Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 16, 2020	2020_833763_0011	010500-20	Complaint

Licensee/Titulaire de permis

Rykka Care Centres LP
3760 14th Avenue Suite 402 MARKHAM ON L3R 3T7

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

Eatonville Care Centre
420 The East Mall ETOBICOKE ON M9B 3Z9

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

IANA MOLOGUINA (763), JULIEANN HING (649)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 28, 29, 30, 31, 2020; June 2, 3, 4, 5, 9, 10, 11, 12, 15, 16, 17, 18, and 19 2020 (on-site); June 20, 23, and 24, 2020 (off-site).

The following intake was completed during this complaint inspection:

Log # 010500-20 was related to infection prevention and control, resident care, alleged abuse, medication management, staffing, and communication.

PLEASE NOTE: A Written Notification and Voluntary Plan of Correction related to LTCHA, 2007, c.8, s. 6 (7) as well as a Written Notification related to O. Reg. 79/10, s. 50 (2) (b) (iii), identified in a concurrent inspection #2020_751649_0006 (Log # 009302-20, Log # 007075-20, and Log # 011445-20) were issued in this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Directors of Care (ADOC), Registered Dietitian (RD), Canadian Armed Forces (CAF) staff, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Dietary Aides, and residents.

During the course of this inspection, the inspector reviewed resident and home records, policies and procedures, and conducted observations, including staff-resident interactions, meal observations and resident care provision.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Continence Care and Bowel Management
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Skin and Wound Care

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

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

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to residents #001, #037, #038, #020, and #026 as specified in the plan.

A complaint was reported to the Ministry of Long-Term Care (MLTC) from the Canadian Armed Forces (CAF) related to resident #001 not having their call bell accessible to them.

During observation by Inspector #649 on a specified date, resident #001 was heard calling out and PSW #140 responded. Upon entering resident #001's room, the inspector observed that their call bell was on the floor beside their bed and not accessible to the resident.

A review of resident #001's care plan indicated that they were at increased risk for falls and that their call bell was to be within reach and checked to ensure that it was

functioning.

In an interview with PSW #140, they acknowledged that resident #001's call bell was not accessible to them based on the above mentioned observation.

In an interview with DOC #125, they told the inspector that resident call bells were to be left within reach and staff needed to check to ensure that resident call bells were accessible to them. They acknowledged that the resident's plan of care was not followed based on the above observation. [s. 6. (7)]

2. A complaint was reported to the MLTC from CAF related to resident plans of care not being followed by staff.

During an observation by Inspector #649 on a specified date, the inspector observed PSW #126 went into resident #037's room and tried to provide a specified care task by themselves. The resident was heard asking PSW #126 to get someone else to help with the care. PSW #140 then entered the resident's room to assist with care.

A review of resident #037's care plan indicated that they required two staff total assistance for the above mentioned care. Further review indicated that resident #037 had a history of responsive behaviours and required two staff for care at all times.

In an interview with PSW #126, they acknowledged that they did not follow resident #037's plan of care when they approached the resident during the above mentioned observation and tried to provide care by themselves.

In an interview with DOC #125, they told the inspector that it was the home's expectation that staff followed the residents' plan of care, and if a resident no longer required two staff for care, they were expected to report this to the registered staff so the appropriate assessment would be completed. [s. 6. (7)]

3. A complaint was reported to the MLTC from CAF related to resident plans of care not being followed by staff.

During observation by Inspector #649 on a specified date, the inspector observed PSW #126 went into resident #038's room and provided a specified care task by themselves.

A review of resident #038's care plan indicated that they required two staff total

assistance for the indicated care. Further review indicated that resident #038 experienced pain related to specified medical diagnoses.

In an interview with PSW #126 they acknowledged they did not follow resident #038's plan of care when they provided care to the resident by themselves during the above mentioned observation.

In an interview with DOC #125, they told the inspector that it was the home's expectation that staff followed the residents' plan of care, and if a resident no longer required two staff for care, they were expected to report this to the registered staff so the appropriate assessment would be completed. [s. 6. (7)]

4. Resident #020 was observed by Inspector #763 at mealtime as a result of concerns raised from CAF to the MLTC about inappropriate diet textures being served to residents. Prior to observation, resident #020's records were reviewed and indicated they were at a specified nutritional risk and were ordered thickened consistency fluids.

On a specified observation date, home staff brought a food tray to resident #020's room, which included a glass of thickened fluids and a glass of regular consistency water. Resident #020 indicated they were too tired to eat. Staff #148 and RPN #149 encouraged resident #020 to eat, however the resident declined and only accepted some of the thickened fluids to drink. Staff #148 offered resident #020 some of the regular consistency water but the resident declined. Staff #148 then assisted the nurse to put resident #020 back to bed.

After staff #148 and RPN #149 put the resident back to bed, they were interviewed. Staff #148 indicated that resident #020 was only ordered thickened fluids because of an acute decline in their health status. Staff #148 noted they were aware that resident #020 was ordered thickened fluids but indicated that resident #020 did not like it. Staff #148 thought that the dietary department recently assessed the resident and deemed it safe to provide resident #020 with regular consistency water. RPN #149 acknowledged what staff #148 indicated.

Resident #020's records were reviewed and indicated the resident was recently ordered thickened fluids due an acute decline in their health status, and that the last dietary assessment indicated the resident was still ordered thickened fluids.

RD #107 was interviewed on a specified date and confirmed that resident #020 was still

ordered thickened fluids during the above observation period. RD #107 indicated that they recently assessed resident #020's diet order but for another reason, and did not change their fluid consistency order. RD #107 confirmed that resident #020 was originally ordered thickened fluids because of an acute decline in their health status. However, RD #107 was unaware that resident #020 did not like thickened fluids and that staff were serving resident #020 regular consistency water. RD #107 noted it was the expectation for staff to follow the diet order in the resident's plan of care as written, and if staff felt a resident benefited from a re-assessment of their thickened fluid diet order, staff were to ensure the RD assessed the resident prior to providing residents with regular consistency fluids. RD #107 confirmed that resident #020's plan of care was not followed during the above observation when the resident was served with regular consistency water. [s. 6. (7)]

5. A complaint was reported to the MLTC related to an allegation of resident neglect.

Record review indicated that resident #026 had cognitive impairment. Resident #026 was interviewed but was unable to provide any specifics related to the allegation of neglect. The resident told the inspector that they had pain to specified areas on their body.

A review of resident #026's care plan indicated they were not toileted, changed in bed, and required two staff total care during continence care. Further review indicated that the resident had tenderness upon touch to certain areas of their body.

In an interview with PSW #108, they indicated that the resident required two staff for continence care only when they were heavily soiled, and that they would usually provide care to resident #026 by themselves.

In an interview with DOC #125, they acknowledged that staff should have provided care to resident #026 as outlined in their plan of care. [649] [s. 6. (7)]

6. The licensee failed to ensure that resident #019's plan of care was revised when the care set out in the plan has not been effective.

As a result of non-compliance identified for resident #012 (see non-compliance for s. 6. (11) (b)), the sample was expanded to include resident #019. Record review indicated resident #019 had cognitive impairment and was at risk of falls. They had a history of multiple falls related to transferring from bed to use the toilet, without calling for staff assistance. Resident #019's plan of care included an intervention of placing the bed in

the lowest position when the resident was in bed to lower the incidence of falls.

Inspector #763 observed resident #019 on a specified date, asleep in their bed, with the resident's bed placed in a high position. The same observation was noted on a subsequent date. It was noted that the bed had the functionality of being positioned lower to the floor, closer to ankle height.

Immediately after observation on the indicated date, inspector interviewed RN #106 to determine what was the appropriate bed position for resident #019's falls management. RN #106 indicated that PSW #103 just told them that they left resident #019's bed in the higher position because they believed that resident #019 was more likely to fall if their bed was placed at a lower position.

After speaking with RN #106, inspector interviewed PSW #103, the regular staff for resident #019, who confirmed that they often left resident #019's bed in the higher position when the resident was in bed. PSW #103 thought this was a more effective intervention for resident #019 to manage their falls risk. PSW #103 indicated that they had been leaving resident #019 in their bed at this higher position during their shifts, but had only informed RN #106 of this change on the specified date.

Inspector re-interviewed RN #106 after speaking with PSW #103. RN #106 indicated that the intervention to keep resident #019's bed at the lowest position was ineffective to manage resident #019's falls, and that this intervention had been removed from their plan of care after RN #106 spoke with the inspector. RN #106 noted that if care interventions were no longer effective, staff were to communicate this change to the team immediately so that the plan of care was updated. RN #106 confirmed that resident #019's plan of care was not updated when ineffective because PSW #103 did not inform RN #106 of the change right away. [s. 6. (10) (c)]

7. The licensee has failed to ensure that, when resident #012 was reassessed and the plan of care was found to be ineffective, different approaches were considered in the revision of their plan of care.

Resident #012's fall management records were reviewed due to concerns brought forward from CAF to the MLTC regarding the resident's care at the home, including a specified injury that seemed to be left untreated. Resident records indicated that they were at risk of falls and had a history of falls from self-transferring and ambulating without a walker. To manage their falls risk, the resident's plan of care included the following

interventions:

- call bell within reach and in working order
- bed placed in the lowest position
- non-slip footwear
- use of specified assistive devices for safe mobility.

Resident records indicated that they had multiple falls during a specified weekend. Prior to this, their last fall was approximately two months before these falls occurred.

Resident #012 had a fall on a specified date and was assessed for injury; staff noted signs of injury and a treatment was applied. Progress notes indicated to continue with current care interventions to manage their falls risk. Resident #012 had another fall the next day. Existing injuries were noted, likely from the fall they had the day before. As per progress notes, resident #012 was reminded to use the call bell and staff were to monitor the resident closely for safety. Resident #012 then had another fall the following morning. Progress notes indicated that the resident's Substitute Decision Maker (SDM) was contacted by RN #143 who updated the SDM of some changes to the resident's health status that increased their risk for falls. RN #143 noted that the resident did not call for help when requiring assistance and that they would ask the activation aide to talk with resident #012 in the resident's native tongue about reminding them to call for help. The progress notes indicated ongoing close monitoring and call bell to be placed within reach of the resident. Resident #012 then had a fourth fall in the afternoon, and was noted to be weaker after the last fall; the physician was informed. Resident #012's injuries were further assessed and noted to be worsening. The following day, progress notes indicated the signs of injury were further worsening. The nurse practitioner (NP) also assessed the resident and provided recommendations, including ordering several tests and treatments, holding a specified medication, and monitoring vital signs.

There were no changes to the resident's falls prevention plan of care noted from the first fall until the fourth fall.

PSW #144, the regular staff assigned to resident #012, and RPN #145, the staff who worked around the time of resident #012's multiple falls, were both interviewed; they confirmed that resident #012 often did not ask for staff assistance when needed, or use the call bell, despite reminders. They also often did not use their assistive device when ambulating. Although resident #012 was at risk of falls, they did not have recent falls until the specified weekend period.

During an interview, RN #143 confirmed that they were the charge nurse on resident #012's unit during the indicated weekend when resident #012 had several falls. RN #143 noted the falls interventions in place for resident #012 included a call bell to be within reach but noted the resident never used it. They also confirmed resident #012's assistive device was to be accessible, the bed was to be left in the lowest position and staff were to ensure resident #012 wore appropriate footwear. RN #143 noted that on an identified date of the first fall, resident #012 fell because they did not use their assistive device when ambulating, which was typical for them. As per RN #143, resident #012 was very independent and did not want to use a call bell but was encouraged to do so. RN #143 indicated the staff tried to monitor the resident more closely at the time of the falls but could not have staff in the resident's room constantly. RN #143 indicated that usually, for residents requiring increased monitoring, staff typically encouraged residents to stay by the nursing station where they were better able to monitor residents than if they were in their room on their own. However, due to the home's COVID-19 outbreak guidelines that included keeping all residents in their rooms on isolation precautions, staff were unable to monitor resident #012 adequately. When asked whether any additional interventions were tried to manage the resident's multiple falls, RN #143 indicated that the falls occurred during a weekend and that they had not seen a resident fall this often during a weekend before.

Given that resident #012 kept falling throughout the weekend and had a history of not following interventions in their plan of care to manage their falls risk, RN #143 confirmed the interventions in place at the time of the falls were ineffective, and that different plan of care approaches were not considered to manage resident #012's falls. It was not until the NP assessed resident #012's status after the resident had multiple falls that further recommendations were considered. [s. 6. (11) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is provided as specified in the plan, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was in compliance with and was implemented in accordance with all applicable requirements under the Act.

In accordance with O. Reg. 79/10, s. 42, the licensee was to ensure that every resident received end-of-life care when required in a manner that met their needs.

A complaint was reported to the MLTC from CAF related to a lack of mouth and eye care orders for residents #017 and #016 who was palliative.

A review of the home's policy titled "Oral and Eye Care (Palliative)" (ID # B 35-05, revised May 1, 2020) indicated as follows:

-Provide oral care at least every two hours or at a more increased frequency as clinically needed to keep the oral mucosa moist and to promote resident’s comfort.
-Use a lightly moistened soft bristle brush, oral swab or oral sponge to gently cleanse the teeth, tongue, gums, and palate. Gently sweep away any oral debris or encrustation.
-Apply oral moistener (saliva substitute spray, gel etc.) as ordered by the physician/nurse practitioner to keep the residents’ oral cavity moist.
-Gently cleanse inner and outer lips (including the corner) with a soft moistened cloth. Gently pat to dry.
-Apply lip balm or vaseline to the outer lips to maintain moisture and prevent lips from chafing or cracking.

-PSWs or care attendants to report any indication of mouth sores, bleeding gums, thrush patches, cracked lips, etc. to the registered staff immediately as noted. Registered staff to assess concerns and consult with physician/nurse practitioner as clinically needed.

A review of physician's orders indicated an order on a specified date for resident #017 to receive comfort measures.

Record review of point of care (POC) documentation for resident #017 did not indicate a task for oral care at the frequency of every two hours as identified in the above mentioned policy. According to the POC documentation, resident #017 was provided mouth care twice daily.

In separate interviews with PSWs #118 and #119, they both told the inspector that they had provided mouth care to resident #017 twice on their shift.

A review of POC documentation for resident #016 did not indicate orders for oral care at the frequency of every two hours as identified in the above mentioned policy. According to the POC documentation, resident #016 was provided mouth care twice daily.

In an interview with PSW #120, they told the inspector they had provided mouth care to resident #016 twice on their shift on a regular basis.

In an interview with DOC #125, they acknowledged that the home's policy was not followed in terms of the frequency of which mouth care was to be provided to residents #016 and #017 who were palliative. They further acknowledged that the task for increased frequency of mouth care for palliative residents was not set up in POC for residents who were to be receiving end of life care. [s. 8. (1)]

2. In accordance with O. Reg 79/10, s. 48 (1), the licensee was required to ensure a falls prevention and management program was developed and implemented in the home to reduce the incidence of falls and the risk of injury.

Specifically, the staff did not comply with the licensee's "Falls Prevention Program" policy (revised September 2019), which required staff to initiate a head injury routine (HIR) immediately after a fall if there was evidence of a head injury. Staff were to follow the HIR protocol laid out in the Resident Care and Services Manual policy titled "Head Injury Routine" (ID # RCS E-35, last reviewed November 4, 2019), the standard of which outlined that residents were to be closely observed and assessed, and vital signs

monitored, according to established guidelines subsequent to a head injury or a suspected head injury.

As a result of non-compliance identified for resident #012, the sample was expanded to include resident #019. Record review indicated resident #019 had cognitive impairment and was at risk of falls. They had a history of multiple falls related to transferring from bed to use the toilet, without calling for staff assistance.

Resident #019 had multiple unwitnessed falls on several specified dates over a three month period. Post fall records were reviewed for all falls and indicated that HIR monitoring was required for all of the specified dates.

The HIR documentation for one of the falls was reviewed and noted to lack critical information. As per the HIR records, resident #019 fell on a specified date and required routine HIR monitoring of eye, motor and verbal responses, as well as blood pressure, pulse, respiration and body temperature values. This monitoring was to occur every 15 minutes for the first hour after the fall, every 30 minutes the next two hours, every hour the next five hours, every four hours the next 16 hours, and every eight hours the next 48 hours (every shift). The HIR documentation for the indicated fall only included blood pressure and pulse information, and only for the first seven checks after the fall, which occurred on an hourly basis. In addition, there was only one record of the resident's respiration rate and body temperature recorded immediately after the resident's fall. Furthermore, documentation for the following day of monitoring was missing. The charge nurse for the unit at the time of inspection was interviewed and confirmed that there was no additional HIR monitoring documentation to support these two dates of falls monitoring.

RPN #142 was interviewed and confirmed that they worked the shift of the indicated fall. RPN #142 noted that they were newly hired at the time and acknowledged they were told to complete the HIR monitoring for resident #019, however they felt that there was not enough training provided to them to complete the monitoring appropriately. RPN #142 also believed it was RN #141's responsibility to fill out the HIR form. RPN #142 indicated that they only completed some of the HIR monitoring when they got a chance during their shift, and not according to the established guidelines. RPN #142 also stated that they monitored some of resident #019's vital signs on these checks, but did not complete the other parts of the form, such as checking eye and motor responses.

RN #141 was interviewed and confirmed that they worked as an RN on the unit on the

date of one of the indicated falls. They were employed as Clinical Program Coordinator for the home during the time of the interview. RN #141 indicated that it was the responsibility of RPN #142 to conduct HIR monitoring for resident #019 on their shift as per the established guidelines on the form, and document what they observed during this monitoring, as these were typical tasks of the unit RPN. RN #141 indicated that if RPN #142 did not know how to complete HIR monitoring for resident #019, or how to fill out the HIR form, they should have notified RN #141 so that education could be provided. RN #141 stated that it was the expectation of registered staff to monitor all parts of the HIR's established guidelines at the specified frequencies. RN #141 confirmed the HIR routine conducted on resident #019 was incomplete for the fall on the specified date, and therefore the home did not comply with their falls prevention and management program policy. [s. 8. (1) (a),s. 8. (1) (b)]

3. In accordance with LTCHA, s. 11 (1) (a), and in reference to O. Reg. 79/10, s. 68 (2) (e) (i) the licensee was required to have an organized program of nutrition care and dietary services that included a weight monitoring system to measure and record monthly weights.

Specifically, the staff did not comply with the licensee's "Resident Weight Monitoring" policy (ID # RCS C-25, last reviewed October 16, 2019), which was part of the licensee's Nutrition Care program and required staff to measure and record residents' weights each month.

Resident #022's records were reviewed as a result of concerns raised from CAF to the MLTC about lack of monthly weights being taken during the COVID-19 outbreak. Records indicated resident #022 was at a specified nutrition risk. Resident #022's dietary assessments indicated that RD #107 assessed the resident on a specified date for significant weight loss over one month. RD #107 trialed several supplements to manage the weight loss, but they were discontinued a month later because resident #022 refused them and gained some weight. RD #107 assessed the resident's food preferences the following month and updated them in the hopes of encouraging their food intake.

Resident #022's weight records were reviewed and indicated that the last weight taken was in March, prior to the COVID-19 outbreak that was declared on March 29, 2020, which was similar to their average weight over the last year. There were no weights recorded for April or May, 2020, while the home was in a COVID-19 outbreak.

Later in the inspection, resident #022 was weighed for the month of June 2020. The June

weight was confirmed with a re-weigh. Based on the weight available for June, resident #022 experienced significant weight loss.

RN #106 was interviewed and confirmed resident #022 had variable intake and required assistance during mealtime due to their medical diagnosis. RN #106 noted resident #022 was a picky eater and had preferential items offered to them throughout the day to maximize their intakes. Their intake often depended on their mood. RN #106 stated that resident #022 was not a concern for them in regards to risk for weight loss although their intake varied from meal to meal. RN #106 acknowledged resident #022 was not weighed in April or May because the home was experiencing a COVID-19 outbreak and was not weighing residents at the time. RN #106 felt resident #022's intake trends were sufficient for monitoring their nutritional status during the outbreak without doing monthly weights.

RD #107 was interviewed and stated that resident #022 was at a specified nutritional risk. RD #107 confirmed that resident #022 was at risk of weight loss because of their variable intake. RD #107 indicated the resident had low weight since they were admitted to the home and had a moderate Body Mass Index (BMI). RD #107 acknowledged that they had previously trialed several supplements to maintain their weight with little success, so the RD's main method to maximize resident #022's intake was to offer them their preferred food items.

RD #107 confirmed that resident #022 was not weighed in April and May and noted this had an impact on their ability to effectively monitor the resident's nutritional status. Given resident #022's intake continued to be variable and they were not accepting supplements to manage any potential weight loss, the resident was at risk of weight loss during the COVID-19 outbreak. RD #107 noted that it would have been more appropriate to monitor resident #022's nutritional status by using a monthly weight, but this was unavailable during the outbreak as residents were not allowed to leave their rooms to be weighed as part of the home's infection prevention and control practices.

DOC #125 was interviewed and stated residents were typically weighed on a monthly basis at the beginning of each month by using the Hoyer lift or wheelchair scales available on each unit. During the COVID-19 outbreak, due to staffing shortages and requirements to keep residents on isolation in their rooms, staff did not weigh residents on a monthly basis in April and May, 2020, and instead prioritized direct resident care. This also meant that residents were not being monitored for significant weight changes during the month of April and May. Staff monitored resident intakes and referred to the RD for assessment if there were any concerns with their nutritional needs. Therefore, the

home did not comply with their policy to measure each resident's weight on a monthly basis. [s. 8. (1) (a),s. 8. (1) (b)]

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

A complaint was reported to the MLTC from CAF alleging that residents may have been administered expired medications.

A review of the home's policy titled "Drug Destruction and Disposal" (ID # RCS F-35, revised January 20, 2020) directed staff as follows:

(i) "Surplus drugs" include all of the following:

(a) individual resident medications which have been discontinued,
(b) all drugs that have expired,
(c) all drugs with illegible labels,
(d) all drugs in containers that do not meet requirements of the Drug and Pharmacies Regulation Act,
(e) after a resident dies, and
(f) when a resident is discharged, and medications are not sent with the resident.

(ii) Surplus non-narcotic/non-controlled substances are removed from the medication cart and stored in a designated Pharmacy provider container on each resident home area. This includes insulin and any other injectables. This is witnessed by another member of staff including a PSW.

On a specified date, Inspector #649 observed several expired medications on the following home areas:

On each home area, there were two medication carts: one on the south hall and the other on the west hall.

(1) Second floor, south hall medication cart:
-Biscodyl 5mg, expiry date February 2020
-Diphenhydramine 25mg, expiry date February 2020

(2) Second floor, west hall medication cart:
-Senokot, expiry date April 2020
-Sodium Bicarbonate 325mg (ward stock), issued October 2019, discard after 6 months

(3) Third floor, west hall medication cart:
-Lax-a-day fiber, expiry date April 2020

(4) Third floor, south hall medication cart:
-Dimenhydrinate 50mg (ward stock), issued July 25, 2019, discard after 6 months
-Cetirizine Hydrochloride 10mg, 11 tablets for a specified resident, issued November 9, 2019, expiry date April 30, 2020

(5) Fifth floor, south hall medication cart:
-Biscodyl 5mg, expiry date January 2020
-Cotazym, 30 tablets for a specified resident, issued March 8, 2019, expiry date August 31, 2019
-Sodium Bicarbonate 325mg, 30 tablets for a specified resident, issued March 8, 2019, expiry date August 31, 2019
-Acetaminophen 325mg, 30 tablets for a specified resident, issued December 31, 2018, expiry date June 2019. The resident passed away in January, 2020
-Loperamide 2mg, 30 tablets for a specified resident, issued May 23, 2019, expiry date October 31, 2019
-Hydralazine 10mg, 29 tablets for a specified resident, issued May 23, 2019, expiry date October 31, 2019
-Loperamide 2mg, 60 tablets for a specified resident, issued May 23, 2019, expiry October 31, 2019. The resident passed away in December, 2019.

In an interview with DOC #125, they told the inspector that the home conducted monthly audits of government stock in the medication rooms, and medication in the medication carts. Any expired medication was to be removed. According to the DOC, the home did not have a staff assigned to this task for some time and had not been completing the audits. The DOC further explained that the home’s expectation was that the designated RPN check the expiry date during the medication administration process, and remove any expired medications. The DOC acknowledged that the home’s drug destruction and disposal policy was not followed based on the above mentioned observations. [s. 8. (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 where the Act and 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, that it is complied with, to be implemented voluntarily.

WN #3: 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 drugs were stored in an area or a medication cart that was secure and locked.

- On a specified date, Inspector #649 observed crushed medication in a medication cup and topical treatment on resident #014's bedside table in their room. Resident #014's roommate was observed sitting in their wheelchair. RPN #102 came into resident #014's room and picked up the crushed medication. The inspector confirmed with RPN #102 that the crushed medication and topical treatment should not have been left on the resident's bedside table.

- On another specified date, Inspector #649 observed topical treatment on resident #013's bedside table. PSW #103 confirmed they had left the treatment at the resident's bedside as they did not want to forget to apply it on the resident.

- On another specified date, Inspector #649 observed resident #014's topical treatment on a bedside table in their room. PSW #104 stated that it was okay to leave the treatment at resident #014's bedside. RPN #105 told the inspector that the treatment should not have been left at resident #014's bedside and removed it.

Further record review did not indicate that any of the above residents self medicated.

In an interview with DOC #125, they explained that oral medication was to be administered by the nurse and the resident observed to ensure that they had taken their medication. They confirmed that no medications including topical treatments were to be left at a resident's bedside, but stored in an area or medication cart that is secure and locked. [s. 129. (1) (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 that drugs that are stored in an area or a medication cart are secure and locked, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The license has failed to ensure that all areas where drugs were stored shall be kept locked at all times, when not in use.

On a specified date, Inspector #649 observed a medication cart unlocked in a specified resident home area. The medication cart was parked across from the nursing station in the hallway. The inspector was able to pull open the medication drawers consisting of residents' medications. There was a wandering resident standing beside the inspector at the time of this observation. Two nurses were observed inside the nursing station with their backs to the unlocked medication cart looking at a computer.

In an interview with RPN #136, they acknowledged that they had left the medication cart unlocked to look at something on the computer with another nurse.

In an interview with DOC #125, they stated that the medication cart was to be secured and locked when unattended. [s. 130. 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all areas where drugs are stored shall be kept locked at all times when not in use, to be implemented voluntarily.

WN #5: 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. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participated in the implementation of the home’s infection prevention and control program (IPAC).

Inspector #763 observed several home areas as a result of concerns raised from CAF to the MLTC regarding the home's implementation of their IPAC management program. It was noted that the Public Health Unit (PHU) declared the home in COVID-19 outbreak on March 29, 2020, and they continued to be on outbreak during the time of this inspection. All residents were deemed COVID-19 negative during the observation period.

In an interview, ADOC #139, the home's IPAC program lead, stated that they followed the home’s established IPAC program policies and procedures as well as recommendations provided by PHU during the outbreak. This included the home's policy titled “Droplet Contact Precautions” (ID # F-05-20, revised March 27, 2020) that indicated staff were to wear eye protection when providing direct resident care and when within two metres of isolated residents. Occupied rooms where residents were on isolation were identified with a “Droplet Contact Precautions” sign. The sign indicated that all visitors should wear eye protection if within two metres of the resident. ADOC #139 noted that as per recommendations from the PHU, once the COVID-19 outbreak was declared, all residents were to remain in their rooms on isolation precautions.

ADOC #139 indicated that throughout the duration of the outbreak, staff were instructed to wear eye protection, such as reusable face shields, and sanitize the face shield with a sanitizer wipe when switching care from one resident to another. Staff were instructed to not wear their face shields in the unit hallways, but only in resident rooms that required droplet contact precautions to be followed. All residents at the time of the outbreak required droplet contact precautions to be used as they were all isolated to their rooms. Signs for isolation precautions were displayed on all resident occupied rooms.

The inspector observed several incidences of staff not wearing eye protection in resident rooms when providing direct care and when being within two metres of residents:

- On a specified date, PSW #116 was observed by Inspector #763 feeding and encouraging resident #022 to eat while the resident was lying in their bed and PSW #116 was at their bedside within one metre of resident #022. PSW #116 was not wearing eye protection. PSW #116 stated that they knew eye protection was required when providing direct resident care, but said they were too busy to retrieve it from the nursing station. PSW #116 indicated that they often did not wear eye protection at mealtime as they were typically too busy to locate the appropriate eye protection.

- On another specified date, PSW #103 was observed by Inspector #763 feeding and cleaning resident #021’s face after the meal, and taking their food tray out of their room. PSW #103 was inside the isolated resident’s room providing direct resident care within two metres of the resident, without wearing eye protection. PSW #103 indicated that they knew eye protection was required in this instance, but did not have appropriate eye protection at the time. PSW #103 indicated that they usually liked wearing goggles but forgot to get them from the lunch room. They were aware that there were additional face shields available for use at the nursing station but found them uncomfortable to use.

- On another specified date, PSW #150 was observed by Inspector #763 providing direct care within two metres to several residents. PSW #150 did not wear eye protection while the care was provided. PSW #150 indicated that they knew eye protection was required in these instances, but noted they forgot to bring eye protection with them on the unit.

ADOC #139 confirmed that staff were expected to wear eye protection when within two metres of residents on isolation and in general when providing direct care to these residents. ADOC #139 confirmed that PSW #116, PSW #103, and PSW #150 did not participate in the home’s implementation of their IPAC management program at the time of the inspector's observation on units where all residents were identified to be on

isolation precautions, and noted that the home was considering implementing the use of eye protection in all home care areas for a more effective approach to IPAC management. [s. 229. (4)]

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 staff participate in the implementation of the home's infection prevention and control program, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On a specified date, Inspector #649 observed the screen on the medication cart open in a specified resident home area, and an identified resident's personal health information was visible. A resident was standing beside the inspector at the time of this observation. Two nurses were observed inside the nursing station with their backs to the unlocked medication screen looking at a computer.

In an interview with RPN #136, they acknowledged that they had left the medication screen open to look at something on a computer with another nurse inside the nursing station.

In an interview with DOC #125, they explained that there was a feature on the computer screen that the nurse should have used to lock it, so that residents' personal health information was not exposed. [s. 3. (1) 11. iv.]

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 has failed to ensure that resident #034 exhibiting altered skin integrity, including pressure ulcers was assessed by a registered dietitian who was a member of the staff of the home, and any changes made to resident #034's plan of care relating to nutrition and hydration were implemented.

A complaint was reported to the MLTC on a specified date related to an allegation of resident neglect.

Resident #034 was no longer in the home at the time of this inspection. Record review indicated that, on a specified date, resident #034 was noted to have a staged pressure wound on a specified area of their body. They were assessed by the NP and specified treatment interventions were ordered. Resident #034 was noted to have an increased temperature several days after. The wound was noted to be warm to touch with redness around the site. The NP followed up with an assessment of the resident on the same day and ordered medication to treat the wound. Additional specified interventions were ordered. Later that day, the resident's health declined, the NP re-assessed the resident and, after discussion between the resident's SDM and consultant physician, the resident was transferred to hospital for further assessment.

Record review indicated no referral was sent to the RD when resident #034 was

identified with a staged pressure wound on the indicated date, therefore the resident was not assessed by the RD.

In an interview with RN #124, they acknowledged that a referral was not sent to the RD.

In an interview with RD #107, they acknowledged that they had not received a referral for resident #034's staged pressure wound, therefore they had not assessed the resident.

In an interview with DOC #125, they told the inspector that staff were expected to complete a referral to the RD as soon as possible after identifying altered skin integrity. [649] [s. 50. (2) (b) (iii)]

2. The licensee has failed to ensure that resident #014 who was exhibiting pressure ulcers was reassessed at least weekly by a member of the registered nursing staff.

A complaint was reported to the MLTC from CAF related to a concern about resident skin and wound care.

Record review indicated that resident #014 had a history of pressure ulcers on different areas of their body. According to the home's assessment process, weekly skin and wound assessments were completed under the assessment tab in Point Click Care (PCC).

A review of this assessment tab indicated that weekly skin and wound assessments for resident #014's wounds were not completed for approximately one month during the COVID-19 outbreak.

In an interview with RPN #128, they acknowledged that no weekly skin and wound assessments for resident #014's specified wounds were completed during the indicated times, and confirmed that both wounds had deteriorated.

In an interview with DOC #125, they explained that the home did not have a dedicated staff competing weekly skin and wound assessment during the above mentioned period, as the assigned nurse went off on a leave, and acknowledged there could have been gaps in the weekly skin and wound assessments until coverage was arranged. [s. 50. (2) (b) (iv)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the planned menu items were offered to residents #008, #029, and #030 at each meal and snack.

Selected residents on a specified home area were observed by Inspector #763 at mealtime on a specified date, as a result of concerns raised from CAF to the MLTC about not offering residents meal options during meal service. The two choices of planned main meal options were chili with romaine salad and fish with sweet potato fries. The inspector observed two staff who served meals to residents #008, #029, and #030 – PSW #147, who served resident #008 and #029, and PSW #120, who served resident #030. The inspector did not observe either staff offering or describing the planned menu items to residents #008, #029, and #030.

Resident #029 was interviewed during the meal service. They stated that since the outbreak began, staff have not been offering them the two choices at meals. During this observation, resident #029 confirmed that they were not offered the two choices of planned menu items, and were just served the chili option. They were unaware of the other options available during the observed mealtime but did not have concerns with the chili that was served.

Resident #008 was also interviewed during the meal service. They were served fish and enjoyed it, but noted that staff did not ask them which of the two planned menu items they wanted.

Resident #030 was observed during the meal service while being fed by a staff member. The inspector overheard resident #030 telling the staff that they did not want any more food after a few bites because they were tired.

PSW #120 was interviewed and said that staff typically used physical show plates or

those displayed on their electronic tablets to provide residents with the option to select which of the two main meal options they wished to receive. PSW #120 explained that show plates and tablets were not being used during the pandemic, but staff were still expected to offer the planned menu items to their residents verbally. PSW #120 confirmed that they served resident #030 at the observed mealtime but did not offer them the two choices of the planned menu items. PSW #120 served resident #030 what PSW #120 thought they wanted.

PSW #147 was interviewed and also said that staff typically used physical show plates or those displayed on their electronic tablets to provide residents with the option to select which of the two main meal options they wished to receive. Staff also referred to the diet binder that listed some residents' preferences as a guide. PSW #147 explained that show plates and tablets were not being used during the pandemic since residents were eating in their rooms. PSW #147 indicated that they knew their residents well, and some had very particular tastes. PSW #147 indicated that they typically offered the two choices of the planned menu items to some of their residents, however with other residents who had particular tastes, PSW #147 did not want to bother them. PSW #147 confirmed that during the observed mealtime, they did not offer the two planned menu items to resident #029 since they knew that the resident did not like fish; they provided them the chilli option. For resident #008, PSW #147 noted that they were a picky eater and felt that the resident would not eat the chili so they served them the fish option.

RD #107 was interviewed and explained that show plates and tablets were not being used during the pandemic but staff were still expected to offer the two choices of the planned menu items to their residents verbally. RD #107 stated that it was not acceptable to assume residents liked one option over another based on their typical preferences, and that residents #008, #029, and #030 should have still been offered both planned menu items even if they typically disliked certain items. RD #107 stated that the starch or vegetable items on either menu option could have been selected by those residents even if they disliked the protein option.

DOC #125 was interviewed and confirmed that staff used physical show plates or those displayed on their electronic tablets to provide residents with the option to select which of the two main meal options they wished to receive at meals. DOC #125 explained that show plates and tablets were not being used during the pandemic because the home was in crisis management, but staff were still expected to offer the planned menu items to their residents verbally before the meal. DOC #125 stated that even if staff were aware of resident preferences, they still needed to offer the planned menu items to all residents

in case the resident decided to have an atypical option at any given meal. DOC #125 confirmed that residents #008, #029, and #030 were not offered their choice of the planned menu items on the above mentioned date. [s. 71. (4)]

Issued on this 22nd day of July, 2020

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

Original report signed by the inspector.