Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 26, 2019	2018_414110_0012	013990-18	Resident Quality Inspection

Licensee/Titulaire de permis

AXR Operating (National) LP, by its general partners
c/o Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

Elginwood
182 Yorkland Street RICHMOND HILL ON L4S 2M9

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

DIANE BROWN (110), JENNIFER BATTEN (672), JOVAIRIA AWAN (648)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 4, 5, 6, 9, 10, 11,12, 13,16, 7, 18,19, 20, 23, 24, 25, 26, 27, 30, 31. August 1, 2, 3, 2018.

The following logs were inspected related to Infection Prevention and Control
Log #007389-18 related to a CI.
Log #008584-18 related to a CI

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Interim Director of Care (IDOC), Recreation Manager (RM), Food Services Manager (FSM), Dietary Aide (DA), Scheduling Clerk, Residents Services Coordinator (RSC), RAI- Coordinator, Environmental Services Manager (ESM), Housekeeper, Registered Nurses (RN), Registered Practical Nurses (RPN), Nurse Practitioner (NP), Staff Educator, Personal Support Workers (PSW), Recreation Aide (RA), Laundry Aide (LA) family members, Residents' Council President and residents.

During the course of the inspection, the inspectors conducted a tour of the home including resident home areas. Observations also included medication administration, meal service, resident and staff interactions. The inspection also included a review of clinical health records, relevant home policies and procedures, education records and other pertinent documents.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **24 WN(s)**
- **8 VPC(s)**
- **6 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

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

Specifically failed to comply with the following:

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

s. 6. (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).

Findings/Faits saillants :

1. The licensee failed to ensure the written plan of care sets out clear directions to staff and others who provide direct care to the resident.

Resident #003 was identified in stage one of the Resident Quality Inspection (RQI) for impaired skin integrity.

Resident #003's Minimum Data Set Assessment (MDS), identified the resident was admitted with multiple areas of altered skin integrity.

A review of resident #003's written plan of care identified an altered skin integrity risk score, and identified areas of altered skin integrity. Interventions to manage the resident's skin concerns included intervention A. Additional information such as frequency or when to provide intervention A was not identified in the review of the written plan of care. A review of resident #003's treatment observation record identified the most recent skin assessment for the two areas of altered skin integrity with an identified intervention not clearly described as intervention A, as identified in the written plan of care.

A review of resident #003's progress notes identified the resident with two areas of altered skin integrity. The assessment noted the areas of altered skin integrity were treatable if treatment and other preventative strategies were adhered to. The plan indicated that intervention A was to be implemented at a specific time.

A review of resident #003's physicians orders identified the resident was to have an

intervention B in place every day at a specific time.
Observations conducted during the course of this inspection identified the following:
Observation 1 on an identified date resident #003 was observed without intervention A or B in place.
Observation 2 on a separate date resident #003 was observed with intervention B in place and while intervention A should have been in place.

An interview with PSW #119 and #120 identified awareness of intervention A but was incorrect in the timing of when the intervention was to be applied.

An interview with RPN #107 identified resident #003 was at high risk of altered skin integrity. RPN #107 indicated resident #003 was to have intervention A and B in place at all times. A further review of the resident's written plan of care with RPN #107 confirmed there were no directions as to when intervention A would be applied to the resident. RPN #107 stated the written plan of care was unclear and acknowledged it did not provide front line staff with clear direction.

The above noted information was reviewed with the interim DOC. The DOC acknowledged the information in the plan of care for resident #003 related to how and when to implement interventions A and B were unclear. The DOC acknowledged resident #003's written plan of care did not set out clear directions to staff who provide direct care to the resident. [s. 6. (1) (c)]

2. Resident #009 was identified in stage one of the RQI for weight loss.

Observations conducted during the inspection identified resident #009 being served 125ml of a nutritional intervention, identified as intervention A on an identified date and meal.

Resident #009's MDS assessment for a significant change dated a month prior, identified that the resident sustained a significant weight loss. The MDS assessment identified nutrition interventions which included 250ml of intervention A three times a day at meals. A review of resident #009's weight history identified a significant weight loss over a period of 30 days. A review of resident #009's diet order at the dining room servery in the diet roster list stated the following:
Add an identified amount of intervention B to 250ml of identified fluid for a specialized drink at all meals.
Breakfast- serve 250mls of a specialized drink.

Lunch and Dinner – serve 125mls of a specialized drink.

Review of a progress note documented by the home's Registered Dietitian (RD) as a Nutrition Reassessment which stated that resident #009 was to receive 250ml of a specialized drink three times a day at meals.

A review of resident #009 written plan of care, identified resident #009 to be at high nutrition risk related to significant weight loss, stating they were to receive 250ml of a specialized drink three times a day at meals.

An interview with PSW #150 identified resident #009 was to receive a specialized drink at meals. Review of resident #009's care plan and diet roster with PSW #150 revealed they were unclear as to which intervention resident #009 was to received based on the conflicting information in the records reviewed.

An interview with PSW #122 revealed PSW staff were directed to use the diet roster in the dining room for a resident's dietary interventions including a specialized drink. PSW #122 reported resident #009 regularly received no more than 125ml of a specialized drink at each meal. Review of the diet roster, for resident #009 with PSW #122 revealed they were unaware why resident #009 was receiving 125ml and not 250mls of the specialized drink based on the information in the diet roster as noted above.

The PSWs interviewed identified that dietary staff would prepare individualized interventions such as specific volumes of specialized drinks for residents requiring the intervention and PSW staff would then provide it to the resident.

Resident #009's diet order was reviewed with DA #130 during a staff interview. DA #130 confirmed they were to prepare individualized interventions such as specialized drinks for residents and provide them to PSW staff during the meal service for designated residents. DA #130 revealed resident #009 was to receive 125ml of the specialized drink lunch and dinner and 250ml at breakfast. DA #130 stated the information in the diet order provided confusing direction to staff providing care.

Resident #009's written plan of care including their diet order as noted above, staff reports, and observation during the lunch meal were reviewed with the home's Registered Dietitian (RD) and interim DOC. The RD confirmed resident was assessed to receive 250ml of the specialized drink due to historical weight loss and a decline in intake. The RD identified resident #009 at high nutrition risk. The RD confirmed resident

#009's written plan of care indicated conflicting information related to the volume of specialized drink A to be offered to the resident, and did not provide clear direction to staff.

An interview with the DOC confirmed resident #009's written plan of care failed to set out clear directions to staff and others who provide direct care related to the provision of organized nutrition interventions as per their assessed need. [s. 6. (1) (c)]

3. During stage one of the RQI, resident #014 was observed on two identified occasions to be sitting with a restraining device in place, identified as intervention A which could not be removed by the resident upon request. Resident #014 triggered through to stage two of the RQI process, related to minimizing of restraining, as a result of the observations made during stage one.

During the record review for resident #014, Inspector #672 reviewed the most recent written plan of care, and the kardex in the Point of Care (POC) system. Both the written plan of care and the kardex indicated that resident #014 was supposed to have a three fall prevention interventions in place, intervention B, C and D but not intervention A. The written plan of care also indicated that the device on resident #014's mobility aide was a PASD and could be removed by the resident upon request.

Inspector #672 observed resident #014 daily while in the home conducting the RQI inspection, but did not observe resident #014 to have two of the required fall prevention interventions, B and D in place.

During an interview resident #014's SDM indicated belief the restraining device, intervention A, had been in place for some time and for the purpose of restraining the resident in an attempt to prevent resident #014 from rising independently, and falling and that the resident could not removed the device upon request.

During an interview , PSW #135 indicated that resident #014 did not use intervention C according to the plan of care and was unaware that this direction was listed within resident #014's plan of care.

During separate interviews, RPN #132, the RAI Coordinator, and the interim DOC indicated that the expectation in the home was that the plan of care should be immediately reviewed and updated to reflect when a resident's needs or preferences

became known or changed; when current interventions were no longer effective, or when new interventions were initiated.

The licensee failed to ensure that resident #014's plan of care set out clear directions to staff and others who provided direct care to the resident, as resident #014 no longer required interventions B, C and D. [s. 6. (1) (c)]

4. 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.

This IP was triggered in stage one of the RQI related to concerns of insufficient staffing.

Resident #027 was identified as residing on an identified home area, described as Home Area A. A record review of the resident's written plan of care identified that the resident ate in the Home Area A dining room and required an identified level of assistance to transfer safely from bed to wheelchair.

A record review of the staffing schedules included a review of an identified 25 day period with scheduling clerk #142. The review identified that Home Area A was one PSW short with no replacement five out of the 25 days reviewed.

An interview with resident #027 revealed that on one of the five days staff informed them that the home area was short staffed and they were unable to get them up for a meal in the dining room. The resident stated they felt awful when told they were unable to go to the dining room. The resident further stated they were ready to be assisted by staff and did not want to have a meal while in bed.

An interview with PSW #143 who worked on the same identified day confirmed the unit was short staffed and unable to get resident #027 to the dining room for a meal. An interview with RPN #126 further confirmed that the unit was short staffed and they were unable to get four residents up for a meal in the dining room including resident #027.

An interview with interim DOC confirmed that the care set out in the written plan of care was not provided to resident #027 when they were unable to go to the dining room for a meal. [s. 6. (7)]

5. This IP was triggered in stage one of the RQI related to concerns of insufficient

staffing.

Resident #028 was identified as residing on Home Area B. A record review of the resident's written plan of care identified the resident ate in the Home Area B dining room for two identified meal and required an identified level of assistance to transfer the resident safely from bed to chair.

A telephone interview with the resident's SDM revealed that they had arrived at the home to visit resident #028 on an identified date and time to find the resident had not been up for meals. The SDM stated the resident should be going to the dining room for identified meals.

A record review of the staffing schedules included a review of an identified 25 day period with scheduling clerk #142. The review identified Home Area B was short one PSW with no shift replacement six days out of the 25 day period reviewed including the identified day the resident's SDM arrived to visit and found the resident having not been up for meals.

A record review of a progress note on the same identified day by RPN #138 stated that resident #028 was in bed throughout the shift.

An interview with RPN #138 revealed that on day shift on the same identified date Home Area B was short both a RPN and a PSW and that they had been called in and arrived to the home area around noon. The interview further revealed that when they arrived on Home Area B a PSW informed them that they were short staffed and unable to get resident #028 up for a meal but that a meal tray was provided to the resident.

An interview with PSW #129 who worked days on the identified date confirmed Home Area B was short one PSW. The PSW revealed that resident #028 did not get up for the identified meal as usual and that they had not asked the resident if they would like to get up for the meal stating they knew they were short and with only two PSWs on the home area and they would be unable to transfer the resident from bed to chair.

An interview with PSW #141 who also worked days on the identified date, confirmed that the home area was short one PSW and that resident #028 was not up for their meal related to the home area working short.

An interview with the interim DOC #106 confirmed that staffing shortage on the identified

date and acknowledged that the resident's written plan of care was not followed in terms of getting the resident up for a meal in the dining room. [s. 6. (7)]

6. Resident #010 triggered through to stage II of the RQI process related to observations made during stage I of the RQI, related to restraints.

Inspector #672 reviewed resident #010's current written plan of care, which indicated that resident #010 was at high nutritional risk, related to their safety in eating. The written plan of care also identified interventions to minimize the safety risk at meals and included staff supervision, cueing and physical assistance.

On an identified date and time resident #010 was observed in an unsafe feeding position, with no supervision. Inspector informed RPN #107, then PSW #115 and assigned PSW #116 attended to resident #010's by providing resident #010 with positioning assistance, then leaving resident #010 unsupervised to eat their meal.

During an interview RPN #107 indicated that resident #010 required supervision and staff support during meals, and should not have been left alone, while a meal had been served.

During an interview with PSW #116 indicated they were the primary PSW responsible for resident #010's care during the day shift, and had served resident #010. PSW #116 further indicated being aware that resident #010 required supervision and assistance with meals, but had not had the opportunity to return to resident #010's to provide assistance or support.

During an interview the interim DOC indicated that the expectation in the home was that each resident's plan of care be followed at all times, and that if a resident's plan of care indicated that the resident required supervision and assistance with meals, they should not be left to eat unsupervised at any time.

The licensee failed to ensure that resident #010 received care as specified in the plan, specific to meals. [s. 6. (7)]

7. Resident #003 was identified in stage one of the RQI for a compromised nutrition status and impaired skin integrity.

Resident #003's Minimum Data Set Assessment of an identified date, revealed the resident had multiple areas of altered skin integrity. The assessment also identified resident #003 had ongoing poor oral food and fluid intake.

A review of resident #003's plan of care identified they were at high nutrition risk as evidenced by the altered areas of skin integrity and significant weight loss over a period of one month. Nutrition interventions in resident #003's plan of care were to provide the identified nutrition intervention A and B three times a day at meals.

Resident #003 was observed during a meal service on an identified date. RPN #107 was observed to provide resident #003 assistance with the offering of fluids . The inspector did not observe intervention A, fluid being offered.

An interview with RPN #107 identified resident #003 to be at high nutrition risk. RPN #107 confirmed resident #003 was offered intervention B but not intervention A revealing they were unaware of the required intervention A three times a day at meals, and acknowledged resident #003 did not receive care as specified in the plan related to the provision of their organized nutrition interventions.

An interview with DA #123 and a review of the resident's diet order in the servery diet list failed to identify intervention A. DA#123 indicated they were unaware of this intervention for resident #003, and confirmed resident #003 did not receive intervention A at the identified observed meal.

An interview with the RD and a review of resident #003's plan of care identified they were to receive interventions A and B to support weight gain and high risk of altered skin integrity as identified in the plan of care.

The RD confirmed staff did not implement resident #003's nutrition care plan as they failed to offer resident #003 intervention A as per their assessed needs to address ongoing weight loss and their high risk of skin imparity.

The above information was reviewed with the home's interim DOC. The DOC acknowledged resident #003's did not receive care as specified in the plan as staff failed to provide nutritional interventions as per their assessed nutrition needs. [s. 6. (7)]

8. Resident #019 was identified in stage one of the RQI for impaired skin integrity.

A review of resident #019's progress note on an identified date, identified resident #019 to have an area of altered skin integrity.

Resident #019's written plan of care, identified the resident was at risk of impaired skin integrity with supporting evidence. Interventions to manage the resident's impaired skin integrity included application of intervention A and intervention B.

A review of resident #019's treatment administration record identified intervention A.

On an identified date and time the inspector observed resident #019 without the required interventions A and B.

An interview with PSW #127, indicated staff were expected to follow a resident's written plan of care as specified for prevention and management of skin concerns.

PSW #127 stated resident #019 did not have any areas of altered skin integrity and with no specific interventions in place for the resident. Following the interview an observation was conducted with PSW #127 of resident #019 on an identified date. PSW #127 confirmed that resident #019 did not have interventions A and B in place.
PSW #127 stated they had been providing care to resident #019 for approximately one month and confirmed they had not applied intervention A to the resident at any time during their care over the three shifts they worked with the resident.

An interview with RPN #126 indicated resident #019 had an area of altered skin integrity. RPN #126 reported resident #019 was at high risk of skin imparity. RPN #127 stated resident #019 required ongoing skin monitoring and implementation of the organized interventions reviewed in the plan of care, to prevent and manage their skin risk, as reviewed above. RPN #126 revealed they were unaware resident #019 did not receive the identified interventions as observed by the Inspector.

The above noted information including the staff interviews and health records for resident #019 were reviewed with the home's interim DOC. The DOC acknowledged the home failed to ensure resident #019 received interventions to prevent and manage their skin risk as specified in their plan of care. [s. 6. (7

9. Related the Log #028848-17:

A Critical Incident Report was submitted to the Director, related to a medication incident/error in administration which altered resident #021's health status.

Inspector #672 reviewed resident #021's progress notes from an identified date and noted the resident began to have a change in health status. Approximately two weeks later the resident presented with symptoms of a change in status and the nurse requested the resident be assessed by the Physician. On the same identified day the Physician documented an assessment which indicated that resident #021 exhibited physical signs and symptoms of a medical condition and an order was received for a treatment, identified as treatment A. The Physician's order was observed to have been signed by two registered staff, which indicated that the order had been fully processed and implemented appropriately.

Inspector reviewed the internal medication incident report, which indicated that the Physician's order had not been processed, and resident #021 had not received treatment A.

Inspector #672 reviewed resident #021's progress notes over one week from the date that treatment A was to be initiated. The resident had experienced another change in status and was assessed by Nurse Practitioner (NP) #140. The NP identified that the further change in the resident's condition was as a result of the unprocessed Physician order for treatment A.

During an interview with RPN #132 they indicated awareness that as a result of failing to process the order appropriately, resident #021 had not received treatment A which contributed to resident #021's further decline in health status.

RN #137 was not available for interview during the inspection.

During an interview with the Acting DOC they verified that the process was not followed in regards to the Physician's order received on an identified date, for resident #021, and the resident did not receive the treatment A. The DOC verified that failing to implement treatment A contributed to the resident's decline in health status.

The licensee failed to ensure that the care set out in resident #021's plan of care was provided to the resident as specified in the plan. [s. 6. (7)]

Additional Required Actions:

CO # - 001, 006 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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system is complied with.

According to O. Reg. 79/10, r. 136. (1), the licensee shall ensure, as part of the medication management system, that a written policy is developed in the home that provides for the ongoing identification, destruction and disposal of,
a) all expired drugs;
b) all drugs with illegible labels;
c) all drugs that are in containers that do not meet the requirements for marking containers specified under subsection 156 (3) of the Drug and Pharmacies Regulation Act; and
d) a resident's drugs where,
(i) the prescriber attending the resident orders that the use of the drug be discontinued;
(ii) the resident dies, subject to obtaining the written approval of the person who has signed the medical certificate of death under the Vital Statistics Act or the resident's attending physician; or

(iii) the resident is discharged and the drugs prescribed for the resident are not sent with the resident under section 128. O. Reg. 79/10, s. 136 (1).

According to O. Reg. 79/10, r. 136. (4), the licensee shall ensure that where a drug that is to be destroyed is a controlled substance, the drug destruction and disposal policy provides that the applicable team document the following in the drug record:
1. The date of removal of the drug from the drug storage area.
2. The name of the resident for whom the drug was prescribed, where applicable.
3. The prescription number of the drug, where applicable.
4. The drug's name, strength and quantity.
5. The reason for destruction.
6. The date when the drug was destroyed.
7. The names of the persons who destroyed the drug.
8. The manner of destruction of the drug.

A review of the licensee's internal policy entitled the "Disposal of Discontinued/Expired Drugs, Narcotics and Controlled Substances"; Index #04-08-10; from the MediSystem Pharmacy manual, as part of the licensee's medication program, indicated the following: "In addition, the Narcotic and Controlled Substances Surplus Drug Form is also completed (or as per facility policy) when placing medication awaiting disposal in the double locked centralized storage area within the facility. This form includes documentation of:
a. Date of removal of the drug from the unit (i.e. narcotic bin in medication cart)
b. Resident name
c. Prescription number
d. Drug name, drug strength, quantity
e. Reason for removal"

Inspector #672 observed the licensee's narcotic destruction storage area on an identified date, along with the attached "Narcotic and Controlled Drug Surplus Record Form", which was the form completed by Registered staff when a narcotic was brought to the area for destruction. The forms captured the dates over a nine week period, which had 43 entries. Of the 43 entries, there were 15 which did not list a reason for the narcotic medication(s) to be destroyed.

During separate interviews RPN #138 and the Acting DOC indicated that the expectation in the home was that when a narcotic or controlled substance was brought to the destruction storage area, the attached "Narcotic and Controlled Drug Surplus Record

Form" was to be completed every time, which was to include the reason for the destruction. Inspector #672 reviewed the forms with RPN #138 and the Acting DOC, who both acknowledged that there were several entries which did not have the reason for the destruction identified or documented on the form, therefore the internal policy entitled "Disposal of Discontinued/Expired Drugs, Narcotics and Controlled Substances"; Index #04-08-10; from the MediSystem Pharmacy manual, as part of the licensee's medication management program, was not complied with.

In addition, Inspector #672 reviewed the internal policy entitled "Narcotic and Controlled Drugs Management" policy, Index #: CARE13-020.01; Effective: August 31, 2016; Reviewed: March 31, 2018; which stated the following:
• "All narcotics and controlled drug(s) will be secured by double locking.
• All narcotic wastage (e.g. half a vial of Morphine) will be double witnessed and signed by two nurses. The unused portion is to be discarded into a biohazardous waste container or sharps container.
Inspector #672 then reviewed the internal policy entitled "Narcotic and Controlled Substances Administration Record"; Index #04-07-10; Last Updated: June 23, 2014; from the MediSystem Pharmacy manual, as part of the licensee's medication program, which stated the following:
"4. All entries must be made at the time the drug is removed from the container.
5. Entries for wasted doses must be filled in completely with an explanation and the signature of a witness on the Narcotic and Controlled Substances Record. The record should have an explanation regarding the damaged ampoule, capsule, or tablet and be placed in the drug destruction container with the completed sheet".

Inspector #672 conducted a medication observation on an identified date during a medication pass, with RPN #100. Inspector #672 observed RPN #100 administer an identified controlled substance to resident #004, and observed that RPN #100 did not have the narcotic control summary sheets present during any part of the medication administration.

Following the administration of the controlled substance, RPN #100 did not complete any documentation within the narcotic control/count summary sheets. Following the medication administration to resident #004, Inspector #672 observed a medication administration a controlled substance to resident #025. Following administration of the controlled substance, there was identified mls of the controlled substance left in the vial, which RPN #100 placed in the garbage can on the medication cart, without wasting the remaining amount with another registered staff member, or signing any documentation

within the narcotic control/count summary sheets.

Inspector #672 remained on the resident home area for approximately one hour following the medication administration observations, and did not observe RPN #100 document within the narcotic control/count summary sheets.

During an interview RPN #100 indicated it was part of their usual practice to dispose of excess controlled substances in the garbage bin, without wasting the substance in the appropriate area, or documenting the wastage with a second registered staff member within the narcotic control/count summary sheets, due to time constraints. RPN #100 further indicated being aware of the expectation in the home that all controlled substances were to be wasted with two registered staff members, and that documentation of administration of all controlled substances were to immediately be documented within the narcotic control/count summary sheets following administration, but indicated the documentation of the administered controlled substances were documented at the end of the shift, while preparing for the narcotic shift change count, with the oncoming registered staff, again due to time constraints.

During an interview the Acting DOC indicated that the expectation in the home is that immediately following administration of a controlled substance, the registered staff member is to immediately sign off on the narcotic control/count summary sheets following administration. The Acting DOC further indicated the expectation in the home was that all controlled substances be wasted with two registered staff members, the wastage was to be appropriately documented, and the liquid was to be emptied from the vial in a manner which rendered the medication impossible to retrieve, such as into a sink or sharp's container. It was not acceptable practice to dispose of a vial of controlled substance into any area without first emptying it first, and until the vial could be emptied with two registered staff witnesses, the controlled substance was to remain under double lock at all times. The Acting DOC further indicated that if one of the other registered staff in the building were not available to witness the wastage, the nurse could always contact one of the managers, and they could immediately come to witness the wastage, and sign the appropriate forms. The Acting DOC indicated that management had met with RPN #100, to review the "Narcotic and Controlled Drugs Management" and the "Narcotic and Controlled Substances Administration Record" policies, and ensure RPN #100 was aware of the expectations in the home, regarding documentation requirements following administration of any controlled substance in the home, and wastage of controlled substances.

Inspector #672 completed a second narcotic count with RPN #100 on an identified date. Following completion of the narcotic count, Inspector #672 observed that the narcotic control/count summary sheets for six controlled substances were incorrect, and there had been no documentation completed on any of the forms since the narcotic count completed during the shift change, at 0700hrs.

Inspector #672 then completed a narcotic count with RPN #145 on an identified date. Following completion of the narcotic count, Inspector #672 observed that the narcotic control/count summary sheets for two controlled substances were incorrect, and there had been no documentation completed on any of the forms since the narcotic count completed during the shift change, at 0700hrs.

During separate interviews, RPNs #100 and #145 indicated that the narcotic count was incorrect due to not documenting any of the controlled substances administered during the medication pass in the appropriate narcotic control/count summary sheets, immediately following the administration of the controlled substances, due to time constraints. RPNs #100 and #145 further indicated awareness of the expectation in the home, that the documentation was to be completed immediately following the administration of the controlled substance.

The licensee failed to ensure that the "Disposal of Discontinued/Expired Drugs, Narcotics and Controlled Substances"; Index #04-08-10; the "Narcotic and Controlled Drugs Management" policy, Index #: CARE13-020.01; Effective: August 31, 2016; Reviewed: March 31, 2018; and the policy entitled "Narcotic and Controlled Substances Administration Record"; Index #04-07-10; Last Updated: June 23, 2014; from the MediSystem Pharmacy manual were complied with. [s. 8. (1) (b)]

Additional Required Actions:

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

WN #3: 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).

s. 31. (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 31 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staffing plan provided for a staffing mix that is consistent with residents' assessed care and safety needs and gets evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

This IP was initiated related to a family concern expressed around insufficient staffing in the home and that the home is often short staffed.

A record review and interview with scheduling clerk #142 identified that the home's staffing plan included the following PSW staffing compliment:
Days- three full time PSWs on each home area (there are four home areas in the LTC home) and two part time PSW staff four days a week.
Afternoons- three full time PSWs on each home area.

Nights-one PSW on each home area and two full time PSW floats.

A record review of the home's staffing schedule from April 1, 2018 to July 25, 2018 identified the following staff shortages with no staff replacement which was also confirmed by scheduling clerk #142 and the interim DOC.

April 1, 2018, 2 day and evening shift PSWs short no replacement.
April 2, 2018, 2 day shift PSWs short replaced with 1 PSW for half shift.
April 10, 2018, 1 day shift PSW short no replacement.
April 22, 2018, 1 day shift PSW short no replacement.
April 28, 2018, 1 day shift PSW short no replacement.
April 29, 2018, 1 day shift PSW short no replacement.
May 1, 2018, 2 day shift PSWs short no replacement.
May 6, 2018, 3 PSWs - two day and one evening shift short no replacement.
May 7, 2018, 1 day shift PSW replaced with 1 PSW for half a shift.
May 10, 2018, 1 evening shift PSW short no replacement.
May 19, 2018, 3 day shift PSWs short no replacement.
May 20, 2018, 4 day shift PSWs short no replacement.
May 23, 2018, 1 day shift PSW short no replacement.
May 26, 2018, 1 day shift PSW short no replacement.
May 29, 2018, 1 day shift PSW short no replacement.
June 1, 2018, 3 PSWs- one day and two evening shifts short no replacement.
June 3, 2018, 2 day shift PSW short replaced with 1 PSW for half a shift.
June 6, 2018, 1 day shift PSW short no replacement.
June 17, 2018, 6 PSWs- four day shift, one evening and one night shift short no replacements.
June 18, 2018, 2 PSWs, one day and one evening shift short no replacements.
June 22, 2018, 2 PSWs, one day and one evening shift short no replacements.
June 23, 2018, 2 PSWs, one day and one evening shift short no replacements.
June 24, 2018, 2 evening shift PSWs short no replacements.
June 25, 2018, 1 day shift PSW short replaced with 1 PSW for half a shift.
June 28, 2018, 1 day shift PSW short no replacement.
July 2, 2018, 1 evening shift PSW short no replacement.
July 3, 2018, 1 evening shift PSW short no replacement.
July 7, 2018, 3 PSWs, one day, one evening and one night shift short no replacements.
July 8, 2018, 2 PSWs, one evening and one night shift short no replacements.
July 9, 2018, 2 day shift PSWs short no replacements.
July 10, 2018, 2 day shift PSWs short no replacements.

July 11, 2018, 1 day shift PSW short no replacements.
July 15, 2018, 3 day shift PSWs short no replacements.
July 22, 2018, 1 day shift PSW short no replacements.
July 25, 2018, 3 day shift PSWs short no replacements

An interview with staffing clerk #142 and the interim DOC confirmed that a process was in place for call in, staff replacement, but that causal and part time staff including agency staff.were often unavailable.

A record review of the Residents' Council meeting minutes of April 2018, identified a concern that the home is short staffed at least once a week.

Staff interviews conducted during the inspection confirmed that staffing was a concern and staff are often working short.

An interview with resident #027, PSW #143 and RPN #126 confirmed that staff were unable to provide for resident #027's need to be taken to the dining room for their meal on an identified date as a result of a staffing shortage in the home area.

An interview with the SDM of resident #028, PSW #129 and RPN #138 confirmed that staff were unable to provide for resident #028's need to be taken to the dining room for a meal on an identified date or their need to be provided with their scheduled second shower of the week as a result of a staffing shortage on the home area.

Interviews with the interim DOC acknowledged that resident care needs can not always be met with the current staffing plan as staff were not available for replacement.

An interview with the Executive Director (ED) confirmed the home's staffing plan was not followed and therefore did not provide for a staffing mix that was consistent with residents' assessed care needs at the time. The ED identified that since January 2018 the home has had a staffing shortage, despite recruitment efforts and that recruitment and retention incentives needed to be considered and have been discussed with the corporate office. The ED further confirmed the home's staffing plan has not been evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. [s. 31. (3)] (110) [s. 31. (3)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the resident is bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

This IP was initiated related to concerns of insufficient staffing.

A record review of a family complaint in the home's complaint binder identified a complaint letter written in 2018, by a family member of resident #026.The letter expressed care concerns related to hygiene and continence care.

A record review of the staffing schedules for an identified two month period with scheduling clerk #142 identified that they were short one PSW with no replacement for 10 days within this time period.

A record review of the resident #026's written plan of care identified that the resident preferred showers and required a mechanical lift with two staff full support to transfer safely.

An interview with resident #026 identified that they preferred a shower but the shower chair can be uncomfortable and was provided a bed bath. When asked by inspector if a bed bath was a suitable substitute, resident #026 indicated that they would prefer if the home fixed the shower chair as they preferred to shower.

Record review of the Follow up Question report in POC for bathing one month prior to the family complaint, identified the resident received one shower and five bed baths and on two occasions the resident refused.

An interview with PSW #143 confirmed that they provided resident #026 with a bed bath as the resident had complained about the comfort of the shower chair. PSW #143 confirmed they had not offered resident a tub bath in place of a shower.

An interview with PSW #146 revealed knowledge that the shower chair was uncomfortable for resident #026 and that they had never thought of offering a tub bath as an option to the resident.

An interview with PSW #144 revealed that resident #026 preferred a shower but the resident would be agreeable to a bed bath if they were short staffed. Staff #144 confirmed they did not shower or provide a bed bath to resident on one of the identified dates above as scheduled.

An interview with full time RPN #126 acknowledged they were aware of resident #026's preference for a shower but unaware that staff were providing bed baths in place of a shower related to the uncomfortable nature of the shower chair. The RPN stated that a tub bath should have been offered to the resident in place of a shower.

An interview with the interim DOC confirmed awareness of the shower chair concern for resident #026 and stated that they were fixing the issue. The interim DOC revealed that a bed bath was not a substitute for a shower and that the resident should have been offered a bath and when a resident refused staff need to re approach and offer a shower the next shift or day. The interim DOC also confirmed that resident #026 did not receive two baths per week according to their preference for an identified month in 2018 for a total of 7 missed occasions and the resident's hair was not washed, confirming the family's written concern. [s. 33. (1)]

2. This IP was triggered related to concerns around insufficient staffing.

A record review of resident #028's plan of care identified the resident preferred showers and the bathing list identified the resident was scheduled to be bathed (showered) on identified days twice per week.

An interview with RPN #100 revealed that they had received a concern at shift report on an identified day in 2018 regarding a hygiene concern related to resident #028.

An interview with resident #028, revealed that they had not had their hair washed and it felt dirty.

A telephone interview was conducted with a family member of resident #028 during the interview they confirmed they had visited their parent at an identified time that week and were concerned about their hair. The family member shared that they mentioned their concern to a registered staff and the staff member revealed they were short staffed and unable to offer the resident a shower.

A record review of the staffing schedules for an identified month in 2018with scheduling clerk #142 identified the home area was short one PSW with no replacement for 6 days on the identified month.

A record review of the POC documentation of resident #028's bathing schedule identified the resident received a sponge bath with no hair washing on 4 occasions and on three occasions there was no documentation to support the resident was bathed during the identified time of review.

An interview with PSW #146 revealed they worked on the identified day the family expressed concern and the home area was short staffed and when short staffed they do not provide baths or showers to residents. When asked about the documentation related to bed baths, the staff revealed that the resident may not have received a bath due to medical concerns.

Interviews with PSW #129 and RPN #138 revealed they worked on another identified date within the month of review and the home area was short staffed on days and they were unable to provide resident #028 a shower.

An interview with the interim DOC revealed the resident did not receive a minimum of two baths per week of their choice, a shower, for the identified month and that the resident should still have been showered with respect to the identified medical concern The interim DOC further confirmed that when a resident's shower or bath was missed the resident should still be offered their bathing choice the next shift or next day to ensure a minimum of two baths per week and that this practice was not followed. [s. 33. (1)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: 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 has failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

Related the Log #028848-17:

A Critical Incident Report was submitted to the Director, related to a medication incident/error which altered the resident's health status, and related to resident #021. According to the CIR, resident #021 had received a Physician's order, to discontinue an identified medication, and to initiate a treatment, both of which had not been processed.

Inspector #672 reviewed resident #021's progress notes from an identified date and noted the resident began to have a change in status. Approximately two weeks later the resident presented with symptoms of a change in status and the nurse requested the resident be assessed by the Physician. On the same identified day the Physician documented an assessment which indicated that resident #021 exhibited physical signs and symptoms of a medical condition then ordered the discontinuation of a medication B

and ordered a treatment, identified as treatment A. The Physician's order was observed to have been signed by two registered staff, which indicated that the order had been fully processed and implemented appropriately.

Inspector reviewed the internal medication incident report, which indicated that the Physician's order was noted to have not been processed, and resident #021 had continued to receive medication A , a week after the order to discontinue, which contributed to resident #021 decline in health status.

Inspector #672 reviewed resident #021's progress notes over one week from the date that treatment A was to be initiated. The resident had experienced a change in status and was assessed by Nurse Practitioner (NP) #140. The NP identified that the further change in the resident's condition was as a result of the unprocessed physician order for treatment A.

Inspector #672 reviewed the internal investigation into the medication incident from an identified date which revealed that RPN #132 had signed the order, indicating that the order had been processed in full, and RN #137 had co-signed the order, verifying that it had been processed and implemented in full.

During an interview with RPN #132 they indicated awareness that as a result of failing to process the order appropriately, resident #021 had not received all medications in accordance with the directions for use specified by the prescriber, over an identified one week period.

RN #137 was not available for an interview during the inspection.

During an interview the Acting DOC indicated that the expectation in the home was that the registered staff member would process the entire Physician's order, which included ensuring the order was entered into the eMAR system, and removing all discontinued medications from the medication cart. The Acting DOC verified that the process was not followed in regards to the Physician's order received for resident #021, as the resident continued to receive medication A over a one week period after it was ordered to be discontinued.

The licensee failed to ensure that all medications were administered to resident #021 in accordance with the directions for use specified by the prescriber, over a one week period, which resulted in resident #021 decline in health status. [s. 131. (1)]

2. The licensee has failed to ensure that all drugs were administered to resident #025 in accordance with the directions for use specified by the prescriber.

Inspector #672 completed a medication administration observation during the medication pass on an identified date, as part of the Medication IP. Inspector #672 observed RPN #100 administer medications to resident #025, during the medication pass. The medication administration included the administration of an identified medication.
Inspector #672 reviewed the physician's orders for resident #025, and observed the same identified medication to be administered along with an order for an identified instrument or tool for the administration.

During the medication administration observation, Inspector #672 observed RPN #100 administer the identified medication not using the ordered instrument for administration. During the administration, resident #025 was noted to have facial grimacing.

During an interview RPN #100 indicated that identified instrument for administration as ordered was not used for resident #025 related to the tool not being readily available.

During an interview with the Acting DOC they indicated that the expectation in the home when a nurse does not have the appropriate tools to meet a resident's care needs was that the staff member was to stop the task, and either look for the tool independently, or the staff member was to call one of the other nursing units to ask a colleague for the item, or someone from the nursing management team. It was not acceptable to not follow a physician's order, or a resident's plan of care, due to not having the required tools immediately on hand. The Acting DOC further indicated that the appropriate tools were available within the home, had RPN #100 called someone else for assistance.

The licensee failed to ensure that all medications were administered to resident #025 in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: 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).

s. 9. (2) The licensee shall ensure there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents. O. Reg. 363/11, s. 1 (3).

Findings/Faits saillants :

1. The licensee failed to ensure all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and locked when are not being supervised by staff.

The following observations were conducted during the RQI:
July 4, 2018 at 1158hrs – North East hallway of Home Area A was observed. The Spa room area was open with soiled utility and garbage chute rooms with open access in shared spa room area. Sharps container observed in unlocked soiled utility room filled with exposed razor blades. No staff observed in vicinity.

An interview and observations conducted with RPN #100 at 1240hrs identified that spa room areas in the home were to remain locked at all times when not in use. Observation conducted during this interview with RPN #100 of the North East hallway spa room on Home Area A identified the door was unlocked, leading to an open soiled utility room with a sharps container filled with exposed razor blades. RPN #100 confirmed the lock was broken, and that the sharps container with exposed razor blades was a safety hazard to residents wandering in the home area.

An interview with the ED identified that spa rooms for resident showers and tubs are secured non-residential areas which must be remain locked at all times except to be unlocked by staff with an access key to unlock the spa area when in use. Observations

and staff interviews related to the spa room on Home Area A were reviewed with the homes ED. The ED reported the home was unaware of the non-functional lock on the spa room door prior to its identification during this inspection, and could not confirm how long the lock had been in disrepair. The ED acknowledged the sharps container full of razors served as a safety hazard to residents on that home area. The ED confirmed the spa door leading to the non-residential spa area was inappropriately equipped to restrict unsupervised access to those areas by residents and would have been accessible to residents on the home area in the absence of supervising staff. [s. 9. (1) 2.]

2. The licensee has failed to ensure that there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents.

The following observations were conducted during the RQI:
Observation 1 –doors leading to external balcony from Home Area A and Home Area B on second floor remain unlocked. No signage on doors noted.
Observation 2 – doors leading to external balcony from Home Area A on the second floor remain unlocked. No audible alarm engaged when door opened. Resident #009 observed seated on balcony in wheelchair with tilt applied. No staff observed to be present on balcony or hallway.
Observation 3 – doors leading to external balcony from Home Area A home area on second floor remained unlocked. No audible alarm engaged when door opened.

A review of the home's administration manual document titled Safety and Security (Description – Door Alarms, Index ADMIN 10.O10.02, March 31, 2018) identified the policy was to maintain a safe and secure environment. Door alarms will not replace resident monitoring and rounds, and all alarm sounds are investigated promptly. The policy further stated the following:
- All doors leading to stairways and the outside of the home must be kept closed and locked, and equipped with a door access control system that is kept on at all times.

The policy did not specify when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents.

An interview was conducted with RPN #100. RPN #100 was unable to specify what direction staff had been provided regarding the monitoring of the doors leading to the external balcony on the second floor. RPN #100 stated these doors remained unlocked throughout the day, and staff on other shifts were to monitor the doors.

An interview with RPN #107 revealed residents on the balcony were expected to be supervised at all times with PSW staff and cannot be left alone as residents could not contact staff if left unsupervised. RPN #107 stated the doors remained open during the day. RPN #107 was unable to demonstrate when and by whom the door access to the second floor external balcony was monitored.

Interviews and observations were conducted with the ESM and ED. The home's ED and ESM acknowledged the doors leading to the external balcony on the second floor was a secure area that required supervised access by residents. The ESM stated that a master key with registered or management staff would be used to unlock the doors through the manual locking mechanism on each door. The ESM and ED were unable to demonstrate when and by whom the door access to the second floor balcony was monitored.

The home's policy as noted above and staff reports were reviewed with the ED. The ED confirmed the homes policy regarding doors leading to outside areas did not provide direction when such doors must be locked or unlocked to permit or restrict unsupervised access to those areas by the residents. [s. 9. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all doors leading to outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be (ii) equipped with a door access control system that is kept on at all times and equipped with an audible door alarm that allows calls to be cancelled only at the point of activation, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure the resident exhibiting altered skin integrity, had been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.
Resident #003 was identified in stage one of the RQI for impaired skin integrity.
Resident #003's Minimum Data Set, identified they were admitted with multiple areas of altered skin integrity.
Review of resident #003's treatment administration record (TAR) identified weekly skin assessments were to be completed. Areas of altered skin integrity identified in the TAR included the identified areas of altered skin integrity.
Corresponding documentation in resident #003's treatment observation record (TOR) for skin assessments identified the weekly skin assessments on an identified date. A further review of the TOR identified three weekly skin assessments were not available for the areas of altered skin integrity.

An interview with RPN #107 identified resident #003 was at high risk of skin imparity. RPN #107 reported that residents with identified areas of altered skin integrity in the home received a weekly skin assessment as scheduled in their TAR. A review of weekly skin assessments in resident #003's TOR with RPN #107 identified three weekly assessments had not been completed.

The above noted information including the staff interviews and clinical records for resident #003 was reviewed with the homes DOC. The DOC acknowledged the weekly skin assessments were not completed for resident #003 on the identified dates for the areas of altered skin integrity. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the resident exhibiting altered skin integrity, including pressure ulcers, had been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Resident #002 triggered in stage one of the RQI related to the resident's worsening incontinence.

A record review of the MDS quarterly review assessment revealed resident #002's level of incontinence. The prior three month MDS assessment, revealed the resident's continence level and identified a change between quarters considered to be a continence decline.

An interview with PSW #146 revealed they had been working with the resident for five to six months and did not describe the resident with a decline in continence decline.

An interview with RPN #100 revealed an explanation behind that resident #002's coded continence decline. RPN #100 confirmed that a continence assessment was required to be completed by nursing on admission, at every quarterly review and when there was a change in status. The RPN acknowledged that a continence assessment had not been completed at the time of the documented continence decline and quarterly review.

Record review of the home's policy entitled Continence Care-Move In #Care2-010-02, reviewed date March 31, 2018 directed nursing staff to complete the continence assessment in Point Click Care (PCC) on admission. Review of policy entitled #CARE2-010-01, reviewed date March 31, 2018 directed nursing staff to complete the continence assessment in PCC with a change in continence.

An interview with the interim Director of Care confirmed, by way of looking at resident's MDS quarterly reviews and assessments, that there had been no continence care assessment since the resident's admission as was required. The interim DOC further confirmed that resident #002 who had been incontinent since admission had not been assessed using a clinically appropriate assessment instrument for continence on admission and at the two subsequent quarterly reviews that followed. [s. 51. (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 to ensure the resident who is incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require., to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee failed to ensure the resident was offered a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner.

Resident #003 was identified in stage one of the RQI for a compromised nutrition status and impaired skin integrity.

On an identified date Inspector #648 observed the AM nourishment pass underway with PSW #115 on resident #003's home area. During the observation, PSW #115 approached the lounge where resident #003 was seated with their eyes closed and with other co-residents . PSW #115 was observed offering a co-resident nourishment. PSW #115 did not approach resident #003 during the entirety of the observed nourishment pass.

Resident #003's Minimum Data Set, identified the resident had ongoing poor oral food and fluids intake. A review of resident #003's clinical records identified resident #003 was at high nutrition risk related to a decline in health status and their identified level of

feeding assistance. Goals for resident #003 included meeting their estimated fluid needs, and interventions included offering prescribed fluids and snacks to the resident.

Staff interviews with PSW #115 and PSW #119 identified they were expected to approach all residents in the home area, including residents who appeared to be asleep, to offer fluids during nourishment pass. PSW #115 stated resident #003 would have refused the nourishment and therefore did not offer the resident any nourishment.

An interview with the home's RD identified that frontline staff completing nourishment pass in between meals were expected to offer a resident an in between fluid and nourishment, providing an opportunity for the resident to refuse. The RD acknowledged resident #003 was known to them for their high nutrition risk related to variable food and fluid intake. The inspector's observation as noted above was reviewed with the RD. The RD confirmed the homes' process had not been implemented to offer resident #003 a nourishment and indicated that if a resident was known to refuse nourishment, this would be included in the written plan of care and confirmed this was not the case.

An interview with the interim DOC reiterated that front line staff were expected to offer a resident nourishment and provide an opportunity for the resident to refuse. The DOC reported staff must still offer a resident nourishment even if they are known to refuse. The DOC acknowledged the home failed to ensure that resident #003 was offered an in-between beverage in the morning as per legislative requirement. [s. 71. (3) (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 the resident was offered a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

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

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

Findings/Faits saillants :

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

During stage one of the RQI, resident #011 brought forward a concern regarding the licensee's reporting and complaints practices in the home, which triggered through to stage two of the RQI, for further follow up. As part of the inspection, Inspector #672 reviewed the licensee's written complaints log for the last three months. During that time frame, seven written complaints had been received.

Inspector #672 observed the date of a complaint letter related to nursing and physiotherapy concerns. The response letter to this complaint was noted and did not meet the 10 day time frame, as there were 14 business days between the complaint letter and response letter.

During an interview with the interim DOC, they indicated that the letter did not meet the required time frame due to the fact that the previous DOC had abruptly left the position during that time period.

During an interview the ED indicated being aware that when the previous DOC unexpectedly left the position, a written complaint had been received, which required a response, but had several other competing priorities in the home at that time, along with struggling to locate the original complaint letter in the previous DOC's belongings. The ED indicated being aware of the legislative requirements regarding responding to complainants within 10 business days, and that the legislation had not been met during this instance, due to the unforeseen circumstances of the previous DOC leaving the position so abruptly.

The licensee failed to ensure that all complaints received were responded to within 10 business days. [s. 101. (1) 1.]

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

During Stage one of the RQI, resident #011 brought forward a concern regarding the licensee's reporting and complaints practices in the home, which triggered through to Stage two of the RQI, for further follow up. As part of the inspection, Inspector #672 reviewed the licensee's complaints log for the last three months. During that timeframe, twenty-six complaints were received by the licensee. Of the twenty six complaints received, twenty-three were missing some part of the documentation required under the legislation, as follows:
Complaint #1 received on an identified date, was missing documentation related to the date any action was taken, the time frames for the action to be taken, the date of response(s) provided to the complainant and a description of the response provided to the complainant.
Complaint #2 received on an identified date, was missing documentation related to the time frame for the action to be taken, follow up actions required, the final resolution, the date of any response provided to the complainant, a description of the response provided to the complainant, and any response made by the complainant.
Complaint #3 received on an identified date, was missing documentation related to the date actions were taken, the time frames for the actions taken, any follow up required for one of the issues brought forward within the complaint, the date the response was provided to the complainant, and a description of the response provided to the complainant related to one of the issues brought forward within the complaint.
Complaint #4 received on an identified date was missing documentation related to the specific nature of two of the concerns brought forward within the complaint, the type of action taken related to three of the concerns brought forward within the complaint, the date of any of the actions taken, any of the follow up required, the final resolution to three of the concerns brought forward within the complaint, any of the dates a response was provided to the complainant, a description of the response(s) provided to the complainant related to three of the concerns brought forward within the complaint, and the response provided by the complainant.
Complaint #5 received on an identified date was missing documentation related to the date actions were taken, the time frames for the actions to be taken, the date any response was provided to the complainant, and the response provided by the complainant.
Complaint #6 was missing documentation related to the date action(s) were taken, time frames for the action(s) to be taken, any follow up required, and the response provided by the complainant.
Complaint #7 was missing documentation related to the type of action taken, the date action(s) were taken, the follow up required, the final resolution (if any), and any response made by the complainant, related to two of the concerns brought forward within

the complaint.
Complaint #8 was missing documentation related to the type of action taken, the date the action(s) were taken (if any), the time frames for the actions to be taken, any follow up required, the final resolution, the date the response was made to the complainant, and the response of the complainant.
Complaint #9 was missing documentation related to exact nature of the complaint, the type of action taken, the date the action(s) were taken (if any), the time frames for the actions taken, any follow up required, the final resolution (if any), and the dates of the responses made to the complainant.
Complaint #10 was missing documentation related to the date action(s) were taken, the time frame for the action(s) taken, the follow up required related to two of the concerns brought forward within the complaint, and the date of the response made to the complainant.
Complaint #11 was missing documentation related to the type of action taken, the date action(s) were taken, the time frame for the action(s) taken, the follow up required, the final resolution, the date of the response made to the complainant, along with a description of the response, and the response made from the complainant.
Complaint #12 was missing documentation related to the date of the action, time frame for the action taken, any follow up required, the date and description of the response provided to the complainant, and the response from the complainant, regarding one of the concerns brought forward in the complaint,
Complaint #13 was missing documentation related to the date action was taken, the follow up required, the final resolution (if any), the date a response was made to the complainant, and a description of the response to the complainant.
Complaint #14 was missing documentation related to the type of action taken, the date action(s) were taken, the time frame for the action(s) taken, the follow up required, the final resolution (if any), the date of the response made to the complainant, along with a description of the response, and the response made from the complainant.
Complaint #15 was missing documentation related to the type of action taken, the date action(s) were taken, the time frame for the action(s) taken, the follow up required, the final resolution (if any), the date of the response made to the complainant, along with a description of the response, and the response made from the complainant.
Complaint #16 was missing documentation related to the type of action taken, the date action(s) were taken, the time frame for the action(s) taken, the follow up required, the final resolution, the date of the response made to the complainant, along with a description of the response, and the response made from the complainant.
Complaint #17 was missing documentation related to the type of action taken, the date action(s) were taken, the time frame for the action(s) taken, the follow up required, the

final resolution, the date of the response made to the complainant, along with a description of the response.
Complaint #18 was missing documentation related to the time frame for the action(s) taken, the follow up required, the final resolution (if any), and a description of the responses provided to the complainant.
Complaint #19 was missing documentation related to the type of action taken, the date action(s) were taken, the time frame for the action(s) taken, the follow up required, the final resolution (if any), the date of the response made to the complainant, along with a description of the response, and the response made from the complainant.
Complaint #20 was missing documentation related to the time frame the action(s) will be taken, and the response from the complainant.
Complaint #21 was missing documentation related to the type of action taken, the date action(s) were taken, the time frame for the action(s) taken, the follow up required, the final resolution (if any), and the response made from the complainant.
Complaint #22 was missing documentation related to the type of action taken, the date action was taken, the time frame for the action(s), the follow up required, the final resolution, and the response made from the complainant, related to one of the areas of concern brought forward in the complaint.
Complaint #23 was missing documentation related to the date action(s) were taken, the time frame for the action(s) taken, the follow up required, the final resolution (if any), the date of the response made to the complainant, along with a description of the response, and the response made from the complainant.
During an interview on July 26, 2018, the Resident Services Coordinator (RSC) indicated being responsible for the complaints log within the home. The RSC further acknowledged that a lot of the complaints were missing required documentation, as per the legislation, but had been unaware of what the legislation required, related specifically to documentation within complaints received by the licensee.

During an interview the DOC indicated that the management team was currently struggling with ensuring that all of the required documentation completed, related to complaints received by the licensee, and was aware that some of the required documentation was missing from some of the complaints received.

The licensee failed to ensure that a documented record was kept in the home, which included all of the required documentation under the legislation, specific to the nature of each verbal or written complaint, the date the complaint was received, the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required, the final resolution, if any, every date on

which any response was provided to the complainant and a description of the response, and any response made by the complainant. [s. 101. (2)]

3. The licensee has failed to ensure that a documented record of all complaints received in the home was reviewed and analyzed for trends, at least on a quarterly basis, and that the analysis took into account the outcome of the analysis when determining what, if any, improvements were required in the home to reduce the number and/or type of complaints received.

During Stage one of the RQI, resident #011 brought forward a concern regarding the licensee's reporting and complaints practices in the home, which triggered through to Stage two of the RQI, for further inspection. As part of the inspection, Inspector #672 requested to see the licensee's documented record of the last quarterly review of the complaints received from the previous quarter, which was to include an analysis of any trends identified, and what changes were made in the home as a result of the analysis.

Inspector #672 reviewed the licensee's complaints logs, and quarterly analysis, and observed that the numbers within the analysis was not the same as the actual number of complaints received. Furthermore, the analysis completed only included a tally of the complaints received by the different departments within the home, but did not assess for trends, and had no section related to continuous quality improvement, in order to take into account the trending of the complaints received, in order to determine what, if any, improvements were required in the home to reduce the number and/or type of complaints received.

During separate interviews the DOC and the RSC indicated that the verbal complaints received by the licensee were reviewed and analyzed on a quarterly basis, but the written complaints received within the quarter were not included in the logging, trending, and analysis conducted. The DOC and RSC both further indicated that the licensee did not keep a documented record which reflected that the review and analysis of the verbal complaints were considered and taken into account when determining what improvements were required in the home. The DOC and RSC indicated being aware that the legislation required that all complaints received by the licensee be analyzed and trended on a quarterly basis, but the DOC indicated believing that the RSC included the written complaints in the analysis, and the RSC indicated believing that the DOC analyzed the written complaints separately, as the verbal and written complaints were not stored within the same binder, and the DOC oversaw the written complaints, whereas the

RSC oversaw the verbal complaints.

The licensee failed to ensure that a documented record of all complaints received in the home was reviewed and analyzed for trends, at least on a quarterly basis, as the written complaints were not included in the quarterly analysis, and the documented record did not reflect that the outcome of the analysis of the verbal complaints was taken into account when determining what improvements were required in the home. [s. 101. (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 to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home had a response provided to the complainant within 10 business days of receipt of the complaint, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that controlled substances were stored in a

separate, double locked stationary cupboard in a locked area, or stored in a separate locked area within the locked medication cart at all times.

Inspector #672 observed the drug destruction bin within the home on an identified date, which was located within the locked medication room, on an identified resident home area. Inspector #672 approached the narcotic destruction bin, and observed that the storage bin door was unlocked and slightly ajar. Inspector #672 opened the destruction bin door, and observed three identified controlled substances were stored within the bin:

During an interview RN #139 indicated that narcotics were supposed to be stored in double locked containers at all times, and that only the DOC had a key to the narcotic destruction bin. Inspector #672 requested RN #139 supervise the narcotic destruction bin, and went to inform the DOC that the narcotic destruction bin was open, with controlled substances stored inside. When the DOC attended the area, Inspector #672 demonstrated that the narcotic destruction bin was not locked, and the controlled substances within could be handled. The DOC immediately locked the destruction bin.

During an interview the DOC indicated that a drug destruction had been completed in the home "a few days ago", and the bin must have been unlocked since then. The DOC further indicated being aware of the legislation which required that controlled substances be stored in a separate, double-locked stationary cupboard in a locked area, or stored in a separate locked area within the locked medication cart, and that the legislation was not met in this instance.

The licensee failed to ensure that the controlled substances in the home which were being stored for destruction were not stored within a double-locked stationary cupboard in a locked area. [s. 129. (1) (b)]

2. As part of the medication IP completed within the RQI process, Inspector #672 completed the medication observation on an identified date with RPN #100. During the medication observation, Inspector #672 observed RPN #100 administer a controlled substance to resident #025. Following administration of the controlled substance, there an amount remaining which RPN #100 placed in the garbage can on the medication cart. The medication cart was stored at the nursing desk at the time of the observation, which was an open area, and the garbage can was not a locked, therefore the controlled substance was not stored in a separate, double-locked stationary cupboard in a locked area, or stored in a separate locked area within the locked medication cart at all times.

During an interview RPN #100 indicated it was part of their usual practice to dispose of excess controlled substances in the garbage bin, without wasting the substance in the appropriate area, due to time constraints. RPN #100 further indicated being aware of the expectation in the home that all controlled substances were to be stored under double lock at all times.

During an interview the Acting DOC indicated that the expectation in the home was that all controlled substances were to remain under double lock at all times. This included left over amounts of controlled substances which were to be wasted.

The licensee failed to ensure that all controlled substances were stored in a separate, double-locked stationary cupboard in a locked area, or stored in a separate locked area within the locked medication cart at all times. [s. 129. (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 controlled substances were stored in a separate, double-locked stationary cupboard in the locked area, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 133. Drug record (ordering and receiving)
Every licensee of a long-term care home shall ensure that a drug record is established, maintained and kept in the home for at least two years, in which is recorded the following information, in respect of every drug that is ordered and received in the home:
1. The date the drug is ordered.
2. The signature of the person placing the order.
3. The name, strength and quantity of the drug.
4. The name of the place from which the drug is ordered.
5. The name of the resident for whom the drug is prescribed, where applicable.
6. The prescription number, where applicable.
7. The date the drug is received in the home.
8. The signature of the person acknowledging receipt of the drug on behalf of the home.
9. Where applicable, the information required under subsection 136 (4). O. Reg. 79/10, s. 133.

Findings/Faits saillants :

1. The licensee has failed to ensure that the drug record maintained in the home recorded the date the drug was ordered, the signature of the person placing the order, the date the drug was received in the home, and the signature of the person acknowledging receipt of the drug on behalf of the home.

Inspector #672 completed the Medication Inspection Protocol, as part of the RQI process within the home, which included reviewing the licensee's drug record documentation. On August 1, 2018, Inspector #672 reviewed the drug record book on each of the four resident home areas, which stored the medication reorder sheets, and the shipping reports from the pharmacy, which accompanied the weekly medication strips, to verify what medications were in the strips. The medication reorder sheets were used to verify medications ordered and received by the home, outside of those found within the weekly medication strips.

On an identified home area , Inspector #672 reviewed the medication reorder sheets and

shipping reports from June 18, 2018, to July 29, 2018, which included five shipping reports, and 80 medications reordered, outside of the routine weekly medication strips. Of the five shipping reports, none of them were signed to indicate that the weekly medication strips had been received or verified by the home. Of the 80 medications reordered, 61 were not signed or dated to indicate that the medications had been received from the pharmacy, and 21 were not signed or dated to indicate the date the medications were reordered, or by whom.
On a second identified resident home area, Inspector #672 reviewed the medication reorder sheets and shipping reports from May 5, 2018, to July 29, 2018, which included 64 medications being reordered outside of the weekly medication strips. Of the 64 medications reordered, 54 were not signed or dated to indicate that the medications had been received from the pharmacy, and 13 were not signed or dated to indicate the date the medications were reordered, or by whom.

On a third identified resident home area, Inspector #672 reviewed the medication reorder sheets and shipping reports from July 1, 2018, to July 29, 2018, which included one shipping report, and 34 medications being reordered outside of the weekly medication strips. Of the 34 medications reordered, 34 were not signed or dated to indicate that the medications had been received from the pharmacy, and one was not signed or dated to indicate the date the medications were reordered, or by whom. The one shipping report was not signed or dated to indicate that the weekly medication strips had been received or verified by the home.

On the fourth identified home area, Inspector #672 reviewed the medication reorder sheets and shipping reports from July 10, 2018, to July 30, 2018, which included two shipping reports, and 23 medications being reordered outside of the weekly medication strips. Of the 23 medications reordered, seven were not signed or dated to indicate that the medications had been received from the pharmacy, and neither of the shipping reports were signed or dated, to indicate that the weekly medication strips had been received or verified by the home.

During separate interviews RPNs #100, #126, and #145 indicated that the expectation in the home was that the medication reorder sheets were supposed to be signed beside each medication, to indicate that the medications had been received appropriately from the pharmacy, as a way of tracking what medications were still outstanding. The shipping reports were expected to be signed at the bottom of the report, where the form had a space available for "Received by", where the nurse was to sign and date the form, to indicate that the weekly medication strip packages had been received for the resident

home area, and had been verified and signed into the system.

During an interview the Acting DOC indicated that the expectation in the home was that all staff ordering a medication were to sign and date beside the order, in the spots available, to reflect who ordered the medication, and the date it was ordered on. The nurse who received the medications from the pharmacy was to sign and date the form, in the spots available, to reflect the date the medications were received, and by whom. The Acting DOC further indicated that the expectation in the home was that the shipping reports be signed by the evening shift nurse, who was the nurse who received the medications from the pharmacy, as the weekly medication strips packages were usually delivered in the mid to late evening. The Acting DOC also indicated that all of the registered staff in the home had been trained on how to order and receive medications from the pharmacy, and were familiar with the forms required to be completed.

The licensee failed to ensure that the drug record maintained in the home recorded the date the drug was ordered, the signature of the person placing the order, the date the drug was received in the home, and the signature of the person acknowledging receipt of the drug on behalf of the home. [s. 133.]

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 drug record maintained in the home recorded the date the drug was ordered, the signature of the person placing the order, the date the drug was received in the home, and the signature of the person acknowledging receipt of the drug on behalf of the home, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that when resident #004 became ill and exhibited symptoms of an infection, that staff recorded the symptoms on every shift.

According to O. Reg 79/10, s. 229 (5) (b), the licensee shall ensure that on every shift the symptoms are recorded and that immediate action is taken as required.

Resident #004 triggered through to Stage two of the RQI, related to Hospitalization and Change in Condition, as a result of MDS information supplied by the home, which indicated that resident #004 had been ill with an identified infection during the previous 180 days.

Inspector #672 reviewed the progress notes for resident #004 over an approximate two month period which revealed that on an identified shift resident #004 was noted to be exhibiting symptoms of an infection.

Inspector #672 reviewed the Physician's orders for resident #004, which indicated that resident #004 was subsequently placed on a treatment the following day. Resident #004 was noted to still be symptomatic while receiving treatment, therefore, and the treatment was reordered for another identified number of days.

Inspector #672 then reviewed the progress notes and vital signs sections of Point Click Care over a 15 day period and noted that there was no documentation related to resident #004's symptoms on 12 of the 15 days and including 23 shifts.

During separate interviews RN #108, RPN #126, and RPN #132 all indicated that documentation was only completed in the home by exception, therefore documentation would only occur on the first day the resident was noted to be ill. The staff further indicated that there were no expectations in the home specific to documentation requirements, when a resident is symptomatic and ill.

During an interview the Acting DOC indicated that the expectation in the home was that staff document on each resident's health status and symptoms, identifying which residents are exhibiting symptoms of an illness on a shift by shift basis. The Acting DOC further indicated that the registered staff in the home had been educated to this policy, and were aware of the expectations.

The licensee failed to ensure that when resident #004 was ill with an infection staff documented the resident's symptoms on a shift by shift basis. [s. 229. (5) (b)]

2. The licensee failed to ensure that when resident #021 became ill and exhibited symptoms of an infection, that staff recorded the symptoms on every shift.

According to O. Reg 79/10, s. 229 (5) (b), the licensee shall ensure that on every shift the symptoms are recorded and that immediate action is taken as required.

Resident #021 triggered through to Stage two of the RQI, related to Hospitalization and Change in Condition, as a result of MDS information supplied by the home, which indicated that resident #021 had been ill with an infection during the previous 180 days.

Inspector #672 reviewed the progress notes for resident #021 and identified a period of time whereby the resident had an infection.

Inspector #672 reviewed the Physician's orders for resident #021, which indicated that resident #021 was placed on a treatment for the infection for a seven day time period.

Inspector #672 then reviewed the progress notes and vital signs sections of Point Click Care over a 7 day period and noted that there was no documentation related to resident #004's symptoms on 4 of the 7 days and including 9 shifts.

During separate interviews RN #108, RPN #126, and RPN #132 all indicated that documentation was only completed in the home by exception, therefore documentation would only occur on the first day the resident was noted to be ill. The staff further indicated that there were no expectations in the home specific to documentation requirements, when a resident is symptomatic and ill.

During an interview the Acting DOC indicated that the expectation in the home was that

staff document on each resident's health status and symptoms, whom are exhibiting symptoms of an illness on a shift by shift basis. The Acting DOC further indicated that the registered staff in the home had been educated to this policy, and were aware of the expectations.

The licensee failed to ensure that when resident #021 was ill with an infection staff documented the resident's symptoms on a shift by shift basis. [s. 229. (5) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when resident's become ill and exhibit symptoms of an upper respiratory infection, that staff recorded the symptoms on every shift and that immediate action is taken as required, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee failed to ensure a care conference of the interdisciplinary team was held

to discuss the plan of care and any other matters of importance to the resident or their substitute decision maker (SDM), if any, within six weeks of admission, and annually after that.

Resident #016 was identified in stage one of the inspection for no care plan invitation through family interview. The resident's substitute decision maker (SDM) stated they had never been invited to participate in a care conference for resident #016 since admission.

A review of resident #016's health records identified they were admitted to the home on an identified date. A progress note following the resident's admission, identified a six week admission care conference. The note stated the SDM did not come in. The progress note include a brief summary of the resident's health status and concluded with no concerns at that time. The note did not include identification of attendees of the meeting, and appeared to be signed by the home's physician.

An interview with RN #152 revealed residents in the home would receive care conferences on admission and on an annual basis to provide SDM and family an opportunity to review a resident's care plan and receive updates on their condition from the interdisciplinary care team in the home. RN# 152 stated attendees and the discussion of the conference would be documented in a resident's health records for the care conference. Review of resident #016's health records with RN #152 did not identify documentation for an admission care conference following the resident's admission, and did not identify documentation for an annual care conference following admission as was required.

An interview with the interim DOC identified that care conferences would be held at six weeks following admission, annually, and on a case by case basis otherwise, for residents in the home and would include an invitation to participate to a resident's SDM. Documentation for resident #016's care conferences was requested by the DOC from the home's Resident Services Coordinator (as reviewed above), were reviewed with the DOC and the RSC. The DOC and RSC were unable to demonstrate that resident #019's SDM had been invited to a six week admission care conference, or that an annual care conference had been held the following current year for the resident.

The interim DOC acknowledged the home failed to ensure an interdisciplinary care conference was held for resident #016 with their SDM within six weeks of the admission of the resident, and at least annually after that. [s. 27. (1)]

WN #15: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied: 4) a physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining.
During stage one of the RQI, resident #014 was observed on two identified occasions to be sitting with a restraining device in place, identified as intervention A which could not be removed by the resident upon request. Resident #014 triggered through to stage two of the RQI process, related to minimizing of restraining, as a result of the observations made during stage one. During Stage two of the RQI, resident #014 was observed on a daily basis to be sitting with intervention A in place.

During separate interviews PSW #116, RPN #132, and the RAI Coordinator indicated that resident #014 utilized intervention A as was observed and was related to resident's history of falling and that intervention A acted as a restraint for resident #014.

The interview with RPN #132 further indicated that a physician's order was required for the use of all restraints in the home, and believed resident #014 had a physician's order in place for the use of intervention A, as a restraint. Upon review of resident #014's

health care record, RPN #132 was unable to locate any physician's order for resident #014's restraint, therefore requested the assistance of the RAI Coordinator, who also could not locate any physician's order for the restraint for resident #014.
During an interview the Director of Care (DOC) indicated that only Physicians ordered restraints in the home, and the documentation of the order should be located under the Physician's Orders section of the health care record, along with being listed within the current Quarterly Medication Review. The DOC further indicated that the expectation in the home was that all restraints have an order in place, prior to initiating the usage of one for any resident, and that the Registered staff had been trained and educated on the usage of restraints in the home, which included that an order was required, prior to utilizing the restraint for any resident in the home.
Inspector #672 reviewed the entire health care record for resident #014, and could not locate an order for resident #014's identified restraint. [s. 31. (2) 4.]

2. The licensee failed to ensure that the restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied: 5) the restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.

During stage one of the RQI, resident #014 was observed on two identified occasions to be sitting with a restraining device in place, identified as intervention A which could not be removed by the resident upon request. Resident #014 triggered through to stage two of the RQI process, related to minimizing of restraining, as a result of the observations made during stage one. During Stage two of the RQI, resident #014 was observed on a daily basis to be sitting with intervention A in place.

During separate interviews PSW #116, RPN #132, and the RAI Coordinator indicated that resident #014 utilized intervention A as was observed and was related to resident's history of falling and that intervention A acted as a restraint for resident #014.

During an interview on July 20, 2018, the Director of Care (DOC) indicated the expectation in the home was that all residents and/or POAs provide consent for the usage of any restraint, which should then be documented within the health care record, prior to initiating the usage of the restraint. The DOC further indicated that all Registered staff had been trained and educated on the usage of restraints, which included that consent was required, prior to utilizing the restraint for any resident in the home.

Inspector #672 reviewed the entire health care record for resident #014, and could not locate any consent for the identified restraint. [s. 31. (2) 5.]

WN #16: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #013's usage of a PASD device was included in the resident's plan of care.

During Stage one of the RQI, resident #014 was observed on two identified occasions to be sitting with a device in place, identified as intervention B. Resident #014 triggered through to stage two of the RQI process, related to minimizing of restraining, as a result of the observations made during Stage one. During Stage two of the RQI, resident #014 was observed on a daily basis to be sitting with intervention B in place.

During an interview PSW #120 indicated that resident #013 was sitting with intervention B in place as a fall prevention intervention. According to PSW #120, the intervention inhibited resident #013's freedom of movement, and the resident was not able to physically or cognitively release themselves from the device.

During an interview RPN #132 indicated that resident #013 utilized intervention B as a PASD, and expected that the PASD would be included in resident #013's plan of care. Upon review of resident #013's plan of care, RPN #132 was unable to locate any mention of resident #013's PASD, therefore requested the assistance of the RAI Coordinator, who also could not locate any mention of the use of intervention B as a PASD for resident #013.

During an interview the RAI Coordinator indicated the expectation in the home was that all PASDs utilized for a resident should be included within the resident's plan of care.

The RAI Coordinator further indicated that following a review of resident #013's plan of care, no mention of the PASD could be located.

During an interview the DOC indicated that the expectation in the home was that all PASDs utilized for any resident should be documented within the resident's plan of care. Inspector #672 reviewed resident #013's entire health care record, and could not locate any mention of intervention B being utilized as a PASD. [s. 33. (3)]

2. The licensee has failed to ensure that resident #010's usage of a PASD device was included in the resident's plan of care.

During Stage one of the RQI, resident #010 was observed on two identified occasions to

be sitting with a device in place, identified as intervention B. Resident #010 triggered through to stage two of the RQI process, related to minimizing of restraining, as a result of the observations made during Stage one. During Stage two of the RQI, resident #010 was observed on a daily basis to be sitting with intervention B in place.

During an interview PSW #116 indicated that resident #010 had intervention B in place at all times outside of meals due to resident #010 risk of falls. According to PSW #116, the intervention B was a PASD and inhibited resident #010's freedom of movement when in place, and the resident was not able to physically or cognitively release themselves from the PASD.

During an interview RPN #132 indicated that resident #010 utilized intervention B as a PASD, and expected that the PASD would be included in resident #010's plan of care. Upon review of resident #010's plan of care, RPN #132 was unable to locate any mention of the PASD, therefore requested the assistance of the RAI Coordinator, who also could not locate any mention of the use of the intervention B as a PASD for resident #010.

During an interview the RAI Coordinator indicated the expectation in the home was that all PASDs utilized for a resident should be included within the resident's plan of care. The RAI Coordinator further indicated that following a review of resident #010's plan of care, no mention of the PASD could be located.

During an interview the DOC indicated that the expectation in the home was that all PASDs utilized for any resident should be documented within the resident's plan of care. Inspector #672 reviewed resident #010's entire health care record, and could not locate any mention of intervention B being utilized as a PASD. [s. 33. (3)]

3. The licensee has failed to ensure that the use of a PASD under subsection (3) to assist resident #013 with routine activities of daily living had been approved by any person provided for in the regulations.

During Stage one of the RQI, resident #013 was observed on two identified occasions to be sitting with a device in place, identified as intervention B. Resident #013 triggered through to stage two of the RQI process, related to minimizing of restraining, as a result of the observations made during Stage one. During Stage two of the RQI, resident #013 was observed on a daily basis to be sitting with intervention B in place.

During an interview PSW #120 indicated that resident #013 utilized intervention B at all times outside of meals due to resident #013's risk of falls and related to the management of a medical condition.

During an RPN #132 indicated that resident #013 utilized intervention B as a PASD. RPN #132 further indicated that an order was required for the use of all PASDs in the home, and believed resident #013 had an order in place for the use intervention B as a PASD. Upon review of resident #013's health care record, RPN #132 was unable to locate an order for resident #013's PASD, therefore requested the assistance of the RAI Coordinator, who also could not locate an order for the use of intervention B as a PASD for resident #013.

During an interview the Director of Care (DOC) indicated that only Physicians ordered PASDs in the home, and the documentation of the order should be located under the Physician's Orders section of the health care record, along with being listed within the current Quarterly Medication Review. The DOC further indicated that the expectation in the home was that all PASDs have an order in place, prior to initiating the usage of one for any resident. The DOC indicated that the Registered staff had been trained and educated on the usage of PASDs in the home, which included that an order was required, prior to utilizing the PASD for any resident in the home.

Inspector #672 reviewed the entire health care record for resident #013, and could not locate an order for resident #013 to utilize intervention B as a PASD.

The licensee failed to ensure that resident #013 had an order in place for use of a PASD under subsection (3). [s. 33. (4) 3.]

4. The licensee has failed to ensure that the use of a PASD under subsection (3) to assist resident #010 with routine activities of daily living had been approved by any person provided for in the regulations.

During Stage one of the RQI, resident #010 was observed on two identified occasions to be sitting with a device in place, identified as intervention B. Resident #010 triggered through to stage two of the RQI process, related to minimizing of restraining, as a result of the observations made during Stage one. During Stage two of the RQI, resident #010 was observed on a daily basis to be sitting with intervention B in place.

During an interview PSW #116 indicated that resident #010 had intervention B in place at all times outside of meals due to resident #010 risk of falls. According to PSW #116, the intervention B was a PASD and inhibited resident #010's freedom of movement when in place, and the resident was not able to physically or cognitively release themselves from the PASD.

During an interview RPN #132 indicated that resident #010 utilized intervention B as a PASD, and expected that the PASD would be included in resident #010's plan of care. Upon review of resident #010's plan of care, RPN #132 was unable to locate any mention of the PASD, therefore requested the assistance of the RAI Coordinator, who also could not locate any mention of the use of the intervention B as a PASD for resident #010.

During an interview the RAI Coordinator indicated that resident #010 utilized intervention B as a PASD, to assist with proper positioning and comfort. The RAI Coordinator further indicated that an order was required for all PASDs in the home, and that resident #010 should have an order, but the RAI Coordinator had been unable to locate an order, when reviewing resident #010's health care record with RPN #132.

During an interview the Director of Care (DOC) indicated that only Physicians ordered PASDs in the home, and the documentation of the order should be located under the Physician's Orders section of the health care record, along with being listed within the current Quarterly Medication Review. The DOC further indicated that the expectation in the home was that all PASDs have an order in place, prior to initiating the usage of one for any resident. The DOC indicated that the Registered staff had been trained and educated on the usage of PASDs in the home, which included that an order was required, prior to utilizing the PASD for any resident in the home.

Inspector #672 reviewed the entire health care record for resident #010, and could not locate an order for resident #010 to utilize intervention B as a PASD.

The licensee failed to ensure that resident #010 had an order in place for use of a PASD under subsection (3). [s. 33. (4) 3.]

5. The licensee has failed to ensure that resident #013's usage of intervention B as a PASD had been consented to.

During Stage one of the RQI, resident #013 was observed on two identified occasions to be sitting with a device in place, identified as intervention B. Resident #013 triggered through to stage two of the RQI process, related to minimizing of restraining, as a result of the observations made during Stage one. During Stage two of the RQI, resident #013 was observed on a daily basis to be sitting with intervention B in place.

During an interview PSW #120 indicated that resident #013 utilized intervention B at all times outside of meals due to resident #013's risk of falls and related to the management of a medical condition.

During an interview RPN #132 indicated that resident #013 utilized intervention B as a PASD, and that consent was required for the use of all PASDs in the home. RPN #132 further indicated the process in the home to secure consent for the usage of a PASD was to speak with the resident and/or contact the Substitute Decision Maker (SDM), once the Physician's order had been received, as part of processing the Physician's order for the PASD. RPN #132 indicated that resident #013 did not have any consent for the usage of the PASD, due to the fact that the home had not secured a Physician's order, therefore none of the Registered staff members had thought about the need for consent to utilize the PASD for resident #013.

During an interview the Director of Care (DOC) indicated the expectation in the home was that all residents and/or POAs provide consent for the usage of a PASD, which should then be documented within the health care record, prior to initiating the usage of the PASD. The DOC further indicated that all Registered staff had been trained and educated on the usage of PASDs, which included that consent was required, prior to utilizing the PASD for any resident in the home.

Inspector #672 reviewed the entire health care record for resident #013, and could not locate any consent for the usage of intervention B to be utilized as a PASD. [s. 33. (4) 4.]

6. The licensee has failed to ensure that resident #010's usage of intervention B as a PASD had been consented to.

During Stage one of the RQI, resident #010 was observed on two identified occasions to be sitting with a device in place, identified as intervention B. Resident #010 triggered through to stage two of the RQI process, related to minimizing of restraining, as a result of the observations made during Stage one. During Stage two of the RQI, resident #010 was observed on a daily basis to be sitting with intervention B in place.

During an interview PSW #116 indicated that resident #010 had intervention B in place at all times outside of meals due to resident #010 risk of falls. According to PSW #116, the intervention B was a PASD and inhibited resident #010's freedom of movement when in place, and the resident was not able to physically or cognitively release themselves from the PASD.

During an interview the RAI Coordinator indicated that resident #010 utilized intervention B as a PASD, to assist with proper positioning and comfort. The RAI Coordinator further indicated that consent was required for all PASDs in the home, and that resident #010 should have consent documented within the health care record, but the RAI Coordinator had been unable to locate any consent, when reviewing resident #010's health care record with RPN #132.

During an interview RPN #132 indicated that resident #010 utilized intervention B as a PASD, and that consent was required for the use of all PASDs in the home. RPN #132 further indicated the process in the home to secure consent for the usage of a PASD was to speak with the resident and/or contact the Substitute Decision Maker (SDM), once the Physician's order had been received, as part of processing the Physician's order for the PASD. RPN #132 indicated that resident #010 did not have any consent for the usage of the PASD, due to the fact that the home had not secured a Physician's order, therefore none of the Registered staff members had thought about the need for consent to utilize the PASD for resident #010.

During an interview the Director of Care (DOC) indicated the expectation in the home was that all residents and/or POAs provide consent for the usage of a PASD, which should then be documented within the health care record, prior to initiating the usage of the PASD. The DOC further indicated that all Registered staff had been trained and educated on the usage of PASDs, which included that consent was required, prior to utilizing the PASD for any resident in the home.

Inspector #672 reviewed the entire health care record for resident #010, and could not locate any consent for the usage of intervention B to be utilized as a PASD. [s. 33. (4) 4.]

WN #17: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee failed to respond in writing within 10 days of receiving family council advice related to concerns or recommendations.

Review of Family Council meeting minutes during RQI activities identified the following:
- Meeting held on April 23, 2018 identified family members were concerned regarding communication about outbreaks in the home and education to staff regarding personal protective equipment and hand hygiene protocols.
- Meeting held on May 12, 2018 identified family members expressed concerns regarding effective communication not always occurring between nursing staff across shifts.

An interview with Family Council member #148 identified they were not aware of any process related to written communication responses by the home for concerns or recommendations raised by Family Council. Family Council member #148 denied receipt of written responses from the home for the concerns raised by family council related to infection control and outbreak management, and staff communication.

An interview with Family Council liaison, RC #112 identified concerns raised by Family Council as noted above would be communicated within the home and addressed by relevant departments. RC #112 stated the home did not have a process to reflect a response in writing to Family Council acknowledging concerns or recommendations made by the council to the home. RC #112 confirmed the home did not provide a response in writing to the homes' Family Council within 10 days for the noted concerns related to infection control and outbreak management and staff communication, as identified by Family council.

Interview with the ED identified the home did not employ the use of a formal documented process to respond in writing within 10 days of receiving a concern or recommendation from family council. Concerns identified by family council as noted were reviewed with the homes ED. The ED confirmed the home did not provide a written response to family council related to concerns regarding infection control and outbreak management, and staff communication. [s. 60. (2)]

WN #18: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 67. A licensee has a duty to consult regularly with the Residents' Council, and with the Family Council, if any, and in any case shall consult with them at least every three months. 2007, c. 8, s. 67.

Findings/Faits saillants :

1. The license failed to ensure regular consultation with the Residents' Council, and in any case, at least three months.

Review of Residents' Council meeting minutes during the RQI identified attendance of the meetings for the last three months of April, May, and June 2018. Attendance of the homes Director of Care (DOC) or ED was not identified in the three months of meeting minutes reviewed.

Interviews were conducted with the Residents' Council president, resident #030, and Residents' Council member, resident #031. Resident's #030 and #031 indicated the home's management was not in attendance at Residents' Council meetings and did not directly consult with Residents' Council regularly, or at a minimum of at least three months.

Interview with the home's Recreation Manager (RM) #148 identified they were the home's assigned Residents' Council representative and helped facilitate Residents' Council meetings and activities. RM #148 reported the home's management, including the DOC or the ED, had not been in attendance or in direct consultation with the home's Residents' Council over the last quarter of Residents' Council meetings.

Interview with the home's ED identified that they had not been in attendance of Residents' Council meetings since 2017. Upon further inquiry, the ED confirmed the home was unable to demonstrate consultation with the Residents' Council on a regular basis, or in any case, at least on a quarterly basis. [s. 67.]

WN #19: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)

(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the contact information of the Director, or the contact information of a person designated by the Director to receive complaints; 2017, c. 25, Sched. 5, s. 21 (1)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(g.1) a copy of the service accountability agreement as defined in section 21 of the Commitment to the Future of Medicare Act, 2004 entered into between the licensee and a local health integration network;
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(l.1) a written plan for achieving compliance, prepared by the licensee, that the Director has ordered in accordance with clause 153 (1) (b) following a referral under paragraph 4 of subsection 152 (1); 2017, c. 25, Sched. 5, s. 21 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee failed to ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, including copies of compliance inspection reports from the past two years for the long term care home.

Observations conducted in the long term care home during the RQI on July 5, 2018, identified the following MOHLTC public inspection reports not posted in the long-term care home from the past two years:
Critical Incident Inspection Report # 2015_0168202_0014 dated September 14, 2015.
RQI Report # 2016_268604_0022 dated February 22, 2017.
Critical Incident Inspection report # 2017_650565_004 dated May 2, 2017.
Complaints Inspection Report #2017_595604_0008 dated April 12, 2017.

Review of the observations and posted information with the homes Executive Director confirmed public inspection reports for the above noted inspections had not been posted in the home at the time. [s. 79. (3) (k)]

WN #20: 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. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
i. names of any 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. 107 (4).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that a Critical Incident Report (CIR) submitted to the Director included the names of the staff members who were present at the incident involving resident #021, nor the names of the staff members who discovered the incident.

Related to Log #028848-17:

A Critical Incident Report was submitted to the Director, related to a medication

incident/error which altered the resident's health status, and related to resident #021. According to the CIR, resident #021 had received a Physician's order, to discontinue an identified medication, and to initiate a treatment, both of which had not been processed.

Inspector #672 reviewed resident #021's progress notes from an identified date and noted the resident began to have a change in status. Approximately two weeks later the resident presented with symptoms of a change in status and the nurse requested the resident be assessed by the Physician. On the same identified day the Physician documented an assessment which indicated that resident #021 exhibited physical signs and symptoms of a medical condition then ordered the discontinuation of a medication B and ordered a treatment, identified as treatment A. The order was not processed, and seven days later, it was noted that resident #021 had continued to recieve the discontinued medication once per day, and had not received the ordered treatment which resulted in resident #021 having a decline in health status.

Inspector #672 reviewed the Physician's orders for resident #021 on the identified date and observed an order to discontinue the identified medication and for the initiation of treatment A. Inspector #672 further observed that the order had been signed off by two registered nursing staff, to indicate that the order had been correctly checked to have been processed and implemented in full.

Inspector #672 reviewed the home's internal investigation into the incident, which indicated that RPN #132 had signed the order for the initial check, which indicated that the order had been processed and checked, and was in the system correctly. RN #137 signed the order for the second check, which indicated that the order had been second checked, to ensure accuracy and completion of the processing of the Physician's order.

During an interview with the Acting DOC indicated that RPN #132 and RN #137 had signed off on the Physician's order for resident #021, which indicated that the order had been fully processed and checked, and was entered into the electronic medication administration system accurately. One week later when resident #021 was again being assessed by the Physician, due to declining health status, it was noted that the order had in fact not been processed accurately, and resident #021 had continued to receive the discontinued medication , and had not received treatment A. This led to a decline in resident #021's health status.

During an interview, RPN #132 indicated that the Physician's order had not been processed accurately, which led to resident #021 continuing to receive the medication for

a one week period, and not receiving treatment A , as per the Physician's order.

During an interview the Acting DOC indicated that the medication incident had first been noted by the Nurse Practitioner (NP) #140, when the NP came to the ED's office, to complain that the order had not been carried out, which had led to a negative effect on the resident.

The CIR did not include the names of RPN #132, or RN #137, who were directly involved in the medication incident, or that the incident was discovered by NP #140. [s. 107. (4) 2. ii.]

2. The licensee failed to ensure that the CIR submitted to the Director, regarding a medication incident involving resident #021, included the action taken in response to the incident, including what care was given, or action taken, as result of the incident, and by whom.

Related to Log #028848-17:

A Critical Incident Report was submitted to the Director, related to a medication incident/error which altered the resident's health status, and related to resident #021. According to the CIR, resident #021 had received a Physician's order, to discontinue an identified medication, and to initiate a treatment, both of which had not been processed. The CI failed to included the action taken in response to the incident, including what care was given, or action taken, as result of the incident, and by whom.

Inspector #672 reviewed the home's internal investigation into the incident, which indicated the home's response to the incident and by whom.

During an interview the Acting DOC indicated that the above actions were taken in response to the incident, in an effort to ensure further similar medication incidents did not occur, and that all staff were properly trained in how to process a Physician's order.

The CIR did not include any of the actions taken as a result of the medication incident, or by whom. [s. 107. (4) 3. i.]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
2. What alternatives were considered and why those alternatives were inappropriate. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the documentation regarding resident #014's identified restraint included what alternatives were considered, and why those alternatives were inappropriate.

During Stage one of the RQI, resident #014 was observed on two identified occasions to be sitting with an identified restraint device in place. Resident #014 triggered through to stage two of the RQI process, related to minimizing of restraining, as a result of the observations made during Stage one. During Stage two of the RQI, resident #014 was observed on a daily basis to be sitting with the identified restraint device in place.

During separate interviews PSW #116, RPN #132, and the RAI Coordinator indicated that resident #014 utilized the identified restraint, due to the resident's history of falls.

During the record review specific to the Minimizing of Restraining IP in Stage two of the RQI process regarding resident #014, Inspector #672 reviewed resident #014's entire health care record in Point Click Care (PCC), Point of Care (POC), and the physical chart, but could not locate any documentation which reflected what alternatives had been trialled for resident #014 prior to utilizing the identified restraint, and why those

interventions had not been effective.

Inspector #672 then reviewed the licensee's internal policy entitled "LTC-Least Restraint Program"; Section: Resident Safety; Index #: CARE10-010.01; Effective Date: August 31, 2016; Reviewed Date: March 31, 2018, which indicated that following:

"The interdisciplinary team will review the resident's need for a restraint, and that all possible alternatives to a restraint have been tried and deemed unsuccessful. This will be documented clearly in the progress notes".

During separate interviews PSWs #116, and #135, RPN #132, and the RAI Coordinator indicated that previous to the identified restraint, resident #014 had other identified interventions, in an attempt to prevent resident #014 from sustaining further falls. PSW #116 and the RAI Coordinator indicated that the interventions had not been effective and explained why. The RAI Coordinator further indicated the rationale for the current identified restraint. The RAI Coordinator indicated that the expectation in the home was that whenever interventions were noted to be ineffective for a resident, documentation should be completed within the health care record which reflected the resident's response to the intervention, when and why the intervention had been deemed ineffective, and what new intervention(s) were being added to the resident's plan of care, in replace of the ineffective intervention(s). The RAI Coordinator reviewed resident #014's health care record with Inspector #672, and was unable to locate any documentation which reflected what alternatives were considered prior to implementing the identified restraint, and why those alternatives had been deemed inappropriate.

During an interview the interim DOC indicated that the expectation in the home was that prior to a resident having a restraint utilized, all appropriate interventions should be trialled first, and the resident's response should be documented within the progress notes, and added to the written plan of care and kardex. If the interventions were deemed to be ineffective, this also needed to be documented, along with the reasons why the interventions had been deemed ineffective, within the progress notes, and the interventions removed from the written plan of care and kardex.

The licensee failed to ensure that the documentation regarding resident #014's identified restraint included what alternatives were considered prior to implementing the restraint, and why those alternatives were deemed to have been inappropriate for resident #014. [s. 110. (7) 2.]

2. The licensee has failed to ensure that there was documentation which included every time resident #014 was released from the identified restraint, and repositioned.
During Stage one of the RQI, resident #014 was observed on two identified occasions to be sitting with a restraint device in place. Resident #014 triggered through to stage two of the RQI process, related to minimizing of restraining, as a result of the observations made during Stage one. During Stage two of the RQI, resident #014 was observed on a daily basis to be sitting with restraint device in place.

During separate interviews PSW #116, RPN #132, and the RAI Coordinator indicated that resident #014 utilized the identified restraint, due to the resident's history of falls. During the record review specific to the Minimizing of Restraining IP in Stage two of the RQI process regarding resident #014, Inspector #672 reviewed resident #014's entire health care record in Point Click Care (PCC), Point of Care (POC), and the physical chart, but could not locate any documentation which reflected when resident #014 was released from the identified restraint, and repositioned.

During separate interviews PSWs #116 and #135 indicated that resident #014 was only repositioned when resident #014 was assisted to the bathroom, and the PSW staff did not document anywhere that resident #014 was released from the restraint, or repositioned, as it was not listed within the POC system that resident #014 had a restraint in place.

During an interview RPN #132 indicated being unaware of any place for the PSW or Registered staff to document if and when a resident was released from a restraint and repositioned, therefore this documentation was not being completed for resident #014, regarding the identified restraint.

During separate interviews the DOC and ED indicated that the documentation regarding each time the resident was released from the restraint and repositioned should be completed within the POC system by the PSW staff. The DOC further indicated that the documentation by the Registered staff was completed within the eMAR system, which reflected that the Registered staff ensured that each resident with a restraint applied was released from the restraint, and repositioned at least every two hours, during the shift. Both the ED and interim DOC indicated it was an expectation in the home for all staff to complete the required documentation for every resident within the home who was being restrained, to reflect each time the resident was released from the restraint and repositioned. The interim DOC indicated that the documentation expectations in the

home specific to restraints were included within the education and training provided to all front line staff upon hire, and annually thereafter.

The licensee failed to ensure that there was documentation from both the PSW and Registered staff which reflected every time resident #014 was released from the identified restraint, and repositioned. [s. 110. (7) 7.]

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 113. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes or improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared. O. Reg. 79/10, s. 113.

Findings/Faits saillants :

1. The licensee has failed to ensure that an analysis of the restraining of residents by use of a physical device in the home was undertaken on a monthly basis.
During Stage one of the RQI process, residents #010, #013, and #014 were observed to have identified restraints being utilized, and triggered through to Stage two of the RQI, specific to Minimizing of Restraining. Due to areas of non-compliance being identified for

residents #010, #013, and #014 during the inspection under the Minimizing of Restraining IP, Inspector #672 requested to view the licensee's program evaluation specific to the restraints being utilized in the home.

During an interview on July 20, 2018, the interim DOC indicated that there was a restraint program in the home, which was overseen by the DOC and the ADOC. The DOC further indicated that currently the management team was not undertaking an analysis of the restraining of residents by use of a physical device in the home, and was unable to provide a list of the residents in the home who were utilizing restraints, and were not conducting any analysis or trending regarding the use of restraints in the home. The DOC indicated being unaware of the legislation which required an analysis of the restraining of residents by use of a physical device in the home to be completed on a monthly basis, believing the requirement was quarterly, but that the analysis had not been completed on a quarterly basis either.

The licensee failed to ensure that an analysis of the restraining of residents by use of a physical device in the home was undertaken on a monthly basis. [s. 113. (a)]

2. The licensee has failed to ensure that once in every calendar year an evaluation was conducted to determine the effectiveness of the licensee's restraints policy, and identify what changes and improvements were required to minimize restraining in the home, and ensure that restraining was done in accordance with the Act and Regulation.

During Stage one of the RQI process, residents #010, #013, and #014 were observed to have identified restraints being utilized, and triggered through to Stage two of the RQI, specific to Minimizing of Restraining. Due to areas of non-compliance being identified for residents #010, #013, and #014 during the inspection under the Minimizing of Restraining IP, Inspector #672 requested to view the licensee's program evaluation specific to the restraints being utilized in the home.

During an interview on July 20, 2018, the interim DOC indicated that all evaluations of the licensee's policies were conducted through the corporate office, and was unsure of how often those evaluations were completed. The DOC further indicated that an annual evaluation in the home by the management team, specific to the restraining of residents by use of a physical device in the home to identify what (if any) changes and improvements were required to minimize the amount of residents utilizing restraints in the home, and ensuring that all incidents of restraining was done in accordance with the Act and Regulation was not being completed at the home level, and did not have any

documentation which reflected that the policy had been reviewed and evaluated. [s. 113. (b)]

WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (5) The licensee shall ensure that a written record is kept of the results of the annual evaluation and of any changes that were implemented. O. Reg. 79/10, s. 116 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written record was kept of the results of the annual evaluation into the medication management system, and of any changes that were implemented as a result of the evaluation.

Inspector #672 completed the Medication Inspection Protocol, as part of the RQI process within the home, which included reviewing the licensee's annual evaluation of the medication management system, and a copy of the written record kept which reflected any changes which were implemented as a result of the annual evaluation.

During an interview on August 2, 2018, the interim DOC indicated that an annual evaluation of the medication management system was completed by the Medical Director, Administrator, Director of Care, the pharmacy service provider, and a registered dietitian, who met annually to evaluate the effectiveness of the medication management system in the home, and to recommend any changes necessary to improve the system. The interim DOC further indicated that this evaluation was completed during routine Professional Advisory Committee (PAC) meetings, but was not captured within the documentation or PAC meeting minutes, and there were no other written records kept, which reflected that an annual evaluation had been completed, or that any changes had been identified and implemented as a result of the annual evaluation. The interim DOC indicated awareness of the legislation which required that a written record of the annual evaluation into the medication management system and any recommended changes which were implemented as a result of the evaluation be kept.

The licensee failed to ensure that a written record of the annual evaluation into the medication management system and any recommended changes which were implemented as a result of the evaluation were documented and kept in the home. [s. 116. (5)]

WN #24: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident was documented, together with a record of the immediate actions taken to assess and maintain the resident's health status.

Inspector #672 completed the Medication Inspection Protocol, as part of the RQI process within the home, which included reviewing the licensee's medication incidents and

adverse drug reactions. Inspector #672 reviewed the medication incidents which occurred in the home over an identified 3 month period. During this time period, there were two medication incidents which occurred in the home, one involving resident #022, and one involving resident #023.

Inspector #672 reviewed the internal medication incident report, related to resident #022. The internal incident report did not include a record of the immediate actions taken to assess and maintain the resident's health status.

Inspector #672 reviewed resident #022's progress notes over an identified period which revealed that the medication incident had been documented, but the documentation did not include a record of the immediate actions taken to assess and maintain the resident's health status. Inspector #672 also reviewed the "vital signs" section of the chart, but there were no assessments documented, which showed that resident #022 had been assessed following the medication incident.

Inspector #672 reviewed resident #023's progress notes over an identified period, which revealed a medication incident had occurred. The documentation of the medication incident failed to include documentation of a record of the immediate actions taken to assess and maintain the resident's health status, or if resident #023 had been assessed at all following the medication incident being noted. Inspector #672 reviewed the internal medication incident related to resident #023. There was no documentation regarding a record of the immediate actions taken to assess and maintain the resident's health status on the internal medication incident report, or within resident #023's chart.

During an interview with the interim DOC, they indicated that following a medication incident, the resident's vital signs and general condition should be assessed by the nurse, and documented in the progress notes. The interim DOC further indicated being unaware if resident #022 or #023 were physically assessed following the medication incidents, as there was no documentation to support that an assessment had been completed. The interim DOC indicated that internal investigations into the medication incidents involving resident #022 and #023 could not be located, and was unaware of investigations into the incidents had been completed.

During an interview the Executive Director (ED) indicated being unaware of any immediate action(s) taken as a result of the medication incidents involving resident #022 or #023, or whether internal investigations had been conducted into either matter, as no documentation could be located, and the DOC in position at the time of both medication

incidents no longer worked in the home.

The licensee failed to ensure that the medication incidents involving residents #022 and #023 included documentation of the immediate actions taken to assess and maintain the resident's health status. [s. 135. (1)]

2. The licensee has failed to ensure that a documented record was kept of the corrective action taken as a result of a medication incident involving resident #023.

Inspector #672 completed the Medication Inspection Protocol, as part of the RQI process within the home, which included reviewing the licensee's medication incidents and adverse drug reactions. Inspector #672 reviewed the medication incidents which occurred in the home over a three month period, one of which involved resident #023.

Inspector #672 reviewed the internal medication incident which indicated a medication incident involving resident #023 on an identified date. The internal medication incident report failed to include corrective action documented, and no corrective action was documented within resident #023's chart, to indicate what the licensee's corrective action (s) were, to assist in ensuring further medication omissions did not occur.

During an interview with the interim DOC they indicated that an internal investigation into the medication incident involving resident #023 could not be located, therefore the interim DOC was unaware of what corrective actions were taken (if any) following the medication incident, as they were not in the DOC position at the time, and was not involved in the medication incident follow up. The interim DOC further indicated being unsure if there had been any follow up completed by the licensee at the time, as documentation of corrective action(s) were usually made on the internal medication incident report. During an interview, the Executive Director (ED) indicated being unaware of any corrective action(s) taken as a result of the medication incident involving resident #023.

The licensee failed to ensure that a documented record was kept of the corrective action taken as a result of a medication incident which occurred involving resident #023. [s. 135. (2)]

3. The licensee has failed to ensure that all medication incidents and adverse drug reactions were documented, reviewed and analyzed; and that corrective actions were taken, as necessary.

Review of the licensee's medication incidents and adverse drug reactions which occurred within the home over an identified three month period was conducted by Inspector #672. It was noted that two medication incidents occurred during that time period.

Inspector #672 reviewed the Professional Advisory Committee (PAC) minutes from meetings held over and identified period of time. There was no documentation within the minutes which reflected that the medication incidents and adverse drug reactions were analyzed for trends, or what the corrective action plans were, in an attempt to prevent further incidents from occurring.

During an interview the interim DOC indicated to Inspector #672 that the medication incidents from the previous quarter were discussed during the PAC meetings, but that the incidents were not analyzed for trends. The interim DOC further indicated that there was not any documentation to reflect any corrective action plans, in an attempt to prevent further medication incidents from occurring.

The licensee failed to ensure that all medication incidents and adverse drug reactions were documented, reviewed and analyzed; and that corrective actions were taken, as necessary. [s. 135. (2)]

4. The licensee has failed to ensure that a written record was kept in the home related to the quarterly reviews which were undertaken of all medication incidents and adverse drug reactions that occurred in the home since the time of the last review, in order to reduce and prevent medication incidents and adverse drug reactions from occurring, and any changes and improvements identified in the review which were implemented.

Inspector #672 completed the Medication Inspection Protocol, as part of the RQI process within the home, which included reviewing the licensee's medication incidents and adverse drug reactions. Inspector #672 reviewed the medication incidents which occurred in the home over an identified three month period. During this time period, there were two medication incidents which occurred in the home, involving resident #022 and #023.

Inspector #672 reviewed the internal medication incident reports related to resident #022 and #023.

There was no documentation regarding a record of the immediate actions taken to assess and maintain the resident's health status on the internal medication incident

report, or within resident #023's chart.

Related the Log #028848-17:

A Critical Incident Report was submitted to the Director, related to a medication incident/error which altered the resident's health status, and related to resident #021. According to the CIR, resident #021 had received a Physician's order, to discontinue an identified medication, and to initiate a treatment, both of which had not been processed.

Inspector #672 reviewed resident #021's progress notes from an identified date and noted the resident began to have a change in status. Approximately two weeks later the resident presented with symptoms of a change in status and the nurse requested the resident be assessed by the Physician. On the same identified day the Physician documented an assessment which indicated that resident #021 exhibited physical signs and symptoms of a medical condition then ordered the discontinuation of a medication B and ordered a treatment, identified as treatment A. The Physician's order was observed to have been signed by two registered staff, which indicated that the order had been fully processed and implemented appropriately.

Inspector #672 reviewed the PAC minutes from meetings held after the CI incident had occurred. The minutes reflected that the medication incidents had occurred, but did not include what any of the corrective action plans were, in an attempt to prevent further incidents from occurring, or if any changes and/or improvements were identified or implemented.

During an interview, the interim DOC indicated that quarterly reviews of all medication incidents and adverse drug reactions were completed during routine PAC meetings. The interim DOC further indicated that any discussion or review regarding possible changes and/or improvements made in order to attempt to reduce and prevent medication incidents and adverse drug reactions from occurring within the home were not captured within any documentation or PAC meeting minutes; and there were no other written records kept, which reflected that any changes had been identified and/or implemented as a result of the evaluations. The interim DOC further indicated that following the incident with resident #021 the management team met with the staff members involved, and had them complete a reflective journal regarding the incident, complete the "Safe Medication Administration Skills Checklist" again, have a Counselling letter added to each of the nurse's employee file, and the Pharmacist came in to provide education to all of the registered staff in the home regarding how to properly and fully process a

Physician's order. Following the medication incident with resident #022. the resident's SDM met with the ED, and discussed the medication policy and expectations in the home, regarding safe medication administration practices, and the need for Physician's orders for all medications administered to the residents. The interim DOC could not recall any follow up, corrective actions, or interventions implemented following the medication incident with resident #023. The interim DOC further indicated that these interventions were not discussed during the PAC meetings, and documentation regarding the interventions were not kept. The Acting DOC indicated awareness of the legislation which required that a written record of any changes and improvements identified and implemented in the quarterly review of medication incidents and adverse drug reactions be kept.

The licensee failed to ensure that a written record was kept of the changes and interventions implemented in the home following medication incidents involving residents #021, #022, and #023, in an attempt to prevent further medication incidents and adverse drug reactions from occurring. [s. 135. (3)]

Issued on this 28th day of February, 2019

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

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) :	DIANE BROWN (110), JENNIFER BATTEN (672), JOVAIRIA AWAN (648)
Inspection No. / No de l'inspection :	2018_414110_0012
Log No. / No de registre :	013990-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 26, 2019
Licensee / Titulaire de permis :	AXR Operating (National) LP, by its general partners c/o Revera Long Term Care Inc., 5015 Spectrum Way, Suite 600, MISSISSAUGA, ON, L4W-0E4
LTC Home / Foyer de SLD :	Elginwood 182 Yorkland Street, RICHMOND HILL, ON, L4S-2M9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Amandeep Bhela

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

Ministère 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

To AXR Operating (National) LP, by its general partners, 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

Ministère 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) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with the LTCHA, 2007, s. 6.(1).

The licensee is ordered to:
1. Conduct a review of resident #003, #009 and #014's written plan of care to ensure that the care set out in the plan of care provides clear direction to staff and others who provide direct to the residents. The review shall include but not be limited to fall prevention, nutrition care and skin and wound care.
2. The written plan of care for resident #003, #009 and #014 shall be reviewed with all direct care staff to ensure the directions are clear and staff are aware of any updates/changes made.
3. Develop and implement a plan to ensure that the written plans of care for ALL residents in the home provide clear directions to staff and others who provide direct care to the residents.
4. The plan shall include an auditing process to ensure the directions in the resident's written plans of care are clear.
5. Maintain documentation to demonstrate steps 1-4 have been completed and available upon inspector request.

Grounds / Motifs :

1. The licensee failed to ensure the written plan of care sets out clear directions to staff and others who provide direct care to the resident.

Resident #003 was identified in stage one of the Resident Quality Inspection (RQI) for impaired skin integrity.

Resident #003's Minimum Data Set Assessment (MDS), identified the resident was admitted with multiple areas of altered skin integrity.

A review of resident #003's written plan of care identified an altered skin integrity risk score, and identified areas of altered skin integrity. Interventions to manage the resident's skin concerns included intervention A. Additional information such as frequency or when to provide intervention A was not identified in the review of the written plan of care. A review of resident #003's treatment observation record identified the most recent skin assessment for the two areas of altered skin integrity with an identified intervention not clearly described as intervention A, as identified in the written plan of care.

A review of resident #003's progress notes identified the resident with two areas of altered skin integrity. The assessment noted the areas of altered skin integrity were treatable if treatment and other preventative strategies were adhered to. The plan indicated that intervention A was to be implemented at a specific time.

A review of resident #003's physicians orders identified the resident was to have an intervention B in place every day at a specific time.
Observations conducted during the course of this inspection identified the following:
Observation 1 on an identified date resident #003 was observed without intervention A or B in place.
Observation 2 on a separate date resident #003 was observed with intervention B in place and while intervention A should have been in place.

An interview with PSW #119 and #120 identified awareness of intervention A but was incorrect in the timing of when the intervention was to be applied.

An interview with RPN #107 identified resident #003 was at high risk of altered skin integrity. RPN #107 indicated resident #003 was to have intervention A and B in place at all times. A further review of the resident's written plan of care with RPN #107 confirmed there were no directions as to when intervention A would be applied to the resident. RPN #107 stated the written plan of care was unclear and acknowledged it did not provide front line staff with clear direction.

The above noted information was reviewed with the interim DOC. The DOC acknowledged the information in the plan of care for resident #003 related to how and when to implement interventions A and B were unclear. The DOC acknowledged resident #003's written plan of care did not set out clear directions to staff who provide direct care to the resident.

(648)

2. Resident #009 was identified in stage one of the RQI for weight loss.

Observations conducted during the inspection identified resident #009 being served 125ml of a nutritional intervention, identified as intervention A on an identified date and meal.

Resident #009's MDS assessment for a significant change dated a month prior, identified that the resident sustained a significant weight loss. The MDS assessment identified nutrition interventions which included 250ml of intervention A three times a day at meals. A review of resident #009's weight history identified a significant weight loss over a period of 30 days. A review of resident #009's diet order at the dining room servery in the diet roster list stated the following:
Add an identified amount of intervention B to 250ml of identified fluid for a specialized drink at all meals.
Breakfast- serve 250mls of a specialized drink.
Lunch and Dinner – serve 125mls of a specialized drink.

Review of a progress note documented by the home's Registered Dietitian (RD) as a Nutrition Reassessment which stated that resident #009 was to receive 250ml of a specialized drink three times a day at meals.

A review of resident #009 written plan of care, identified resident #009 to be at high nutrition risk related to significant weight loss, stating they were to receive 250ml of a specialized drink three times a day at meals.

An interview with PSW #150 identified resident #009 was to receive a

specialized drink at meals. Review of resident #009's care plan and diet roster with PSW #150 revealed they were unclear as to which intervention resident #009 was to received based on the conflicting information in the records reviewed.

An interview with PSW #122 revealed PSW staff were directed to use the diet roster in the dining room for a resident's dietary interventions including a specialized drink. PSW #122 reported resident #009 regularly received no more than 125ml of a specialized drink at each meal. Review of the diet roster, for resident #009 with PSW #122 revealed they were unaware why resident #009 was receiving 125ml and not 250mls of the specialized drink based on the information in the diet roster as noted above.

The PSWs interviewed identified that dietary staff would prepare individualized interventions such as specific volumes of specialized drinks for residents requiring the intervention and PSW staff would then provide it to the resident.

Resident #009's diet order was reviewed with DA #130 during a staff interview. DA #130 confirmed they were to prepare individualized interventions such as specialized drinks for residents and provide them to PSW staff during the meal service for designated residents. DA #130 revealed resident #009 was to receive 125ml of the specialized drink lunch and dinner and 250ml at breakfast. DA #130 stated the information in the diet order provided confusing direction to staff providing care.

Resident #009's written plan of care including their diet order as noted above, staff reports, and observation during the lunch meal were reviewed with the home's Registered Dietitian (RD) and interim DOC. The RD confirmed resident was assessed to receive 250ml of the specialized drink due to historical weight loss and a decline in intake. The RD identified resident #009 at high nutrition risk. The RD confirmed resident #009's written plan of care indicated conflicting information related to the volume of specialized drink A to be offered to the resident, and did not provide clear direction to staff.

An interview with the DOC confirmed resident #009's written plan of care failed to set out clear directions to staff and others who provide direct care related to the provision of organized nutrition interventions as per their assessed need. [s.

6. (1) (c)]

An interview with the DOC confirmed resident #009's written plan of care failed to set out clear directions to staff and others who provide direct care related to the provision of organized nutrition interventions as per their assessed need.

(648)

3. During stage one of the RQI, resident #014 was observed on two identified occasions to be sitting with a restraining device in place, identified as intervention A which could not be removed by the resident upon request. Resident #014 triggered through to stage two of the RQI process, related to minimizing of restraining, as a result of the observations made during stage one.

During the record review for resident #014, Inspector #672 reviewed the most recent written plan of care, and the kardex in the Point of Care (POC) system. Both the written plan of care and the kardex indicated that resident #014 was supposed to have a three fall prevention interventions in place, intervention B, C and D but not intervention A. The written plan of care also indicated that the device on resident #014's mobility aide was a PASD and could be removed by the resident upon request.

Inspector #672 observed resident #014 daily while in the home conducting the RQI inspection, but did not observe resident #014 to have two of the required fall prevention interventions, B and D in place.

During an interview resident #014's SDM indicated belief the restraining device, intervention A, had been in place for some time and for the purpose of restraining the resident in an attempt to prevent resident #014 from rising independently, and falling and that the resident could not removed the device upon request.

During an interview, PSW #135 indicated that resident #014 did not use intervention C according to the plan of care and was unaware that this direction was listed within resident #014's plan of care.

During separate interviews, RPN #132, the RAI Coordinator, and the interim DOC indicated that the expectation in the home was that the plan of care should be immediately reviewed and updated to reflect when a resident's needs or preferences became known or changed; when current interventions were no longer effective, or when new interventions were initiated.

The licensee failed to ensure that resident #014's plan of care set out clear directions to staff and others who provided direct care to the resident, as resident #014 no longer required interventions B, C and D. [s. 6. (1) (c)]

The severity of this issue was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of the issue was a level 3 widespread as it related to three out of three residents reviewed.

The home had a level 3 compliance history as there was one or more related non compliance within the last 3 years that included:
-written notification (WN) issued November 15, 2016 in report #2016_268604_0022 related to s. 6. (1)(c).
- voluntary plan of correction (VPC) issued May 29, 2017 in report #2016_650565_0004 related to s. 6. (10)(c), and a written notification (WN) related to s. 6. (1)(a), and s. 6. (10)(c).
- written notification (WN) issued January 2, 2018 in report #2018_643111_0001 related to s. 6. (5).

(110)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : May 30, 2019

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

Ministère 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 : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 8. (1) (b).

The licensee is ordered to:
1. Develop, implement and submit a plan to ensure that the home's policy "Disposal of Discontinued/Expired Drugs, Narcotics and Controlled Substances"; Index #04-08-10 is complied with.
2. The plan must include education to all registered staff of the identified policy.
3. Maintain records of the education provided to staff and be available upon inspector request.
4. The plan must include an auditing process to ensure the above mentioned policy is complied with.

Please submit the written plan for achieving compliance for inspection 2018_414110_0012 to Jennifer Batten, LTC Homes Inspector, MOHLTC, by email to CentralEastSAO.MOH@ontario.ca by within two weeks of receipt of this order. Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

1. 1. The licensee failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system is

complied with.

According to O. Reg. 79/10, r. 136. (1), the licensee shall ensure, as part of the medication management system, that a written policy is developed in the home that provides for the ongoing identification, destruction and disposal of,
a) all expired drugs;
b) all drugs with illegible labels;
c) all drugs that are in containers that do not meet the requirements for marking containers specified under subsection 156 (3) of the Drug and Pharmacies Regulation Act; and
d) a resident's drugs where,
(i) the prescriber attending the resident orders that the use of the drug be discontinued;
(ii) the resident dies, subject to obtaining the written approval of the person who has signed the medical certificate of death under the Vital Statistics Act or the resident's attending physician; or
(iii) the resident is discharged and the drugs prescribed for the resident are not sent with the resident under section 128. O. Reg. 79/10, s. 136 (1).

According to O. Reg. 79/10, r. 136. (4), the licensee shall ensure that where a drug that is to be destroyed is a controlled substance, the drug destruction and disposal policy provides that the applicable team document the following in the drug record:
1. The date of removal of the drug from the drug storage area.
2. The name of the resident for whom the drug was prescribed, where applicable.
3. The prescription number of the drug, where applicable.
4. The drug's name, strength and quantity.
5. The reason for destruction.
6. The date when the drug was destroyed.
7. The names of the persons who destroyed the drug.
8. The manner of destruction of the drug.

A review of the licensee's internal policy entitled the "Disposal of Discontinued/Expired Drugs, Narcotics and Controlled Substances"; Index #04-08-10; from the MediSystem Pharmacy manual, as part of the licensee's medication program, indicated the following:

"In addition, the Narcotic and Controlled Substances Surplus Drug Form is also completed (or as per facility policy) when placing medication awaiting disposal in the double locked centralized storage area within the facility. This form includes documentation of:
a. Date of removal of the drug from the unit (i.e. narcotic bin in medication cart)
b. Resident name
c. Prescription number
d. Drug name, drug strength, quantity
e. Reason for removal"

Inspector #672 observed the licensee's narcotic destruction storage area on an identified date, along with the attached "Narcotic and Controlled Drug Surplus Record Form", which was the form completed by Registered staff when a narcotic was brought to the area for destruction. The forms captured the dates over a nine week period, which had 43 entries. Of the 43 entries, there were 15 which did not list a reason for the narcotic medication(s) to be destroyed.

During separate interviews RPN #138 and the Acting DOC indicated that the expectation in the home was that when a narcotic or controlled substance was brought to the destruction storage area, the attached "Narcotic and Controlled Drug Surplus Record Form" was to be completed every time, which was to include the reason for the destruction. Inspector #672 reviewed the forms with RPN #138 and the Acting DOC, who both acknowledged that there were several entries which did not have the reason for the destruction identified or documented on the form, therefore the internal policy entitled "Disposal of Discontinued/Expired Drugs, Narcotics and Controlled Substances"; Index #04-08-10; from the MediSystem Pharmacy manual, as part of the licensee's medication management program, was not complied with.

In addition, Inspector #672 reviewed the internal policy entitled "Narcotic and Controlled Drugs Management" policy, Index #: CARE13-020.01; Effective: August 31, 2016; Reviewed: March 31, 2018; which stated the following:
• "All narcotics and controlled drug(s) will be secured by double locking.
• All narcotic wastage (e.g. half a vial of Morphine) will be double witnessed and signed by two nurses. The unused portion is to be discarded into a biohazardous waste container or sharps container.
Inspector #672 then reviewed the internal policy entitled "Narcotic and

Controlled Substances Administration Record"; Index #04-07-10; Last Updated: June 23, 2014; from the MediSystem Pharmacy manual, as part of the licensee's medication program, which stated the following:
"4. All entries must be made at the time the drug is removed from the container. 5. Entries for wasted doses must be filled in completely with an explanation and the signature of a witness on the Narcotic and Controlled Substances Record. The record should have an explanation regarding the damaged ampoule, capsule, or tablet and be placed in the drug destruction container with the completed sheet".

Inspector #672 conducted a medication observation on an identified date during a medication pass, with RPN #100. Inspector #672 observed RPN #100 administer an identified controlled substance to resident #004, and observed that RPN #100 did not have the narcotic control summary sheets present during any part of the medication administration.

Following the administration of the controlled substance, RPN #100 did not complete any documentation within the narcotic control/count summary sheets. Following the medication administration to resident #004, Inspector #672 observed a medication administration a controlled substance to resident #025. Following administration of the controlled substance, there was identified mls of the controlled substance left in the vial, which RPN #100 placed in the garbage can on the medication cart, without wasting the remaining amount with another registered staff member, or signing any documentation within the narcotic control/count summary sheets.

Inspector #672 remained on the resident home area for approximately one hour following the medication administration observations, and did not observe RPN #100 document within the narcotic control/count summary sheets.

During an interview RPN #100 indicated it was part of their usual practice to dispose of excess controlled substances in the garbage bin, without wasting the substance in the appropriate area, or documenting the wastage with a second registered staff member within the narcotic control/count summary sheets, due to time constraints. RPN #100 further indicated being aware of the expectation in the home that all controlled substances were to be wasted with two registered staff members, and that documentation of administration of all controlled

substances were to immediately be documented within the narcotic control/count summary sheets following administration, but indicated the documentation of the administered controlled substances were documented at the end of the shift, while preparing for the narcotic shift change count, with the oncoming registered staff, again due to time constraints.

During an interview the Acting DOC indicated that the expectation in the home is that immediately following administration of a controlled substance, the registered staff member is to immediately sign off on the narcotic control/count summary sheets following administration. The Acting DOC further indicated the expectation in the home was that all controlled substances be wasted with two registered staff members, the wastage was to be appropriately documented, and the liquid was to be emptied from the vial in a manner which rendered the medication impossible to retrieve, such as into a sink or sharp's container. It was not acceptable practice to dispose of a vial of controlled substance into any area without first emptying it first, and until the vial could be emptied with two registered staff witnesses, the controlled substance was to remain under double lock at all times. The Acting DOC further indicated that if one of the other registered staff in the building were not available to witness the wastage, the nurse could always contact one of the managers, and they could immediately come to witness the wastage, and sign the appropriate forms. The Acting DOC indicated that management had met with RPN #100, to review the "Narcotic and Controlled Drugs Management" and the "Narcotic and Controlled Substances Administration Record" policies, and ensure RPN #100 was aware of the expectations in the home, regarding documentation requirements following administration of any controlled substance in the home, and wastage of controlled substances.

Inspector #672 completed a second narcotic count with RPN #100 on an identified date. Following completion of the narcotic count, Inspector #672 observed that the narcotic control/count summary sheets for six controlled substances were incorrect, and there had been no documentation completed on any of the forms since the narcotic count completed during the shift change, at 0700hrs.

Inspector #672 then completed a narcotic count with RPN #145 on an identified date. Following completion of the narcotic count, Inspector #672 observed that

the narcotic control/count summary sheets for two controlled substances were incorrect, and there had been no documentation completed on any of the forms since the narcotic count completed during the shift change, at 0700hrs.

During separate interviews, RPNs #100 and #145 indicated that the narcotic count was incorrect due to not documenting any of the controlled substances administered during the medication pass in the appropriate narcotic control/count summary sheets, immediately following the administration of the controlled substances, due to time constraints. RPNs #100 and #145 further indicated awareness of the expectation in the home, that the documentation was to be completed immediately following the administration of the controlled substance.

The licensee failed to ensure that the "Disposal of Discontinued/Expired Drugs, Narcotics and Controlled Substances"; Index #04-08-10; the "Narcotic and Controlled Drugs Management" policy, Index #: CARE13-020.01; Effective: August 31, 2016; Reviewed: March 31, 2018; and the policy entitled "Narcotic and Controlled Substances Administration Record"; Index #04-07-10; Last Updated: June 23, 2014; from the MediSystem Pharmacy manual were complied with. [s. 8. (1) (b)]

The severity of this issue was determined to be a level 2 as there was minimal harm or potential for actual harm to the resident. The scope of the issue was a level 3, widespread, as it occurred on three of the four home areas.
The home had a level 2 compliance history as there was one or more unrelated non-compliance in last three years that included:
-voluntary plan of correction (VPC) issued November 15, 2016 in report #2016_268604_0022 related to r. 8. (1)(b) and medication.

(672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 30, 2019

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

Ministère 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 : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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;
(b) set out the organization and scheduling of staff shifts;
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident;
(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
(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).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 31. (3).

The Licensee is ordered to implement the following immediately upon receipt of this order:

1. Develop a plan to hire and retain Personal Support Workers (PSW's) to facilitate the adherence of the home's staffing plan.
2. Review the process for staff replacement and call ins to ensure roles and responsibilities are clearly defined for the replacement of staff on days, afternoons and nights including weekends.
3. The process for staff replacement must be clearly identified in writing.
4. All staff involved in the replacement and call in replacement process shall be informed.
5. The staffing plan shall be implemented in the replacement of staff and when working short staffed.
6. The Executive Director shall request an invitation to attend a Residents' Council and Family Council meeting between March-May, 2019, to discuss the Ministry Order of s. 31. (3) and the home's plan to address this requirement.
7. A record shall be kept for all steps 1-6 and available for review by the Inspector.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the staffing plan provided for a staffing mix that is consistent with residents' assessed care and safety needs and gets evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

This IP was initiated related to a family concern expressed around insufficient staffing in the home and that the home is often short staffed.

A record review and interview with scheduling clerk #142 identified that the home's staffing plan included the following PSW staffing compliment:
Days- three full time PSWs on each home area (there are four home areas in the LTC home) and two part time PSW staff four days a week.
Afternoons- three full time PSWs on each home area.
Nights-one PSW on each home area and two full time PSW floats.

A record review of the home's staffing schedule from April 1, 2018 to July 25, 2018 identified the following staff shortages with no staff replacement which was also confirmed by scheduling clerk #142 and the interim DOC.

April 1, 2018, 2 day and evening shift PSWs short no replacement.
April 2, 2018, 2 day shift PSWs short replaced with 1 PSW for half shift.
April 10, 2018, 1 day shift PSW short no replacement.
April 22, 2018, 1 day shift PSW short no replacement.
April 28, 2018, 1 day shift PSW short no replacement.
April 29, 2018, 1 day shift PSW short no replacement.
May 1, 2018, 2 day shift PSWs short no replacement.
May 6, 2018, 3 PSWs - two day and one evening shift short no replacement.
May 7, 2018, 1 day shift PSW replaced with 1 PSW for half a shift.
May 10, 2018, 1 evening shift PSW short no replacement.
May 19, 2018, 3 day shift PSWs short no replacement.
May 20, 2018, 4 day shift PSWs short no replacement.
May 23, 2018, 1 day shift PSW short no replacement.
May 26, 2018, 1 day shift PSW short no replacement.
May 29, 2018, 1 day shift PSW short no replacement.
June 1, 2018, 3 PSWs- one day and two evening shifts short no replacement.
June 3, 2018, 2 day shift PSW short replaced with 1 PSW for half a shift.
June 6, 2018, 1 day shift PSW short no replacement.
June 17, 2018, 6 PSWs- four day shift, one evening and one night shift short no replacements.
June 18, 2018, 2 PSWs, one day and one evening shift short no replacements.
June 22, 2018, 2 PSWs, one day and one evening shift short no replacements.
June 23, 2018, 2 PSWs, one day and one evening shift short no replacements.
June 24, 2018, 2 evening shift PSWs short no replacements.
June 25, 2018, 1 day shift PSW short replaced with 1 PSW for half a shift.
June 28, 2018, 1 day shift PSW short no replacement.
July 2, 2018, 1 evening shift PSW short no replacement.
July 3, 2018, 1 evening shift PSW short no replacement.
July 7, 2018, 3 PSWs, one day, one evening and one night shift short no replacements.
July 8, 2018, 2 PSWs, one evening and one night shift short no replacements.
July 9, 2018, 2 day shift PSWs short no replacements.
July 10, 2018, 2 day shift PSWs short no replacements.

July 11, 2018, 1 day shift PSW short no replacements.
July 15, 2018, 3 day shift PSWs short no replacements.
July 22, 2018, 1 day shift PSW short no replacements.
July 25, 2018, 3 day shift PSWs short no replacements

An interview with staffing clerk #142 and the interim DOC confirmed that a process was in place for call in, staff replacement, but that causal and part time staff including agency staff.were often unavailable.

A record review of the Residents' Council meeting minutes of April 2018, identified a concern that the home is short staffed at least once a week.

Staff interviews conducted during the inspection confirmed that staffing was a concern and staff are often working short.

An interview with resident #027, PSW #143 and RPN #126 confirmed that staff were unable to provide for resident #027's need to be taken to the dining room for their meal on an identified date as a result of a staffing shortage in the home area.

An interview with the SDM of resident #028, PSW #129 and RPN #138 confirmed that staff were unable to provide for resident #028's need to be taken to the dining room for a meal on an identified date or their need to be provided with their scheduled second shower of the week as a result of a staffing shortage on the home area.

Interviews with the interim DOC acknowledged that resident care needs can not always be met with the current staffing plan as staff were not available for replacement.

An interview with the Executive Director (ED) confirmed the home's staffing plan was not followed and therefore did not provide for a staffing mix that was consistent with residents' assessed care needs at the time. The ED identified that since January 2018 the home has had a staffing shortage, despite recruitment efforts and that recruitment and retention incentives needed to be considered and have been discussed with the corporate office. The ED further confirmed the home's staffing plan has not been evaluated and updated at least

annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. [s. 31. (3)] (110) [s. 31. (3)]

The severity of this issue was determined to be a level 3 as there was actual harm/risk as the care needs of residents was impacted. The scope of the issue was a level 3 widespread as it related three out of three residents reviewed.

The home had a level 2 compliance history as there was one or more unrelated non compliance within the last 3 years.

(110)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 31, 2019

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

Ministère 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 : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 33. (1).

Upon receipt of this order the licensee shall implement the following:
1. The Licensee shall ensure that a suitable bathing substitute is available to Resident #026 or an alternative including tub bath is offered. Follow-up with resident #026 shall be documented to ensure the resident's bathing preference is being honored.
2. Resident #026's plan of care shall be updated to reflect the use of a suitable bathing substitute.
3. The DOC shall ensure that a standard of care for bathing practices for resident's with identified medical conditions.
4. At each shift report for two months, registered staff shall share the standard of practice with front line staff.
5. The home shall review the process of ensuring that residents are bathed, at a minimum of twice a week by the method of his or her choice including hair washing including when short staffed.
6. At each shift report for two months, registered staff shall share the expectation of regulation 33 (1) with front line staff and the steps to be taken with a scheduled bath could not occur.
7. A record shall be kept for steps 1-6 for review by an inspector.

Grounds / Motifs :

1. The licensee has failed to ensure that the resident is bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's

hygiene requirements, unless contraindicated by a medical condition.

This IP was initiated related to concerns of insufficient staffing.

A record review of a family complaint in the home's complaint binder identified a complaint letter written in 2018, by a family member of resident #026.The letter expressed care concerns related to hygiene and continence care.

A record review of the staffing schedules for an identified two month period with scheduling clerk #142 identified that they were short one PSW with no replacement for 10 days within this time period.

A record review of the resident #026's written plan of care identified that the resident preferred showers and required a mechanical lift with two staff full support to transfer safely.

An interview with resident #026 identified that they preferred a shower but the shower chair can be uncomfortable and was provided a bed bath. When asked by inspector if a bed bath was a suitable substitute, resident #026 indicated that they would prefer if the home fixed the shower chair as they preferred to shower.

Record review of the Follow up Question report in POC for bathing one month prior to the family complaint, identified the resident received one shower and five bed baths and on two occasions the resident refused.

An interview with PSW #143 confirmed that they provided resident #026 with a bed bath as the resident had complained about the comfort of the shower chair. PSW #143 confirmed they had not offered resident a tub bath in place of a shower.

An interview with PSW #146 revealed knowledge that the shower chair was uncomfortable for resident #026 and that they had never thought of offering a tub bath as an option to the resident.

An interview with PSW #144 revealed that resident #026 preferred a shower but the resident would be agreeable to a bed bath if they were short staffed. Staff

#144 confirmed they did not shower or provide a bed bath to resident on one of the identified dates above as scheduled.

An interview with full time RPN #126 acknowledged they were aware of resident #026's preference for a shower but unaware that staff were providing bed baths in place of a shower related to the uncomfortable nature of the shower chair. The RPN stated that a tub bath should have been offered to the resident in place of a shower.

An interview with the interim DOC confirmed awareness of the shower chair concern for resident #026 and stated that they were fixing the issue. The interim DOC revealed that a bed bath was not a substitute for a shower and that the resident should have been offered a bath and when a resident refused staff need to re approach and offer a shower the next shift or day. The interim DOC also confirmed that resident #026 did not receive two baths per week according to their preference for an identified month in 2018 for a total of 7 missed occasions and the resident's hair was not washed, confirming the family's written concern. [s. 33. (1)] (110)

2. This IP was triggered related to concerns around insufficient staffing.

A record review of resident #028's plan of care identified the resident preferred showers and the bathing list identified the resident was scheduled to be bathed (showered) on identified days twice per week.

An interview with RPN #100 revealed that they had received a concern at shift report on an identified day in 2018 regarding a hygiene concern related to resident #028.

An interview with resident #028, revealed that they had not had their hair washed and it felt dirty.

A telephone interview was conducted with a family member of resident #028 during the interview they confirmed they had visited their parent at an identified time that week and were concerned about their hair. The family member shared that they mentioned their concern to a registered staff and the staff member revealed they were short staffed and unable to offer the resident a shower.

A record review of the staffing schedules for an identified month in 2018with scheduling clerk #142 identified the home area was short one PSW with no replacement for 6 days on the identified month.

A record review of the POC documentation of resident #028's bathing schedule identified the resident received a sponge bath with no hair washing on 4 occasions and on three occasions there was no documentation to support the resident was bathed during the identified time of review.

An interview with PSW #146 revealed they worked on the identified day the family expressed concern and the home area was short staffed and when short staffed they do not provide baths or showers to residents. When asked about the documentation related to bed baths, the staff revealed that the resident may not have received a bath due to medical concerns.

Interviews with PSW #129 and RPN #138 revealed they worked on another identified date within the month of review and the home area was short staffed on days and they were unable to provide resident #028 a shower.

An interview with the interim DOC revealed the resident did not receive a minimum of two baths per week of their choice, a shower, for the identified month and that the resident should still have been showered with respect to the identified medical concern The interim DOC further confirmed that when a resident's shower or bath was missed the resident should still be offered their bathing choice the next shift or next day to ensure a minimum of two baths per week and that this practice was not followed. [s. 33. (1)]

The severity of this issue was determined to be a level 2 as there was minimal harm or potential for actual harm as resident care needs were not met. The scope of the issue was a level 2 patterned as it related two out of three residents reviewed.
The home had a level 2 compliance history as there was one or more unrelated non compliance within the last 3 years.

(110)

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : May 31, 2019

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

Ministère 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 : 005

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 131. (2).

The licensee is ordered to:
(1) Develop and implement a plan to ensure that all medications are administered to the resident as specified by the prescriber.
(2) Conduct random monthly supply audits to ensure that each resident home area is supplied with the equipment required to administer medications as per the routes identified by the prescriber.
(3) Keep a documented record of the supply audits conducted.
(4) Conduct random medication administration observations twice per month for a six month period, for residents receiving injectable medications, to ensure staff are administering the medications as per the route ordered, according to best practice standards.
(5) Keep a documented record of the observational audits conducted.
(6) Conduct and document random audits over an eight week period of new Physician's orders, to ensure what is prescribed to the resident is administered.
(7) Develop and implement a plan which outlines corrective actions taken and by whom, if staff fail to implement the interventions as identified.
(8) Conduct periodic audits to ensure that staff are implementing the interventions as identified.

Grounds / Motifs :

1. The licensee has failed to ensure that all drugs were administered to resident #025 in accordance with the directions for use specified by the prescriber.

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

Related the Log #028848-17:

A Critical Incident Report was submitted to the Director, related to a medication incident/error which altered the resident's health status, and related to resident #021. According to the CIR, resident #021 had received a Physician's order, to discontinue an identified medication, and to initiate a treatment, both of which had not been processed.

Inspector #672 reviewed resident #021's progress notes from an identified date and noted the resident began to have a change in status. Approximately two weeks later the resident presented with symptoms of a change in status and the nurse requested the resident be assessed by the Physician. On the same identified day the Physician documented an assessment which indicated that resident #021 exhibited physical signs and symptoms of a medical condition then ordered the discontinuation of a medication B and ordered a treatment, identified as treatment A. The Physician's order was observed to have been signed by two registered staff, which indicated that the order had been fully processed and implemented appropriately.

Inspector reviewed the internal medication incident report, which indicated that the Physician's order was noted to have not been processed, and resident #021 had continued to receive medication A , a week after the order to discontinue, which contributed to resident #021 decline in health status.

Inspector #672 reviewed resident #021's progress notes over one week from the date that treatment A was to be initiated. The resident had experienced a change in status and was assessed by Nurse Practitioner (NP) #140. The NP identified that the further change in the resident's condition was as a result of the unprocessed physician order for treatment A.

Inspector #672 reviewed the internal investigation into the medication incident from an identified date which revealed that RPN #132 had signed the order, indicating that the order had been processed in full, and RN #137 had co-signed the order, verifying that it had been processed and implemented in full.

During an interview with RPN #132 they indicated awareness that as a result of

failing to process the order appropriately, resident #021 had not received all medications in accordance with the directions for use specified by the prescriber, over an identified one week period.

RN #137 was not available for an interview during the inspection.

During an interview the Acting DOC indicated that the expectation in the home was that the registered staff member would process the entire Physician's order, which included ensuring the order was entered into the eMAR system, and removing all discontinued medications from the medication cart. The Acting DOC verified that the process was not followed in regards to the Physician's order received for resident #021, as the resident continued to receive medication A over a one week period after it was ordered to be discontinued.

The licensee failed to ensure that all medications were administered to resident #021 in accordance with the directions for use specified by the prescriber, over a one week period, which resulted in resident #021 decline in health status. [s. 131. (1)]

2. The licensee has failed to ensure that all drugs were administered to resident #025 in accordance with the directions for use specified by the prescriber.

Inspector #672 completed a medication administration observation during the medication pass on an identified date, as part of the Medication IP. Inspector #672 observed RPN #100 administer medications to resident #025, during the medication pass. The medication administration included the administration of an identified medication.
Inspector #672 reviewed the physician's orders for resident #025, and observed the same identified medication to be administered along with an order for an identified instrument or tool for the administration.

During the medication administration observation, Inspector #672 observed RPN #100 administer the identified medication not using the ordered instrument for administration. During the administration, resident #025 was noted to have facial grimacing.

During an interview RPN #100 indicated that identified instrument for

administration as ordered was not used for resident #025 related to the tool not being readily available.

During an interview with the Acting DOC they indicated that the expectation in the home when a nurse does not have the appropriate tools to meet a resident's care needs was that the staff member was to stop the task, and either look for the tool independently, or the staff member was to call one of the other nursing units to ask a colleague for the item, or someone from the nursing management team. It was not acceptable to not follow a physician's order, or a resident's plan of care, due to not having the required tools immediately on hand. The Acting DOC further indicated that the appropriate tools were available within the home, had RPN #100 called someone else for assistance.

The licensee failed to ensure that all medications were administered to resident #025 in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

The severity of this issue was determined to be a level 2 as there was minimal harm or potential for actual harm as resident as the medication administration order was not followed. The scope of the issue was a level 1 isolated as it related to one out of three residents reviewed.
The home had a level 3 compliance history as there was one or more related non compliance within the last 3 years that included:
-written notification (WN) issued November 15, 2016 in report #2016_268604_0022 related to r. 131.(3)
- written notification (WN) issued January 2, 2018 in report #2018_643111_0001 related to r. 131.(1).

(672)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : May 30, 2019

Order # / Ordre no : 006

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (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).

Order / Ordre :

The licensee must be compliant with the LTCHA, 2007, s. 6. (7).

The licensee is ordered to:
1. The FSM shall ensure that resident #003 and #010 are provided with the nutritional care set out in their plan of care.
2. The FSM and RD shall review the process of instituting orders by the RD to ensure the residents received the prescribed nutritional interventions and identify gaps related to this process.
3. Between March 15 and April 30, 2019 an audit shall be completed of each resident at high nutritional risk to ensure all nutrition interventions (pertaining to meals and snacks) are provided as set out in the resident's plan of care.
4. A record shall be kept of the audit along with the follow-up action completed when nutritional care was identified to be not provided as set out in the resident's plan of care.
5. The licensee must develop a plan to ensure that residents required to eat in the dining room are provided this care.
6. A record shall be keep that demonstrates that all registered staff have been informed of the requirement.
7. Develop and implement a process to ensure that when a resident is served a meal outside of the dining room, the meal is not served to the resident until a staff member is available to provide the level of assistance required, as indicated in the resident's plan of care.
8. Develop and implement a plan for ensuring that a process is in place to ensure that when a resident is served fluids or a meal, the resident is positioned appropriately, to safely ingest the food and fluid items being served.
9. Conduct audits three times weekly for an eight week period, to include all three meals and to ensure residents are positioned appropriately to safely ingest

the food and fluid items being served, and to ensure when a resident is served a meal outside of the dining room, the meal is not served to the resident until a staff member is available to provide the level of assistance required, as indicated in the resident's plan of care.
10. Keep a documented record of the audits conducted, along with any plan which outlines corrective actions taken and by whom, if staff fail to implement the interventions as identified.
11. Develop and implement a process to ensure that when a resident is noted to have a poor food and fluid intake, the FSM/RD is notified.
12. Conduct monthly audits for a six month period of the food and fluid intake sheets, to ensure the FSM/RD was notified when a resident was noted to have a poor food and fluid intake.
13. A record shall be kept of the audits, along with the follow-up action completed if it was observed that the FSM/RD was not notified when a resident was noted to have a poor food and fluid intake.

Grounds / Motifs :

1. This IP was triggered in stage one of the RQI related to concerns of insufficient staffing.

Resident #028 was identified as residing on Home Area B. A record review of the resident's written plan of care identified the resident ate in the Home Area B dining room for two identified meal and required an identified level of assistance to transfer the resident safely from bed to chair.
A telephone interview with the resident's SDM revealed that they had arrived at the home to visit resident #028 on an identified date and time to find the resident had not been up for meals. The SDM stated the resident should be going to the dining room for identified meals.

A record review of the staffing schedules included a review of an identified 25 day period with scheduling clerk #142. The review identified Home Area B was short one PSW with no shift replacement six days out of the 25 day period reviewed including the identified day the resident's SDM arrived to visit and found the resident having not been up for meals.

A record review of a progress note on the same identified day by RPN #138 stated that resident #028 was in bed throughout the shift.

An interview with RPN #138 revealed that on day shift on the same identified date Home Area B was short both a RPN and a PSW and that they had been called in and arrived to the home area around noon. The interview further revealed that when they arrived on Home Area B a PSW informed them that they were short staffed and unable to get resident #028 up for a meal but that a meal tray was provided to the resident.

An interview with PSW #129 who worked days on the identified date confirmed Home Area B was short one PSW. The PSW revealed that resident #028 did not get up for the identified meal as usual and that they had not asked the resident if they would like to get up for the meal stating they knew they were short and with only two PSWs on the home area and they would be unable to transfer the resident from bed to chair.

An interview with PSW #141 who also worked days on the identified date, confirmed that the home area was short one PSW and that resident #028 was not up for their meal related to the home area working short.

An interview with the interim DOC #106 confirmed that staffing shortage on the identified date and acknowledged that the resident's written plan of care was not followed in terms of getting the resident up for a meal in the dining room. [s. 6. (7)]

(110)

2. 4. 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.
This IP was triggered in stage one of the RQI related to concerns of insufficient staffing.
Resident #027 was identified as residing on an identified home area, described as Home Area A. A record review of the resident's written plan of care identified that the resident ate in the Home Area A dining room and required an identified level of assistance to transfer safely from bed to wheelchair.
A record review of the staffing schedules included a review of an identified 25 day period with scheduling clerk #142. The review identified that Home Area A was one PSW short with no replacement five out of the 25 days reviewed.

An interview with resident #027 revealed that on one of the five days staff informed them that the home area was short staffed and they were unable to get them up for a meal in the dining room. The resident stated they felt awful when told they were unable to go to the dining room. The resident further stated they were ready to be assisted by staff and did not want to have a meal while in bed.

An interview with PSW #143 who worked on the same identified day confirmed the unit was short staffed and unable to get resident #027 to the dining room for a meal. An interview with RPN #126 further confirmed that the unit was short staffed and they were unable to get four residents up for a meal in the dining room including resident #027.

An interview with interim DOC confirmed that the care set out in the written plan of care was not provided to resident #027 when they were unable to go to the dining room for a meal. [s. 6. (7)]

(110)

3. Resident #010 triggered through to stage II of the RQI process related to observations made during stage I of the RQI, related to restraints.

Inspector #672 reviewed resident #010's current written plan of care, which indicated that resident #010 was at high nutritional risk, related to their safety in eating. The written plan of care also identified interventions to minimize the safety risk at meals and included staff supervision, cueing and physical assistance.

On an identified date and time resident #010 was observed in an unsafe feeding position, with no supervision. Inspector informed RPN #107, then PSW #115 and assigned PSW #116 attended to resident #010's by providing resident #010 with positioning assistance, then leaving resident #010 unsupervised to eat their meal.

During an interview RPN #107 indicated that resident #010 required supervision and staff support during meals, and should not have been left alone, while a meal had been served.

During an interview with PSW #116 indicated they were the primary PSW responsible for resident #010's care during the day shift, and had served resident #010. PSW #116 further indicated being aware that resident #010 required supervision and assistance with meals, but had not had the opportunity to return to resident #010's to provide assistance or support.

During an interview the interim DOC indicated that the expectation in the home was that each resident's plan of care be followed at all times, and that if a resident's plan of care indicated that the resident required supervision and assistance with meals, they should not be left to eat unsupervised at any time.

The licensee failed to ensure that resident #010 received care as specified in the plan, specific to meals.

(672)

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

Resident #003 was identified in stage one of the RQI for a compromised nutrition status and impaired skin integrity.

Resident #003's Minimum Data Set Assessment of an identified date, revealed the resident had multiple areas of altered skin integrity. The assessment also identified resident #003 had ongoing poor oral food and fluid intake.

A review of resident #003's plan of care identified they were at high nutrition risk as evidenced by the altered areas of skin integrity and significant weight loss over a period of one month. Nutrition interventions in resident #003's plan of care were to provide the identified nutrition intervention A and B three times a day at meals.

Resident #003 was observed during a meal service on an identified date. RPN #107 was observed to provide resident #003 assistance with the offering of fluids . The inspector did not observe intervention A, fluid being offered.

An interview with RPN #107 identified resident #003 to be at high nutrition risk. RPN #107 confirmed resident #003 was offered intervention B but not intervention A revealing they were unaware of the required intervention A three times a day at meals, and acknowledged resident #003 did not receive care as specified in the plan related to the provision of their organized nutrition interventions.

An interview with DA #123 and a review of the resident's diet order in the servery diet list failed to identify intervention A. DA#123 indicated they were unaware of this intervention for resident #003, and confirmed resident #003 did not receive intervention A at the identified observed meal.

An interview with the RD and a review of resident #003's plan of care identified they were to receive interventions A and B to support weight gain and high risk of altered skin integrity as identified in the plan of care.

The RD confirmed staff did not implement resident #003's nutrition care plan as they failed to offer resident #003 intervention A as per their assessed needs to address ongoing weight loss and their high risk of skin imparity.

The above information was reviewed with the home's interim DOC. The DOC acknowledged resident #003's did not receive care as specified in the plan as staff failed to provide nutritional interventions as per their assessed nutrition needs.

(648)

5. . Resident #019 was identified in stage one of the RQI for impaired skin integrity.

A review of resident #019's progress note on an identified date, identified resident #019 to have an area of altered skin integrity.

Resident #019's written plan of care, identified the resident was at risk of impaired skin integrity with supporting evidence. Interventions to manage the resident's impaired skin integrity included application of intervention A and intervention B.

A review of resident #019's treatment administration record identified intervention A.

On an identified date and time the inspector observed resident #019 without the required interventions A and B.

An interview with PSW #127, indicated staff were expected to follow a resident's written plan of care as specified for prevention and management of skin concerns.

PSW #127 stated resident #019 did not have any areas of altered skin integrity and with no specific interventions in place for the resident. Following the interview an observation was conducted with PSW #127 of resident #019 on an identified date. PSW #127 confirmed that resident #019 did not have interventions A and B in place.
PSW #127 stated they had been providing care to resident #019 for approximately one month and confirmed they had not applied intervention A to the resident at any time during their care over the three shifts they worked with the resident.

An interview with RPN #126 indicated resident #019 had an area of altered skin integrity. RPN #126 reported resident #019 was at high risk of skin imparity. RPN #127 stated resident #019 required ongoing skin monitoring and implementation of the organized interventions reviewed in the plan of care, to prevent and manage their skin risk, as reviewed above. RPN #126 revealed they were unaware resident #019 did not receive the identified interventions as observed by the Inspector.

The above noted information including the staff interviews and health records for resident #019 were reviewed with the home's interim DOC. The DOC acknowledged the home failed to ensure resident #019 received interventions to prevent and manage their skin risk as specified in their plan of care.

(648)

6. Related the Log #028848-17:

A Critical Incident Report was submitted to the Director, related to a medication incident/error in administration which altered resident #012's health status.

Inspector #672 reviewed resident #021's progress notes from an identified date and noted the resident began to have a change in health status. Approximately two weeks later the resident presented with symptoms of a change in status and the nurse requested the resident be assessed by the Physician. On the same identified day the Physician documented an assessment which indicated that resident #021 exhibited physical signs and symptoms of a medical condition and an order was received for a treatment, identified as treatment A. The Physician's order was observed to have been signed by two registered staff, which indicated that the order had been fully processed and implemented appropriately.

Inspector reviewed the internal medication incident report, which indicated that the Physician's order had not been processed, and resident #021 had not received treatment A.

Inspector #672 reviewed resident #021's progress notes over one week from the date that treatment A was to be initiated. The resident had experienced another change in status and was assessed by Nurse Practitioner (NP) #140. The NP identified that the further change in the resident's condition was as a result of the unprocessed Physician order for treatment A.

During an interview with RPN #132 they indicated awareness that as a result of failing to process the order appropriately, resident #021 had not received treatment A which contributed to resident #021's further decline in health status.

RN #137 was not available for interview during the inspection.

During an interview with the Acting DOC they verified that the process was not followed in regards to the Physician's order received on an identified date, for resident #021, and the resident did not receive the treatment A. The DOC verified that failing to implement treatment A contributed to the resident's decline

in health status.

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

The severity of this issue was determined to be a level 3 as there was actual harm/risk. The scope of the issue was a level 3 widespread as it related more than three out of three residents reviewed.

The home had a level 3 compliance history as there was one or more related non compliance within the last 3 years that included:
-written notification (WN) issued November 15, 2016 in report #2016_268604_0022 related to s. 6.(1)(c) and s. 6.(7).
- voluntary plan of correction (VPC) issued March 29, 2017 in report #2017_650565_0004 related to s. 6. (1)(a), s. 6. (1)(a), s.6.(1)(a) and s. 6. (10) (c).
- written notification (WN) issued January 2, 2018 in report #2018_643111_0001 related to s. 6 (5).

(110)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : May 31, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 26th day of February, 2019

Signature of Inspector /
Signature de l'inspecteur :

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

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