Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 8, 2016	2016_327570_0014	008633-16	Resident Quality Inspection

Licensee/Titulaire de permis

CVH (No.6) GP Inc. as general partner of CVH (No.6) LP
c/o Southbridge Care Homes Inc. 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

Orchard Villa
1955 VALLEY FARM ROAD PICKERING ON L1V 3R6

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

SAMI JAROUR (570), AMBER LAM (541), CATHI KERR (641), DENISE BROWN (626), LYNDA BROWN (111), MARIA FRANCIS-ALLEN (552), PATRICIA MATA (571)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 5 - 8, 11 - 15, 18, 2016

The following intakes were reviewed and inspected upon concurrently during this inspection:

Follow-up Logs:

- 002604-16 - related to CO#001 - Duty to protect s. 19(1) compliance date April 30, 2016 issued under inspection # 2015_365194_0028.
- 014267-16 – related to CO #002- O.Reg.79/10, s.131(1) & (2) medications administered that were discontinued and not administering medications as ordered due date May 26, 2016 issued under inspection # 2016_360111_0009
- 014268-16 – related to CO #001- O.Reg. 79/10, s.8(1)(b) Falls Prevention and Management policy was not followed with due date June 30, 2016 issued under inspection # 2016_360111_0009

Critical incidence Logs:
- 003951-16, 012213-16, 013375-16, 014899-16, 014998-16, 016061-16, 016655-16 - specific to staff to resident alleged abuse/neglect.
- 019833-16, 019884-16, 019887-16, 019889-16, 020497-16, 020874-16, 020882-16 - specific to staff to resident alleged neglect of a resident in relation to falls and falls risk management .
- 009725-14, 014533-16 and 011764-16 - specific to a fall with injury, resulting in change in resident's condition;
- 014122-16 - specific to an injury during self-transferring.
- 013742-16 - specific to improper care.
- 019309-16 - specific to missing resident.
- 020155-16 - specific to medication error.
- 020052-16 - specific to missing money.

Complaints Logs:
- 013653-16, 016653-16, 017964-16 - specific to residents care issues.
- 013668-16 - specific to staff to resident abuse/neglect
- 018031-16 - specific to staffing issues.
- 019532-16 - specific to discharge of a resident.
-020075-16 - specific to responding to complaints and care issues.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Residents, Families, Registered Nurses (RN), Resident Care Area Managers (RCAM), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Nurse Administrative Assistant, Dietary Manager, Dietitian, Programs Manager, Housekeeping staff, Occupational Therapist (OT), Physiotherapist (PT), and Dietary Aide.

During the course of this inspection, the inspector(s) toured the home, observed

dining services, medication administration practices, infection control practices and staff to resident interactions and provision of care; reviewed clinical health records of identified residents, relevant policies, licensee's internal investigations, staff educational records, relevant program evaluations, complaints log, Residents and Family Councils minutes.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **15 WN(s)**
- **7 VPC(s)**
- **3 CO(s)**
- **1 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2015_365194_0028	571
O.Reg 79/10 s. 8. (1)	CO #001	2016_360111_0009	111

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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. (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 is based on the resident's preferences.

Related to Log #013653-16 for resident #026:

Review of clinical health records indicated the resident is cognitively intact and able to make own decisions. The resident requires no assistance with meals and has no evidence of swallowing difficulties or other ailments associated with eating.

Review of the plan of care related to eating directs the staff as followed:
- resident is to sit up on the side of the bed for all meals. Is capable of sitting on the edge of bed to eat and take medications
- staff must insist that the resident sits up
- all staff to be aware that resident will tell new staff or infrequent staff that the resident does not get up on the side of bed for meals
- PSW to report to charge nurse any refusal to sit up.

Documentation found in multidisciplinary progress notes dated indicated the following "resident sits up for meals. Knows they have to otherwise - no meal"

Review of the food and fluid flow sheet completed by staff indicated the resident did not receive the following meals during a six week period in 2016: Breakfast - six meals; lunch four meals; dinner three meals.

During an interview with the resident on July 11, 2016 at noon - found the resident lying in bed. The resident explained it is his/her preference to have meals sitting in bed with head of bed elevated but there is some staff that refuse and tell the resident to get up and go to the dining room. The resident did not identify who the staff members were. The resident explained being in bed for most of the day as it is painful to weight bear. The resident indicated PSW #122 did not bring a breakfast tray “this morning” and allegedly told the resident he/she should "have gotten up". The resident indicated on a weekly basis that he/she may miss meals 3 times for the week because a meal tray is not brought to the room. The resident indicated it was not any particular meal that was missed - could be breakfast, lunch or dinner.

During interviews on July 11 and 12, 2016 with PSWs #122, 124, 125 and RPNs #104 and 120 all indicated they have been told the resident should not be given medications or meals in bed until sitting up in bed with both feet hanging at the side of the bed. The staff members indicated they have never refused to give meals to the residents. They indicated at times the resident has become frustrated with their request to have the resident sit up in the bed and will tell them to "keep the food". The PSWs indicated if the resident misses any meals, the resident receives snacks from the nourishment cart.

During an interview with DOC on July 14, 2016 she confirmed the resident was able to make own decisions. The DOC acknowledged it is within the resident's right to make the decision surrounding positioning during meals.

Therefore the home has failed to ensure the plan of care is based on the resident's preferences. [s. 6. (2)]

2. The licensee failed to ensure the plan of care was provided to residents #002, 057, 058 and 062 as specified in the plan related to falls prevention and management.

Related to Log #019833-16 for resident #002:

A critical incident report was received by the Director on an identified date in 2016 for a fall incident involving resident #002. The CIR indicated the resident #002 sustained a fall from wheelchair near the nursing station as the resident was to have a personal alarm in place and the alarm was not activated as it was not turned on. The resident was a high risk for falls. No injury was sustained as a result of the fall.

Review of the progress note for resident #002 following the fall indicated the staff heard the resident's attachment to the wheelchair falling on the floor. The resident then reached for the bar and then slipped to the floor from the wheelchair. No injuries noted. The seat belt alarm was not reset and PSW re-educated re: important to reset the seat belt alarm. Post fall huddle done. Fall factor checklist, Scott Falls assessment and post fall investigation completed. Fall tracking sheet updated and care plan updated.

Review of the current plan of care for resident #002 indicated under safety devices/restraints that attachment to wheelchair is used when up in wheelchair as PASD for maintaining position. Interventions included resident has tendency to remove safety devices including alarming device. Ensure that alarming device is initiated when in wheelchair/bed. Under falls/balance, high risk for falls, sustained falls on eleven identified dates. Interventions include: check every hour, falls prevention interventions in place: safety devices including alarming device, resident removes safety devices and staff to ensure that all are in place and reapply if removed.

Therefore, resident #002's plan of care was not followed when sustained a fall on an identified date as alarming device was applied but not activated to alert staff.

Related to Log # 019889-16 for resident #057:

A critical incident report was received by the Director on an identified date of 2016 for an allegation of neglect that occurred on same date. The CIR indicated resident #057 is high risk for falls and was found with personal alarming device that "may not have been turned on". The resident did not sustain a fall. The CIR indicated the staff had been re-instructed to assess at beginning of shift all residents at high risk for falls to ensure personal safety device is in place and working.

Review of the current plan of care for resident #057 indicated the resident is a high risk for falls related to weakness and high Scott's falls risk assessment score. Under Safety Devices/Restraints due to attempting to self transfer. Interventions included: alarming devices in place at all times; Keep door open to ensure staff hear alarm; Staff to check

alarms every shift that they are turned on and functioning properly; resident will unclip personal alarm and self transfer to the bathroom-staff to make sure to put clip alarm at the back- away from resident's reach.

The resident was not provided care as specified in the plan related to safety devices when the alarming device was applied but not turned on to alert staff.

Related to Log #019887-16 for resident #058:

A critical incident report was received by the Director on an identified date in 2016 for an allegation of staff to resident neglect that occurred earlier on same day. The CIR indicated resident #058 is at high risk for falls and was to wear a personal alarming device. The resident was found with personal alarm device not turned on. The resident did not sustain a fall.

Review of the current plan of care for resident #058 indicated the resident was a high risk for falls related to history of falls on seven identified dates during a four months period in 2016 and Scott's fall risk screen. Under safety devices/restraints related to falls risk. Interventions included: has a floor mat down when in bed, mat should be taken up and put out of the way when up; to wear a personal alarm when in chair or bed. Staff to respond to alarm and make sure that resident #058 always gets assistance while using toilet.

On an identified date, the resident was not provided care as set out in the plan of care related to safety devices when the personal alarm device was not turned on.

Related to Log # 019884-16 for resident #062:

A critical incident report was submitted to the Director on an identified date in 2016 for an allegation of staff to resident neglect that occurred earlier same day. The CIR indicated that resident #062 sustained a fall with no injury and determined a staff member failed to ensure resident #062 personal alarming device was turned on. The resident was a high risk for falls.

Review of the current plan of care for resident #062 indicated the resident was a high risk for falls related to identified multiple diagnosis, history of falls, and Scott's fall risk screen. Interventions included alarming device and staff to ensure the device is on at all times, check that all alarms are working and activated. (111)

On an identified date, resident #062 was not provided care as set out in the plan of care related to safety devices when the personal alarming device was not turned on.

Related to Log # 020497-16 for resident #062:

Critical Incident Report was submitted to the Director on an identified date in 2016 due to an alleged neglect of resident #062 specific to the resident's personal alarm not turned on when staff saw the resident walking out from room with the alarm not ringing. The resident did not sustain a fall related to this incident.

Review of clinical records for resident #062 indicated the resident had multiple diagnoses that include cognition impairment; the resident had been identified as a high risk for falls related to history of falling and other impairments. The resident was readmitted to the home following recent hospitalization on an identified date in 2016 and since then the resident had gotten frail and weak.

On July 14, 2016 interview with PSW #144 indicated to Inspector #641 that resident #062 was at high risk for falls and that alarming devices were in place, a fall's mat on the floor, and staff were to put the bed in the lowest position when the resident was in bed.

On July 18, 2016 at 1035 hours interview with RPN #158 indicated to inspector #626 that resident #062 used a personal alarm when in bed and chair to alert staff for falls prevention.

On July 18, 2016 interview with PSW #144 indicated to inspector #626 that resident #062 had a chair alarm due to risk of falling. The PSW indicated the alarm is checked every hour.

The alarming device was not turned on as directed in the plan of care for resident #062 on an identified date when the resident was noticed by staff walking without the alarm ringing to alert staff.

The resident was not provided care as specified in the plan of care related to safety devices when resident #062's alarming device was not turned on to alert staff on two identified dates.

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

provided to the resident as specified in the plan, related to nutrition and hydration.

Related to Log #017964-16 for resident #046:

A complaint was made by the resident's substitute decision maker (SDM) on an identified date in 2016. The SDM indicated the resident is at risk of choking on liquids due to a medical condition and all liquids must be thickened. The SDM indicated on an identified date at one meal time, water without a thickening agent was offered to the resident. On an identified date, the complainant went in to visit at 1120 hours and found the resident with a glass of water without a thickening agent. The complainant took the water to the nurse and the nurse said the complainant was correct and the water should have been thickened.

The home also submitted a Critical Incident Report (CIR) to the Director on an identified date indicating that a written complaint was received by the resident's SDM about the same incident described above.

Review of the licensee's investigation concluded that the resident was offered liquids with no thickening agent.

Review of the resident's care plan and other clinical health documentation all indicated the resident was on honey thick fluids and should not be offered fluids with a straw due to swallowing concerns.

Interview with PSW #146 explained the resident required thickened fluids and was also on boost. The resident was total assistance for eating. Staff member was not aware or does not recall hearing that the resident was ever given fluids without a thickening agent. Information regarding dietary requirements can be found in the kardex, staff dining room and nourishment cart. This information was confirmed by RPN #104, #120 and PSW #126.

Therefore, resident #046’s plan of care was not followed when staff did not provide thickened fluids to the resident as identified in the plan of care. [s. 6. (7)]

4. The licensee failed to comply with LTCHA, 2007, s. 6 (7), by not ensuring the care set out in the plan of care was provided to resident #048 as specified in the plan, related to bathing and falls prevention.

Related to Log #013742-16 for resident #048:

Critical Incident Report (CIR) indicated on an identified date in 2016, personal support worker (PSW) #131 was assisting resident #048 with shower when the shower chair tipped over with the resident still in it. The resident sustained an injury to a body part.

Review of clinical records for resident #048 indicated was admitted with multiple diagnosis including cognitive impairment.

Review of clinical records and interviews on July 11 and 14, 2016 with PSWs #124,131 and 145 indicated resident #048 is totally dependent in activities of daily living.

Review of resident #048's plan of care in effect at time of the incident indicated the resident was at moderate risk for falls. The plan of care indicated the following interventions under bathing and shampooing:
- Total dependence. Full staff performance of activity during entire shift
- Two+persons physical assist d/t skin issues.
- Shower twice a week.
- Staff to take extra caution while providing showers due to skin issues.
- Staff to call BSO for support if they find resident #048 is exhibiting responsive behaviours during showers.

On July 11, 2016 interview with PSW #131 indicated that his/her understating that the resident requires two person assist with transfer from bed to the shower chair but not for the whole shower process. PSW #131 indicated that during the shower another PSW was available in the tub room assisting another resident with shower and that PSW was available to assist if needed. PSW #131 indicated the shower areas in the tub room were divided by privacy curtains.

On July 14, 2016 interview with PSW #145 indicated being aware that resident #048 needed two person assist with showers and that he/she assisted with transfer of resident to the shower chair and started shower with staff #131. PSW #145 indicated that he/she assisted in holding the shower chair as resident had a tendency to lean. PSW #145 further indicated that he/she had to leave the tub room to attend to another resident and on his/her way back he/she found that resident #048 had already fallen.

Review of progress notes for resident #048 indicated:
-on an identified date in 2016, RPN #135 documented that resident #048's substitute

decision maker (SDM) voiced some concerns regarding residents shower, as staff reported the resident can be resistive; BSO referral completed to asses resident during shower.
-on an identified date in 2016, RPN #136 documented that resident #048 was observed during shower, tolerated well. No responsive behaviours or distress noted.
-on an identified date in 2016, BSO/PSW #137 documented that resident #048 was observed during shower this morning, resident tolerated shower well. No responsive behaviors and no stiffness noted. Resident is a two person shower. BSO will update SDM with findings".

Review of MDS assessments (three most recent assessments) indicated the resident required physical help in part of bathing activity by two or more staff.

Review of the licensee's investigation notes and interview on July 14, 2016 with the DOC who explained at the time of the incident the resident's care plan indicated two person assist required for showers but was not clear to specify if the two person required for transfer or for the whole showering process. The plan of care has been updated following the incident to have two staff for the whole showering process due to poor control of a body part.

Resident #048's progress notes, MDS assessments and plan of care indicated the resident requires a minimum of two person assist for bathing/showering. Therefore, the plan of care was not followed as directed when resident #048 was assisted during a shower on an identified date in 2016 by one staff contrary to the directions in the plan of care of two or more persons. [s. 6. (7)] (570)

5. The licensee failed to comply with LTCHA, 2007, s. 6 (7), by not ensuring the care set out in the plan of care was provided to residents #051, 065 and 066 as specified in the plan, related to Falls Prevention and Management.

Related to Log #014533-16 for resident #051:

Resident #051 had a diagnosis that included cognition impairment. Resident had been identified as a high risk for falls and required an assistive device for mobility.

Review of progress notes for resident #051 during a six months period indicated the resident sustained fifteen falls. Two of the documented falls indicated that the alarm was not attached or connected as follows:

-on an identified date in 2016 the "resident was observed laying on right side on floor of residents room". "It was suspected that resident was attempting to self-transfer from wheelchair to bed". "Resident alarm was not sounding, as it was not attached". The resident denied hitting a specified body part, no injuries noted and ROM completed and all extremities were within normal limits. Resident was assisted back to chair by two staff members.
-on a later identified date in 2016, the resident was found laying on the floor outside the floor mattress; was covered with bed sheets. The resident's bed alarm was not buzzing at the time of fall as it was not connected. As per PSW, the resident had an alarm at the beginning of the shift. The resident was noted groaning in pain when an identified body part was touched. The resident was assisted to wheelchair using lift with help of 3 staff, no skin tears and bruises noted, refused PRN Tylenol when offered. Denied pain, remained awake most of the shift calling out.

The plan of care dated (in place at time of above falls) indicated the following:
- Falls and or Balance – High Risk for falls. Interventions include: ensure that call bell within reach at all times; two staff for transfers & toileting; resident may try to self transfer and may fall, staff to know the resident whereabouts at all times; Bed/chair Alarm with string in place at all times.
- Safety Devices/Restraints - Interventions include: check resident when in bed hourly and record on hourly PASD sheet; encourage resident to use side-rail for repositioning self, provide resident with call bell when in bed (q1h while in bed), Registered staff will sign PASD sheet as per policy while device is in use (right side rail when in bed), falls mat in place, bed alarm in place for safety

The bed/chair alarm was not in place as per plan of care for resident #051 for the above two documented falls.

Related to Intake # 020874-16 for resident #065:

Critical Incident Report (CIR) was submitted to the Director on an identified date in 2016 due to an alleged neglect of resident #065 when staff noted the personal alarm for the resident was not working on identified date one day prior. The resident did not sustain a fall from this incident.

Resident #065 had diagnoses that include cognition impairment with history of previous injuries. Resident had been identified as at high risk for falls.

The current plan of care indicated the following:
- Falls and or Balance – High Risk for falls; interventions include: resident #065 is sliding out of wheelchair despite repositioned frequently by staff; Non Slip Mat placed on seat to prevent slipping off seat; Staff will continue to check and reposition resident #065 to ensure the resident is properly seated; Staff to ensure that alarming device is clipped to the resident when in wheel chair or bed; Staff to check Q shift that alarm is working.
- Safety devices/restraints - related to sliding out of wheelchair, will try to get self transfer from bed or wheelchair; interventions include: Staff to ensure that alarming device is clipped to resident #065 when up in wheelchair or bed, staff to check Q shift that alarming device is working.

On July 14, 2016 interview with the DOC indicated that PSW staff on July 12, 2016 at 2100 hours reported to RN #161 that resident #065's personal alarm was not working. The RN did not follow up on that until the issue was noted by the DOC while reviewing the 24 hours report.

During an interview on July 18, 2016, the DOC indicated the resident was already up in wheelchair the next morning of the incident date when batteries were replaced. The DOC indicated that RN #161 should have checked the alarm when PSW staff reported to him/her the resident's alarm was not working.

During an interview on July 15, 2016, RPN #104 indicated to inspector #641 that resident #065 had an alarm on the wheelchair because of sliding out of the chair.

On July 18, 2016 interview with RPN #104 and PSW #107 indicated to inspector #626 that resident #065 requires an alarm while in bed or chair due to high risk for falls.

Therefore, resident #065 who is identified as high risk for falls was not provided care as specified in the plan of care related to safety devices when the resident's personal alarm was discovered not working on an identified date till the next morning.

Related to Intake #020882-16 for resident #066:

Critical Incident Report (CIR) was submitted to the Director on an identified date in 2016 due to an alleged neglect of resident #066 identified at high risk for falls when the resident's personal alarm was taken away by staff and given to a co-resident two days prior. The resident did not sustain a fall from this incident.

Review of progress notes for resident #066 during a three months period in 2016 indicated the resident sustained one fall on an identified date with a minor injury to a body part.

The current plan of care for resident #066 indicated the following:
Falls and or Balance – Interventions include: Bed/chair alarm and fall mattress put in place. Ensure both are in place and working at all times.

On July 18, 2016 interview with RPN #156 indicated to inspector #626 that resident #066 had a chair and bed alarm as the resident had been known to slide out of the wheelchair and self transfer. PSW staff check alarms if functioning when they get the resident up and when providing care.

On July 18, 2016 interview with PSW #157 indicated to inspector #626 that resident #066 had an alarm that can be attached to the bed or the chair. The alarm was used as the resident forgets and bends forward or stands up and that will result in a fall.

The plan of care was not followed as directed when staff took away resident #066's personal alarm on an identified date leaving the resident without an alarm to alert staff until the situation was discovered and rectified by the DOC two days later. (570)

6. The licensee has failed to ensure that resident #056 was reassessed and the plan of care reviewed and revised when the care set out in the plan has not been effective.

Related to Log #016061-16 for resident #056:

Critical Incident Report (CIR) was submitted to the Director on an identified date for an alleged incident of staff to resident neglect occurring one day prior. The CIR indicated that resident #056 had been left on the toilet for an extended period of time from day shift until discovered by the evening shift. When assessed by a Physician one day later after the incident, the resident was weak. In addition, the resident was unable to void. The Physician instructed that the resident be sent to the hospital for assessment.

A review of the plan of care for resident #056 indicated the resident had multiple diagnoses including cognitive impairment. Before the incident, the resident was independent with mobility. The resident's toileting plan of care indicated: the resident was able to tell staff when needed to use the toilet; call bell was to be in reach and staff were to remind the resident to call when needed help; staff to provide assistance with

personal care; the resident will go to toilet and will not ask for assistance before using the toilet; the resident will often refuse care and assistance from staff; limited assistance by one staff member.

During the course of this inspection, Inspector #571 reviewed the following records belonging to resident #056: clinical records, including progress notes, flow sheets, Physician orders and notes, copies of hospital notes, and the licensee's investigation records. In addition, several staff members were interviewed. After review of these records and interviews it was determined the following staff were present and or discovered the incident: RPNs #133, #152, PSWs #147, #148, #150, RNs #149, #151.

-PSW #150 worked day shift on the day of the incident and was assigned as resident #056's care provider.

A review of the licensee's investigation notes for their interview with PSW #150, indicated that resident #056 was in the bathroom for an "extensive period of time" and that each time PSW #150 saw the resident, the resident was in the bathroom. She did not see the resident up and about. In addition, the resident did not receive breakfast or lunch, but was served fluids in the bathroom. PSW #150 indicated he/she reported to RPN #133 later that morning that the resident was in the bathroom and was still there later that morning. He/she indicated he/she checked on resident #056 at least every two hours. PSW #150 indicated that two staff members asked the resident to get off the toilet but the resident refused with no reasons given for this refusal.

In an interview with PSW #150, she indicated that resident #056 was observed on the toilet multiple times from morning until near the end of the day shift. PSW #150 only saw the resident on the toilet except when briefly observed the resident standing in the bathroom during the mid morning. PSW #150 informed RPN #133 that the resident was on the toilet and constipated in the morning. The resident did not go for breakfast or lunch which only happens rarely according to PSW #150. At the end of day shift, PSW #150 informed RPN #133 that the resident was appeared to be confused based on interactions with the resident during the day shift.

-RPN #133 worked day shift on the date of the incident and was the Charge Nurse for the unit on day shift where resident #056 resided.

A review of the licensee's investigation notes for their interview with RPN #133, indicated RPN #133 believed that resident #056 was on and off the toilet during the day shift. RPN

#133 was informed by PSW #150 during the mid morning that the resident was on the toilet and constipated and requested that RPN #133 assess the resident. RPN #133 assessed the resident and offered prune juice which the resident refused. At mid-day, PSW #150 reported that the resident was still on the toilet. At that time, RPN #133 assisted the resident with fixing pants and informed PSW #150 that the resident was ready to come for lunch. RPN #133 did not assess the resident after missing lunch and did not assess the resident at end of day shift after PSW #150 reported that resident #056 was confused.

In an interview, RPN #133 indicated that the resident was off and on the toilet most of the day shift. In early morning, RPN #133 assessed the resident's abdomen while sitting on the toilet, it was soft and gave the resident juice. At mid-day, the RPN gave the resident pants and told the resident to come for lunch then instructed PSW #150 to help the resident. RPN #133 informed Resident Care Area Manager (RCAM) #154 that the resident was up and down to the toilet at that time and RCAM #154 stated "okay". RPN #133 asked PSW #150 about the resident at mid-afternoon and was told the resident had gone back to bed but had gotten back up to the bathroom. The resident did not have breakfast or lunch. The RPN was not concerned about the resident missing breakfast and lunch despite being diabetic as the resident has "goodies" in room. Also, the RPN was not concerned about PSW #150's report that the resident was confused as the resident is normally confused.

In a progress note documented on the date of the incident, RPN #133 documented that the "resident was noticed sitting on toilet for most of the shift straining self". In addition, the RPN indicated the resident had ice cream and three units of fluid while sitting on toilet. Also, at end of day shift, the PSW reported that "resident is confused now. Will monitor."

The report sheet that the licensee uses to communicate between shifts was reviewed for the date of the incident. Under the heading "Days" an entry was noted stating that resident #056 had been on the toilet for a "long time straining self".

- PSW #147 started work on evening shift on day of the incident and was assigned to care for resident #056.

In a written statement taken after the incident by RN #151, PSW #147 indicated that PSW #150 had told evening staff in report that resident #056 had been on the toilet for a long time. She asked the resident if wanted to get off the toilet but the resident refused.

PSW #147 informed RPN #152 before supper that it was not good for the resident to be on the toilet that long and that they had to do something about it.

In an interview, PSW #147 indicated that all evening staff was informed by PSW #150 during report that resident #056 had been on the toilet for a long time. PSW #147 checked on the resident after rounds and informed RPN #152 that he/she was concerned about resident #056 and that the resident might need to go to the hospital. PSW #147 then asked PSW #148 to try to get the resident to come to the dining room for supper. PSW #148 was unsuccessful.

- RPN #152 worked evening shift on the date of the incident and was the Charge Nurse for the unit on evening shift where resident #056 resided.

In a written statement taken after the incident by RN #151, RPN #152 indicated that PSW #150 had reported that resident #056 was on the toilet straining for a long time. The RPN did not see the resident in the dining room for supper and the first time he/she saw the resident was after the meal service. The resident was confused, unable to stand and had a pulse of 124. RPN #152 immediately requested help from RN #151 and called Charge RN #149.

In an interview, RPN #152 indicated he/she had not realized that resident #056 had been on the toilet for a long time until PSW #148 informed him/her after the meal service that the resident was "still on the toilet". He/she asked PSW #148 what he/she meant by "still on the toilet" and was informed the resident had been there for some time. RPN #152 immediately went to resident #056's room and found the resident sitting on the toilet unable to stand up and confused.

In a progress note documented, RPN #152 documented that he/she was informed by staff that the resident had been sitting on the toilet since start of evening shift. He/she did not note the resident to be in distress. The resident was alert and responsive and indicated waiting for someone to bring a watermelon; denied pain or discomfort; could move both legs; had a pulse rate of 124; had two reddened area of two body parts.

-RN #151 happened to be at the nursing station on the date of incident in his/her capacity as Infection Control nurse.

In an interview, RN #151 indicated that RPN #152 requested help with resident #056. RN #151 indicated that he/she saw resident #056 with legs straightened out and was leaning

to one side; the resident did not make sense when spoke and was unable to stand. RN #151 advised the staff to assist the resident off the toilet with the mechanical lift. When the resident was raised RN #151 observed the resident’s body part was swollen. The resident was thirsty and drank several glasses of fluid before and after being put back to bed. A review of the written statement on the date of the incident from RN #151 indicated the same information.

-RN #149 was the Charge RN for the building and responded to the unit after being called.

In an interview with RN #149 indicated that he/she was called to the unit when received resident #056 on the toilet, alert and oriented but unable to walk. When the resident was assisted to bed via mechanical lift, RN #149 noted the resident to have swelling of an identified body part. Resident #056 was also complaining of pain which is unusual for the resident. A review of the written statement on the date of the incident from RN #149 that evening indicated the same information.

In an interview on July 12, 2016, the DOC indicated that as a result of the incident, resident #056 experienced the following outcomes:

-open areas to an identified body part; unable to void, although the DOC indicated she was not sure if the resident's inability to void occurred on the date of the incident or as a result of being on the toilet for an extended period of time; before the incident the resident was very mobile and could walk to the dining room, was able to get up to bathroom unassisted; after the incident the resident couldn't walk at all or only for a step or two; resident #056 is now more dependent for ADL's; the resident still cannot walk except in room.

After review of the clinical records and interviews, despite several inconsistencies in the evidence gathered, it is evident that that the following occurred:

- resident #056 did spend a long period of time on the toilet on an identified date but was checked on by staff
- no effective intervention was provided or offered to the resident to assist with passing stool except for an offer of prune juice nor was a physician contacted
- the resident is diabetic and missed breakfast, lunch and supper; the resident did receive ice cream and drinks while sitting on the toilet
- there was no evidence to support that the resident was assessed by the either RPN

#133 or #152 for an identified period of time.
-resident was able to ambulate independently to the dining room and around the unit before the incident. After the incident, the resident was treated at the hospital for not voiding and for constipation. In addition, the resident began to use a wheelchair after the incident and was only able to take steps in room as of this inspection on July 15, 2016.

Therefore, the licensee failed to ensure that resident #056 was reassessed and the plan of care reviewed and revised when the care set out in the plan has not been effective. [s. 6. (10) (c)] (571)

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that a drug was not administered to resident #004 unless it was prescribed.

Related to resident #004:

Review of the progress notes for resident #004 indicated on an identified day, Resident was supposed to receive a specific dose of diabetic medication at a specific time of day but instead was accidently given the wrong diabetic medication by the staff member . Resident was the one who alerted the staff member by stating "that's the wrong

medication". When resident pointed out the mistake the resident had already been administered the wrong medication. Immediately writer stopped giving the medication and notified supervisor of the mistake. Supervisor notified doctor and a new medication was ordered to give right away and it was given. No other changes were made. Resident continued with regular schedule of diabetic medication. Medication Incident report filled out. There was no indication the blood sugar was monitored both after the medication incident occurred or from the next shift.

Review of the health record for resident #004 indicated the resident is diagnosed with Diabetes Mellitus. The physician orders indicated the resident had specific diabetic medications to be administered at specific times of day, *HIGH ALERT; glucose monitoring is to be done twice daily; if resident is displaying signs of symptoms of hypoglycemia overnight, please do a glucometer check and record.

Review of the medication incident indicated resident #004 had received the wrong diabetic medication at a specific time of day as ordered by agency RPN #132. The incident report indicated the SDM and physician were notified soon after the medication error was identified, the Pharmacy and DOC notified later in the day.

Review of the glucose monitoring record for resident #004 indicated on the day of the incident, the blood sugar levels were taken as per original medical order, twice daily. A medication error occurred where the resident received the wrong diabetic medication.

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

1. Related to Critical Incident Log # 020155-16 for resident #029:

A critical incident report was received by the Director on an identified day for a medication incident/adverse drug reaction involving resident #029 that occurred on a specific day in 2016.

Review of the health care record for resident #029 indicated the resident had several diagnoses.

Review of the resident medication administration record (MAR) for a specific month in 2016 indicated the following medications were to be administered:

- cardiac medication to be given twice daily
- anticoagulant medication with alternating dosages to be given once a day
- a vitamin to be given once a day
- all other medications ordered to be given once a day

Review of the home's investigation, progress notes and interview of staff /resident indicated on an identified day, resident #029 had been administered by RPN #120 both doses of the cardiac medication at the same time, received the anticoagulant medication at the wrong time of day and received Vitamin at the wrong time of day. The resident began demonstrating lowered blood pressure and elevated heart rate later the same morning and the physician ordered vital signs checked every hour , hold an identified diuretic medication for 2-3 days, hold the anticoagulant medication for that day and call MD if systolic BP is below 90 . Two days later, an identified medication was reduced. There was no indication in the CIR that anticoagulant and vitamin were also given in error.

Review of the med cart on July 11, 2016 at 12:00 hrs for resident #029 indicated the resident still had an identified diuretic medication put on hold, in strip pack unopened and had a direction change sticker in place. An identified cardiac medication for a specific administration time was not available.

Review of the MAR indicated the diuretic medication was discontinued and a new order for the diuretic medication was to be administered at a specific time.

Interview with RPN #121 indicated on July 11, 2016 she had signed the MAR at 08:00 as giving the diuretic medication but could not indicate why the medication was still in the strip pack. The RPN indicated she thought the diuretic medication had been discontinued but then indicated after reviewing the physician order that she had completed a medication error by omitting to administer the new order at the specified time as ordered. The RPN indicated no action taken regarding the cardiac medication being unavailable until after discussion with the inspector when the drug was ordered from the pharmacy.

Related to resident #052:

Interview with RPN #121 also indicated on July 11, 2016 resident #052 did not receive an identified medication for a specific time as ordered as it was not available in the strip pack and the RPN documented on the MAR as not available. The RPN indicated she had

not taken any other action related to the medication not being administered.

Review of the medication strip pack for resident #052 indicated the identified medication was available for two other administration times in the package. Review of physician order for resident #052 indicated the resident was to receive the identified medication three time daily 30 minutes pre-meals.

Review of the healthcare record for resident #052 indicated the resident was diagnosed with specified medical condition for which the medication was prescribed. (111)

2. Related to Log #018031-16

On July 13, 2016 Inspector #541 was on Pine unit at approximately 1130 hours and overheard a family member of resident #044 indicated the resident had not had breakfast as of 1000 hours and had not received the morning medication as of that time.

Inspector #541 reviewed the Medication Administration Record (MAR) for resident #044 for July 13, 2016. The resident was to receive the four identified medications at 0800 hours. All four of the medications were not administered until 1033 hours.

The MAR for resident #064 and resident #068 were also reviewed and revealed the following:

Resident #064 was scheduled to receive an identified medication at 0800 hours. The medication was not administered until 1121 hours.

Resident #068 was scheduled to receive five identified medication, including a narcotic, at 0800 hours.

Resident # 068 was administered all the five identified medications at 1113 hours. It was also noted that a narcotic medication was administered at 1113 hours for the 0800 hour scheduled administration and was then administered again at 1127 hours for the 1200 hour scheduled administration time.

The Nurse Consultant #162 indicated in an interview on August 30, 2016, that the licensee's expectation for administration of medication is that a nurse must give medication as per the Medication Administration Record within one hour before or after

medication administration time. (571)

The medication administration time for residents #029, 052, 044, 064, and 068 was outside the parameter of the one hour window before or after the prescribed time of administration as per the licensee's expectation. (570) [s. 131. (2)]

Additional Required Actions:

CO # - 002, 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".
DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure that all doors leading to non-residential areas were locked to restrict unsupervised access to those areas by residents.

Throughout the Resident Quality Inspection, unsupervised access to non-residential areas of the home was observed. The following was noted:

- a door at the back of the enclosed courtyard off of the Atrium was unlocked; this door lead to the retirement home where an unlocked door in a stairwell lead to the back of the home.

- the door from the dining room to the kitchenette on the Cedar unit was also observed propped open with no staff present on three separate occasions and was accessible to residents as the dining room door was unlocked.

Therefore, the licensee failed to lock the identified doors to restrict unsupervised access to non-residential areas by residents. [s. 9. (1) 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 by ensuring that all doors leading to non-residential areas are locked to restrict unsupervised access to those areas by residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 10. Elevators

Specifically failed to comply with the following:

s. 10. (1) Every licensee of a long-term care home shall ensure that any elevators in the home are equipped to restrict resident access to areas that are not to be accessed by residents. O. Reg. 79/10, s. 10 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the elevators were equipped to restrict access to areas that were not to be accessed by residents.

During this inspection the following issues were observed:

- the elevator between the Birch and Cedar units lead to the basement which is a non-resident area; this area did not have hand rails or a call system; within this area, Inspector #571 was able to access several storage rooms, one of which contained paint, paint thinners and solvents. In addition, the electrical/boiler room, the garbage room and three unlocked doors to the outside were accessible. Staff were not present to supervise the area.

- the elevator between the Birch and Cedar units also allowed access to the kitchenettes on the Cedar and Aspen units via the rear door of the elevator on the second and first floor; these kitchenettes contained steam tables, coffee makers, hot water machine, a house keeping closet and dish room-the steam table, coffee maker, and hot water machine were observed on in the kitchenettes. Staff were not present to supervise the area.

Therefore, the licensee failed to equip the elevator noted above to restrict access to areas that were not to be accessed by residents. [s. 10. (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 by ensuring that elevators in the home are equipped to restrict resident access to areas that are not to be accessed by residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s. 15 (2) (c), by not ensuring resident #066's wheelchair was maintained in a safe condition and in a good state of repair.

Related to Log # 020874-16 for resident #066:

Review of progress notes for resident #066 during a three months period in 2016, indicated the following:
- on a specified date and time, resident sustained a fall. The progress note indicated after the resident was transferred to the wheelchair, the chair tipped backwards. The anti-tippers on the wheelchair were loose and turned up causing the chair to flip backwards. A small red area was noted on the back of resident's head.
- on that same day, a few hours after the fall, RPN #159 documented the physiotherapist indicated the anti-tippers should lock in place, and these did not. The physiotherapist was to speak with technician in regards to ordering new anti-tippers.
- on same day, soon after the physiotherapist assessment, resident #066's manual wheelchair was seen by the Occupational Therapist (OT) #160 due to a report that the resident tipped backwards with his/her wheelchair. The wheelchair's anti-tippers did not seem to belong to the wheelchair itself; anti-tippers should also lock in place and the pair on the resident's wheelchair did not. The OT notified Motion Specialties, mobility equipment technician, to have the anti- tippers replaced with the appropriate type for client's brand of wheelchair.
- 21 days later, OT #160 received reports that resident #066 has been sliding forward in wheelchair. The resident continued to have complaints about the wheelchair: ROHO cushion was overinflated and the OT took some air out while the resident was out of the wheelchair; back support brackets were tightened by the technician from Motion Specialties; The technician also recommended for the rear wheels to be moved back

slightly to make the wheelchair more stable and less likely to tip; The OT was to follow up with the resident during next visit.

On July 18, 2016 at 1300 hours, inspector #626 noted the anti-tippers located at the back of resident #066's wheelchair were loose. The anti-tip guard on the left side was loose and turned inwards. The right anti-tip guard was loose and shorter than the right side. RPN #156 attempted to adjust the anti-tippers but was not effective. RPN #156 indicated to inspector #626 that the resident required a new wheelchair but the family refused to replace the wheelchair.

On July 18, 2016 at 1407 hours, inspector #570 observed resident #066's manual wheelchair while the resident was in bed; the wheelchair had two anti-tippers; inspector noted that both anti-tippers were loose and were not locking in place and did not prevent the wheelchair from being tipped backwards.

On July 18, 2016 interview with physiotherapist (PT) #155 in relation to resident #066's wheelchair indicated to inspector #570 that the anti-tippers did not seem to lock in place to prevent the wheelchair from tipping backwards. PT #155 indicated the anti-tippers needed to be fixed and that he would contact the vendor and would ask the OT to have a look at the wheelchair.

Record review and staff interviews failed to indicate that resident #066's wheelchair was repaired to ensure resident's safety and reduce the risk for tipping backwards when in the wheelchair. [s. 15. (2) (c)]

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 resident #066's wheelchair is maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident-staff communication and response system was available in every area accessible by residents.

During this inspection the following issues were observed:

- an enclosed courtyard accessible by residents through the Pine unit on the main floor did not contain a resident-staff communication and response system so that residents could call for help if necessary; signage posted on the door indicated that the door to this courtyard was left unlocked from 0830 to 1630 hours; this courtyard was observed unsupervised by staff.

- an enclosed courtyard accessible by residents through the Atrium on the first floor did not contain a resident-staff communication and response system so that residents could call for help if necessary; signage posted on the door indicated that the door to this courtyard is unlocked from 0830 to 2030 hours; this courtyard was observed unsupervised by staff; the first floor is accessible to residents via the main elevator or stairs in the dining room.

- an enclosed balcony on the Cedar unit had an unlocked door and it was accessible to residents; no resident-staff communication and response system was available for residents to call for help if necessary.

Therefore, the licensee failed to ensure the resident-staff communication and response system is available in two courtyards and one balcony accessible by residents. [s. 17. (1) (e)]

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 by ensuring that resident-staff communication and response system is available in every area accessible by residents including enclosed courtyards and balconies, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the policy to minimize the restraining of residents was complied with. s. 29 (1) (b)

Related to resident #020:

A review of the health records indicated that resident #020 was admitted to the home on an identified day in 2016 with diagnoses which includes Dementia. Resident #020 used a wheelchair with the capacity to tilt/recline for mobility.

On July 8, 2016, the resident was observed sitting in his/her wheelchair which was in the tilt or reclining position. A review of the resident's health record determined that there was no order or consent for the tilt wheelchair. There was also no documented information in the resident's plan of care pertaining to the use of this device as a restraint or Personal Assistive Safety Device (PASD).

During an interview on July 8, 2016, PSW #110 indicated that the tilt wheelchair was used for the resident as a PASD. Interview with RPN #109 indicated that the tilt wheelchair was not used for resident #020 as a restraint or PASD and should not be placed in the tilt or reclining position. RPN #109 also confirmed there were no physician's or nursing with extended class order, consent from the SDM and plan of care for the tilt wheelchair.

The licensee's Physical Restraint Policy, Reference #RESI-10-01-01, Version – November 2012 list of approved physical restraints, to include the front closing seatbelt, tilt feature, when engaged, on a wheelchair or geriatric chair. The home's Physical Restraint Policy also outlines that a physician's or nursing order, consent and plan of care is required for use of a restraint. [s. 29. (1) (b)]

2. Related to resident #002

A review of the health records indicated that resident #002 was admitted to the home on a specified date in 2010 with diagnoses which includes cognitive impairment.

The review of health records information indicated that resident #002 used one side rail in the up position for bed mobility and a lap tray used for maintaining position, while in the wheelchair as PASDs. The resident was observed on July 6, 2016, by inspector #641 wearing a seatbelt while up in the wheelchair.

Resident #002 was observed sitting in his/her wheelchair on July 6, 7, 8 and 11, 2016 wearing an alarm seatbelt. On July 8, 2016 the RN #114 in the presence of inspector #626 gently pulled the alarm seatbelt forward and the seatbelt did not open or unlock. Resident #002 was asked to remove the alarm seatbelt and was unable to remove the belt. In separate interviews on July 8, 2016 PSW #119 and RN #114 both confirmed that resident #002 did not have a restraint but did have bed rail and lap tray as PASDs.

Registered Nurse (RN) #114 also identified the alarm seatbelt was a PASD. On review of resident #002 health records, the alarm seatbelt was noted as a fall prevention strategy in the plan of care and not as a restraint or PASD. There was no consent from the SDM or physician order for the device.

The licensee's Physical Restraint Policy, Reference #RESI-10-01-01, Version – November 2012 list of approved physical restraints, to include the front closing seatbelt, tilt feature, when engaged, on a wheelchair or geriatric chair. The home's Physical Restraint Policy also outlines that a physician's or nursing order, consent and plan of care is required for use of a restraint.

AliMed manufacturer information provided by the Administrator on July 8, 2016 indicate the E-Z Release Seatbelt is not a restraint and is designed to be easily opened and removed by most residents.

On July 11, 2016, the DOC indicated that the alarm seatbelt will open, if the residents attempts to stand. On July 11, 2016, the resident attempted to stand with PSW #119 present and the alarm seatbelt did not loosen or unlock and prevented the resident from standing. [s. 29. (1) (b)]

3. Related to resident #012:

A review of the health records indicated that resident #012 was admitted to the home on a specified date in 2014, with diagnoses which includes Alzheimer disease.

On July 6, 2016 resident #012 was observed sitting in wheelchair with an alarm front closure seat belt which was loose and improperly applied. The resident was observed pulling on the alarm seat belt. During a second observation on July 6, 2016, inspector(s) #626 and #571 were unable to loosen or open the alarm seat belt by gently pulling it forward. On July 7 and 8, 2016, resident #012 was observed in the wheelchair which was in the tilt/reclining position and the alarm seat belt was properly applied. On July 8, 2016 RN #114 gently pulled the alarm seat belt forward and was unable to loosen or unlock the device.

On review of resident #012 health records, the alarm seat belt was noted in the plan of care as a safety and fall prevention strategy but not as a restraint or PASD. There was no consent from the SDM or physician order for the alarm seat belt. There was no physician order documented for the tilt wheelchair.

AliMed manufacturer information provided by the Administrator on July 8, 2016 indicate the E-Z Release Seat belt is not a restraint and is designed to be easily opened and removed by most residents.

In an interview on July 11, 2016 RN #114 indicated that the alarm seat belt was not considered to be restraint because the belt will open or unlock, if the resident attempts to stand. On July 11, 2016 the DOC confirmed that the alarm seat belt will open if the residents attempts to stand.

The licensee's Physical Restraint Policy, Reference #RESI-10-01-01, Version – November 2012 list of approved physical restraints, to include the front closing seat belt, tilt feature, when engaged, on a wheelchair or geriatric chair. The home's Physical Restraint Policy also outlines that a physician's or nursing order, consent and plan of care is required for use of a restraint. [s. 29. (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 the Physical Restraint Policy #RESI-10-01-01 is complied with, specifically as it relates to:
- Restraining of a resident is ordered or approved by a physician or registered nurse in the extended class;
- Restraining of a resident is consented by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent; and
- Restraining of the resident is included in the plan of care and provides for all the requirements under s.31 of the LTCHA, 2007 Act, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staffing plan:
(c) promotes continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident and
(d) includes a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8(3) of the Act, cannot come to work
(e) gets evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices

Related to Log #018031-16

An anonymous complaint was received indicating that the home was short staffed at times and as a result, resident care was affected.

On July 13, 2016 Inspector #552 was informed by staff on Pine unit that they were working short. Inspector #552 was informed they normally had six PSWs on the unit and they only had four. Staff indicated the PSWs normally had eleven residents assigned to them but they had to pick up an additional 3-4 residents each.

On July 13, 2016 Inspector #541 was on Pine unit at approximately 1130 hours and overheard a family member of resident #044 indicated the resident had not had breakfast as of 1000 hours and had not received the morning medication as of that time.

Inspector #541 reviewed the Medication Administration Record (MAR) for resident #044 for July 13, 2016. The resident was to receive the four identified medications at 0800 hours. All four of the medications were not administered until 1033 hours.

The MAR for resident #064 and resident #068 were also reviewed and revealed the following:

Resident #064 was scheduled to receive an identified medication at 0800 hours. The medication was not administered until 1121 hours.

Resident #068 was scheduled to receive five identified medication, including a narcotic, at 0800 hours.

Resident # 068 was administered all the five identified medications at 1113 hours. It was also noted that a narcotic medication was administered at 1113 hours for the 0800 hour

scheduled administration and was then administered again at 1127 hours for the 1200 hour scheduled administration time.

On July 13, 2016 at approximately 0930 hours this inspector requested the staffing plan from the home's Administrator and was provided with the master schedule document for the month of July 2016. The document represents the staffing schedule for registered and non registered staff for the month of July 2016. Inspector #541 asked for the home's staffing plan and was provided with a document titled: Quality Program Evaluation - Nursing and PSW staffing services. This document is an overview of any staffing concerns identified during the month of May 2016.

Inspector #541 reviewed regulation 31(3) with the home's administrator and asked for the home's staffing plan that contains the information as required as per O. Regulation 79/10 s. 31.

On July 13, 2016 Inspector #570 spoke with the Administrator regarding the staffing plan during which time the Administrator stated she will put something in writing for inspector. The Administrator further stated that the staff are aware of what to do when there is a shortage.

On July 14, 2016 Inspector #541 was provided with an undated document titled Nursing and Personal Support Contingency Plan as the home's staffing plan.

All three documents identified as part of the staffing plan and provided to Inspector #541 as part of the staffing plan did not provide documented evidence of the following as required under O. Regulation 79/10 s. 31(3):

- O. Reg 79/10 s. 31(3)c Promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident.

- O. Reg 79/10 s. 31(3)d include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8(3) of the Act, cannot come to work. [s. 31. (3)]

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 by ensuring the staffing plan in the home:
- promotes the continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident,
- includes a back-up plan for nursing and personal care staffing that addresses situations when staff cannot come to work, and
- gets evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The Licensee has failed to comply with O. Reg. 79/10, s. 68 (2) (a) by not ensuring policies and procedures relating to nutrition care and dietary services and hydration are implemented in consultation with a registered dietitian who is a member of the staff of the home.

Inspector #541 requested the home's weight change policy from the Food Service Manager and was provided with policy #RESI-05-02-07 titled Weight Change Program.

Page 1 of the policy, under Procedures stated that registered nursing staff:
1. Compare to previous month's weight; and any weight with a 2.5 kg difference from the previous month requires a re-weigh. Registered staff is to direct care staff to re-weigh the resident.

Resident # 008's weights were reviewed for a three months period in 2016. Resident #008 was noted to have a significant weight change of 4.3 kg between two consecutive months in 2016. The home's Registered Dietitian assessed resident #008's weight loss on a specified month and indicated that the weight done in previous month was likely an error, there was no re-weigh completed.

Resident #22's weights were reviewed for a four months period in 2016; Between two specified consecutive months in 2016 resident was noted to differ by 2.9 kg and there is no documented re-weigh completed. Between two other consecutive months in 2016, resident #022's weight was noted to differ by 6.4 kg (9.95%) and no documented re-weigh was completed. Resident #022's significant weight change was assessed by the home's Registered Dietitian.

Resident #002's weights were reviewed for four months period in 2015/2016; Between two consecutive identified months, resident #002's weights differed by 24.3 kg and no documented re-weigh was completed.

On July 11, 2016 inspector #541 interviewed the home's Registered Dietitian (RD) regarding the expectations when a resident's weight varies greatly from the previous month. The RD stated the expectation was that if the resident's weight differs by 2.5 kg or more from the previous month's weight, then a re-weigh would be completed. (541) [s. 68. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring policies and procedures relating to nutrition care and dietary services and hydration specific to Weight Change Program is complied with, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to immediately forward a written complaint that had been received concerning the care of a resident or the operation of the home to the Director.

Related to Log #019532-16 for resident #061:

A review of the health records indicated that resident #061 was admitted to the home on an identified date in 2015 with diagnoses which includes cognition impairment. The resident was discharged from the home after 16 months since admission.

In the course of inspecting complaint Log #019532-16 pertaining to resident #061, which involved concerns about the discharge of the resident from the home, an additional complaint was made by the substitute decision maker (SDM) of resident #061. The complainant indicated that a complaint letter was sent to the home by e-mail in an identified date one month prior to discharge regarding a comment made to paramedics by a PSW student.

In an interview on July 14, 2016 the DOC confirmed the complaint received by e-mail from the complainant was treated as a verbal complaint and was not immediately forwarded to the Director. [s. 22. (1)]

WN #11: 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. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure the results of every investigation for allegations of abuse and neglect involving residents and the actions taken were reported to the Director

Related to Log #012213-16 for resident #046:

Critical Incident Report (CIR) was reported to the Director on an identified date for an incident of alleged neglect. The CIR indicated that a family member found resident #046 sitting in the lounge with soiled clothing.

On July 08, 2016, during an interview, the Director of Care indicated to Inspector #571 that after the investigation, she was unable to determine that neglect had occurred and that she failed to report the results of the investigation to the Director.

Therefore, the licensee failed to report to the Director the result of the investigation into the identified incident and the actions taken in response to this same incident. [s. 23. (2)]

2. Related to Log # 003951-16 for resident #041:

Critical Incident Report (CIR) was reported to the Director on an identified date for an allegation of neglect occurring on the same day. The CIR indicated that resident #041 complained that the night shift staff did not toilet him/her after ringing the call bell.

On July 08, 2016, during an interview, the Director of Care indicated to Inspector #571 that after the investigation of the allegation of neglect, no evidence of neglect was found. The DOC confirmed that the results of the investigation was not reported to the Director.

Therefore, the licensee failed to report to the Director the result of the investigation into the identified incident and the actions taken in response to this same incident.

The above incidents occurred prior to the due date of Compliance Order (CO #001), under LTCHA, 2007, s. 19, issued during inspection #2015_365194_0028 on Jan 15, 2016 with a compliance date of April 30, 2016. The Compliance Order was found to be in compliance during this inspection, therefore no additional action is required at this time. [s. 23. (2)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director included the following description of the individuals involved in the incident:
(ii) names of any staff members or other persons who were present at or discovered the incident.

Related to Log # 019889-16 for resident #057:

A critical incident report was received by the Director on an identified date for an allegation of neglect that occurred earlier on that same day. The CIR indicated resident #057 is high risk for falls and was found with personal alarming device "may not have been turned on". The resident did not sustain a fall. The CIR indicated the staff had been re-instructed to assess at beginning of shift all residents at high risk for falls to ensure personal safety device is in place and working. The CIR did not identify the staff member involved in the incident.

Related to Log #019887-16 for resident #058:

A critical incident report (CIR) was received by the Director on an identified date for an allegation of staff to resident neglect that occurred on earlier that same day. The CIR indicated resident #058 is at high risk for falls and was to wear a personal alarming

device. The resident was found with personal alarm device not turned on. The resident did not sustain a fall.The CIR did not identify the staff member involved in the allegation.

Interview of DOC on July 13, 2016 indicated an investigation was completed regarding the incidents that occurred on an identified date with resident #057 and resident #058 and staff involved in both incidents were PSW # 138 & #139. The DOC indicated both staff received disciplinary action as result of failing to ensure alarming device was checked at beginning of each shift and activated. [s. 104. (1) 2.]

2. Related to Log # 019884-16 for resident #062:

A critical incident report (CIR) was submitted to the Director on an identified date for an allegation of staff to resident neglect that occurred on that same day. The CIR indicated that resident #062 sustained a fall with no injury and determined a staff member failed to ensure resident #062 personal alarming device was turned on. The resident was a high risk for falls. The CIR did not indicate which staff was present when the incident occurred.

On July 13, 2016 interview with the DOC and review of the licensee's investigation indicated it was improper care and not neglect and PSW #140 was present when the fall occurred and was not identified on the CIR.

Related to Intake # 020497-16 for resident #062:

Critical Incident Report (CIR) was submitted to the Director on an identified date due to an alleged neglect of resident #062 when the personal alarm for the resident was not turned on that same day.

The Critical Incident Report failed to identify all staff members that were present or discovered the incident. The DOC did not add information related to the staff identified as PSW, RPN and RN on the CIR submitted to the MOHLTC [s. 104. (1) 2.]

3. Related to Intake # 020874-16 for resident #065:

Critical Incident Report (CIR) was submitted to the Director on an identified date due to an alleged neglect of resident #065 when staff noted the personal alarm for the resident was noted not working on an identified date (one day prior to submission date) and reported the issue to the RN supervisor.

The Critical Incident Report failed to identify all staff that were present or discovered the incident. The DOC identified the RN supervisor (RN #161) but did not add information related to the staff who discovered and reported the incident to the RN #161 on the CIR submitted to the MOHLTC [s. 104. (1) 2.]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 107. (3) 4, by not ensuring that the Director was informed no later than one business day after the occurrence of an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident was taken to a hospital.

Related to Log #014533-16 for resident #051:

A critical Incident Report (CIR) was received on an identified date in 2016 for resident #051's fall sustained on an identified date in 2015.

Review of the CIR and progress notes for resident #051 indicated the resident had a confirmed diagnosis of an injury to a body part on an identified date in 2015 when the resident was transferred to hospital for assessment due to complaints of increased pain in a body part.

Therefore the Director was not notified of the incident involving resident #051until the CIR was submitted on an identified date in 2016 after over twelve months of the resident's confirmed injury. [s. 107. (3)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee has failed to ensure that appropriate actions are taken in response to medication incident involving resident #004.

Related to resident #004:

Review of the progress notes for resident #004 indicated on an identified day, Resident was supposed to receive a specific dose of diabetic medication at a specific time of day but instead was accidently given the wrong diabetic medication by the staff member. Resident was the one who alerted the staff member by stating "that's the wrong medication". When resident pointed out the mistake the resident had already been administered the wrong medication.. Immediately writer stopped giving the medication and notified supervisor of the mistake. Supervisor notified doctor and a new medication was ordered to give right away and it was given. No other changes were made. Resident continued with regular schedule of diabetic medication. Medication Incident report filled out. There was no indication the blood sugar was monitored both after the medication incident occurred or from the next shift.

Review of the health record for resident #004 indicated the resident is diagnosed with Diabetes Mellitus. The physician orders indicated the resident had specific diabetic medications to be administered at specific times of day, *HIGH ALERT; glucose monitoring is to be done twice daily; if resident is displaying signs of symptoms of hypoglycemia overnight, please do a glucometer check and record.

Review of the medication incident indicated resident #004 had received the wrong diabetic medication at a specific time of day as ordered by agency RPN #132. The incident report indicated the SDM and physician were notified soon after the medication error was identified, the Pharmacy and DOC notified later in the day.

Review of the glucose monitoring record for resident #004 indicated on the day of the incident, the blood sugar levels were taken as per original medical order, twice daily. A medication error occurred where the resident received the wrong diabetic medication with no indication the blood sugar was monitored both after the medication incident occurred or from the next shift in relation to the medication error.

Therefore, the resident was not reassessed for glucose monitoring when a medication incident occurred where the resident received the wrong insulin and the wrong dose and the medication is considered a high alert medication. (111) [s. 134. (b)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 148. Requirements on licensee before discharging a resident

Specifically failed to comply with the following:

s. 148. (2) Before discharging a resident under subsection 145 (1), the licensee shall,
(a) ensure that alternatives to discharge have been considered and, where appropriate, tried; O. Reg. 79/10, s. 148 (2).
(b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident; O. Reg. 79/10, s. 148 (2).
(c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration; and O. Reg. 79/10, s. 148 (2).
(d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident. O. Reg. 79/10, s. 148 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that before discharging a resident under subsection 145 (1) a written notice was provided to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident.

Complaint Log #019532-16 was initiated by the substitute decision maker (SDM) of resident #061 in relation to concerns about the discharge of the resident from the home.

A review of the health records indicated that resident #061 was admitted to the home on an identified date in 2015 with multiple diagnoses which includes cognition impairment. The Administrator and Director of Care determined that the home could no longer meet

the needs of the resident. Subsequently, the resident was discharged from the home on an identified date in 2016 after 16 months from admission date. The resident is now receiving care in an alternative setting.

The review of health records information indicated that resident #061 demonstrated responsive behaviours toward staff. There were no documented incidents involving residents. The resident was sent to hospital on a Form 1 on four occasions in two months period prior to discharge for responsive behaviours. Resident #061 was involved in incidents which resulted in an injury of staff. The home provided Incident Reports for three employees and one PSW student who were injured by the resident.

A review of health records revealed that the resident was provided with one-on-one supervision, Ontario Shores Centre for Mental Health Sciences services, Psychiatrist and the BSO team was involved with the resident. On July 14, 2016, the Administrator provided written notation of the meeting on early date of the month of discharge with the SDM, indicating the SDM was informed the home was unable to meet the needs of the resident and would request appropriate placement for the resident through CCAC.

During another interview on July 14, 2016, the SDM indicated to inspector #626 that the meeting held on an identified date (month of discharge), discussed the resident's behaviour, Ontario Shores and sending the resident out to hospital. Noted in the progress notes on an identified date, the DOC documented the SDM and CCAC were informed that based on resident #06's unprovoked, unpredictable responsive behaviours, the resident would be transferred to hospital and will be discharged from the home. According to documentation in the progress notes, the physician also contacted CCAC on an identified date (month of discharge) and spoke with a placement coordinator. During the conversation, the physician informed the placement coordinator that despite medical management and non-pharmacological measures, the resident's behaviour posed a risk and discussed the option of discharging the resident from the facility.

The resident was transferred to hospital on an identified date in 2016 and was discharged from the home. One day following discharge date a letter was sent to Ontario Shores outlining the resident's condition and behaviour and reason for discharge; this letter was also sent to the family. The SDM indicated the letter was sent to the resident's spouse who is not the SDM; This letter was received four or five days following discharge date.

The Administrator confirmed that a letter was sent to the resident's mailing address one

day following discharge date, indicating that the resident was discharged, after the resident was discharged from the home. [s. 148. (2)]

Issued on this 9th day of September, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SAMI JAROUR (570), AMBER LAM (541), CATHI KERR (641), DENISE BROWN (626), LYNDA BROWN (111), MARIA FRANCIS-ALLEN (552), PATRICIA MATA (571)
Inspection No. / No de l'inspection :	2016_327570_0014
Log No. / Registre no:	008633-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Sep 8, 2016
Licensee / Titulaire de permis :	CVH (No.6) GP Inc. as general partner of CVH (No.6) LP c/o Southbridge Care Homes Inc., 766 Hespeler Road, Suite 301, CAMBRIDGE, ON, N3H-5L8
LTC Home / Foyer de SLD :	Orchard Villa 1955 VALLEY FARM ROAD, PICKERING, ON, L1V-3R6
	Angela Rodrigues

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

To CVH (No.6) GP Inc. as general partner of CVH (No.6) LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a corrective action plan for the following:

- develop and implement an RN/RPN-led monitoring process for front line staff to demonstrate that all safety equipment related to falls, including alarming devices, are applied and functioning at the beginning of each shift and more frequently based on the resident's assessed needs

- develop and implement a communication and reporting protocol between PSW's, RPN's and RN's so that information regarding residents identified at moderate or high risk for falls and residents exhibiting new potentially harmful responsive behaviours or a significant change in condition, is clear, accurate and acted upon immediately, including updating of plan of care

The corrective action plan is to be submitted to Sami Jarour via email to OttawaSAO.MOH@ontario.ca by September 23, 2016.

Grounds / Motifs :

1. 1. The licensee has failed to ensure the plan of care was provided to residents #002, 057, 058 and 062 as specified in the plan related to falls prevention and management.

Related to Log #019833-16 for resident #002:

A critical incident report was received by the Director on an identified date in 2016 for a fall incident involving resident #002. The CIR indicated the resident #002 sustained a fall from wheelchair near the nursing station as the resident was to have a personal alarm in place and the alarm was not activated as it was not turned on. The resident was a high risk for falls. No injury was sustained as a

result of the fall.

Review of the progress note for resident #002 following the fall indicated the staff heard the resident's attachment to the wheelchair falling on the floor. The resident then reached for the bar and then slipped to the floor from the wheelchair. No injuries noted. The seat belt alarm was not reset and PSW re-educated re: important to reset the seat belt alarm. Post fall huddle done. Fall factor checklist, Scott Falls assessment and post fall investigation completed. Fall tracking sheet updated and care plan updated.

Review of the current plan of care for resident #002 indicated under safety devices/restraints that attachment to wheelchair is used when up in wheelchair as PASD for maintaining position. Interventions included resident has tendency to remove safety devices including alarming device. Ensure that alarming device is initiated when in wheelchair/bed. Under falls/balance, high risk for falls, sustained falls on eleven identified dates. Interventions include: check every hour, falls prevention interventions in place: safety devices including alarming device, resident removes safety devices and staff to ensure that all are in place and reapply if removed.

Therefore, resident #002's plan of care was not followed when sustained a fall on an identified date as alarming device was applied but not activated to alert staff.

Related to Log # 019889-16 for resident #057:

A critical incident report was received by the Director on an identified date of 2016 for an allegation of neglect that occurred on same date. The CIR indicated resident #057 is high risk for falls and was found with personal alarming device that "may not have been turned on". The resident did not sustain a fall. The CIR indicated the staff had been re-instructed to assess at beginning of shift all residents at high risk for falls to ensure personal safety device is in place and working.

Review of the current plan of care for resident #057 indicated the resident is a high risk for falls related to weakness and high Scott's falls risk assessment score. Under Safety Devices/Restraints due to attempting to self transfer. Interventions included: alarming devices in place at all times; Keep door open to ensure staff hear alarm; Staff to check alarms every shift that they are turned on

and functioning properly; resident will unclip personal alarm and self transfer to the bathroom-staff to make sure to put clip alarm at the back- away from resident's reach.

The resident was not provided care as specified in the plan related to safety devices when the alarming device was applied but not turned on to alert staff.

Related to Log #019887-16 for resident #058:

A critical incident report was received by the Director on an identified date in 2016 for an allegation of staff to resident neglect that occurred earlier on same day. The CIR indicated resident #058 is at high risk for falls and was to wear a personal alarming device. The resident was found with personal alarm device not turned on. The resident did not sustain a fall.

Review of the current plan of care for resident #058 indicated the resident was a high risk for falls related to history of falls on seven identified dates during a four months period in 2016 and Scott's fall risk screen. Under safety devices/restraints related to falls risk. Interventions included: has a floor mat down when in bed, mat should be taken up and put out of the way when up; to wear a personal alarm when in chair or bed. Staff to respond to alarm and make sure that resident #058 always gets assistance while using toilet.

On an identified date, the resident was not provided care as set out in the plan of care related to safety devices when the personal alarm device was not turned on.

Related to Log # 019884-16 for resident #062:

A critical incident report was submitted to the Director on an identified date in 2016 for an allegation of staff to resident neglect that occurred earlier same day. The CIR indicated that resident #062 sustained a fall with no injury and determined a staff member failed to ensure resident #062 personal alarming device was turned on. The resident was a high risk for falls.

Review of the current plan of care for resident #062 indicated the resident was a high risk for falls related to identified multiple diagnosis, history of falls, and Scott's fall risk screen. Interventions included alarming device and staff to ensure the device is on at all times, check that all alarms are working and

activated. (111)

On an identified date, resident #062 was not provided care as set out in the plan of care related to safety devices when the personal alarming device was not turned on.

Related to Log # 020497-16 for resident #062:

Critical Incident Report was submitted to the Director on an identified date in 2016 due to an alleged neglect of resident #062 specific to the resident's personal alarm not turned on when staff saw the resident walking out from room with the alarm not ringing. The resident did not sustain a fall related to this incident.

Review of clinical records for resident #062 indicated the resident had multiple diagnoses that include cognition impairment; the resident had been identified as a high risk for falls related to history of falling and other impairments. The resident was readmitted to the home following recent hospitalization on an identified date in 2016 and since then the resident had gotten frail and weak.

On July 14, 2016 interview with PSW #144 indicated to Inspector #641 that resident #062 was at high risk for falls and that alarming devices were in place, a fall's mat on the floor, and staff were to put the bed in the lowest position when the resident was in bed.

On July 18, 2016 at 1035 hours interview with RPN #158 indicated to inspector #626 that resident #062 used a personal alarm when in bed and chair to alert staff for falls prevention.

On July 18, 2016 interview with PSW #144 indicated to inspector #626 that resident #062 had a chair alarm due to risk of falling. The PSW indicated the alarm is checked every hour.

The alarming device was not turned on as directed in the plan of care for resident #062 on an identified date when the resident was noticed by staff walking without the alarm ringing to alert staff.

The resident was not provided care as specified in the plan of care related to safety devices when resident #062's alarming device was not turned on to alert

staff on two identified dates.

2. The licensee failed to comply with LTCHA, 2007, s. 6 (7), by not ensuring the care set out in the plan of care was provided to resident #048 as specified in the plan, related to bathing and falls prevention.

Related to Log #013742-16 for resident #048:

Critical Incident Report (CIR) indicated on an identified date in 2016, personal support worker (PSW) #131 was assisting resident #048 with shower when the shower chair tipped over with the resident still in it. The resident sustained an injury to a body part.

Review of clinical records for resident #048 indicated was admitted with multiple diagnosis including cognitive impairment.

Review of clinical records and interviews on July 11 and 14, 2016 with PSWs #124,131 and 145 indicated resident #048 is totally dependent in activities of daily living.

Review of resident #048's plan of care in effect at time of the incident indicated the resident was at moderate risk for falls. The plan of care indicated the following interventions under bathing and shampooing:
- Total dependence. Full staff performance of activity during entire shift
- Two+persons physical assist d/t skin issues.
- Shower twice a week.
- Staff to take extra caution while providing showers due to skin issues.
- Staff to call BSO for support if they find resident #048 is exhibiting responsive behaviours during showers.

On July 11, 2016 interview with PSW #131 indicated that his/her understating that the resident requires two person assist with transfer from bed to the shower chair but not for the whole shower process. PSW #131 indicated that during the shower another PSW was available in the tub room assisting another resident with shower and that PSW was available to assist if needed. PSW #131 indicated the shower areas in the tub room were divided by privacy curtains.

On July 14, 2016 interview with PSW #145 indicated being aware that resident #048 needed two person assist with showers and that he/she assisted with

transfer of resident to the shower chair and started shower with staff #131. PSW #145 indicated that he/she assisted in holding the shower chair as resident had a tendency to lean. PSW #145 further indicated that he/she had to leave the tub room to attend to another resident and on his/her way back he/she found that resident #048 had already fallen.

Review of progress notes for resident #048 indicated:
-on an identified date in 2016, RPN #135 documented that resident #048's substitute decision maker (SDM) voiced some concerns regarding residents shower, as staff reported the resident can be resistive; BSO referral completed to asses resident during shower.
-on an identified date in 2016, RPN #136 documented that resident #048 was observed during shower, tolerated well. No responsive behaviours or distress noted.
-on an identified date in 2016, BSO/PSW #137 documented that resident #048 was observed during shower this morning, resident tolerated shower well. No responsive behaviors and no stiffness noted. Resident is a two person shower. BSO will update SDM with findings".

Review of MDS assessments (three most recent assessments) indicated the resident required physical help in part of bathing activity by two or more staff.

Review of the licensee's investigation notes and interview on July 14, 2016 with the DOC who explained at the time of the incident the resident's care plan indicated two person assist required for showers but was not clear to specify if the two person required for transfer or for the whole showering process. The plan of care has been updated following the incident to have two staff for the whole showering process due to poor control of a body part.

Resident #048's progress notes, MDS assessments and plan of care indicated the resident requires a minimum of two person assist for bathing/showering. Therefore, the plan of care was not followed as directed when resident #048 was assisted during a shower on an identified date in 2016 by one staff contrary to the directions in the plan of care of two or more persons. [s. 6. (7)] (570)

3. The licensee failed to comply with LTCHA, 2007, s. 6 (7), by not ensuring the care set out in the plan of care was provided to residents #051, 065 and 066 as specified in the plan, related to falls prevention and management.

Related to Log #014533-16 for resident #051:

Resident #051 had a diagnosis that included cognition impairment. Resident had been identified as a high risk for falls and required an assistive device for mobility.

Review of progress notes for resident #051 during a six months period indicated the resident sustained fifteen falls. Two of the documented falls indicated that the alarm was not attached or connected as follows:
-on an identified date in 2016 the "resident was observed laying on right side on floor of residents room". "It was suspected that resident was attempting to self-transfer from wheelchair to bed". "Resident alarm was not sounding, as it was not attached". The resident denied hitting a specified body part, no injuries noted and ROM completed and all extremities were within normal limits. Resident was assisted back to chair by two staff members.
-on a later identified date in 2016, the resident was found laying on the floor outside the floor mattress; was covered with bed sheets. The resident's bed alarm was not buzzing at the time of fall as it was not connected. As per PSW, the resident had an alarm at the beginning of the shift. The resident was noted groaning in pain when an identified body part was touched. The resident was assisted to wheelchair using lift with help of 3 staff, no skin tears and bruises noted, refused PRN Tylenol when offered. Denied pain, remained awake most of the shift calling out.

The plan of care dated (in place at time of above falls) indicated the following:
- Falls and or Balance – High Risk for falls. Interventions include: ensure that call bell within reach at all times; two staff for transfers & toileting; resident may try to self transfer and may fall, staff to know the resident whereabouts at all times; Bed/chair Alarm with string in place at all times.
- Safety Devices/Restraints - Interventions include: check resident when in bed hourly and record on hourly PASD sheet; encourage resident to use side-rail for repositioning self, provide resident with call bell when in bed (q1h while in bed), Registered staff will sign PASD sheet as per policy while device is in use (right side rail when in bed), falls mat in place, bed alarm in place for safety

The bed/chair alarm was not in place as per plan of care for resident #051 for the above two documented falls.

Related to Intake # 020874-16 for resident #065:

Critical Incident Report (CIR) was submitted to the Director on an identified date in 2016 due to an alleged neglect of resident #065 when staff noted the personal alarm for the resident was not working on identified date one day prior. The resident did not sustain a fall from this incident.

Resident #065 had diagnoses that include cognition impairment with history of previous injuries. Resident had been identified as at high risk for falls.

The current plan of care indicated the following:
- Falls and or Balance – High Risk for falls; interventions include: resident #065 is sliding out of wheelchair despite repositioned frequently by staff; Non Slip Mat placed on seat to prevent slipping off seat; Staff will continue to check and reposition resident #065 to ensure the resident is properly seated; Staff to ensure that alarming device is clipped to the resident when in wheel chair or bed; Staff to check Q shift that alarm is working.
- Safety devices/restraints - related to sliding out of wheelchair, will try to get self transfer from bed or wheelchair; interventions include: Staff to ensure that alarming device is clipped to resident #065 when up in wheelchair or bed, staff to check Q shift that alarming device is working.

On July 14, 2016 interview with the DOC indicated that PSW staff on July 12, 2016 at 2100 hours reported to RN #161 that resident #065's personal alarm was not working. The RN did not follow up on that until the issue was noted by the DOC while reviewing the 24 hours report.

During an interview on July 18, 2016, the DOC indicated the resident was already up in wheelchair the next morning of the incident date when batteries were replaced. The DOC indicated that RN #161 should have checked the alarm when PSW staff reported to him/her the resident's alarm was not working.

During an interview on July 15, 2016, RPN #104 indicated to inspector #641 that resident #065 had an alarm on the wheelchair because of sliding out of the chair.

On July 18, 2016 interview with RPN #104 and PSW #107 indicated to inspector #626 that resident #065 requires an alarm while in bed or chair due to high risk for falls.

Therefore, resident #065 who is identified as high risk for falls was not provided care as specified in the plan of care related to safety devices when the resident's personal alarm was discovered not working on an identified date till the next morning.

Related to Intake #020882-16 for resident #066:

Critical Incident Report (CIR) was submitted to the Director on an identified date in 2016 due to an alleged neglect of resident #066 identified at high risk for falls when the resident's personal alarm was taken away by staff and given to a co-resident two days prior. The resident did not sustain a fall from this incident.

Review of progress notes for resident #066 during a three months period in 2016 indicated the resident sustained one fall on an identified date with a minor injury to a body part.

The current plan of care for resident #066 indicated the following:
Falls and or Balance – Interventions include: Bed/chair alarm and fall mattress put in place. Ensure both are in place and working at all times.

On July 18, 2016 interview with RPN #156 indicated to inspector #626 that resident #066 had a chair and bed alarm as the resident had been known to slide out of the wheelchair and self transfer. PSW staff check alarms if functioning when they get the resident up and when providing care.

On July 18, 2016 interview with PSW #157 indicated to inspector #626 that resident #066 had an alarm that can be attached to the bed or the chair. The alarm was used as the resident forgets and bends forward or stands up and that will result in a fall.

The plan of care was not followed as directed when staff took away resident #066's personal alarm on an identified date leaving the resident without an alarm to alert staff until the situation was discovered and rectified by the DOC two days later. (570)

4. The licensee has failed to ensure that resident #056 was reassessed and the plan of care reviewed and revised when the care set out in the plan has not been effective.

Related to Log #016061-16 for resident #056:

Critical Incident Report (CIR) was submitted to the Director on an identified date for an alleged incident of staff to resident neglect occurring one day prior. The CIR indicated that resident #056 had been left on the toilet for an extended period of time from day shift until discovered by the evening shift. When assessed by a Physician one day later after the incident, the resident was weak. In addition, the resident was unable to void. The Physician instructed that the resident be sent to the hospital for assessment.

A review of the plan of care for resident #056 indicated the resident had multiple diagnoses including cognitive impairment. Before the incident, the resident was independent with mobility. The resident's toileting plan of care indicated: the resident was able to tell staff when needed to use the toilet; call bell was to be in reach and staff were to remind the resident to call when needed help; staff to provide assistance with personal care; the resident will go to toilet and will not ask for assistance before using the toilet; the resident will often refuse care and assistance from staff; limited assistance by one staff member.

During the course of this inspection, Inspector #571 reviewed the following records belonging to resident #056: clinical records, including progress notes, flow sheets, Physician orders and notes, copies of hospital notes, and the licensee's investigation records. In addition, several staff members were interviewed. After review of these records and interviews it was determined the following staff were present and or discovered the incident: RPNs #133, #152, PSWs #147, #148, #150, RNs #149, #151.

-PSW #150 worked day shift on the day of the incident and was assigned as resident #056's care provider.

A review of the licensee's investigation notes for their interview with PSW #150, indicated that resident #056 was in the bathroom for an "extensive period of time" and that each time PSW #150 saw the resident, the resident was in the bathroom. She did not see the resident up and about. In addition, the resident did not receive breakfast or lunch, but was served fluids in the bathroom. PSW #150 indicated he/she reported to RPN #133 later that morning that the resident was in the bathroom and was still there later that morning. He/she indicated he/she checked on resident #056 at least every two hours. PSW #150 indicated that two staff members asked the resident to get off the toilet but the resident

refused with no reasons given for this refusal.

In an interview with PSW #150, she indicated that resident #056 was observed on the toilet multiple times from morning until near the end of the day shift. PSW #150 only saw the resident on the toilet except when briefly observed the resident standing in the bathroom during the mid morning. PSW #150 informed RPN #133 that the resident was on the toilet and constipated in the morning. The resident did not go for breakfast or lunch which only happens rarely according to PSW #150. At the end of day shift, PSW #150 informed RPN #133 that the resident was appeared to be confused based on interactions with the resident during the day shift.

-RPN #133 worked day shift on the date of the incident and was the Charge Nurse for the unit on day shift where resident #056 resided.

A review of the licensee's investigation notes for their interview with RPN #133, indicated RPN #133 believed that resident #056 was on and off the toilet during the day shift. RPN #133 was informed by PSW #150 during the mid morning that the resident was on the toilet and constipated and requested that RPN #133 assess the resident. RPN #133 assessed the resident and offered prune juice which the resident refused. At mid-day, PSW #150 reported that the resident was still on the toilet. At that time, RPN #133 assisted the resident with fixing pants and informed PSW #150 that the resident was ready to come for lunch. RPN #133 did not assess the resident after missing lunch and did not assess the resident at end of day shift after PSW #150 reported that resident #056 was confused.

In an interview, RPN #133 indicated that the resident was off and on the toilet most of the day shift. In early morning, RPN #133 assessed the resident's abdomen while sitting on the toilet, it was soft and gave the resident juice. At mid-day, the RPN gave the resident pants and told the resident to come for lunch then instructed PSW #150 to help the resident. RPN #133 informed Resident Care Area Manager (RCAM) #154 that the resident was up and down to the toilet at that time and RCAM #154 stated "okay". RPN #133 asked PSW #150 about the resident at mid-afternoon and was told the resident had gone back to bed but had gotten back up to the bathroom. The resident did not have breakfast or lunch. The RPN was not concerned about the resident missing breakfast and lunch despite being diabetic as the resident has "goodies" in room. Also, the RPN was not concerned about PSW #150's report that the

resident was confused as the resident is normally confused.

In a progress note documented on the date of the incident, RPN #133 documented that the "resident was noticed sitting on toilet for most of the shift straining self". In addition, the RPN indicated the resident had ice cream and three units of fluid while sitting on toilet. Also, at end of day shift, the PSW reported that "resident is confused now. Will monitor."

The report sheet that the licensee uses to communicate between shifts was reviewed for the date of the incident. Under the heading "Days" an entry was noted stating that resident #056 had been on the toilet for a "long time straining self".

- PSW #147 started work on evening shift on day of the incident and was assigned to care for resident #056.

In a written statement taken after the incident by RN #151, PSW #147 indicated that PSW #150 had told evening staff in report that resident #056 had been on the toilet for a long time. She asked the resident if wanted to get off the toilet but the resident refused. PSW #147 informed RPN #152 before supper that it was not good for the resident to be on the toilet that long and that they had to do something about it.

In an interview, PSW #147 indicated that all evening staff was informed by PSW #150 during report that resident #056 had been on the toilet for a long time. PSW #147 checked on the resident after rounds and informed RPN #152 that he/she was concerned about resident #056 and that the resident might need to go to the hospital. PSW #147 then asked PSW #148 to try to get the resident to come to the dining room for supper. PSW #148 was unsuccessful.

- RPN #152 worked evening shift on the date of the incident and was the Charge Nurse for the unit on evening shift where resident #056 resided.

In a written statement taken after the incident by RN #151, RPN #152 indicated that PSW #150 had reported that resident #056 was on the toilet straining for a long time. The RPN did not see the resident in the dining room for supper and the first time he/she saw the resident was after the meal service. The resident was confused, unable to stand and had a pulse of 124. RPN #152 immediately requested help from RN #151 and called Charge RN #149.

In an interview, RPN #152 indicated he/she had not realized that resident #056 had been on the toilet for a long time until PSW #148 informed him/her after the meal service that the resident was "still on the toilet". He/she asked PSW #148 what he/she meant by "still on the toilet" and was informed the resident had been there for some time. RPN #152 immediately went to resident #056's room and found the resident sitting on the toilet unable to stand up and confused.

In a progress note documented, RPN #152 documented that he/she was informed by staff that the resident had been sitting on the toilet since start of evening shift. He/she did not note the resident to be in distress. The resident was alert and responsive and indicated waiting for someone to bring a watermelon; denied pain or discomfort; could move both legs; had a pulse rate of 124; had two reddened areas of two body parts.

-RN #151 happened to be at the nursing station on the date of incident in his/her capacity as Infection Control nurse.

In an interview, RN #151 indicated that RPN #152 requested help with resident #056. RN #151 indicated that he/she saw resident #056 with legs straightened out and was leaning to one side; the resident did not make sense when spoke and was unable to stand. RN #151 advised the staff to assist the resident off the toilet with the mechanical lift. When the resident was raised RN #151 observed the resident's body part was swollen. The resident was thirsty and drank several glasses of fluid before and after being put back to bed. A review of the written statement on the date of the incident from RN #151 indicated the same information.

-RN #149 was the Charge RN for the building and responded to the unit after being called.

In an interview with RN #149 indicated that he/she was called to the unit when received resident #056 on the toilet, alert and oriented but unable to walk. When the resident was assisted to bed via mechanical lift, RN #149 noted the resident to have swelling of an identified body part. Resident #056 was also complaining of pain which is unusual for the resident. A review of the written statement on the date of the incident from RN #149 that evening indicated the same information.

In an interview on July 12, 2016, the DOC indicated that as a result of the

incident, resident #056 experienced the following outcomes:

-open areas to an identified body part; unable to void, although the DOC indicated she was not sure if the resident's inability to void occurred on the date of the incident or as a result of being on the toilet for an extended period of time; before the incident the resident was very mobile and could walk to the dining room, was able to get up to bathroom unassisted; after the incident the resident couldn't walk at all or only for a step or two; resident #056 is now more dependent for ADL's; the resident still cannot walk except in room.

After review of the clinical records and interviews, despite several inconsistencies in the evidence gathered, it is evident that that the following occurred:

- resident #056 did spend a long period of time on the toilet on an identified date but was checked on by staff
- no effective intervention was provided or offered to the resident to assist with passing stool except for an offer of prune juice nor was a physician contacted
- the resident is diabetic and missed breakfast, lunch and supper; the resident did receive ice cream and drinks while sitting on the toilet
- there was no evidence to support that the resident was assessed by the either RPN #133 or #152 for an identified period of time.
-resident was able to ambulate independently to the dining room and around the unit before the incident. After the incident, the resident was treated at the hospital for not voiding and for constipation. In addition, the resident began to use a wheelchair after the incident and was only able to take steps in room as of this inspection on July 15, 2016.

Therefore, the licensee failed to ensure that resident #056 was reassessed and the plan of care reviewed and revised when the care set out in the plan has not been effective. [s. 6. (10) (c)] (571)

An order is issued due to the severity, scope and history of the non-compliance found in relation to plan of care. Non-compliance with plan of care was identified involving multiple residents. Due to this non-compliance, there was a potential risk of harm to residents when their care and safety needs are not met. In addition, resident #056 was actually harmed when the plan of care was not revised when ineffective and resident #048 was actually harmed when the care plan was not followed as directed. In addition, a review of the compliance history

of the licensee indicated the following ongoing non-compliance related to plan of care: June 23, 2015, Inspection # 2015_360111_0014 compliance order issued under s. 6. (10); July 30, 2015, Inspection # 2015_293554_0009 compliance order issued under s. 6 (2); January 15, 2016, Inspection #2015_365194_0028 compliance order issued under s. 6 (2). (570)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2016

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2016_360111_0009, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

The licensee shall:

- immediately upon being served with this Compliance Order conduct a 15 day audit of current electronic medication administration records (eMar) for all residents receiving a specified diabetic medication including resident #004 to assess accuracy in diabetic medication administration.

- develop and implement a monitoring process to ensure all residents receiving a specified diabetic medication including resident #004 are receiving the right diabetic medication at the right dose, using the right route at the specified time as prescribed specifically when the medication is administered to residents by registered nursing staff specifically by new registered nursing staff or an agency or casual registered nursing staff.

Grounds / Motifs :

1. The licensee failed to ensure that a drug was not administered to resident #004 unless it was prescribed.

Related to resident #004:

Review of the progress notes for resident #004 indicated on an identified day, Resident was supposed to receive a specific dose of diabetic medication at a specific time of day but instead was accidently given the wrong diabetic medication by the staff member . Resident was the one who alerted the staff member by stating "that's the wrong medication". When resident point out the

mistake the resident had already been administered the wrong medication. Immediately writer stopped giving the medication and notified supervisor of the mistake. Supervisor notified doctor and a new medication was ordered to give right away and it was given. No other changes were made. Resident continued with regular schedule of diabetic medication. Medication Incident report filled out. There was no indication the blood sugar was monitored both after the medication incident occurred or from the next shift.

Review of the health record for resident #004 indicated the resident is diagnosed with Diabetes Mellitus. The physician orders indicated the resident had specific diabetic medications to be administered at specific times of day, *HIGH ALERT; glucose monitoring is to be done twice daily; if resident is displaying signs of symptoms of hypoglycemia overnight, please do a glucometer check and record.

Review of the medication incident indicated resident #004 had received the wrong diabetic medication at a specific time of day as ordered by agency RPN #132. The incident report indicated the SDM and physician were notified soon after the medication error was identified, the Pharmacy and DOC notified later in the day.

Review of the glucose monitoring record for resident #004 indicated on the day of the incident, the blood sugar levels were taken as per original medical order, twice daily. A medication error occurred where the resident received the wrong diabetic medication. (111)

The decision to re-issue an order is based on resident #004 receiving the wrong insulin and the wrong dose putting the resident at risk of harm specifically when there was no indication the resident's blood sugar was monitored both after the medication error occurred or from the next shift. This history of repeated non-compliance, along with the scope and risks associated with the noted medication administration practices in the home were considered when the decision to re-issue this CO was made. (570)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2016

Order # / Ordre no : 003

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 shall:

- immediately upon being served with this Compliance Order and for 15 consecutive days after that date, conduct a daily audit of at least 10 percent of the electronic medication records (eMar) currently in use in each of the six Resident Home Areas (RHA) to assess accuracy;

- ensure that the eMar audit process includes a visual verification of all key elements of the medication administration process, including but not limited to ensuring that the right resident is receiving the right medication, at the right dose, using the right route at the specified time;

- take effective corrective actions when registered nursing staff are not administering medication in line with legislative requirements, established practice standards, policies or procedures; and

- review the current medication administration routines to ensure appropriate support systems are in place when employing new or casual nurses or when the usual RN/RPN deployment pattern is altered.

Grounds / Motifs :

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

1. Related to Critical Incident Log # 020155-16 for resident #029:

A critical incident report was received by the Director on an identified day for a

medication incident/adverse drug reaction involving resident #029 that occurred on a specific day in 2016.

Review of the health care record for resident #029 indicated the resident had several diagnoses.

Review of the resident medication administration record (MAR) for a specific month in 2016 indicated the following medications were to be administered:
- cardiac medication to be given twice daily
- anticoagulant medication with alternating dosages to be given once a day
- a vitamin to be given once a day
- all other medications ordered to be given once a day

Review of the home's investigation, progress notes and interview of staff /resident indicated on an identified day, resident #029 had been administered by RPN #120 both doses of the cardiac medication at the same time, received the anticoagulant medication at the wrong time of day and received Vitamin at the wrong time of day. The resident began demonstrating lowered blood pressure and elevated heart rate later the same morning and the physician ordered vital signs checked every hour , hold an identified diuretic medication for 2-3 days, hold the anticoagulant medication for that day and call MD if systolic BP is below 90 . Two days later, an identified medication was reduced. There was no indication in the CIR that anticoagulant and vitamin were also given in error.

Review of the med cart on July 11, 2016 at 12:00 hrs for resident #029 indicated the resident still had an identified diuretic medication put on hold, in strip pack unopened and had a direction change sticker in place. An identified cardiac medication for a specific administration time was not available.

Review of the MAR indicated the diuretic medication was discontinued and a new order for the diuretic medication was to be administered at a specific time.

Interview with RPN #121 indicated on July 11, 2016 she had signed the MAR at 08:00 as giving the diuretic medication but could not indicate why the medication was still in the strip pack. The RPN indicated she thought the diuretic medication had been discontinued but then indicated after reviewing the physician order that she had completed a medication error by omitting to administer the new order at the specified time as ordered. The RPN indicated no action taken regarding the

cardiac medication being unavailable until after discussion with the inspector when the drug was ordered from the pharmacy.

Related to resident #052:

Interview with RPN #121 also indicated on July 11, 2016 resident #052 did not receive an identified medication for a specific time as ordered as it was not available in the strip pack and the RPN documented on the MAR as not available. The RPN indicated she had not taken any other action related to the medication not being administered.

Review of the medication strip pack for resident #052 indicated the identified medication was available for two other administration times in the package. Review of physician order for resident #052 indicated the resident was to receive the identified medication three time daily 30 minutes pre-meals.

Review of the healthcare record for resident #052 indicated the resident was diagnosed with GERD. (111)

2. Related to Log #018031-16

On July 13, 2016 Inspector #541 was on Pine unit at approximately 1130 hours and overheard a family member of resident #044 indicated the resident had not had breakfast as of 1000 hours and had not received the morning medication as of that time.

Inspector #541 reviewed the Medication Administration Record (MAR) for resident #044 for July 13, 2016. The resident was to receive the four identified medications at 0800 hours. All four of the medications were not administered until 1033 hours.

The MAR for resident #064 and resident #068 were also reviewed and revealed the following:

Resident #064 was scheduled to receive an identified medication at 0800 hours. The medication was not administered until 1121 hours.

Resident #068 was scheduled to receive five identified medication, including a

narcotic, at 0800 hours.

Resident # 068 was administered all the five identified medications at 1113 hours. It was also noted that a narcotic medication was administered at 1113 hours for the 0800 hour scheduled administration and was then administered again at 1127 hours for the 1200 hour scheduled administration time.

The Nurse Consultant #162 indicated in an interview on August 30, 2016, that the licensee's expectation for administration of medication is that a nurse must give medication as per the Medication Administration Record within one hour before or after medication administration time. (571)

The medication administration time for residents #029, 052, 044, 064, and 068 was outside the parameter of the one hour window before or after the prescribed time of administration as per the licensee's expectation. (570)

This order is issued under s.131(2) because the licensee was previously ordered to develop and implement a monitoring process to ensure that all medications are administered to all residents in accordance with the direction for use, and as specified by the prescriber during inspection #2015_365194_0028 with a compliance date of February 29, 2016 and then re-issued during inspection #2016_360111_0009 with a compliance date of May 26, 2016. This history of repeated non-compliance, along with the scope and risks associated with the noted medication administration practices in the home were considered when the decision to issue this CO was made. (570)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 8th day of September, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Sami Jarour

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