Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 26, 2018	2018_643111_0007	005438-18	Resident Quality Inspection

Licensee/Titulaire de permis

Regional Municipality of Durham
605 Rossland Road East WHITBY ON L1N 6A3

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

Hillsdale Estates
590 Oshawa Blvd. North OSHAWA ON L1G 5T9

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

LYNDA BROWN (111), KELLY BURNS (554)

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): April 12-13, 17-20 and 23-25, 2018

The following follow-ups were completed concurrently during this inspection:
-Log #001228-18 related to plan of care.
-Log # 001229-18 related to duty to protect from abuse.

The following complaints were completed concurrently during this inspection:
-Log #023544-17 related to pain management and end of life care.
-Log # 025467-17 related to refusal of admission.
-Log # 002061-18 related to improper care.

The following critical incidents were also inspected concurrently during this inspection:
-Log # 007430-18 (CIR), # 026888-17(CIR), # 025519-17 (CIR) & #021873-17(CIR), Log # 025323-17 (CIR) & 022037-17(CIR): related to resident to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Resident Care Coordinators (RCC), Registered Nurses, (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Behavioural Supports Ontario (BSO) team, residents, families, Resident Council president, Family Council chairperson, Infection Prevention and Control (IPAC) nurse, RAI Coordinator, environmental staff, and Registered Dietitian.

During the course of the inspection, the inspectors completed a tour of the home, observed medication administration, observed medication storage area, reviewed current and discharged resident health records, reviewed medication incidents, Medication Management and Professional Advisory Committee Meeting Minutes, and reviewed the following licensee policies: Abuse and neglect -Prevention, Reporting & Investigating, Responsive Behaviour Prevention and Management Program, Infection Prevention and Control Program (Routine Practices and Additional Precautions – Contact, Droplet and Airborne), Medication Administration Program, Palliative – End of Life Care, and Pain Management Program.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Admission and Discharge
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #902	2017_578672_0013	111
LTCHA, 2007 S.O. 2007, c.8 s. 6. (1)	CO #901	2017_578672_0013	111

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee has failed to ensure that there is a written policy that promotes zero tolerance of abuse and neglect of residents and that it was complied with.

There were four critical incident reports (CIR) submitted to the Director for witnessed, resident to resident abuse related to resident #034 towards two different residents (#035 and #036) as follows:
-Related to log #021873-17:
A CIR was submitted to the Director for a witnessed resident to resident abuse incident. The CIR indicated on a specified date in 2017 at a specified time, environmental services staff member #137 witnessed resident #034 engage in a resident to resident abuse incident in an identified area towards resident #035, resulting in resident #035 sustaining a fall. Both residents were immediately separated and RN #133 notified. Resident #035 had no injuries but was upset as a result of the incident. The CIR was completed by Resident Care Coordinator (RCC) #118.
-Related to log # 025519-17:
A CIR was submitted to the Director for a witnessed resident to resident abuse incident. The CIR indicated on a specified date in 2017, at a specified time, (approximately one month after the first incident) RPN #125 witnessed resident #034 engage in a resident to resident abuse incident in an identified area, towards resident #036, resulting in resident #036 sustaining a fall. Resident #036 sustained injuries to specified areas, complained of pain to specified areas and was upset by the incident. The CIR was completed by RCC #118.
-Related to log # 026888-17:
A CIR was submitted to the Director for a witnessed resident to resident abuse incident. The CIR indicated on a specified date in 2017 at a specified time, (approximately two weeks later), two visitors witnessed resident #034 engage in a resident to resident abuse

incident in an identified area, towards resident #036, resulting in resident #036 sustaining a fall. Resident #036 sustained an injury to a specified area. The CIR was completed by RCC #118.
-Related to Log # 007430-18:
A CIR was submitted to the Director for a witnessed resident to resident abuse incident. The CIR indicated on a specified date in 2018 at a specified time, (approximately five months later), PSW #136 witnessed resident #034 engage in a resident to resident abuse incident in an identified area, towards resident #035, resulting in resident #035 sustaining a fall. Resident #035 was upset at the time of the incident. The CIR was completed by RCC #118.

Review of the Licensee's policy "Abuse and Neglect-Prevention, Reporting & Investigation" (ADM-01-03-05;reviewed September 2016) indicated under Reporting/Investigation Procedures:
-(page 6/18) all staff, volunteers and affiliated personnel must immediately report any alleged, suspected or witnessed incidents of abuse or neglect to the appropriate supervisor on duty.
-(Page 11/18) any person reporting alleged witnessed, or suspected abuse will be required to participate in an investigatory process as required, including providing written and verbal statements. Supervisor, manager or delegate is responsible for initiating the investigation commencing with documentation of details, including details of the allegation/incident, dates, timing of events, names of witnesses and others involved.

Interview with RN #133 by Inspector #111, indicated the first incident involving resident #034 and resident #035 was not reported or investigated because the RN did not think it was abuse. The RN indicated the resident was initially upset but then calmed down, so the RN did not contact the on-call manager as per the licensee's policy to report the incident.

Interview with RCC #118 by Inspector #111 confirmed that the RCC's were responsible for conducting the investigations for any critical incident reports they completed. The RCC indicated that all staff involved in the incidents are interviewed but didn't usually document the investigations. The RCC confirmed there were no documented evidence of investigations for the four CIR's involving resident #034. The RCC indicated, regarding the last critical incident, the RCC was notified of the resident to resident altercation the following day and interviewed staff to determine what happened, including RN #133. The RCC confirmed there was no documented evidence of the investigation and confirmed no written statements were obtained as per the licensee's policy.

Interview with the DOC by Inspector #111 confirmed the RCC should have completed written investigations for the four CIRs related to resident to resident abuse as per the licensee's policy. The DOC confirmed there was no documented evidence of any investigations into the four witnessed resident to resident abuse incidents that occurred.

The licensee failed to ensure their policy "Abuse and Neglect-Prevention, Reporting & Investigation", specifically related to investigations, was complied with related to four witnessed, resident to resident abuse incidents that involved resident #034. [s. 20. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

There were four critical incident reports (CIR's) submitted to the Director (as stated under WN #001) for witnessed, resident to resident abuse from resident #034 towards two residents (#035 and #036) related to: Log # 021873-17, Log # 025519-17, Log # 026888-17 and Log # 007430-18.

In addition, review of the progress notes for resident #034 indicated there were additional incidents of resident to resident altercations involving resident #034 towards resident #035 and other unidentified resident's until the resident was transferred to hospital on a specified date for a psychiatric assessment as per the following:
-on a specified date and time in 2017, resident #035 was found on the floor in an identified area after resident #034 had engaged in an altercation with resident #035 and no injuries were sustained.
-two weeks later, at a specified time, staff witnessed resident #034 engage in an altercation with an unidentified resident in an identified area and no injury was sustained. Later the same day, resident #034 was witnessed engaging in an altercation with an unidentified resident in an identified area and no injuries were sustained.
-three days later, at a specified time, staff witnessed resident #034 engaging in an altercation with an unidentified resident and no injuries were sustained.
-approximately two months later, at a specified time, resident #034 was witnessed engaging in an altercation with resident #035. Later the same day, a second altercation was witnessed with resident #034 towards resident #035. There were no injuries noted to resident #035 for either incident.
-approximately two weeks later, at a specified time, staff witnessed resident #034 in an identified area, engage in an altercation towards unidentified residents, removing them from a specified area.
-approximately two weeks later, at a specified time, staff observed resident #034 sitting in an identified area watching TV and then engage in an altercation towards two unidentified residents.

Review of the written plan of care for resident #034, that were in place at the time of the incidents indicated, the resident demonstrated specified responsive behaviours. The resident had more than one altercation towards a specific resident. There were two specified triggers identified but did not indicate which specific resident provided the trigger. There were a number of interventions in place to address resident #034 responsive behaviours which included the administration of medication and to notify the physician.

Further interventions identified on the critical incident reports that were taken to prevent a recurrence included:
-after the first critical incident (CIR), the physician was notified and ordered a specified medication, a Dementia Observation Sheet (DOS) was started and the Behavioural Supports Ontario (BSO) was notified. Staff were also reminded to ensure that resident #034 and resident #035 were kept separated.

-after the second critical incident (CIR), one to one monitoring of resident #034 was initiated, additional medication changes (as per psychogeriatric assessment recommendations), staff requested a TV be put in resident #034 room to avoid going to an specified area that was a trigger. Staff were also to keep resident #034 and resident #036 separated.
-after the third critical incident (CIR), one to one monitoring of resident #034 was initiated, staff were to monitor resident #034 and resident #035 when in close proximity to each other, staff were to keep resident #034 away from a specified common area if behaviour was unstable/unsafe, BSO remained involved and were awaiting further involvement of psychogeriatric assessment.
-after the last critical incident (CIR), resident #034 was transferred to hospital for psychiatric assessment.

Interview with Behavioural Supports Ontario (BSO - PSW #114 and #115) by Inspector #111, indicated the BAT, DOS and Tip Sheet were put in place for resident#034 which included the identified responsive behaviours, the triggers and interventions to manage the resident's responsive behaviours. They both indicated a clinical monitoring flow sheet was also provided to staff when the resident #034 was placed on one to one monitoring to see what behaviours were occurring. They both indicated resident #034 was on the one to one monitoring for short periods of time after each critical incident report was submitted but only during specified times over a four month period in 2018.

Interview with the DOC by Inspector #111, indicated the DOC was unable to verify who all the recipient residents were that were involved in the altercations with resident #034 on the five specified dates in 2017. The DOC was only able to identify one of the recipient residents involved, (the second incident in 2017) and was resident #035. The DOC indicated resident #034 was on permanent one to one monitoring for day and evening shifts for two months in 2017 and for the remainder of 2018 until the resident was transferred to hospital for a psychiatric assessment.

Review of the health care record for resident #034 indicated a psychiatric assessment referral was not submitted in 2017. One of the interventions requested by staff in 2017 had no documented evidence to indicate this occurred. The plan of care indicated an identified intervention was put in place for the resident to avoid going to an identified area, but the resident continued to go to the identified area. In addition, while one to one monitoring was to be in place for resident #034, resident #034 was able to engage in another resident to resident abuse incident with resident #036 (second CIR) and again towards resident #035 (last CIR) while in the specified area that staff were supposed to

be closely monitoring (or removing the resident from) and keeping both residents away from one another. The written plan of care interventions had contradictory directions to staff. The physician was inconsistently contacted despite resident #034 involved in altercations towards resident #035, #036 and other unidentified residents.

The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between resident #034 and other residents (resident #035, #036 and unidentified residents) by identifying and implementing interventions. [s. 54. (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. 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 :

The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, specific to Medication Management.

Under O. Reg. 79/10, s. 114 (1) Every licensee of a long-term care home shall develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents.

Under O. Reg. 79/10, s. 114 (2) - The licensee shall ensure that written policies and

protocols are 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.

The licensee's policy, 'Medication Administration Program' (#INTERD-03-03-19) (revised date of November 2017) indicates that the home has an interdisciplinary medication management system in place that provides safe medication management and optimizes effective drug therapy outcomes for residents. This program includes safe storage, administration and security of drugs.

Registered Nurse (RN) #108, and #119, Resident Care Coordinator (RCC) #117, Manager of Nursing Practise and the Director of Care (DOC) indicated, to Inspector #554 on four separate dates, that medications are not to be left unattended with a resident, unless that resident has been approved for self-administration of medications.

The DOC indicated that there is no specific licensee policy stating that medications cannot be left unattended with residents, but indicated such would be implied in education and or training provided to registered nursing staff, specific to medication management.

- On a specified date, the family of resident #039 informed registered nursing staff that eight medications (including controlled substances) were found in resident #039's mobility aide. Documentation, in the medication incident, stated that the registered nursing staff were unable to identify when resident #039 had been administered the medications.

- On a specified date, the family of resident #039 informed an RPN that a controlled substance medication was found in resident #039's bed. Documentation, in the medication incident, stated that the RPN was unable to identify when resident #039 had been administered the medication.

RN #119 indicated, to Inspector #554 that registered nursing staff are not to leave medications unattended.

RCC #117, who is the lead for the Medication Management Program, indicated to Inspector #554 on an identified date, that medications are not to be left unattended with residents. RCC #117 indicated that upon review of two separate medication incidents that occurred on specified dates, an unidentified registered nursing staff had left

medications unattended with resident #039.

Resident #039 has no order for self-administration of medications.

The licensee failed to ensure the any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, related to Medication Management, specifically as documented in two separate medication incidents involving residents #039. [s. 8. (1) (b)] (554)

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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, specific to Medication Management, to be implemented voluntarily.

WN #4: 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:
1. All doors leading to stairways and the 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,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

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).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

The licensee has failed to ensure that all doors that residents do not have access to must be, kept closed and locked.

On April 12, 2018 during the initial tour of the home, Inspector #111 observed the doors leading to the tub/shower rooms on the following resident home areas were found unlocked: Maple Grove, Primrose Path, Blueberry Hill and Apple Blossom. These tub/shower rooms had cleaning chemicals accessible to residents.

On April 18, 2018, observation of the tub/shower room doors by Inspector #111 on Primrose were found unlocked. The rooms contained Arjo Disinfectant Cleanser IV that had a poisonous symbol on the label.

Interview with RPN #116 by Inspector #111, indicated the expectation is that the tub/shower room doors are to be kept locked at all times.

Interview with the DOC by Inspector #111 indicated awareness that tub/shower room doors had been found unlocked and the expectation was that all tub/shower room doors are to be locked at all times.

The licensee failed to ensure all doors that residents do not have access to, specifically the tub/shower rooms,were kept closed and locked. [s. 9. (1)](554)

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 that residents do not have access to must be, kept closed and locked, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

The licensee failed to ensure that residents have their personal items, including personal aids, labelled within 48 hours of admission and in the case of acquiring new items.

On April 12, 2018, during the initial tour of the home, Inspector #111 observed a specified number of unlabelled personal items that were used and visible in the tub/shower rooms, on four identified units.

On April 17, 2018, Inspector #554 also observed a specified number of unlabelled personal items that were used and visible in the tub/shower rooms, on five identified units.

PSW #100 indicated, to Inspector #554 that personal items are to be labelled for individual resident use. The PSW, who was assigned to work on a specified unit indicated being unaware of which resident an unlabelled and used personal item belonged to.

RCC #117 and #118 indicated, to Inspector #554 that all resident personal items are to be labelled for individual resident use on admission and as new items are acquired.

Infection Control Practitioner (ICP) indicated, to Inspector #554, that all resident personal items are to be labelled by nursing staff, specifically PSW's on admission and as new items are acquired. ICP indicated this has been an area identified as needing improvement during audits by the ICP and RCC's.

The licensee failed to ensure that residents have their personal items, including personal aids,were labelled within 48 hours of admission and in the case of acquiring new items. [s. 37. (1) (a)](554)

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents have their personal items, including personal aids, labelled within 48 hours of admission and in the case of acquiring new items,, to be implemented voluntarily.

WN #6: 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 :

The licensee failed to ensure that drugs are stored in an area or a medication cart that is secure and locked.

On April 18, 2018 at 0857 hours, Inspector #554 observed a bottle of medication, which was approximately half full, sitting on top of a medication cart in the hallway outside the dining room on a specified resident home area. The bottle of medication was observed left unattended for specified period of time.

Two residents were observed in the vicinity of the medication cart, during this observation.

RN #108, who was the Charge Nurse assigned to the specified resident unit, indicated, to Inspector #554, that medication was not to be left unattended, that registered nursing staff are to ensure that all medication was cleared from the top of the medication cart and locked inside the medication cart whenever registered nursing staff are not present. RN #108 indicated there were residents residing on the resident home area with cognitive impairment.

RCC #117 indicated, to Inspector #554, that medication was to be stored inside medication carts and that the medication cart is to be locked whenever registered nursing staff are not present. RCC #117 indicated that all registered nursing staff have been provided direction, including education specific to safe medication practices.

The licensee failed to ensure that drugs are stored in an area or a medication cart that is secure and locked. [s. 129. (1) (a)](554)

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 are stored in an area or a medication cart that is secure and locked, to be implemented voluntarily.

WN #7: 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. (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 :

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

Medication Incidents for a three month period were reviewed by Inspector #554.

The following was documented, by registered nursing staff, during this review:

- on a specified date in 2017 – Resident #042 was prescribed a specified medication at a specified dose daily by mouth. The weekly medication strip for a four day period in 2017 that was packaged by the pharmacy service provider and contained the specified medication but less than the prescribed dose. The medication discrepancy was noted by a registered nursing staff five days later.

- on a specified date in 2018 – Resident #043 was prescribed a specified medication at a specified dose daily by mouth. An RPN working three days later, identified that the prescribed medication was not administered to the resident.

- on a specified date in 2018 (five days later) – Resident #043 was prescribed a different specified medication at a specified dose daily by mouth. An RPN working the following shift identified that the prescribed medication was not administered to the resident.

- on a specified date in 2018 – Resident #044 was prescribed three specified medications at specified doses, daily by mouth. An RPN working the following shift identified that the prescribed medications were not administered to the resident.

- on a specified date in 2018 – Resident #045 was prescribed a specified medication at a specified dose daily by mouth. An RPN working the following shift identified that the prescribed medication was not administered to the resident.

-on a specified date in 2018 (two days later) – Resident #045 was not provided with the

same prescribed specified medication at a specified dose daily by mouth. An RPN working the following shift identified that the prescribed medication was not administered to the resident.

-on a specified date in 2018 (the same day) – Resident #046 was prescribed a specified medication at a specified dose daily by mouth. An RPN working the following shift identified that the prescribed medication was not administered to the resident.

- on a specified date in 2018 – Resident #047 was prescribed a specified medication at a specified dose daily by mouth. An RPN working the following shift identified that the prescribed medication was not administered to the resident.

- on a specified date in 2018 – Resident #002 was prescribed a specified medication, at a specified dose, daily at a specified time, by mouth. An RPN working the following day identified that the prescribed medication was not administered to the resident.

RCC #117, who is the lead for the Medication Management Program, and RN #119 indicated, to Inspector #554 on two specified dates, that registered nursing staff are to administer drugs in accordance with directions specified by the physician. RCC #117 indicated that in the above identified medication incidents registered nursing staff had not followed the prescriber's direction in administering medications to residents #042, #043, #044, #045, #047, and #002.

The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber. [s. 131. (2)] (554)

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 were administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #8: 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 :

The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction is, documented together with a record of the immediate actions taken to assess and maintain the resident's health, and reported to the resident, the resident's Substitute Decision Maker (SDM), 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 to the resident and the

pharmacy service provider.

Medication Incidents for a three month period were reviewed by Inspector #554.

During this review, there were sixteen documented medication incidents, of which involved nine residents. Residents identified by the licensee or designate in the medication incidents were #042, #043, #044, #045, #046, #047, #039, and #002.

The review failed to provide support of the immediate actions taken, by registered nursing staff, to assess and maintain the resident's health were documented, specifically for resident #043 medication incidents occurring on two specified dates; resident #044, #045 medication incidents occurring on two specified dates; resident #046 , #047 and resident #002 medication incident occurring on s specified date.

Documentation reviewed further failed to provide support that the Physician, and SDM were notified of the medication incidents involving residents #043, #044, #045, #046, #047, and #002; nor was there documentation to support that pharmacy service provider was notified of the medication incidents involving #043, #044, #045, #046, #047 and #039.

RCC #117, who is the lead for the Medication Management Program, and RCC #118 indicated, to Inspector #554, that when a medication incident occurs, registered nursing staff are to document the actions taken to assess and monitor the resident health, as well the date and time the Physician, SDM, and pharmacy provider were notified of the medication incident; RCC #117 and #118 indicated that all is to be documented on the 'Medication Incident Report Form'. RCC #117 indicated that the registered nursing staff have been inconsistent in such documentation. RCC #117 confirmed that the identified medication incidents failed to provide documentation specific to medication incidents for residents #039, #042, #043, #044, #045, #046, #047, and #002.

The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction is, documented together with a record of the immediate actions taken to assess and maintain the resident's health, and reported to the resident, the resident's SDM, if any, 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. [s. 135. (1)](554)

2. The licensee failed to ensure that, all medication incidents and adverse drug reactions

are documented, reviewed and analyzed, that corrective action is taken as necessary, and that a written record is kept of everything required under clauses (a) and (b).

Medication Incidents for a three month period were reviewed by Inspector #554.

During this review, there were sixteen documented medication incidents, of which involved nine residents. Residents identified by the licensee or designate in the medication incidents were #039, #042, #043, #044, #045, #046, #047 and #002.

The review failed to provide supporting documentation that medication incidents occurring on specified dates involving resident #039, resident #043, resident #045, resident #046, resident #047, resident #002 and an unknown resident, were reviewed and analyzed. Nor was their documentation indicating the corrective action had been taken.

RCC #117, who is the lead for the Medication Management Program, indicated, to Inspector #554, that medications incidents are to be reviewed by the Resident Care Coordinator assigned to each resident home area. RCC #117 indicated that there are three RCC's, and that each RCC has an assigned floor, and four resident home areas. RCC #118 confirmed, with Inspector #554, the process described by RCC #117 in reviewing medication incidents.

RCC #117 and #118 indicated that the above identified medication incidents had not been reviewed and analyzed, nor were corrective actions taken and documented.

The licensee failed to ensure that, all medication incidents and adverse drug reactions are documented, reviewed and analyzed, that corrective action is taken as necessary, and that a written record is kept of everything required under clauses (a) and (b). [s. 135. (2)](554)

3. The licensee failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that had occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, any changes and improvements identified in the review implemented, and a written record kept of everything are provided for in clause (a) and (b).

Medication Incidents for a three month were reviewed by Inspector #554.

During this review, there were sixteen documented medication incidents, of which involved nine residents. Residents identified by the licensee or designate in the medication incidents were #039, #042, #043, #044, #045, #046, #047and #002.

Medication Management Committee, as well as the Professional Advisory Committee (PAC) meeting minutes were reviewed, for a specified date in 2018.

The PAC meeting minutes identified that prior to the meeting, the Medical Director, Pharmacy Consultant, and RCC #117, who is the lead for Medication Management, met to 'discuss medication errors and overall use of medication'.

Documentation in the Medication Management Committee, and or the PAC meeting minutes failed to provide support that a quarterly review was undertaken of all medication incidents and adverse drug reactions that had occurred, nor was there documentation of any changes and improvements identified.

RCC #117 indicated, to Inspector #554, that the review should have included medication incidents which had occurred during the three month period. RCC #117 indicated that the quarterly review of medication incidents did not occur, at the specified meeting, as it was their first meeting since becoming the lead for the medication management program, and the focus of discussions was specific to the transition from one pharmacy provider to another. RCC #117 indicated that a quarterly review of medication incidents and adverse drug reactions has not occurred in the home since the fall of 2017.

The licensee failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that had occurred in the home since the time of the last review (fall of 2017) in order to reduce and prevent medication incidents and adverse drug reactions, any changes and improvements identified in the review implemented, and a written record kept of everything provided for in clause (a) and (b), specifically a quarterly review of medication incidents for a three month period had not been reviewed. [s. 135. (3)](554)

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 medication incident involving a resident and every adverse drug reaction is, documented together with a record of the immediate actions taken to assess and maintain the resident's health, and reported to the resident, the resident's Substitute Decision Maker (SDM), 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, all medication incidents and adverse drug reactions are documented, reviewed and analyzed, that corrective action is taken as necessary, and that a written record is kept of everything required under clauses (a) and (b); a quarterly review was undertaken of all medication incidents and adverse drug reactions that had occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, any changes and improvements identified in the review implemented, and a written record kept of everything provided for in clause (a) and (b), to be implemented voluntarily.

WN #9: 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 :

The licensee failed to ensure that staff participate in the implementation of the infection prevention and control program, specifically the use of personal protective equipment.

On April 12, 2018, during the initial tour of the home, Inspector #111, observed for a specified resident room with signage on the residents door indicating specified precautions in place and to use goggles when performing personal care. There was also Personal Protective Equipment (PPEs) hanging on the door but no goggles were

available for use.

Infection Control Practitioner(ICP) indicated, to Inspector #554, that the licensee follows best practise guidelines, specifically Provincial Infectious Diseases Advisory Committee (PIDAC) and Public Health Canada Guidelines. ICP indicated that PPE's are required when entering a resident room identified as being in specified precautions included, gown, gloves, mask and goggles.

On a specified date, resident #021 was observed in a different specified resident's room and unit. Signage on the door of the identified resident’s room indicated that resident was under specified precautions and PPE's to be worn included: gown, goggles, mask with a visor and gloves. A yellow caddie containing PPEs were observed hanging on the door and available for staff and others to use. Inspector #554 did not observe goggles or mask with visor in the yellow PPE caddie hanging on the door of an identified resident room.

PSW #100, who was assigned to work on the identified unit indicated, to Inspector #554 that upon entry to the specified resident's room, staff and others applied a gown, gloves and a mask. PSW #100 indicated that staff do not wear goggles and or masks with a visor, nor have they been directed to wear goggles or mask with visor when caring for residents in specified precautions.

RN #101, who is the Charge Nurse, assigned to the specified unit indicated, to Inspector #554, that staff and others are to wear gowns, gloves and a mask when entering resident’s rooms for residents identified as being in specified precautions. RN #101 indicated they have had no direction to wear goggles and or mask with visors.

ICP indicated all staff have been provided training specific to infection prevention and control, specifically use of PPE’s. ICP indicated that gaps in donning of PPE’s have been identified as an area needing improvement in the home. ICP stated that "a few months ago, it was identified that the home had no masks with visors, and had only a limited supply of goggles". ICP indicated that an order had been placed for masks with visors, but unsure if the supply had arrived. ICP indicated staff are expected to wear identified PPE’s as per signage indicated on resident’s door, and indicated that PSW's should be notifying registered nursing staff or Environmental Supervisor if supplies are not available for use.

The licensee failed to ensure that staff participate in the implementation of the infection prevention and control program, specifically use of personal protective equipment. [s.

229. (4)](554)

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

WN #10: 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 :

The licensee failed to ensure that the following rights of residents are fully respected and promoted, specifically every resident has the right to have their 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 their records of

personal health information, including their plan of care, in accordance with that Act, specifically:
- as it relates to an individual's physical or mental health
- as it relates to the provision of health care to the individual

During a medication observation, on a specified date, Inspector #554 observed RPN #109 dispose of resident #001's medication packaging strip into the waste receptacle bin on the side of the medication cart. The medication packaging strip contained the resident's name, unit location, date, and prescribed medications for resident #001 including medication names and associated dosages.

RPN #109, who was the assigned RPN on the resident home area was observed disposing of three other resident's medication packing strips in this same manner.

RPN #110, who was the assigned RPN on a different specified resident home area and RPN #132, who was the assigned RPN on a different resident home area, were both observed disposing of resident's medication packing strips into the waste receptacle bin on the sides of their medication carts.

RPN #109 indicated, to Inspector #554, that the medication packaging strips for residents prescribed medication are disposed of into the waste receptacle bin on the medication cart and at the end of the schedule shift are disposed of into the waste receptacle bin in the medication room.

RPN #132 indicated, to Inspector #554, that medication strips are disposed of into the waste receptacle bin on the side of the medication cart, and then taken to a waste receptacle in the utility room.

RN #108, who was the assigned Charge Nurse on the fourth floor, where all three resident home areas are located, indicated, to Inspector #554, that the practise around disposal of medication packaging strips is inconsistent amongst registered nursing staff. RN #108 indicated that all registered nursing staff have been provided direction, during an in service with Medical Pharmacy (the former pharmacy service provider) that medication packaging strips contain Personal Health Information (PHI) and are to be disposed of by shredding the strips via use of an electronic shredder which is provided by the licensee.

RCC #117, who is the lead for medication management, indicated, to Inspector #554,

that registered nursing staff are to dispose of used medication packaging strips by placing the medication strip into a plastic bag, and pouring water onto the used strips; RCC #117 indicated that water helps to dissolves PHI on the medication strip, and then the plastic bag is tied off and disposed of into the waste receptacle bins. RCC indicated that all registered nursing staff have been directed to do such.

RPN #109 and #132 indicated that they do not pour water onto the used medication packing strips prior to or following disposal into general waste receptacles.

The licensee failed to ensure that the following rights of residents are fully respected and promoted, specifically every resident has the right to have their personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act. [s. 3. (1) 11. iv](554)

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee has failed to ensure that abuse of a resident by anyone, that resulted in harm or risk of harm by a person who had reasonable grounds to suspect that abuse occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director.

Related to Log # 007430-18:

A critical incident report (CIR) was submitted to the Director on a specified date by RCC #118, for a resident to resident abuse incident. The CIR indicated that on a specified date and time, PSW #136 witnessed resident #034 engage in resident to resident abuse towards resident #035 in a specified area resulting in the resident sustaining a fall. The CIR indicated resident #035 was upset at the time of the incident.

Interview with RCC #118 by Inspector #111 indicated, that they became aware of the resident to resident abuse incident when they returned to work the next day. The RCC indicated RN #133 was working when the incident occurred. The RCC determined the incident was abuse and should have been reported to the MOHLTC the previous day by the RN. The RCC indicated the MOHLTC was notified when a CIR was submitted (the day after the incident occurred).

Interview with RN #133 by Inspector #111, confirmed the incident was not reported to the MOHLTC because the RN did not think it was abuse. The RN indicated the resident was upset initially, but then calmed down and was not crying so the RN did not report the incident. The RN indicated the incident was reported the following day to the RCC (#118).

The licensee has failed to ensure that when RN #133 had reasonable grounds to suspect that abuse of a resident by another resident, that resulted in harm or risk of harm, immediately reported the suspicion and the information upon which it was based to the Director. [s. 24. (1)](111)

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

The licensee failed to ensure that procedures and interventions developed, were implemented:
(a) to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and
(b) to minimize the risk of altercations and potentially harmful interactions between and among residents and,
(c) that direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours posed a potential risk to the resident or others.

Related to Log #001228-18:

A follow up inspection was completed for a Compliance Order that was issued under s.6(1) under the Act, related to resident #038 for the plan of care that did not set out the planned care for resident #038 related to an identified responsive behaviour.

Review of the licensee's Responsive Behaviour Prevention and Management policy (INTERD-03-09-01) reviewed January 13, 2015 indicated under procedure:
-plans of care and resident specific strategies to prevent and manage responsive behaviours will be communicated to all staff providing care on a shift by shift basis as well as on an ongoing basis.

-Incidents of responsive behaviours in dementia, and incidents involving altercations and harmful interactions between and among residents will be documented appropriately and thoroughly in the residents chart. Additionally, refer to the Abuse and Neglect –Prevention, Reporting & Investigation policy regarding additional required documentation.

Review of the Abuse and Neglect-Prevention, Reporting & Investigation policy (ADM-01-03-05: revised September 2016) indicated under preventing sexual abuse: cognitively impaired residents identified as high risk to abuse other residents through observation, assessment and observed sexual behaviours will be referred to BSO for assessment and interventions and will be monitored at a level required to provide safety.

Observation of resident #038 on a specified date and time, by Inspector #111, indicated the resident was demonstrating a responsive behaviour to an identified resident. The co-resident was asking the Inspector for assistance to redirect resident #038 away. A staff member who was in close proximity, was notified and then redirected resident #038 away from the co-resident.

Interview with RPN #106 (who was working on the unit that resident #038 resided) by Inspector #111, indicated no awareness of identified responsive behaviours towards other residents. by resident #038.

Review of the current written plan of care for resident #038 indicated the resident demonstrated identified responsive behaviours. There were three identified triggers and specified interventions included.

Review of the progress notes for resident #038 for an eight month period indicated there were eight incidents of responsive behaviours towards other residents. The documentation did not identify who the recipient residents were to determine which residents were at risk of harm or who were harmed as a result of the resident's behaviours.

Interview with BSO PSWs (#114 & #115) by Inspector #111, both indicated no awareness that resident #038 demonstrated any of the identified responsive behaviours towards other residents "in a long time". They both clarified that resident #038 had not demonstrated those responsive behaviours since the resident's cognitive status had declined. Both PSW’s confirmed they had no awareness of any further incidents of responsive behaviours towards other residents in the last nine months.

Interview with RPN #134 by Inspector #111, indicated that they could not identify who all the recipient residents were, who were involved in the responsive behaviours and/or altercations on the specified dates whom the RPN documented resident #038 was involved in. The RPN indicated resident #051 was the recipient involved in some of the incidents but could not specify which ones.

Interview with DOC by Inspector #111, indicated she was unable to identify which residents were involved in the altercations with resident #038 on the specified dates. The DOC indicated RPN #134 was the staff who documented the incidents and should have documented who the recipient residents were.

The licensee failed to ensure their Responsive Behaviour policy (which included portions of the Abuse & Neglect Prevention policy) that were developed, were implemented to assist residents and staff who were at risk of harm or who were harmed as a result of resident #038 responsive behaviours or altercations, as the BSO was not referred to when the incidents occurred and the incidents were not thoroughly documented on to indicate who the recipient residents were in the altercation. The direct care staff were also not advised at the beginning of every shift of each resident whose responsive behaviours required heightened monitoring because those behaviours posed a potential risk to the resident or others. [s. 55. (b)](111)

Issued on this 25th day of July, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LYNDA BROWN (111), KELLY BURNS (554)
Inspection No. / No de l'inspection :	2018_643111_0007
Log No. / No de registre :	005438-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 26, 2018
Licensee / Titulaire de permis :	Regional Municipality of Durham 605 Rossland Road East, WHITBY, ON, L1N-6A3
LTC Home / Foyer de SLD :	Hillsdale Estates 590 Oshawa Blvd. North, OSHAWA, ON, L1G-5T9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Gina Peragine

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

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

Order / Ordre :

The licensee must be compliant with s.20(1) of the LTCHA.

Specifically, the licensee shall ensure the written policy that promotes zero tolerance of abuse and neglect of residents, specifically related to how investigations are to be completed, is complied with when completing any investigations into alleged, suspected or witnessed incidents of abuse towards residents.

Grounds / Motifs :

1. The licensee has failed to ensure that there is a written policy that promotes zero tolerance of abuse and neglect of residents and that it was complied with.

There were four critical incident reports (CIR) submitted to the Director for witnessed, resident to resident abuse related to resident #034 towards two different residents (#035 and #036) as follows:
-Related to log #021873-17:
A CIR was submitted to the Director for a witnessed resident to resident abuse incident. The CIR indicated on a specified date in 2017 at a specified time, environmental services staff member #137 witnessed resident #034 engage in a resident to resident abuse incident in an identified area towards resident #035, resulting in resident #035 sustaining a fall. Both residents were immediately separated and RN #133 notified. Resident #035 had no injuries but was upset as a result of the incident. The CIR was completed by Resident Care Coordinator (RCC) #118.
-Related to log # 025519-17:

A CIR was submitted to the Director for a witnessed resident to resident abuse incident. The CIR indicated on a specified date in 2017, at a specified time, (approximately one month after the first incident) RPN #125 witnessed resident #034 engage in a resident to resident abuse incident in an identified area, towards resident #036, resulting in resident #036 sustaining a fall. Resident #036 sustained injuries to specified areas, complained of pain to specified areas and was upset by the incident. The CIR was completed by RCC #118.
-Related to log # 026888-17:
A CIR was submitted to the Director for a witnessed resident to resident abuse incident. The CIR indicated on a specified date in 2017 at a specified time, (approximately two weeks later), two visitors witnessed resident #034 engage in a resident to resident abuse incident in an identified area, towards resident #036, resulting in resident #036 sustaining a fall. Resident #036 sustained an injury to a specified area. The CIR was completed by RCC #118.
-Related to Log # 007430-18:
A CIR was submitted to the Director for a witnessed resident to resident abuse incident. The CIR indicated on a specified date in 2018 at a specified time, (approximately five months later), PSW #136 witnessed resident #034 engage in a resident to resident abuse incident in an identified area, towards resident #035, resulting in resident #035 sustaining a fall. Resident #035 was upset at the time of the incident. The CIR was completed by RCC #118.

Review of the Licensee's policy "Abuse and Neglect-Prevention, Reporting & Investigation" (ADM-01-03-05;reviewed September 2016) indicated under Reporting/Investigation Procedures:
-(page 6/18) all staff, volunteers and affiliated personnel must immediately report any alleged, suspected or witnessed incidents of abuse or neglect to the appropriate supervisor on duty.
-(Page 11/18) any person reporting alleged witnessed, or suspected abuse will be required to participate in an investigatory process as required, including providing written and verbal statements. Supervisor, manager or delegate is responsible for initiating the investigation commencing with documentation of details, including details of the allegation/incident, dates, timing of events, names of witnesses and others involved.

Interview with RN #133 by Inspector #111, indicated the first incident involving resident #034 and resident #035 was not reported or investigated because the RN did not think it was abuse. The RN indicated the resident was initially upset but then calmed down, so the RN did not contact the on-call manager as per the

licensee's policy to report the incident.

Interview with RCC #118 by Inspector #111 confirmed that the RCC's were responsible for conducting the investigations for any critical incident reports they completed. The RCC indicated that all staff involved in the incidents are interviewed but didn't usually document the investigations. The RCC confirmed there were no documented evidence of investigations for the four CIR's involving resident #034. The RCC indicated, regarding the last critical incident, the RCC was notified of the resident to resident altercation the following day and interviewed staff to determine what happened, including RN #133. The RCC confirmed there was no documented evidence of the investigation and confirmed no written statements were obtained as per the licensee's policy.

Interview with the DOC by Inspector #111 confirmed the RCC should have completed written investigations for the four CIRs related to resident to resident abuse as per the licensee's policy. The DOC confirmed there was no documented evidence of any investigations into the four witnessed resident to resident abuse incidents that occurred.

The licensee failed to ensure their policy "Abuse and Neglect-Prevention, Reporting & Investigation", specifically related to investigations, was complied with related to four witnessed, resident to resident abuse incidents that involved resident #034. [s. 20. (1)]

The severity of this issue was determined to be a level 3 as there was actual risk/harm to two residents (resident #035 and #036). The scope of the issues was a level 3 as it related to four of the four incidents reviewed. The home had a level 4 hisotry of on-going non-compliance with this section of the Act that included:
-Written notifications (WN) issued July 8, 2014 (2014_365194_0007).
-Voluntary plan of correction (VPC) issued January 9, 2017 (2017_598570_0001),
-Compliance order (CO) issued July 9, 2015 (2015_291552_0019) was issued for s.19(1) which included s.20(1). (111)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 27, 2018

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 54. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s. 54(b).

Specifically, the licensee shall ensure:
-Steps are taken to minimize the risk of altercations and potentially harmful interactions between residents demonstrating physically abusive responsive behaviours by implementing identified interventions.
-Registered nursing staff and BSO team to review and revise the written plan of care for any current residents identified at high risk for demonstrating physically aggressive and/or abusive responsive behaviours towards other residents, to ensure that all interventions identified are actually in use and effective in minimizing potentially harmful interactions between residents.
-actions to be taken and by whom, when staff fail to implement the interventions as identified.

Grounds / Motifs :

1. The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

There were four critical incident reports (CIR's) submitted to the Director (as stated under WN #001) for witnessed, resident to resident abuse from resident #034 towards two residents (#035 and #036) related to: Log # 021873-17, Log #

025519-17, Log # 026888-17 and Log # 007430-18.

In addition, review of the progress notes for resident #034 indicated there were additional incidents of resident to resident altercations involving resident #034 towards resident #035 and other unidentified resident's until the resident was transferred to hospital on a specified date for a psychiatric assessment as per the following:
-on a specified date and time in 2017, resident #035 was found on the floor in an identified area after resident #034 had engaged in an altercation with resident #035 and no injuries were sustained.
-two weeks later, at a specified time, staff witnessed resident #034 engage in an altercation with an unidentified resident in an identified area and no injury was sustained. Later the same day, resident #034 was witnessed engaging in an altercation with an unidentified resident in an identified area and no injuries were sustained.
-three days later, at a specified time, staff witnessed resident #034 engaging in an altercation with an unidentified resident and no injuries were sustained.
-approximately two months later, at a specified time, resident #034 was witnessed engaging in an altercation with resident #035. Later the same day, a second altercation was witnessed with resident #034 towards resident #035. There were no injuries noted to resident #035 for either incident.
-approximately two weeks later, at a specified time, staff witnessed resident #034 in an identified area, engage in an altercation towards unidentified residents, removing them from a specified area.
-approximately two weeks later, at a specified time, staff observed resident #034 sitting in an identified area watching TV and then engage in an altercation towards two unidentified residents.

Review of the written plan of care for resident #034, that were in place at the time of the incidents indicated, the resident demonstrated specified responsive behaviours. The resident had more than one altercation towards a specific resident. There were two specified triggers identified but did not indicate which specific resident provided the trigger. There were a number of interventions in place to address resident #034 responsive behaviours which included the administration of medication and to notify the physician.

Further interventions identified on the critical incident reports that were taken to prevent a recurrence included:
-after the first critical incident (CIR), the physician was notified and ordered a

specified medication, a Dementia Observation Sheet (DOS) was started and the Behavioural Supports Ontario (BSO) was notified. Staff were also reminded to ensure that resident #034 and resident #035 were kept separated.
-after the second critical incident (CIR), one to one monitoring of resident #034 was initiated, additional medication changes (as per psychogeriatric assessment recommendations), staff requested a TV be put in resident #034 room to avoid going to an specified area that was a trigger. Staff were also to keep resident #034 and resident #036 separated.
-after the third critical incident (CIR), one to one monitoring of resident #034 was initiated, staff were to monitor resident #034 and resident #035 when in close proximity to each other, staff were to keep resident #034 away from a specified common area if behaviour was unstable/unsafe, BSO remained involved and were awaiting further involvement of psychogeriatric assessment.
-after the last critical incident (CIR), resident #034 was transferred to hospital for psychiatric assessment.

Interview with Behavioural Supports Ontario (BSO - PSW #114 and #115) by Inspector #111, indicated the BAT, DOS and Tip Sheet were put in place for resident #034 which included the identified responsive behaviours, the triggers and interventions to manage the resident's responsive behaviours. They both indicated a clinical monitoring flow sheet was also provided to staff when the resident #034 was placed on one to one monitoring to see what behaviours were occurring. They both indicated resident #034 was on the one to one monitoring for short periods of time after each critical incident report was submitted but only during specified times over a four month period in 2018.

Interview with the DOC by Inspector #111, indicated the DOC was unable to verify who all the recipient residents were that were involved in the altercations with resident #034 on the five specified dates in 2017. The DOC was only able to identify one of the recipient residents involved, (the second incident in 2017) and was resident #035. The DOC indicated resident #034 was on permanent one to one monitoring for day and evening shifts for two months in 2017 and for the remainder of 2018 until the resident was transferred to hospital for a psychiatric assessment.

Review of the health care record for resident #034 indicated a psychiatric assessment referral was not submitted in 2017. One of the interventions requested by staff in 2017 had no documented evidence to indicate this occurred. The plan of care indicated an identified intervention was put in place

for the resident to avoid going to an identified area, but the resident continued to go to the identified area. In addition, while one to one monitoring was to be in place for resident #034, resident #034 was able to engage in another resident to resident abuse incident with resident #036 (second CIR) and again towards resident #035 (last CIR) while in the specified area that staff were supposed to be closely monitoring (or removing the resident from) and keeping both residents away from one another. The written plan of care interventions had contradictory directions to staff. The physician was inconsistently contacted despite resident #034 involved in altercations towards resident #035, #036 and other unidentified residents.

The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between resident #034 and other residents (resident #035, #036 and unidentified residents) by identifying and implementing interventions. [s. 54. (b)]

The severity of this issue was determined to be a level 3 as there was actual risk/harm to two specified residents (resident #035 and #036) and there was ongoing altercations with resident #034 towards other unidentified residents. The scope of the issue was a level 1 as it related one resident involved in four out of the four critical incidents of resident to resident physical abuse.The home had a level 4 history of on-going non-compliance with this section of the Act that included:
-Compliance order (CO) issued on April 18, 2016 (2016_389601_0008),
-Written notification (WN) issued on July 18, 2017 (2017_578672_0013). (111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 27, 2018

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

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

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

RENSEIGNEMENTS 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)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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 June, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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