to staff and others who provide direct care to the residents; that staff and others involved in different aspects of care collaborated with each other in the assessment of the residents, so that their assessments are integrated, consistent with and complement each other; that the care set out in the plan of care is provided to residents as specified in the plan; that staff and others who provide direct care to residents are kept aware of the contents of the plans of care and given convenient and immediate access to them and to ensure residents have their plan of care reviewed and revised when their care needs change or care is no longer necessary, to be implemented voluntarily.

WN #7: 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 resident #023 under the nursing and personal support services and the pain management programs, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

The following non-compliance was identified during an inspection for complaint intake #011094-20 related to the plan of care, for resident #023.

According to the clinical record on a date in April 2020, resident #023 displayed pain and another symptom. Analgesia and a diagnostic test were ordered prior to being transported to the hospital, two days later.
i. A review of the electronic Medication Administration Record (eMAR) and progress notes identified that RPN #127, worked with resident #023 on the date after the pain was first documented.
RPN #127 administered an as needed analgesic in the morning which was noted to be effective at 1407 hours.
A review of the clinical record for the identified shift did not include the location of the pain, an assessment of the area, which to the recall of the staff they assessed, nor any changes in the resident's abilities or activities, which was confirmed by RPN #127.

ii. A review of the eMAR and progress notes identified that RPN #177 worked with resident #023 on the evening that the pain was first documented as well as the following evening. During these shifts analgesic was administered for evidence of moaning and/or pain.
A review of the record did not include the location of the pain, nor any changes in the resident's abilities or activities, which was confirmed by RPN #177.

iii. The Digital Prescriber's Orders, included documentation that the physician was contacted by RN #126, two days after the initial documentation of pain, and orders were

received to transport the resident to the hospital, and for additional medication. The Clinical Indicators section of the document noted that the resident was in pain, noted an injury and suggested that additional medication was administered.
Later that day, an "Orders - Administration Note" identified that a medication was not given as the resident was transferred to the hospital, by RN #126.
There was no documentation regarding the assessment of the resident, when the analgesic was administered, transport to the hospital or substitute decision maker (SDM) notification in the clinical record, on review of the progress notes and eMAR.
Interview with RN #126 confirmed that they assessed the resident, administered analgesic, arranged transport to the hospital and notified the SDM; however, in omission failed to document the actions taken as required.

Not all actions taken with respect to resident #023 including assessments, reassessments, interventions and the resident's responses to interventions were documented. [s. 30. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any actions taken with respect to a resident under a required program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #8: 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 :

1. The licensee has failed to ensure that when resident #020 demonstrated physically responsive behaviours, strategies were developed and implemented to respond to the behaviours, where possible.

The following non-compliance was identified during an inspection for complaint intake #011507-20 and supporting CIS intake #012138-20 both related to the prevention of abuse and neglect.

Interview with PSW #120 identified that the resident had the potential to demonstrate a specified responsive behaviour, as communicated to them by other staff members.
Staff #105 indicated that the resident demonstrated the behaviour on or around a date in May 2020, during the provision of care, with PSW #120; which was supported by the PSW who included specific actions displayed by the resident.
A review of the current care plan did not include that the resident had the potential for the behaviour which was confirmed by ADOC #135.
Interview with RPN #127 regarding the resident's behaviours resulted in modifications to the plan which included specific examples of the behaviour that the resident displayed, newly identified strategies and interventions to respond to the behaviours.

When the resident demonstrated behaviours, strategies were not developed or implemented. [s. 53. (4) (b)]

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 when a resident demonstrates responsive behaviours, strategies are developed and implemented to respond to the behaviours, where possible, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents who required assistance with eating and drinking were not served a meal until someone was available to provide the assistance as required by the residents.

The following non-compliance was identified during an inspection for complaint intake #011507-20 and supporting CIS intakes #010811-20 and #012138-20, all related to the prevention of abuse and neglect.

Observations of meal services on a resident home area, were completed including on two dates in June 2020 and one date in July 2020.
The observations identified that residents were served a prepared meal tray, as sent up to the home area by dietary staff, due to infection prevention and control precautions which were in place due to COVID-19.
Nursing staff were observed to deliver trays to resident rooms although staff were not always immediately available to provide assistance with eating.
Interview with PSW #103 identified the process in place for meal delivery which included that once the meal service cart was delivered to the home area, the nursing staff

delivered the trays room by room. The trays were then placed in resident rooms until staff were available to assist the resident(s) with eating, as per their assessed needs. Residents' full meal trays were observed covered in some resident rooms without staff in attendance to assist on a number of occasions.

i. According to the care plan, resident #014 required staff assistance at meal times.
On a date in June 2020, at 0850 hours, the resident was observed alert and ready for the breakfast meal.
The resident's prepared and covered meal tray was positioned on a bedside table in their room; however, not within their reach.
At 0938 hours, PSW #103, began to assist the resident with their meal after the staff requested that the hot cereal be warmed up by a co-worker.
The PSW confirmed that the resident required assistance by staff.

ii. On a date in June 2020, resident #024 who required assistance of staff at meal times was observed in their room with their lunch meal tray on the beside table at 1327 hours.
At 1345 hours, the meal tray remained undisturbed on the beside table.
At 1356 hours, the resident was observed to be provided assistance by PSW #123.

iii. On a date in July 2020, residents #009, #021 and #024, who each required assistance of staff at meal times were found in their rooms with meal trays in place at 1245 hours.
At 1252 hours, the meal trays remained untouched.
At 1258 hours, resident #021 was observed to be provided assistance by ADOC #135.
At 1259 hours, PSW #149 was observed to enter resident #009's room to assist the resident.
At 1259 hours staff had not yet provided assistance to resident #024.

Not all residents who required assistance with eating and drinking were served a meal when someone was available to provide the assistance as required. [s. 73. (2) (b)]

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 who require assistance with eating and drinking are not served a meal until someone is available to provide the assistance as required by the residents, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(b) a sufficient supply of clean linen, face cloths and bath towels are always available in the home for use by residents; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a sufficient supply of clean linens, face cloths and bath towels always available in the home for use by residents.

The following non-compliance was identified during the inspection for complaint intake #011507-20 and supporting CIS intake #010811-20 both related to prevention of abuse and neglect.

Staff communicated concerns that there was an insufficient supply of linen available for resident use.
On a date in June 2020, a resident home area was toured during the day shift by Inspector #130, including resident rooms and linen storage areas. It was observed that at least 20 resident beds did not have a bed spread or blanket, some beds had only a top sheet and others had a blanket but no top sheet.
The linen room on the home area included no towels, face cloths, sheets, pillow cases, blankets or bedspreads.
The PSW linen cart, in the hallway, was noted to have eight towels, four face cloths and two fitted sheets.
PSW #186 confirmed there were no reusable incontinent bed pads, pillow cases, top sheets, bedspreads, or blankets available and that staff had to “beg” every day for supplies.
The same day, resident #039 was observed in bed with only a top sheet. They stated that they had to ask for a blanket every night because they were cold and that they were never given a bedspread.
During a tour of the laundry room, staff #181 confirmed there was always a shortage of linen. There were no spare clean bed spreads, blankets or sheets and only 20 clean reusable incontinent bed pads available.
The Resident and Family Experience Coordinator observed the linen storage area and confirmed there was a shortage of linen.

There was an insufficient supply of clean linens, face cloths and bath towels available for use by residents. [s. 89. (1) (b)]

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 there is a sufficient supply of clean linens, face cloths and bath towels always available in the home for use by residents, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

The following non-compliance was identified during an inspection for complaint intake #011507-20 and supporting CIS intakes #010811-20 and #012138-20 all related to the prevention of abuse and neglect.

The home's policy, Prevention of Abuse - Definitions of Abuse, VII-G-10.00 (a), dated April 2019, identified, in part:
Emotional abuse was defined as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of knowledge or infantilization that were performed by anyone other than a resident.
Physical abuse was defined as the use of physical force by anyone, other than a resident, that caused pain or may cause pain and any undue physical force by team members when they provided care to a resident. Examples included but were not limited to: forced feeding, rough handling and slapping.

Verbal abuse was defined as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling, demeaning, or degrading nature which diminished a resident's sense of well being, dignity, or self worth, that was made by anyone other than a resident. Examples included but were not limited to: demeaning and or insulting comments and verbal measures used to discipline a resident.
Neglect was defined as the failure to provide the care and assistance required for the health, safety, and/or well being of a resident and included inaction and/or a pattern of inaction that jeopardized the health, safety or well being of a resident. Examples included but were not limited to: withholding services.
The home's policy, Prevention of Abuse and Neglect of a Resident, VII-G-10.00, current revision April 2019, stated, if any team member or volunteer witnessed an incident, or had knowledge of an incident, that constituted resident abuse or neglect, all team members were responsible to immediately take these steps:
1. Stop the abusive situation and intervene immediately if safe for them to do so while ensuring the safety of the resident.
2. Remove resident from the abuser, or if that is not possible, remove the abuser from the resident if safe for them to do so while ensuring the safety of the resident.
3. Immediately inform the Executive Director and/or nurse in the care community.

On a date in May 2020, staff #104 sent an email to hospital partner manager #132, which was also copied to staff #105, where they alleged concerns with the care and services provided to residents which included abuse and neglect.
Staff members #104 and #105 were interviewed by Inspector #168 for additional information regarding their observations and concerns.
It was confirmed that staff members #104 and #015 had not received training on the home's policy, Prevention of Abuse and Neglect of a Resident, VII-G-10.00 (a), April 2019, prior to the email.

i. Staff #105 was interviewed, by Inspector #168, regarding the email, at which time they identified that they witnessed PSW #120, in their opinion, abuse resident #020, during the provision of care.
Interview with PSW #120 acknowledged the interaction with the resident when they demonstrated responsive behaviours during the provision of care.
PSW #120 and staff #105 confirmed that the care was completed during the interaction, therefore the alleged abuse was not immediately stopped.
Interview with staff #105 confirmed that they had not immediately reported the concern to the ED and/or nurse in the care community.

ii. In the email it was alleged that resident(s) were abused.
The resident involved was identified as resident #011 during an interview with staff #104, conducted by the home and hospital partner staff.
During an interview, with Inspector #168 staff #104 identified that it was their co-worker, staff #105, who had witnessed the identified incident first hand.
During an interview, with Inspector #168 staff #105 identified that they witnessed PSW #111 abuse resident #011 during the provision of care.
PSW #111 was interviewed by Inspector #130, acknowledged on the identified shift they were unfamiliar with the resident's behaviours, admitted to an interaction with the resident and acknowledged it was not appropriate.
Staff #105 confirmed they did not immediately intervene when they witnessed the abuse, nor did they immediately inform the ED and/or nurse in the care community.
The abuse was reported, without specific identifiers, in the email.

iii. In the email it was alleged that resident(s) were abused.
The resident involved was identified as resident #012 during an interview with staff #104, conducted by the home and hospital partner staff.
During an interview with Inspector #168, staff #104 stated they witnessed PSW #110, abuse resident #012.
Staff #104 confirmed that although they did remain with the resident after the interaction, they did not immediately intervene when they witnessed abuse nor did they immediately inform the ED and/or nurse in the care community.
The abuse was reported, without specific identifiers, in the email.

iv. In the email it was stated that staff #104 witnessed the staff attempt the provision of care which was not consistent with the residents needs and was not appropriate.
This resident was identified to be former resident #013, during an interview with staff #104 by home staff and hospital partner staff.
During an interview, with Inspector #168, staff #104, identified that they did not witness the alleged incident; however, made the assumption based on a statement made by PSW #112.
Staff #104 confirmed in an interview they did not immediately inform the ED and/or nurse in the care community, when they suspected abuse occurred.
The abuse was reported, without specific identifiers, in the email.

v. The email included a number of concerns related to improper or unsafe care.
During an interview with Inspector #168, staff #104 identified concerns that residents

#024 and #009 were provided care which was not safe. The situations could be considered abuse or neglect according to the definitions as defined in the home's policy. Staff #104 confirmed that they did not take any immediate actions regarding their identified observations and concerns; however, did report a change in status for resident #024 to registered nursing staff for reassessment.

During an interview with Inspector #168, staff #105 identified concerns that residents #024, #009 and #017 were provided care, by PSW #112, which was not safe. The situations could be considered abuse or neglect according to the definitions as defined in the home's policy. On at least one occasion PSW #112 attempted to provide specified care to resident #024 which was not consistent with their care needs. Staff #105 identified that they did stop PSW #112 from assisting resident #024 and re-instructed them on a number of occasions regarding their practices and activities; however, did not report the allegations immediately.

The home's policy was not complied with. (#130 and #168) [s. 20. (1)]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that was reported was immediately investigated.

The following non-compliance was identified during an inspection for complaint intake #011507-20 and supporting CIS intakes #010811-20 and #012138-20 all related to the prevention of abuse and neglect.

A Critical Incident System (CIS) report was submitted in May 2020, which indicated that on the day prior, Sienna Senior Leadership team was made aware by hospital partner executives of an email they received from a staff member who worked at the home during the COVID-19 outbreak.
The email was written by staff #104 and was initially sent to hospital partner manager #132 and staff #131, eight days prior to notification of the email to the long term care home.
Although the email did not identify specific residents by name, specific incidents, nor dates, it identified alleged situations which included resident abuse, improper and unsafe care and a lack of care.

Hospital partner manager #132 was interviewed and identified that when the email was received, they were also assigned a role at Camilla Care Community. They confirmed they they received the email regarding allegations of abuse, from staff #104, on a date in May 2020, reviewed the email the following day; however, did not take action with respect to the allegations.

Hospital partner manager #132 confirmed they failed to immediately investigate the allegations. [s. 23. (1) (a)]

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with s. 24 (1) 2 in that persons who had reasonable grounds to suspect abuse of a resident, failed to report the alleged abuse immediately to the Director in accordance with s. 24 (1) 2 of the LTCHA.

Pursuant to s.152 (2) the licensee was vicariously liable for staff members failing to comply with subsection 24 (1).

The following non-compliance was identified during an inspection for complaint intake #011507-20 and supporting CIS intakes #010811-20 and #012138-20 all related to the prevention of abuse and neglect.

A Critical Incident System (CIS) report was submitted in May 2020, which indicated that on the day prior, Sienna Senior Leadership team was made aware by hospital partner executives of an email they received from a staff member who worked at the home during the COVID-19 outbreak.
According to the CIS, the email raised concerns regarding the quality of care and allegations of abuse.
The Director was notified of the allegations by the ED, via INFOLINE.
The email referred to in the CIS report was sent to Inspector #130 by hospital partner manager #130 on a date in June 2020.
The email was written by staff #104 and was initially sent to hospital partner manager

#132 and staff #131 eight days prior to notification of the email to the long term care home. The email was copied to staff #105.

i. Although the email did not identify specific residents by name, specific incidents, nor dates, it identified alleged situations which included resident abuse, improper and unsafe care and a lack of care.
Hospital partner manager #132 was interviewed by Inspector #130 and identified that when the email was received, they were also assigned a role at Camilla Care Community. They confirmed that they received the email regarding allegations of abuse from staff #104 on a date in May 2020, reviewed the email the following day; however, did not take action with respect to the allegations which included reporting.

ii. Staff #104 was interviewed by Inspector #168, regarding their email and confirmed that not all allegations identified in the email were witnessed by them and that their coworker, identified as staff #105, had also witnessed staff to resident abuse.
During the interview staff #104 communicated allegations of abuse, that they were aware of for residents including but not limited to #011, #012 and #013, which were not reported prior to the email.

iii. Staff #105 was interviewed by Inspector #168, regarding the email and communicated allegations of abuse, including but not limited to abuse of resident #020, which was not previously reported.

iv. Following interviews with staff #104 and #105, Inspector #168, spoke with the aED of Camilla Care Community, regarding additional allegations identified during the interviews.
The aED confirmed that they were not aware of the additional allegations and submitted a CIS report for the additional concerns identified regarding a number of residents including #009, #017 and #024.

Staff #104 and #105 and hospital partner manager #132 confirmed they failed to immediately report the allegations of abuse. (#130 and #168) [s. 24. (1)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #015, who was incontinent, received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions and that where the condition or circumstances of the resident required, an assessment was conducted with a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

The following non-compliance was identified during an inspection for complaint intake #011507-20 and supporting CIS intakes #010811-20 and #012138-20, all related to the prevention of abuse and neglect.

Resident #015 was identified to be incontinent of bowel and bladder according to their current care plan which included the intervention of a continence care product.
A review of the clinical record did not include a continence assessment, as confirmed by RN #124.

The assessment was not completed. [s. 51. (2) (a)]

WN #15: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff who provided direct care to residents, as a condition of continued contact with residents, received training in the areas of: mental health issues, behaviour management and any other areas provided for in the regulations.

In accordance with O. Reg. 79/10, s. 221 (1) 3, 4 and O. Reg. 79/10, s. 219 (3) the home was required to provide all staff who provided direct care to residents with at least annual training in the area of continence care and bowel management and pain management.

A request was made of the home to produce training records for direct care staff for mandatory training, including but not limited to the areas of mental health issues, behaviour management, continence care and bowel management and pain management.
According to the aED, hospital partner manager #130 and ADOC #136, the home utilized a computerized software program to meet most of their training needs called Relias.
The hospital partner manager #130 identified, based on a review of 2019 records, that three identified staff members who were assigned to a specific job code did not receive the annual training in areas of mental health issues, behaviour management, continence care and bowel management and pain management due to a computer coding error.
A review of the training transcripts for three staff did not include the completion of training in the areas identified.
It was identified that the home did not have a record of other training completed by the three staff in the mandatory areas identified and that the coding error had since been corrected.
The home conducted a random sampling of other staff, with other job codes and all mandatory training requirements were completed.

The training was not completed as required. [s. 76. (7)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every verbal complaint made to a staff member concerning the care of a resident had a response provided within 10 business days of receipt of the complaint.

The following non-compliance was identified during an inspection for complaint intake #011507-20 and supporting CIS intakes #010811-20 and #012138-20, all related to the prevention of abuse and neglect.

Hospital partner manager #132 was informed by an email, that staff #104 had identified concerns with continence care provided to residents. This email was copied to staff #105 .
Interview with staff #105 identified that prior to the email, they had discussed a concern regarding continence care for residents with registered nursing staff, before they reported it to the DOC; although an exact date was not provided.
During an interview, with Inspector #130 the DOC recalled that they had received the complaint from staff #105 and investigated the concern the same day.
ADOC #135 confirmed that they had spoken with the registered nursing staff regarding the concern, and discussed the concern at shift report in an effort to prevent recurrence.
Staff #105 identified that they were not provided a response to their concern, which was confirmed by the DOC and ADOC #135.

A verbal complaint made which concerned the care of residents was not responded to within 10 business days of receipt of the complaint. [s. 101. (1) 1.]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 234. Staff records

Specifically failed to comply with the following:

s. 234. (1) Subject to subsections (2) and (3), every licensee of a long-term care home shall ensure that a record is kept for each staff member of the home that includes at least the following with respect to the staff member:
1. The staff member's qualifications, previous employment and other relevant experience.
2. Where applicable, a verification of the staff member's current certificate of registration with the College of the regulated health profession of which he or she is a member, or verification of the staff member's current registration with the regulatory body governing his or her profession.
3. Where applicable, the results of the staff member's police record check under subsection 75 (2) of the Act.
4. Where applicable, the staff member's declarations under subsection 215 (4). O. Reg. 79/10, s. 234 (1); O. Reg. 451/18, s. 4.

Findings/Faits saillants :

1. The licensee has failed to ensure that a record was kept for each registered nursing staff member, that included verification of the staff member's current certificate of registration with the College of their regulated health profession, or verification of the staff member's current registration with the regulatory body governing his or her profession.

It was identified by the Office Manager that the DOC maintained records of registered nursing staff for verification of their current certificate of registration with the College of Nurses of Ontario (CNO).
ADOC #135 completed a search of the DOC's electronic files to locate any verification records for 2020.
ADOC #135 was able to locate a "table" created by the home for 2018 and 2019 which identified the registered nursing staff members by name and their registration status; however, there was no record of any verification for the registered staff for 2020.
Interview with the aED confirmed they had been unable to locate a record in the home for the verification of the registered staff members current certificate of registration with the CNO, for 2020 and that this activity was recently completed, which confirmed that all registered nursing staff members were registered with the CNO.
Interview with the DOC, by Inspector #130, confirmed that they had completed a document, a "table" which included verification records for 2020 for registered nursing staff, as in previous years; however, was not able to produce the record.

A record was not maintained for each registered nursing staff member as required. [s. 234. (1) 2.]

Issued on this 21st day of October, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère 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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LISA VINK (168), GILLIAN HUNTER (130), HELENE DESABRAIS (615), SHERRI COOK (633)
Inspection No. / No de l'inspection :	2020_556168_0013
Log No. / No de registre :	010431-20, 010644-20, 010811-20, 010843-20, 011094-20, 011507-20, 012138-20, 012142-20, 012158-20, 012159-20, 012200-20
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Sep 29, 2020
Licensee / Titulaire de permis :	Vigour Limited Partnership on behalf of Vigour General Partner Inc. 302 Town Centre Blvd, Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Camilla Care Community 2250 Hurontario Street, MISSISSAUGA, ON, L5B-1M8
	Tracy Richardson

Ontario

Ministry of Long-Term Care

Ministère 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

Name of Administrator /
Nom de l’administratrice
ou de l’administrateur :

To Vigour Limited Partnership on behalf of Vigour General Partner Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère 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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Order / Ordre :

The licensee must be compliant with s. 229 (4) of Ontario Regulation 79/10.

Specifically, the licensee must:
1. Develop and implement a monitoring process to ensure compliance of all staff with the IPAC program, including proper use of PPE, donning and doffing of PPE and cohorting of residents and staff. A documented record must be kept.
2. Retrain all registered staff and managers on the home's relevant policies and expectations related to Infection Prevention and Control. The training must be documented and include but not be limited to the following:
• the definition of an outbreak;
• the use of surveillance monitoring tools;
• the required documentation and monitoring of residents exhibiting symptoms of infections;
• the notification of physicians, nurse practitioners, substitute decision makers, Public Health unit and ministry;
• immediate measures and precautions to be taken when an outbreak is suspected, to reduce the transmission of disease;
• identify the responsibilities of all staff and managers.
3. Each resident home area must maintain a surveillance monitoring record and communicate the results to the oncoming shift.
4. The designated manager will analyze the surveillance monitoring records from each resident home area daily to identify trends. A documented record must be kept.
5. Surveillance Monitoring Record Analysis' will be communicated and reviewed at all IPAC and quarterly Professional Advisory Council meetings. A record of this review will be maintained.
6. Conduct weekly audits for a three month period of time and until staff are observed to be compliant with the IPAC program. A documented record must be kept.

Grounds / Motifs :

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

The following non-compliance was identified during the inspection for complaint intake #011507-20 and supporting CIS intake #010811-20 both related to prevention of abuse and neglect and supporting CIS intakes #012158-20,

#012159-20 and #012200-20 each related to reports regarding critical incidents and infection prevention and control program.

The home's policy, LTC Infection Prevention and Control, IX-F-10-00, April 2019, identified "In the event that documented surveillance of resident signs and symptoms suggests that a potential outbreak may be in progress, immediate measures must be implemented to reduce the transmission of disease. The Infection Control Practitioner (ICP), in consultation with the Medical Director or the local Public Health Unit (PHU), will review surveillance data and confirm that an outbreak is occurring".
i. The nurse would: Implement initial infection control measures as appropriate according to signs and symptoms presented, including isolation of affected resident(s) and use of additional precautions. Do not wait for confirmation of the organism; review status of all residents in resident home area/neighborhood, ensuring line listing is fully completed; communicate with ICP and ensure team members follow all recommendations made; notify attending physician and obtain any orders; and ensure any new cases are reported to ICP as soon as possible.
ii. The Infection Control Practitioner or designate would: review the line listing and identify if the definition of an outbreak was met; communicate suspected outbreak to all resident home areas/neighborhoods; communicate suspected outbreak to all Department Managers and Medical Director; and notify the local Public Health Unit (PHU) of suspected outbreak and identify any testing or special measures to be implemented.

A. A review of clinical records identified that during three months in 2019/2020, there were clusters of residents exhibiting respiratory symptoms throughout the home which suggested potential outbreaks.
This information was confirmed by Peel Regional Public Health in July 2020.

B. A further review of clinical records, Infection Prevention and Control (IPAC) meeting minutes, quarterly Professional Advisory Council (PAC) meeting minutes, daily Leadership Meeting minutes, monthly Leadership Meeting minutes, IPAC risk assessments and staff interviews, identified:
i. Immediate measures to reduce the transmission of disease, such as isolating residents, implementing appropriate precautions, including signage, and testing to identify causative organism, were not consistently implemented.

ii. Line listings were not fully completed. Documentation recorded in progress notes identified that residents exhibiting symptoms of respiratory illness were not consistently added to the surveillance lists.
Residents added to the surveillance list were not added in chronological order, suggesting they were not added on a daily basis and when symptoms were first identified.
iii. The ICP was not immediately notified of all new cases.
iv. The ICP did not review and analyze the surveillance data on a daily basis, communicate suspected outbreaks to all resident home areas, communicate suspected outbreaks to all Department Managers and Medical Director, or consult with the local PHU and confirm that an outbreak was occurring.
v. During the COVID-19 outbreak, symptomatic COVID-19 positive residents and COVID-19 negative residents and staff assigned to their care, were not consistently co-horted.
vi. Excessive use of personal protective equipment (PPE), for example double masking and black plastic bags were worn by staff, as identified through the IPAC assessment conducted in April 2020.
vii. It was identified that staff were initially observed to be wearing garbage bags over their clothing and on their feet as PPE, and continued to wear gloves while they washed their hands instead of changing gloves.

It was confirmed through record reviews, meeting minute reviews, IPAC assessments and interview with aED, DOC and ADOC #133 that not all staff participated in the implementation of the infection prevention and control program.

The severity of this issue was a level 3 as there was actual risk and harm to the residents.
The scope was level 3 as it was widespread.
The home had a level 2 compliance history as they had previous non-compliance to a different subsection. (130)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 29, 2020

Ontario

Ministry of Long-Term Care

Ministère 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

Order # / No d'ordre : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

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

Specifically the licensee must:
1. Ensure that all residents, with an identified diagnosis, who experience specified events, are cared for and assessed in accordance with the home's relevant policies and procedures related to the diagnosis.
2. Ensure that the care provided, is consistently documented as identified in the procedures, by auditing activities for a period of two months or until compliance is consistently achieved.
3. Identify and implement a system to ensure that registered nursing staff are complying with the procedures.
4. Maintain a written record of the steps and actions taken as part of the system to ensure compliance.

Grounds / Motifs :

1. The licensee has failed to ensure that any procedures in the required Nursing and Personal Support Services program was complied with.

In accordance with LTCHA s. 8 (1) the licensee was to ensure that there was an organized program of nursing services for the home to meet the assessed needs of the residents.

The following non-compliance was identified during an inspection for complaint

intake #010644-20 related to falls prevention and management and the Residents' Bill of Rights and CIS intake #010431-20 regarding falls prevention and management for resident #010.

A. The home's procedures, for management of a specified diagnosis, procedures number VIII-C-10.30, current revision May 2019 and number VII-C-10.30(b), dated May 2019, were reviewed.
The documents identified detailed directions for staff to follow under specific situations, including interventions, reassessment, notification, referrals and documentation.

i. A review of the clinical record identified that on a specified date resident #010, had an assessment value at an undesired level and other observations were recorded. RPN #109 recorded that the resident was given an intervention. When rechecked, approximately one hour later, the assessment value was noted be be improved, their intake was recorded and there was a note that the physician was notified. Orders were received to hold medication and to contact the physician the next day with an assessment value.
Interview with RPN #109 confirmed that on the identified shift, they did not follow the procedures when they provided the intervention, which was not consistent with the procedure and that they did not have an order for the intervention. They did not repeat the test at the frequency identified in the procedure. They confirmed that they did not notify the SDM nor did they send a referral to report the incident. To their recall they rechecked the assessment value, when they administered medications later in the shift; however, failed to document this assessment.

The procedure was not complied with.

B. The home's procedure, for management of a specified diagnosis, procedure number VIII-C-10.20, current revision May 2019, provided staff direction if identified assessment values were abnormally high or low compared to resident's usual values, which included when to repeat the procedure, additional actions to take and documentation requirements.

i. According to the clinical record on a day in May 2020, resident #010 had an elevated assessment value, an intervention was provided and their intake was

recorded.
Progress notes by RPN #118 identified that almost three hours later, the assessment value remained elevated and after an additional 15 minutes the value was noted to be even higher. The physician was called and prescribed a medication which was administered.
Interview with RPN #118 identified that in their opinion the assessment value was considered high. To their recall they did repeat the testing procedure on the resident; although failed to document the results which they had communicated to the oncoming staff verbally at shift report. They confirmed that they did not take additional action as noted in the procedure. To their recollection they did monitor the resident due to the change in status; however, did not document their assessment findings.
ii. According to the clinical record three days later, the resident refused a meal and only took fluids. Documentation by RPN #118 identified an elevated assessment value. Medication was administered as prescribed, the resident was not in distress, was alert and responsive and their intake was monitored.
Interview with RPN #118 identified what, in their opinion, was the "range" for the resident's assessment value and that the resident had a number of changes to their medication orders.
A review of the electronic Medication Administration Record (eMAR), for May 2020, identified that resident's value range, during the time of the assessment, was below the range identified by the RPN.
RPN #118 recalled direction that they provided to PSW staff regarding the resident and confirmed that they did not repeat the testing procedure nor other aspects of the procedure.

iii. According to the clinical record later that day, the oncoming shift RPN #109 made the decision to withhold a prescribed intervention, due to the elevated assessment value noted previously. The RPN noted their assessment findings of the resident. An assessment of vital signs identified an elevated assessment value and a temperature of 38.1 degrees Celsius. Scheduled acetaminophen was administered. The physician was called and orders were received for medications, which were given. Later during the shift the resident was afrebile and sleeping.
Interview with RPN #109 confirmed that in their opinion the identified assessment value was considered high. They identified that they may have repeated the testing procedure; however, failed to document the results, along

with other monitoring they completed, and confirmed that they did not follow other direction as noted in the procedure.
iv. The following day, according to the clinical record, the resident had an elevated assessment value, a numeric value, as recorded by RPN #119, on an identified form. The same value was also recorded as "high" by RPN #109, approximately 40 minutes later in the progress notes. The physician was called and prescribed a medication which was administered by RPN #119.
Interview with RPN #119 identified that in their opinion the assessment value was considered high. To their recall they identified that they did repeat the testing procedure, assessed the resident's value a total of three times, which remained elevated; although, failed to document the results, as well as the monitoring completed and other assessment findings. They confirmed that they did not carry out the remainder of the procedure. The physician was not contacted again until the resident had passed away later in the shift. The resident's plan was not revised.

The procedures were not complied with.

The severity of this issue was determined to be a level 3 as there was actual harm to a resident.
The scope of the issue was a level 1 as it related to one resident.
The home had a level 3 history as they had previous non-compliance to the same subsection, that included:
• voluntary plan of correction (VPC) with a report date of December 14, 2017 (2017_543561_0015).
(168)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Oct 29, 2020

Ontario

Ministry of Long-Term Care

Ministère 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

Order # / No d'ordre : 003

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s.19 (1) of the Long-Term Care Homes Act.

Specifically the licensee must:
1. Ensure that all residents including resident #023 are protected from neglect by staff.
2. Ensure that all staff comply with the IPAC program and take immediate measures and actions to reduce the transmission of infections when symptomatic residents are first identified.
3. Residents shall:
i. Be assessed, interventions carried out and care provided in accordance with care needs, with changes in condition; and have assessments, interventions and the residents' responses documented.
ii. Have medications and treatments administered and reassessed in accordance with care requirements, assessed needs and prescribers orders.
iii. Have their substitute decision makers afforded the opportunity to participate fully in the development and implementation of the residents' plans of care.

Grounds / Motifs :

1. The licensee has failed to ensure that all residents, including resident #023 were not neglected by the licensee or staff.

O. Reg. 79/10 s. 5 identified neglect as the failure to provide a resident with the treatment, care services or assistance required for health, safety or well-being and included inaction or a pattern of inaction that jeopardized the health, safety or well being of one or more residents.

A. The following non-compliance was identified during the inspection for

complaint intake #011507-20 and supporting CIS intake #010811-20 both related to prevention of abuse and neglect and supporting CIS intakes #012158-20, #012159-20 and #012200-20 each related to reports regarding critical incidents and infection prevention and control program.

As a part of the provincial response to the COVID-19 pandemic in long-term care homes, a hospital partner signed a Voluntary Management Contract (VMC) to act as temporary manager of Camilla Care Community, in May 2020. Prior to the implementation of the VMC, the hospital partner provided expertise and support to Camilla Care Community which started in April 2020.
In April 2020, the home had its first laboratory confirmed case of COVID-19 and an outbreak was declared in the home by Peel Public Health unit.
Later that month the hospital partner received a letter from the Sienna President and Chief Executive Officer which requested staffing support, citing significant staffing shortages.
A Critical Incident System (CIS) report, submitted in May 2020, indicated that nine days prior, hospital partner manager #132 was informed by email that a staff member, who worked at Camilla Care Community witnessed instances of alleged staff to resident abuse, and unsafe practices that impacted the safety of the residents.
According to an Initial Report of the Temporary Manager, dated in June 2020, for a time period between April 2020 and June 2020, the hospital partner assessment team witnessed a number of concerns related to infection prevention and control. COVID-19 positive residents and COVID-19 negative residents shared the same rooms, lack of signage and/or inaccurate signage to clearly show which residents were COVID-19 positive versus negative; that staff did not know which precautions were required when they cared for the residents. Not all Camilla Care Community nursing staff were aware of how and when to swab residents for COVID-19 testing. Staff were not proficient in the use of personal protective equipment (PPE) which included how to safely put on and take off (don and doff) equipment, the required frequency to change PPE throughout a shift, or the need to change PPE when they moved from a COVID-19 positive resident to a COVID-19 negative resident. PPE (i.e. masks, gloves, gowns etc.) was not consistently/properly used by all staff; some staff did not wear masks while others wore double masks. Staff were seen caring for COVID-19 positive residents, then went to the nursing station without removal of PPE. Staff were initially observed with garbage bags over their clothing and on

their feet as PPE, and kept gloves on while they washed their hands instead of changing their gloves.

During this inspection, a review of clinical records identified that during three months in 2019/2020, there were clusters of residents, who exhibited respiratory symptoms throughout the home, which suggested potential outbreaks.
This information was confirmed by Peel Public Health in July 2020, during the course of the inspection.
A further review of clinical records, Infection Prevention and Control (IPAC) meeting minutes, quarterly Professional Advisory Council (PAC) meeting minutes, daily Leadership Meeting minutes, monthly Leadership Meeting minutes, IPAC risk assessments and staff interviews, identified:
i. Immediate measures to reduce the transmission of disease, such as the isolation of residents, the implementation of appropriate precautions which included signage and testing to identify causative organism, were not consistently implemented.
ii. Line listings were not fully completed. Documentation recorded in progress notes identified that residents who exhibited symptoms of respiratory illness were not consistently added to the surveillance lists. Residents who were added to the surveillance list were not added in chronological order, which suggested that they were not added on a daily basis and when symptoms were first identified.
iii. The Infection Control Practitioner (ICP) was not immediately notified of all new cases.
iv. The ICP did not review and analyze the surveillance data on a daily basis; communicate suspected outbreaks to all resident home areas, Department Managers or the Medical Director; or consult with the local Public Health Unit (PHU) to confirm that an outbreak was occurring.
v. During the COVID-19 outbreak, symptomatic COVID-19 positive residents and COVID-19 negative residents and staff assigned to their care, were not consistently co-horted.
vi. Excessive use of PPE, ie, double masking and black plastic bags being worn, was identified through IPAC assessment completed on a date in April 2020.
vii. A review of the "Infection Control Surveillance Record(s)" for each resident home area, for three months in 2019/2020, identified that surveillance lists had been completed on a monthly basis and not on a daily basis as required. Not all

residents were monitored every shift until their symptoms resolved, symptomatic residents had not been added to the surveillance list in chronological order and/or when symptoms were first identified. A review of progress notes, identified that not all residents with respiratory symptoms were included in the surveillance lists during the identified months.
viii. Registered staff reported critical staffing shortages in nursing and dietary departments prior to the redeployment of hospital partner staff.

The licensee's pattern of inaction related to infection prevention and control and outbreak management jeopardized the health, safety or well-being of one or more residents. (#130)

B. The following non-compliance was identified during an inspection for complaint intake #011094-20 related to plan of care, for resident #023. According to the clinical record resident #023 had identified diagnoses. They presented with pain and another symptom on a date in April 2020, and two days later was transferred to the hospital with an injury, treated and re-admitted to the home eight days later.
A recent Minimum Data Set (MDS) assessment identified their cognitive, transfer, toileting and mobility status.
They had their temperature monitored and was screened for COVID-19 symptoms consistently at least twice a day since a date in April 2020, according to the records.
Their electronic Medication Administration Records (eMAR) for April 2020, noted that they had a routine order for acetaminophen 325 milligrams (mg), two tablets, four times a day at 0900, 1300, 1800 and 2100 hours, which was consistently signed as administered as prescribed. Staff documented the resident's pain level four times a day with the administration of the routine acetaminophen.
Additionally, they had an order for acetaminophen 325 mg, two tablets, every four hours, as needed, for a fever over 38 degrees Celsius (°C) and not to exceed 3200 mg daily from all sources.

A review of a twelve day time period in April 2020, was conducted including review of progress notes, selected Daily Active Screening records, assessments, temperature summary records and the eMAR, along with interviews with staff and the substitute decision makers (SDMs) which identified

the following:

On a date in April 2020, in the morning the resident was documented to have an elevated temperature. There was no documentation of a reassessment until later in the evening, when it was identified that their temperature was reduced.

The next day, in the morning, the resident presented with an elevated temperature which was treated with an additional dose of acetaminophen with effect, according to the record. As recorded by ADOC #135, the resident had interventions put in place and a test completed. They were documented to have an elevated temperature in the evening and later that shift it was reduced. According to the eMAR they were administered 3250 mg of acetaminophen in the 24 hour time period.

The following day, an additional dose of acetaminophen was administered in the morning, for an elevated temperature with effect. The physician documented that the resident had symptoms and a test result was pending. According to the eMAR they were administered 3250 mg of acetaminophen in the 24 hour time period.

The following day, there was no documentation in the progress notes; however, temperature readings were recorded within normal limits.
There was no evidence that the resident reported pain according to the pain levels recorded on the eMAR or in the Point of Care (POC) follow up question report. The records did not include that there was a change in the resident's abilities or level of care provided. There were no assessments for an incident recorded under Assessments in Point Click Care (PCC).

The following day, the progress notes identified the resident to have an elevated temperature in the morning which improved later on the day shift. During the afternoon shift, an assessment of the resident was documented, including intake and symptoms. They were afebrile later in the shift. There was no evidence that the resident reported pain according to the pain levels recorded on the eMAR or in the POC follow up question report. The records did not include that there was a change in the resident's abilities, level of care provided or reports of any pain.

The following day, in the morning an additional dose of acetaminophen was administered for an elevated temperature with effect. The test results were received. Interventions were in place with treatment to include acetaminophen, they were to be monitored and tracked as documented by the DOC. In the evening, according to the progress notes they presented with an elevated temperature which was treated with routinely ordered acetaminophen with effect. According to the eMAR they were administered 3250 mg of acetaminophen in the 24 hour time period.
There was no evidence that the resident reported pain according to the pain levels recorded on the eMAR or in the POC follow up question report. The records did not include that there was a change in the resident's abilities, level of care provided or reports of any pain.
According to the SDM, they spoke with a staff member regarding the resident. During this conversation they were notified that two days prior, an incident occurred, the resident had complaints of pain and they were informed of the test result. The SDM identified to the Inspector, that this conversation was the first communication that they had regarding the resident being tested, an incident or symptoms displayed.

The following day, in the morning the resident had an elevated temperature which was treated with an additional dose of acetaminophen. Their temperature later on the day shift remained elevated. A note prior to lunch identified that they presented with an elevated temperature, observations were noted, an intervention was provided for comfort and staff continued to monitor. The resident had an elevated temperature during the evening shift. According to the eMAR they were administered 3250 mg of acetaminophen in the 24 hour time period. There was no evidence that the resident reported pain according to the pain levels recorded on the eMAR, or in the POC follow up question report. The records did not include that there was a change in the resident's abilities, level of care provided or reports of any pain.

The following day, in the morning an additional dose of acetaminophen was administered for an elevated temperature with effect. According to the documentation by ADOC #135, the SDM was notified of the resident's test result. Their temperature in the afternoon was improved. Later that shift, an additional dose of acetaminophen was administered for an elevated temperature with effect and no other symptoms were noted. According to the eMAR they

were administered 3900 mg of acetaminophen in the 24 hour time period. There was no evidence that the resident reported pain, according to the pain levels recorded on the eMAR or in the POC follow up question report. The records did not include that there was a change in the resident's abilities, level of care provided or reports of any pain.
According to the SDM they spoke with RN #108 during the evening who reported that the resident experienced pain, analgesic was given and the SDM was encouraged to contact the home the following day.

The following day, an additional dose of acetaminophen was administered in the morning for an elevated temperature with effect. Later that shift the resident was assessed and assessment finding were documented. The following shift they were reassessed, with assessment finding recorded along with documentation of their food and fluid intake. According to the eMAR they were administered 3250 mg of acetaminophen in the 24 hour time period. There was no evidence that the resident reported pain, according to the pain levels recorded on the eMAR or in the POC follow up question report. The records did not include that there was a change in the resident's abilities, level of care provided or reports of any pain.

According to the SDM they spoke with RN #126 who reported that the home did not have a physician onsite, they were attempting to get a diagnostic test ordered and they had administered acetaminophen to the resident.

The following day, in the morning, an additional dose of acetaminophen was administered for an elevated temperature with effect. A progress note from the physician included the status of the resident and that a medication was prescribed. RPN #127 documented that the resident presented with symptoms, other than pain. The SDM was contacted regarding the resident's condition and interventions. There was no evidence in the clinical record that there was a discussion related to pain during this call with the SDM, which was confirmed by RPN #129. According to the eMAR they were administered 3250 mg of acetaminophen in the 24 hour time period. There was no evidence that the resident reported pain according to the pain levels recorded on the eMAR or in the POC follow up question report. The records did not include that there was a change in the resident's abilities, level of care provided or reports of any pain.
According to the SDM they spoke with, who they believe to be RN #126, who communicated that the home suspected that the resident had an injury, they

continued to receive acetaminophen and the plan was to have a diagnostic test completed in three days.

The following day, the resident was identified to be afebrile. A progress note, prior to noon, by RPN #127 identified that in the morning the resident was in a lot of pain especially when a specific area was touched, another symptom was noted and care was provided with the help of staff. The physician was informed and ordered a diagnostic test and an analgesic to be given every four hours as needed. The SDM was informed of the resident's condition and interventions.
There was no record that the analgesic was administered during the day shift after the order was received, which was confirmed by RPN #127, who administered the routine dosage of acetaminophen twice on the shift.
A note was recorded at 1500 hours which identified the resident had a pain assessment completed by RPN #127; however, the staff reported that this assessment was completed earlier in the day. The pain intensity was described, the description of pain was included and observations of the resident were noted.
During the evening, the resident was administered the analgesic by RPN #177, with an initial pain level score of two, suggestive of mild pain. The record noted that the resident was moaning when talking at times and that staff would continue to monitor. RPN #177 had no recall of the location of the resident's pain when interviewed, nor did they recall if they assessed the area of suspected injury; however, recalled that the resident was in bed and required additional assistance by staff.
Later on the night shift, RN #125 noted the medication was effective. There was no additional documentation regarding the resident's pain, level of assistance required or an assessment of the suspected area of injury. RN #125 identified that they were not aware of reports of pain on their shift and for that reason there were no concerns recorded.
The resident was administered the analgesic the following morning, by RPN #127, according to the progress notes for facial grimacing and a pain level score of zero, suggestive of no pain. The medication was noted to be effective, with a pain level score of two, a score level higher than the initial assessment.
Interview with RPN #127 identified that to their recall they did reassess the resident, they remained in bed during the shift and required additional assistance by staff; however, they failed to document their actions and assessment. They identified that the resident was in some pain with care, which

was believed to be in the suggested location; however, if it was of concern they would have contacted the physician for additional analgesic or to arrange transport to hospital.
During the evening, RPN #177 administered the analgesic with effect. The progress notes identified that the resident appeared to be in pain and they would be monitored. RPN #177 had no recall of the location of the resident's pain when interviewed, nor did they recall if they assessed the resident for the suspected injury; however, recalled that the resident was in bed and required additional assistance by staff.

There was no documented assessments, the following day in the progress notes. The clinical record included a diagnostic test report, with the same day, which noted an injury. The progress notes included one entry an "Order - Administration Note" which noted that a medication was not administered at 1400 hours as the resident was transferred to the hospital by RN #126. A review of the Digital Prescriber's Orders identified that a phone order was received from the physician on the identified date, to transfer the resident to the hospital and for an analgesic to be given immediately and then before/at time of transfer to hospital.
In the Clinical Indicator section of the document it was written that the resident was in pain, noted the injury and that medication was given from the emergency drug box. Interview with RN #126 confirmed that they, following a review of the clinical record, were not aware of what was the cause of the injury to the resident, and that if the resident was involved in an incident, they would have required staff assistance. During the interview RN #126 stated that they recalled that they contacted the physician and transported the resident to the hospital. In their opinion the resident was in more pain than previously identified and due to the activity of transport to the hospital, they requested additional analgesic. It was indicated that they contacted the SDM regarding the transfer. RN #126 confirmed that they did not document their assessments, nor actions taken; however, completed all necessary activities. A review of the Emergency Starter Box Ordering Form identified that the medication was signed out for use by the resident.

The resident was transferred to the hospital.

The Ambulance Call Report dated that same day, noted that long-term care

home staff reported an incident and a time frame when it occurred, that there was no assessment by medical doctor, that a diagnostic procedure was attempted but patient did not tolerate, the observations and assessment findings of long-term, care home staff, along with the administration of the analgesic. The resident was admitted to the hospital for the injury and was treated four days later.

The resident was neglected by the licensee or staff when:
i. The SDM was not given the opportunity to participate fully in the plan of care when they were not consulted to consent for testing and were not notified of the test results when immediately known to the home. Additionally, the SDM reported challenges with communicating with staff at the home during this time period, to discuss changes in the resident's needs.
ii. The physician was not contacted for direction when the resident required additional acetaminophen to manage their temperature and the dose administered exceeded the maximum dose in a 24 hour time period, on eight occasions.
iii. A physician's note, included the presence of an assessment finding which was not previously documented.
iv. As needed pain medication was not administered when first ordered, during the day shift despite the pain assessment which identified that the resident experienced pain.
v. Documentation from the time that pain was first recorded until transported to hospital, did not include assessments of the resident's change in condition related to the injury, any change in care needs and the resident's response; with the exception of the effectiveness of the as needed analgesic, which was administered three times.
vi. Interview with the DOC and ADOC #135 confirmed that the cause of the injury was not investigated for a causative agent. There was no documentation related to an incident or some type of event when first known to the SDM, or during the time frame documented on the Ambulance Call Report.

Resident #023 was neglected.

The severity of this issue was determined to be a level 3 as there was actual harm to residents.
The scope of the issue was a level 3 as it was identified to be widespread.

The home had a level 3 history as they had previous non-compliance to the same subsection, that included:
• voluntary plan of correction (VPC) with a report date of March 26, 2019 (2019_766500_0007). (168)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 08, 2020

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Order # / No d'ordre : 004

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

Pursuant to / Aux termes de :

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

Order / Ordre :

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

Specifically the licensee must:
1. Ensure that resident #023 has their medication orders, for acetaminophen, reviewed and revised by their attending physician to be consistent with their care needs.
2. Ensure that resident #023 and every other resident, is administered drugs, including acetaminophen and another medication, in accordance with the directions for use as specified by the prescriber.

Grounds / Motifs :

1. The licensee has failed to ensure a drug was administered to resident #010 in accordance with the directions for use specified by the prescriber.

The following non-compliance was identified during an inspection for complaint intake #010644-20 related to falls prevention and management and the Residents' Bill of Rights and CIS intake #010431-20 regarding falls prevention and management for resident #010.

According to the electronic Medication Administration Record (eMAR) resident #010 had a current physician's order for a medication to be administered in the evening with supper at 1800 hours.
The eMAR included "High Alert" direction to not give the medication if less than 50 per cent (%) of supper was consumed.
Point of Care (POC) task documentation, for the question, "Eating - how much I consumed" required staff to record the percentage that the resident consumed during the meal.

The documentation identified that on four days in May 2020, the resident consumed 0-25 % of their supper meal.
A review of the eMAR for May 2020, identified that on three of the identified dates in May 2020, the evening dosage of the medication was administered by RPN #116.
Following a review of the clinical record, RPN #116 confirmed that the medication was administered; however, not in accordance with the directions for use as indicated on the eMAR, on the three dates, when it was given despite the intake consumed at the supper meal.

A drug was not administered to resident #010 in accordance with the directions for use as specified. (615)

2. The licensee has failed to ensure that acetaminophen was administered to resident #023 in accordance with the directions for use specified by the prescriber.

The following non-compliance was identified during an inspection for complaint intake #011094-20 related to plan of care, for resident #023.

According to the eMAR resident #023 had orders for routine and as needed acetaminophen. A time frame of nine days in April 2020 was reviewed.
The orders from the Physician Medication Review, signed in March 2020, were for:
-acetaminophen 325 milligrams (mg), two tablets, by mouth four times a day and also an as needed (PRN);
-acetaminophen suppository 650 mg, every four hours as needed, for fever over 38 degrees Celsius (°C), maximum of two doses/24 hour period and directions "do not exceed 3200 mg daily from all sources";
-acetaminophen tablets, 325 mg, give two tablets, by mouth every four hours, as needed, for fever over 38 °C, maximum of two doses/24 hour period and directions "do not exceed 3200 mg daily from all sources";
-acetaminophen suppository 650 mg, every four hours, as needed for pain, maximum of four doses/24 hour period and directions "do not exceed 3200 mg daily from all sources"; and
-acetaminophen tablets 325 mg, give two tablets, by mouth every four hours, as needed for pain, maximum of four doses/24 hour period and directions "do not

exceed 3200 mg daily from all sources".

A review of the progress notes and eMAR identified that the resident was administered their routine dosage of acetaminophen 325 mg, two tablets, four times a day at 0900, 1300, 1800 and 2100 hours consistently which was a total for 2600 mg of acetaminophen in a 24 hour period.

i. On a date in April 2020, the resident presented with an elevated temperature and was administered as needed acetaminophen 325 mg, two tablets, with effect.
The resident was administered an additional 650 mg of acetaminophen, for a total of 3250 mg of acetaminophen in the 24 hour time period.
ii. The following day, the resident presented with an elevated temperature and was administered as needed acetaminophen 325 mg, two tablets, with effect.
The resident was administered an additional 650 mg of acetaminophen, for a total of 3250 mg of acetaminophen in the 24 hour time period.
iii. The following day, the resident presented with an elevated temperature and was administered as needed acetaminophen 325 mg, two tablets, with effect.
The resident was administered an additional 650 mg of acetaminophen, for a total of 3250 mg of acetaminophen in the 24 hour time period.
iv. The following day, the resident presented with an elevated temperature and was administered as needed acetaminophen 325 mg, two tablets.
The resident was administered an additional 650 mg of acetaminophen, for a total of 3250 mg of acetaminophen in the 24 hour time period.
v. The following day, the resident presented with an elevated temperature at 0556 hours and again at 1949 hours and was administered as needed acetaminophen 325 mg, two tablets, on each occasion, both with effect.
The resident was administered an additional 1300 mg of acetaminophen, for a total of 3900 mg of acetaminophen in the 24 hour time period.
vi. The following day, the resident presented with an elevated temperature and was administered as needed acetaminophen 325 mg, two tablets, with effect.
The resident was administered an additional 650 mg of acetaminophen, for a total of 3250 mg of acetaminophen in the 24 hour time period.
vii. The following day, the resident presented with an elevated temperature and was administered as needed acetaminophen 325 mg, two tablets, with effect.
The resident was administered an additional 650 mg of acetaminophen, for a total of 3250 mg of acetaminophen in the 24 hour time period.

Interview with ADOC #135, following a review of the prescriber's orders and eMAR confirmed that the resident exceeded their optimal dose of acetaminophen on the identified dates, and that it was the expectation that staff followed up with the physician regarding the concern.

The medication was not given in accordance with the prescriber's directions.

The severity of this issue was a level 2 as there was minimal harm to the residents.
The scope was level 3 as it related to three out of three residents reviewed.
The home had a level 2 compliance history as they had previous non-compliance to a different subsection. (615)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 08, 2020

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 Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

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

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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 des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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

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

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

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère 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 29th day of September, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LISA VINK

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