Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

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

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Oct 25, 2019	2019_715672_0005 (A2)	002061-18, 020792-18, 027448-18, 001139-19, 002757-19, 003184-19, 003654-19, 006865-19, 011869-19	Complaint

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

Amended by JENNIFER BATTEN (672) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

The previous amended report, which was issued on October 10, 2019, did not include the provisions under CO #003, under s. 52. The report has been amended.

Issued on this 25th day of October, 2019 (A2)

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

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Amended by JENNIFER BATTEN (672) - (A2)

Amended 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 16, 17, 21-24, 27-31, June 3-7, 10-14, 19, 2019

The following intakes were inspected during this complaint inspection:

Log #001139-19, related to a complaint regarding skin and wound care, nutrition and hydration, staffing levels and pain control.

Log #003184-19, related to a complaint regarding falls management

Log #027448-18, related to a complaint regarding continence care, skin and wound care, falls management, personal support services related to nail care and sufficient staffing in the home

Logs #026117-18 and #027448-18, related to a complaint and Critical Incident Report regarding an allegation of staff to resident abuse

Log #020792-18, related to a complaint regarding sufficient staffing in the home and activities of daily living not being provided as required

Logs #003654-19 and #006865-19, related to withholding approval for admission to the home

Log #011869-19, related to a Critical Incident Report regarding an allegation of resident to resident abuse

Log #002061-18, related to a complaint regarding an allegation of improper care

Log #002757-19, related to the follow up of Compliance Order #001, from inspection #2018_643111_0007, related to LTCHA, 2007, s.20(1), with a compliance due date of April 29, 2019.

PLEASE NOTE: A Written Notification and Compliance Order related to LTCHA, 2007, r. 52. (2), identified in a concurrent inspection #2019_598570_0012 (Log #017363-18; Log #018945-18 and Log #021231-18) and a Voluntary Plan of Compliance related to LTCHA, 2007, s. 24. (1), identified in a concurrent inspection #2019_598570_0012 (Log #031011-18) were issued in this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, Regional Manager of Quality, Director of Care (DOC), RAI Coordinator, Resident Care Coordinators (RCC), Non-Clinical Nursing Manager, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Food Service Director (FSD), Food Service Workers (FSW), Social Worker (SW), Physiotherapists (PT), Occupational Therapists (OT), Registered Dietitian (RD), Physicians (MD), Staffing Clerks, Recreational Aides (RA), Infection Control Nurse (ICN), residents, family members, and visitors to the home.

The following Inspection Protocols were used during this inspection:

Admission and Discharge
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of the original inspection, Non-Compliances were issued.
11 WN(s)
8 VPC(s)
3 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. 20. (1)	CO #001	2018_643111_0024	672

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

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #032’s plan of care was based on an assessment of the resident and the resident's needs and preferences.

Inspector #672 reviewed resident #032’s continence care and bowel management while reviewing the completion of continence assessments in the home. During interviews related to the completion of continence assessments, PSWs #174 and #140, and RPNs #132 and #134 indicated that resident #032’s continence level had declined over the last several months for both bowel and bladder.

Inspector #672 reviewed resident #032’s current written plan of care along with the previous written plan of care. Both written plans of care indicated resident #032 exhibited a specified level of continence related to both bowel and bladder, and required a specified level of assistance from an identified number of staff members to assist with the task of toileting. Inspector #672 then reviewed two of resident #032’s specified MDS assessments. The first MDS assessment indicated resident #032 required a specified level of assistance from an identified number of staff members for the task of toileting. The second MDS assessment indicated resident #032 required the same specified level of assistance but from a different identified number of staff members for the task of toileting. Both MDS assessments indicated resident #032 exhibited a different specified level of

continence related to both bowel and bladder than was indicated in the written plan of care and as indicated by PSWs #174 and #140, and RPNs #132 and #134.

During an interview, the RAI Coordinator indicated the expectation in the home was that registered staff were expected to immediately update the resident's plan of care to reflect the changes in the resident's needs and preferences, and provide clear directions to the staff regarding the level of assistance required for each activity of daily living.

During an interview, RCC #105 reviewed resident #032's plan of care with Inspector #672, and indicated it did not reflect the resident's current needs and preferences, as it did not accurately reflect the resident's true continence level and level of physical assistance required for the task of toileting. [s. 6. (2)]

2. The licensee has failed to ensure that staff and others collaborated with each other in the assessment of resident #010.

Related to Log #003184-19:

A complaint was received by the Director regarding an incident on a specified date and time when resident #010 was found on the floor by staff.

Prior to the incident of being found on the floor, resident #010 used a specified mobility aid to ambulate in their room and a different mobility aid for longer distances, such as to the dining room.

A review of the progress notes from a specified time period included the following:

- On a specified date and time, RN #124 documented that the resident was found on the floor. No apparent injury was noted and the family was notified.

- The following day RN #142 documented a referral for OT was made as staff reported that resident was increasingly difficult to transfer and used another transfer device. Later that day RPN #153 documented that the resident denied pain and had no voiced concerns but several hours later RPN #143 documented that a follow-up assessment indicated the resident was noted to be lethargic, denied pain and staff used the specified transfer device for transfers. RPN #143 further documented that an OT referral was made due to identified concerns and

requested an assessment for the staff to utilize another specified transfer device for the resident.

- The next day RN #148 documented that staff had reported to the nurse that the resident had a brief unresponsive episode. The resident's family member was informed and a note was left in the physician's book regarding the unresponsive episode. A few hours later, Physiotherapist #103 documented that the RN reported the resident had an unresponsive episode and the PSWs reported a specified concern during transfers over the past two days. The resident's physical condition was not stable enough at that moment for an assessment to be completed by the Physiotherapist. The Physiotherapist posted an identified transfer logo for transfers and notified staff. That evening, RN #156 documented that resident #010 was observed to be attempting to self-transfer. Health teaching was provided to the resident about the importance of waiting for assistance for transferring, especially since the resident's recent fall.

- The following day RPN #145 documented that the resident had no complaints of pain or discomfort related to the previous fall sustained. Extensive bruising was observed on an identified area of the resident.

- Two days later RN #157 documented they were called by staff to assess resident #010 and observed bruising to an identified area, along with two identified physical injuries. Resident #010 exhibited minimal grimacing on palpation and movement of the area and remained alert and calm with no voiced complaints. The resident was transferred to hospital for further assessment.

A review of the x-ray report from hospital indicated that there was an identified injury to the area. A review of the follow-up mobile x-ray report indicated also indicated an identified injury was present.

During an interview with Inspector #571, PSW #146 indicated that after the resident's fall, the resident was transferred to a chair via an identified transfer device. After the nurse assessed the resident, the resident was transferred to the toilet. PSW #146 assisted PSW #152 to transfer the resident off of the toilet. PSW #146 indicated that a specified concern was observed during the transfer so they informed RPN #143.

In an interview with Inspector #571, RPN #143 indicated that RN #124 had assessed the resident after the fall, and documented their findings. RPN #143

further indicated they had assumed that the RN had informed the physician of resident #010's fall.

In an interview with Inspector #571, RN #124 indicated they had assessed resident #010 after the fall, with RPN #143. No evidence of an injury was found during that assessment and the resident was transferred via an identified transfer device. RN #124 further indicated they had not been made aware of any specified concerns during further transfers with the resident.

In an interview with Inspector #571, RN #148 indicated that they informed physician #151 of the resident's unresponsive episode. RN #148 did not work on the date of resident #010's fall of the following day, and made an assumption that physician #151 had been informed of the fall that had occurred. The RN indicated if a resident sustained a minor fall with no injury observed, they might put a notation in the physician's communication book rather than calling the physician directly to inform of a resident fall. RN #148 further indicated that if there was a change in a resident's condition then the physician would be called directly to be informed of the incident. RN #148 indicated that they considered a change in a resident's ability to assist during a transfer to be a change in condition. The RN did not speak to physician #151 about resident #010's change in ability to assist during a transfer, as they were more focused on the resident's unresponsive episode from earlier that day.

In an interview with Inspector #571, physician #151 indicated that they did not recall being notified of the resident's fall or of the resident's change in ability to assist during a transfer. The physician further indicated that the staff should have realized that when the resident could no longer assist in their transfers there was an injury present. Physician #151 indicated that resident #010 had sustained an identified injury, and the fact that the resident was not sent to the hospital sooner would not have changed the outcome, however, there could have been serious complications, which fortunately did not happen.

The staff failed to collaborate with the physician in their assessment of resident #010 after the resident fell and could no longer provide the same level of assistance during transfers. [s. 6. (4) (a)]

3. The licensee has failed to ensure that staff involved in the different aspects of resident #019's care collaborated with each other so that their assessments were integrated, consistent with and complemented each other.

Related to Log #001139-19:

A complaint was received by the Director related to resident #019, regarding skin and wound care, nutrition and hydration, staffing levels and pain control.

During a telephone interview, resident #019's SDM indicated to Inspector #672, that resident #019 passed away in the home after acquiring an identified area of altered skin integrity along with another medical diagnosis. Resident #019's SDM further indicated that the area of altered skin integrity had worsened over a specified time period which resulted in the nursing team putting identified interventions in place.

A review of resident #019's progress notes for a specified time period revealed the following:

- Between a specified time period, resident #019 experienced an identified symptom on a number of occasions.

- Between another specified time period, resident #019 was noted to have experienced an identified symptom on a number of occasions, and received an identified intervention.

There was no documentation in resident #019's health care record that resident #019's primary physician, MD #162, was notified of resident #019's symptom for longer than one month, and had been exhibiting this symptom daily during a specified time period.

During an interview, MD #162 indicated their expectation was that the registered staff would notify them directly if a resident was experiencing an identified symptom for "more than a day or two". MD #162 further indicated they could not recall being notified resident #019 had exhibited the identified symptom during the specified time period, or that the resident exhibited the identified symptom daily during another specified time period. MD #162 indicated if they had been notified of the resident's identified symptom, they would have documented about them in the "Physician's progress notes" section of resident #019's health care record. Following a review of their documentation in resident #019's health care record, MD #162 felt confident they were not notified of resident #019's identified symptoms. MD #162 further indicated they were "not surprised" they had not

been notified of resident #019's changing condition, as there had been "longstanding communication issues" in the home between the nursing and medical staff, which MD #162 indicated they had spoken to the DOC about on several occasions. MD #162 further indicated they had recently changed the process of how communication occurred between the nursing staff and the physicians in the home, in the hope of assisting communication and physician notification, to help improve resident outcomes. MD #162 indicated if they had been aware of resident #019's changing condition, there may have been interventions which could have been implemented to assist in ensuring the resident's comfort.

During separate interviews, RPNs #132 and #134 indicated they could not recall notifying MD #162 of resident #019's changing condition, but had notified RNs #160 and #166, who would have been responsible for communicating with the physician. RNs #160 and #166 indicated they believed they had notified MD #162 of resident #019's changing condition by leaving a notation in the physician's book. Inspector #672 reviewed the physician's book with RNs #160 and #166 during the specified time period, and could not locate any documentation which indicated MD #162 had been notified of resident #019's increased temperatures.

During an interview, Resident Care Coordinator (RCC) #105 indicated the expectation in the home was for either the RPN or the RN to keep each resident's primary care physician up to date on the resident's current health condition, by contacting the physician directly. RCC #105 further indicated it was only appropriate to leave notes in the physician's book related to non-urgent information which was not time sensitive, and should not include any information regarding a resident's condition.

The licensee failed to ensure that the nursing and medical staff collaborated with each other regarding resident #019's changing health condition, so that their assessments were integrated, consistent with and complemented each other. [s. 6. (4) (a)]

4. The licensee has failed to ensure that the care set out in resident #011's plan of care was provided to the resident as specified in the plan.

Related to Log #027448-18:

A written complaint was received by the Director from resident #011's substitute decision maker (SDM), related to continence care, skin and wound care, falls management, personal support services related to nail care and sufficient staffing in the home.

During a telephone interview, resident #011's SDM indicated that following meetings with the nursing management team in the home, it was agreed upon that resident #011 would receive a specified intervention.

Inspector #672 reviewed resident #011's documentation from three separate specified time periods, specific to the specified intervention. The directions listed and highlighted at the top of the resident's documentation directed that resident #011 was to receive the specified intervention at specific times. The documentation further showed that resident #011 was not receiving the intervention as directed.

During an interview, PSW #104 indicated that resident #011 was not receiving the specified intervention as directed.

During separate interviews, RPN #132, RCC #105 and the DOC indicated that resident #011 was not receiving the specified intervention, and instead received a different level of assistance related to toileting. During an interview, RCC #105 indicated they were not aware that a specified document was still being utilized and documented on by all of the PSWs providing care for resident #011, and stated they would update the documentation and inform staff that resident #011 was no longer to be receiving the specified intervention as was outlined in the documentation. RCC #105 and the DOC both indicated that the expectation in the home was that each resident's plan of care was to be provided to the resident as specified in the plan.

Inspector #672 reviewed resident #011's documentation approximately two weeks following the interview with RCC #105 and observed the documentation was still present, and indicated resident #011 was to receive the specified intervention. During separate interviews, PSW #123 and RPN #134 both indicated that resident #011 was supposed to continue to receive the specified intervention as directed on the documentation.

The licensee failed to ensure that the care set out in resident #011's plan of care was provided to the resident as specified in the plan, by not ensuring that resident

#011 received the specified intervention as directed in the resident's care plan and specified documentation sheets. [s. 6. (7)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended: CO# 001

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 resident plans of care are based on an assessment of the resident and the resident's needs and preferences, and are provided to the resident 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 the internal policy related to skin and wound care was complied with.

In accordance with O. Reg. 79/10, r. 48 (1), the licensee was required to ensure that the following interdisciplinary programs were developed and implemented in the home: 2) A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.

Under O. Reg 79/10. s. 30 (1), every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

Under O. Reg 79/10. r. 50 (2) (b) (iii), a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is to be assessed by the 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.

Under O. Reg 79/10. r. 50 (2) (b) (iv), a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is to be reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Inspector #672 reviewed the licensee's internal policy specific to areas of altered skin integrity, which directed that upon discovery of an area of altered skin integrity, registered staff were to initiate a baseline assessment using a clinically appropriate assessment instrument, send referrals to the dietitian, Skin and Wound Care Champion, occupational therapist and physiotherapist, ensure the plan of care was established outlining interventions and treatments, reassess the resident weekly and revise the care plan accordingly. The internal policy also directed what assessment tool(s) and documentation was to be completed and included in the resident's health care record on a weekly basis.

Related to Log #001139-19:

A complaint was received by the Director related to resident #019, regarding skin and wound care, nutrition and hydration, staffing levels and pain control.

During a telephone interview, resident #019's SDM indicated to Inspector #672 that resident #019 passed away in the home after acquiring an area of altered skin integrity along with another medical diagnosis. Resident #019's SDM further indicated that the area of altered skin integrity had worsened significantly over a specified time period, which resulted in the nursing team putting specified interventions in place.

A review of resident #019's progress notes indicated the resident had acquired an area of altered skin integrity which was noted to have deteriorated over a specified time period. Resident #019 was further observed to have acquired three other areas of altered skin integrity approximately three weeks after the first area was observed, and two other areas of altered skin integrity approximately one week later.

Based on a review of resident #019's health care records, the first specified baseline assessment for resident #019 was completed four days after the initial observation of the area of altered skin integrity was observed.

Inspector #672 reviewed resident #019's skin and wound assessments completed during a specified approximate six week time period and noted that regarding the five areas of altered skin integrity observed after the initial area of altered skin integrity was found, Inspector #672 could not observe any assessments of the areas to have been completed by the registered staff. Regarding the initial area of altered skin integrity, Inspector #672 noted there appeared to be missing weekly assessments, and of the assessments which were completed, there appeared to be specified documentation missing, as per the instructions provided to the registered staff within the licensee's internal written policy specific to areas of altered skin integrity.

During an interview, the DOC indicated the expectation in the home was that every resident who exhibited altered skin integrity was to be reassessed at least weekly by a member of the registered nursing staff which was to be documented in a clinically appropriate wound assessment that included specified documentation as directed within the licensee's internal written policy.

Inspector #672 reviewed resident #019's health care record for a specified time

period, regarding referrals to the dietitian, occupational therapist and physiotherapist related to the observed areas of altered skin integrity. No referrals were observed to have been completed and documented in resident #019's health care record during that time period. Inspector #672 then reviewed the health care record for referrals to the Skin and Wound Care Champion and did not observe any completed referrals related to any of resident #019's areas of altered skin integrity, outside of the initial area first observed.

During separate interviews, RPNs #132 and #134 indicated they were the regular part time and full time RPNs on resident #019's home area and completed the interventions for resident #019's areas of altered skin integrity most often. RPNs #132 and #134 indicated the expectation in the home was that every resident who exhibited altered skin integrity was to be reassessed at least weekly by a member of the registered nursing staff, which was to be documented in a clinically appropriate wound assessment that included specified documentation as directed within the licensee's internal written policy. RPNs #132 and #134 further indicated they did not routinely send referrals to the OT/PT when a resident was observed to have an area of altered skin integrity, and would only send a referral to the dietitian if the resident was not already being followed for another issue. RPNs #132 and #134 further indicated the referrals would sometimes be delivered verbally, either by calling the RD on the telephone or updating the RD in person during the RD's observation rounds during meals. RPNs #132 and #134 indicated if referrals were given verbally they should always be documented within the resident's progress notes and could not recall requesting any referrals for resident #019 related to the areas of altered skin integrity. RPNs #132 and #134 further indicated they were unaware of one of the specified assessment tools registered staff were directed to complete within the licensee's internal policy and had not completed some of the other instructions listed within the policy.

During separate interviews, OT#164, PT#103 and RD #135 indicated they had not received referrals regarding each of resident #019's areas of altered skin integrity. PT#103 indicated they never received referrals related to any resident's areas of altered skin integrity, unless the area was directly related to the resident's mobility device. RD #135 indicated they were aware that resident #019 had an area of altered skin integrity, but had not been informed or were aware the area had worsened. RD #135 further indicated they were unaware of resident #019's five other areas of altered skin integrity observed during the specified six week time period. RD #135 indicated if they were informed of resident #019's areas of altered skin integrity, there may have been further nutritional interventions which

could have been implemented for the resident. OT#164 indicated they had not received any referrals regarding resident #019's areas of altered skin integrity, but was involved in a request for resident #019 to obtain a specified intervention following the observation of the first area of altered skin integrity but prior to the subsequent areas being observed.

After review of the licensee's internal written policy regarding areas of altered skin integrity, Inspector #672 observed several areas of non-compliance with the policy, specific to resident #019, therefore expanded the scope of assessment related to assessing compliance with the internal policy to include two more residents with exhibited areas of altered skin integrity. On a specified date, RN #163 indicated that residents #023 and #024 had experienced areas of altered skin integrity within a specified period of time.

Related to Resident #023:

During review of resident #023's health care record, Inspector #672 observed the resident's Treatment Administration Records (TARs) for a specified time period, which indicated in a specified month, the resident had an existing area of altered skin integrity. The following month, resident #023 was noted to have another area of altered skin integrity.

During review of resident #023's assessments completed during the specified time period related to both areas of altered skin integrity, Inspector #672 noted there appeared to be missing weekly assessments and of the assessments which were completed, there appeared to be documentation missing, as per the instructions provided to the registered staff within the licensee's internal written policy specific to areas of altered skin integrity.

Inspector #672 then reviewed resident #023's health care record related to referrals to the registered dietitian, Skin and Wound Care Champion, occupational therapist and physiotherapist regarding one of the areas of altered skin integrity from when it was first noted. No referrals were observed to have been completed and documented in resident #023's health care record during the specified time period.

Related to Resident #024:

During review of resident #024's health care record, Inspector #672 observed the

resident's TARs for a specified time period, which indicated that in a specified month, the resident had two existing areas of altered skin integrity. Approximately two months later, resident #024 was noted to have four new areas of altered skin integrity. Inspector #672 reviewed resident #024's health care record for a specified time period regarding referrals to the dietitian, occupational therapist and physiotherapist related to the areas of altered skin integrity. No referrals were observed to have been completed and documented in resident #024's health care record during that time period.

Review of the physician's orders indicated resident #024 had a physician's treatment order which specified assessments of the areas were to be completed weekly on a specified day and shift. Inspector #672 then reviewed resident #024's assessments completed during a specified time period, related to the areas of altered skin integrity and noted there appeared to be missing weekly assessments and of the assessments which were completed, there appeared to be documentation missing, as per the instructions provided to the registered staff within the licensee's internal written policy specific to areas of altered skin integrity.

During separate interviews, RPNs #132 and #134, RNs #160 and #166, RCCs #105 and #176, and the RAI Coordinator all indicated the expectation in the home was that each resident with exhibited areas of altered skin integrity was to be assessed and documented upon by a member of the registered nursing staff on a weekly basis, which was to include specified documentation as directed within the licensee's internal written policy.

During an interview, OT #164 indicated the expectation in the home was for staff to send referrals when a resident was noted to be at risk for pressure related injuries. OT #164 further indicated if a referral was not sent prior to the resident's skin breaking down, a referral should be sent once an area of altered skin integrity was observed. OT #164 stated that communication within the multidisciplinary team could be more collaborative and felt that the nursing team did not keep occupational therapy updated regarding resident's health care status, specifically related to areas of altered skin integrity. OT #164 indicated they were contacted if a device was requested for a resident, or was noted to be malfunctioning, and had not received any referrals related to residents #023 and #024's areas of altered skin integrity. OT #164 indicated they were only aware of some of resident #023 and #024's areas of altered skin integrity after speaking with the staff on the resident home areas during conversations regarding pressure relief interventions.

OT #164 indicated they felt that "a lot more could have been done for (resident #024) to prevent their (areas of altered skin integrity)", if they had the opportunity to be involved in resident #024's care during the early stages, when specified interventions could have been implemented when the resident was first observed to exhibit areas altered skin integrity.

During an interview, RD #135 indicated the expectation in the home was for a referral to be sent each time a resident's area of altered skin integrity was noted to improve or decline. RD #135 further indicated they did not receive any referrals related to resident #023's areas of altered skin integrity improving and declining during a specified time period. RD #135 indicated they did not receive any referrals related to resident #024's areas of altered skin integrity, and was only aware of two of the areas, but was not aware of the four newer areas of altered skin integrity.

During separate interviews, RCCs #105, #176 and the DOC indicated that the expectation in the home was for all staff members to follow each internal policy, including the internal policy related to areas of altered skin integrity. RCCs #105 and #176 further indicated they were aware that weekly skin assessments were not always being completed on a weekly basis, that referrals to the RD/OT/PT were not routinely being sent and that other specified directions and instructions provided for within the licensee's internal policy were not being followed.

The licensee failed to ensure that the internal policy related to areas of altered skin integrity was complied with, specific to residents #019, #023 and #024 receiving assessments on a weekly basis, referrals to the RD/OT/PT/Wound Care Champion following observation of areas of altered skin integrity; having a baseline assessment using a clinically appropriate assessment instrument completed upon discovery of each area of altered skin integrity; or having a 'Pressure Injury/Wound Assessment Record' completed, which was to include specified documentation related to each of the areas of altered skin integrity. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended: CO# 002

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when resident #019's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for that purpose.

Related to Log #001139-19:

A complaint was received by the Director related to resident #019, regarding skin and wound care, nutrition and hydration, staffing levels and pain control.

During a telephone interview, resident #019's SDM indicated to Inspector #672 that resident #019 passed away in the home after acquiring an area of altered skin integrity along with another medical diagnosis. Resident #019's SDM further indicated a belief that resident #019 had been experiencing pain, which had not been well controlled. As a result of the concerns that resident #019's pain was not being well managed, the SDM indicated they felt they did not have the opportunity to spend the resident's last days sharing time together and had to spend the time advocating for resident #019 to receive better pain management. Resident #019's SDM indicated they had brought these concerns forward to the

nursing staff on resident #019's home area, to the attending physician and to RCC #105, which resulted in a palliative care conference being held. During the care conference, resident #019's SDM indicated the health care team assured them that resident #019's pain could be managed appropriately in the home and a hospital transfer was not necessary. Resident #019's SDM further indicated that resident #019's pain had not been well managed following the care conference.

A review of the physician's progress notes indicated that following an assessment of the resident and a conversation with the SDM, resident #019 was deemed palliative. The physician's progress notes indicated that resident #019 was frequently observed to be in pain, breakthrough pain medications were being "used frequently", and pain medication dosages would be increased to assist with resident #019's pain control.

Inspector #672 reviewed resident #019's medication list, and observed that over a specified period of time, pain medications were ordered or modified in an attempt to assist resident #019 with pain control.

A review of resident #019's health care record showed that between the date when resident #019 was deemed palliative, and the date resident #019 passed away in the home, there was no record of pain assessments being performed.

During separate interviews, RPNs #132 and #134, and RNs #160 and #166 could not recall completing any pain assessments to assess resident #019's pain during the specified period of time. RPNs #132 and #134, and RNs #160 and #166 further indicated the expectation in the home was that clinically appropriate pain assessment instruments specifically designed for the purpose of assessing the resident's pain were to be used any time a resident had complaints of a new or different type of pain, or if their pain was not well controlled with current interventions.

Inspector #672 then expanded the scope of assessment related to completion of assessments using clinically appropriate pain assessment instruments, specifically designed for the purpose of assessing a resident's pain. The inspection was expanded to include two additional residents, residents #039 and #040, who experienced frequent pain and/or changes to their pain medications due to uncontrolled pain.

Related to Resident #039:

During an interview, resident #039 indicated they suffered from constant moderate to severe pain to an identified area on a daily basis, which worsened through the night time hours, therefore negatively affected their sleep cycle. Resident #039 further indicated they utilized pain medications on a daily basis, which were only moderately effective in relieving their pain symptoms. Resident #039 stated the nursing staff did not ask questions regarding their pain symptoms, other than asking about the location of the pain and if the pain medication was effective.

Inspector #672 reviewed resident #039's physician's orders for a specified period of time, related to pain control, which indicated pain medications were ordered for resident #039.

A review of resident #039's progress notes and physician's notes for the specified time period indicated that resident #039 continued to have complaints of pain during this time, which resulted in increases to the pain medications.

During separate interviews, RPN #134 and RN #160 indicated that resident #039 experienced pain on a daily basis, which was often not relieved by the current intervention of routine and breakthrough pain medications being utilized. RPN #134 and RN #160 further indicated they could not recall completing any assessment using clinically appropriate pain assessment instruments for the assessment of resident #039's pain, when the resident had complaints of pain, was exhibiting symptoms of pain, and had multiple changes to their pain medications.

Related to Resident #040:

During an interview, resident #040 indicated they suffered from generalized moderate to severe pain which was most often felt in specified areas of the body on a daily basis. Resident #040 further indicated they utilized pain medications on a daily basis, which were only moderately effective in relieving their pain symptoms, and could not recall if nursing staff asked questions regarding their pain symptoms prior to or following administration of the pain medications.

Inspector #672 reviewed resident #040's physician's orders from a specified time period, related to pain control which indicated resident #040 had no changes made to their pain medication orders during that time period and noticed

breakthrough pain medications were administered frequently. Resident #040 had various pain medication orders during the specified time period, which included both short and long acting pain medications, which were administered both routinely and on an as needed basis.

Inspector #672 reviewed resident #040’s electronic Medication Administration Records (eMARs) and progress notes for the specified time period, which indicated that resident #040 expressed daily complaints of pain and received both routine and breakthrough pain medications.

During separate interviews, RPN #134 and RN #160 indicated that resident #040 experienced pain on a daily basis, which was treated by routine and breakthrough pain medications. RPN #134 further indicated that resident #040 continued to have verbal complaints of pain following administration of the pain medications, along with exhibiting specified responsive behaviours. RPN #134 and RN #160 indicated they could not recall completing any pain assessments for resident #040 during the identified time period, despite the resident’s continued expressed verbal complaints of pain and exhibited responsive behaviours when their pain was not relieved by interventions.

During separate interviews, RCC #105 and the RAI Coordinator indicated the expectation in the home regarding completion of pain assessments was that staff were expected to complete formal pain assessments any time a resident had complaints of a new or different type of pain, if the pain was not well controlled with current interventions, and during the RAI-MDS assessment, for residents who had pain listed as an issue within their written plan of care and/or MDS assessment.

The licensee failed to ensure that when residents #019, #039 and #040’s pain was not relieved by initial interventions, the residents were assessed using a clinically appropriate assessment instrument specifically designed for that purpose.

The following findings of non-compliance were identified by Inspector #570 during a Critical Incident System Inspection (#2019_598570_0012) conducted concurrently with this Complaint Inspection (#2019_715672_0005) and issued under this report.

2) The licensee has failed to ensure that when the resident's pain was not relieved

by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Related to Log #017363-18:

A Critical Incident Report was submitted to the Director related to an incident which involved resident #002.

A review of progress notes for resident #002 indicated that on a specified date and time the resident was observed by RPN #109 to have an injury on an identified area, and the resident complained of pain, therefore an identified pain medication was administered by RPN #109. Two days later, RPN #118 documented that resident #002 received an identified pain medication for ongoing complaints of pain and monitoring continued. Several hours after that, RPN #111 noted that the previous pain medication had been ineffective and resident #002 continued to complain of significant pain to the area. Routine pain medications were given with little effect, a notation was made in the doctor's book for the doctor to assess the resident's pain, and staff continued to monitor resident #002's condition. The next day, PSW staff stated that the resident was in severe pain when repositioned and breakthrough pain medications were given with little effect. Later that day, resident #002 continued to complain of pain and was assessed by RN #117. Resident #002 was then transferred to hospital, where they were diagnosed with an identified injury. The resident returned to the home from the hospital and an identified intervention was put in place.

Inspector #570 reviewed resident #002's health records. The record review did not indicate any documented evidence that pain assessments were completed using a clinically appropriate assessment instrument when the resident complained of pain during the specified time period prior to being transferred to the hospital for assessment. A pain assessment was noted to be completed after the resident returned from hospital with the specified injury.

During an interview, RPN #106, indicated that on a specified date, resident #002's identified body part was observed to be swollen and the resident complained of pain. Interventions in an attempt to assist the pain were implemented with little effect. RPN #106 indicated that they assessed the resident's pain but could not locate any pain assessment tools completed for resident #002.

During an interview, RPN #111 indicated that on a specified date, resident #002's

identified body part was observed to be swollen and the resident complained of pain as they rubbed the area. RPN #111 indicated they did not initiate the objective pain assessment tool although they had documented in the progress notes that the resident complained of severe pain in the area and pain medications had been provided with little effect.

During an interview, RPN #109 indicated they had not initiated a pain assessment tool when the resident complained of pain, but the resident had been given an identified intervention for the pain, with little effect.

During an interview, RCC #105 indicated that registered staff should have assessed resident #002's pain using the Objection Pain Assessment Tool but none could be found to have been completed for resident #002 when the resident complained of pain during the specified time period.

During an interview, the DOC indicated that the registered staff should have been using the Objective Pain Assessment Tool to assess resident's pain prior to the licensee implementing a new pain assessment tool in the Point Click Care (PCC) documentation system.

Resident #002 was not assessed using a clinically appropriate instrument when pain medications were noted to have been ineffective during a specified period of time. (Inspector #570)

3) Related to Log #018945-18:

A Critical Incident Report was submitted to the Director which indicated that on a specified date, resident #001 sustained an identified injury while utilizing a mobility aid. The resident was transferred to hospital due to increased pain related to the identified injury, where they received a specified diagnosis and returned to the home the following day.

A review of the progress notes for resident #001 indicated on a specified date and time, RPN #116 documented that PSW staff stated that resident #001 sustained an identified injury while utilizing a mobility aid and the resident complained of discomfort to the area. Three days later, RN #119 assessed resident #001. RN #119 documented that PSW staff stated that resident #001 complained of pain when the area was touched. The resident was assessed by the physician and was transferred to hospital. The next day the resident returned to the home with a

confirmed diagnosis and an identified medical intervention. Shortly after returning to the home from the hospital, the resident was noted to be exhibiting non-verbal signs of pain. Specified medications were given with poor effect.

Inspector #570 reviewed resident #001's clinical records. The record review did not indicate any documented evidence that a pain assessment was completed using a clinically appropriate assessment instrument when the resident returned from hospital, complained of pain and was provided a specified pain medication, with poor effect.

During an interview, RPN #106, indicated that on a specified date, resident #001's injury was assessed. The resident did not complain of pain and there was no signs that could be associated with the injury observed at that time. The RPN indicated that PSW #107 reported that the resident had sustained an identified injury while using a mobility aid.

During an interview, RCC #105 indicated that registered staff should have assessed resident #001 for pain using the "Objective Pain Assessment Tool" but it was not completed for the resident when the resident complained of pain on the date the injury occurred and after the resident returned from hospital. The RCC further indicated that there was no documentation in the progress notes regarding pain until three days after the injury occurred.

During an interview, the DOC indicated that registered staff should have been using the Objective Pain Assessment Tool to assess resident's pain prior to the licensee implementing a new pain assessment tool on the new PCC documentation system in January 2019.

Resident #001's pain was not assessed using a clinically appropriate assessment instrument identified as the "Objective Pain Assessment Tool" after the resident received a confirmed medical diagnosis, and received a specified pain medication to assist with pain control with poor effect. (Inspector #570)

4) Related to Log #021231-18:

A Critical Incident Report was submitted to the Director which indicated that on a specified date, resident #016 complained of pain to an identified area. The resident continued to complain of pain over a specified period of time, therefore an assessment was completed by the RN and a mobile x-ray was taken. The x-

ray confirmed resident #016 had an identified medical diagnosis and pain medications were administered to resident #016.

A review of the progress notes for resident #016 indicated that on a specified date and time, reside #016 reported pain in an identified area. RPN #183 attempted to reposition the resident slightly which increased the discomfort and a breakthrough pain medication was given.

On a specified date, a breakthrough pain medication was administered to resident #016 for complaints of pain to the identified area. Resident #016 continued to complain of pain, therefore their name was placed in the doctor's book for further assessment. Several days later the progress notes indicated that the resident had complaints of pain and received breakthrough pain medications. The physician was informed that the resident had continued ongoing complaints of pain. An x-ray of the identified area was ordered and indicated the resident had an identified medical diagnosis. The resident continued to complain of discomfort to the identified area. Breakthrough pain medications continued to be administered for the complaints of pain along with an identified intervention.

Inspector #570 reviewed resident #016's clinical health records including the electronic records and paper chart. The record review did not indicate any documented evidence that pain assessments were completed using a clinically appropriate assessment instrument although the resident received a specified medical diagnosis and had ongoing complaints of pain to the identified area which breakthrough pain medications were observed to be ineffective to manage.

During an interview, RN #117, indicated that resident #016 had ongoing complaints of pain before the resident was diagnosed with the identified injury. Review of the progress notes for resident #016 with RN #117, indicated the resident complained of pain over a specified time period. RN #117 indicated the RPNs should have completed the Objective Pain Assessment Tool but could not locate any completed pain assessments. RN#117 confirmed that they did not complete a pain assessment after they assessed the resident.

During an interview, RPN #161, indicated that prior to using the Point Click Care (PCC) documentation system, staff used to document pain assessments using the Objective Pain Assessment Tool. Review of the progress notes for resident #016 with RPN #161 indicated that a pain assessment had not been initiated for resident #016 when the resident complained of pain to the identified area and

continued to have complaints of pain over a specified time period.

The resident was not reassessed using a clinically appropriate assessment instrument after the pain medications were found to be ineffective. (Inspector #570) [s. 52. (2)]

Additional Required Actions:

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

(A2)
The following order(s) have been amended: CO# 003

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that an allegation of staff to resident abuse was immediately reported to the Director.

Related to Log #026117-18:

A Critical Incident Report (CIR) was submitted to the Director regarding an allegation of staff to resident abuse, more than 24 hours after the allegation was reported by resident #011's SDM.

Inspector #672 reviewed the CIR, and observed the report did not indicate the after-hours Ministry action line was contacted, in order to immediately inform the Director of the allegation of staff to resident abuse. Inspector #672 further observed the CIR indicated the allegation was brought forward on a specified date and time by resident #011's SDM, yet the CIR was not filed until more than 24 hours after the allegation was reported.

During an interview, the DOC indicated the allegation was brought forward on a specified date by resident #011's SDM, but did not contact the after-hours Ministry action line or immediately initiate the critical incident report in order to immediately inform the Director of the allegation of staff to resident abuse. The DOC further

indicated being aware of the legislative requirement that the Director be immediately notified of all allegations of resident abuse and neglect.

The licensee failed to ensure that an allegation of staff to resident abuse was immediately reported to the Director. The DOC was notified of the allegation of staff to resident abuse and did not inform the Director of the allegation until more than 24 hours after the allegation was brought forward.

The following finding of non-compliance was identified by Inspector #570 during a Critical Incident System Inspection (#2019_598570_0012) conducted concurrently with this Complaint Inspection (#2019_715672_0005) and issued under this report.

2) The licensee has failed to ensure that RN #117 immediately reported abuse of resident #034 by resident #031.

Related to Log #031011-18:

A Critical Incident Report was submitted to the Director for a resident to resident incident of alleged abuse on a specified date.

A review of the progress notes as documented by RN #117 for resident #031 indicated that on a specified date, resident #034 displayed specified responsive behaviours. These responsive behaviours caused resident #031 to respond with exhibited responsive behaviours, which resulted in resident #034 sustaining an injury to an identified area. The day after the incident occurred, RN #117 documented that the incident was reported to the Ministry of Health and Long Term Care via the after hours line.

The allegation of abuse by resident #031 toward resident #034 was not immediately reported to the Director. (Inspector #570) [s. 24. (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 the Director is informed of every allegation of resident abuse immediately, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (2) Every licensee of a long-term care home shall ensure that there is a written staffing plan for the programs referred to in clauses (1) (a) and (b). O. Reg. 79/10, s. 31 (2).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written staffing plan for the nursing and personal support services programs in the home.

Related to Log #027448-18:

A written complaint was received by the Director from resident #011's SDM, related to continence care, skin and wound care, falls management, personal support services related to nail care and sufficient staffing in the home.

Related to Log #001139-19:

A complaint was received by the Director related to resident #019, regarding skin and wound care, nutrition and hydration, staffing levels and pain control.

Related to Log #020792-18:

A written complaint was received by the licensee which was forwarded to the Director related to resident #027, regarding the resident not receiving the required level of assistance required due to lack of staffing, which resulted in the resident not receiving specified personal care.

During separate telephone interviews, the complainants related to Log #027448-18 and Log #001139-19 verified to Inspector #672, and the complainant related to Log #020792-18 verified to Inspector #570, that they had concerns regarding the staffing levels in the LTCH. All of the complainants felt that there was not enough staff working in the resident home areas to consistently meet each resident's care needs.

During separate interviews, PSWs #104, 123, 158, 159, 170 and 171, RPNs #132 and 134, RNs #144 and #160, PT #103 and RCC #105 all indicated a belief that the home did not consistently have enough staff working on the resident home areas to meet each resident's care needs in a timely manner. The staff members indicated the resident home areas were short of staff either through a lack of staff being scheduled to work, or the resident home areas would frequently work short staffed due to sick calls, with no contingency plan to implement for staff replacements.

On a specified date, Inspector #672 requested a copy of the internal written staffing plan for the nursing and personal support services programs from Staffing Clerk (SC) #136. SC #136 indicated they were unaware of the existence of a written staffing plan, and indicated they followed the Collective Bargaining Agreement seniority lists if/when replacing sick calls. SC #136 further indicated the DOC was in charge of overseeing the nursing staff allocation within the LTCH. Inspector #672 then requested a copy of the internal written staffing plan for the

nursing and personal support services programs from the DOC. Two days later, the DOC provided a document they indicated they had created the previous day, which indicated the number of nursing staff members allocated on each shift. The DOC further indicated they did not have any other written staffing plan for the nursing and personal support services programs, and did not have a written contingency plan to be implemented in the event of sick calls or other staffing emergencies. [s. 31. (2)]

2. The licensee has failed to ensure that there was a staffing plan in the home which provided for a staffing mix that was consistent with residents' assessed care and safety needs.

Related to Log #020792-18:

A written complaint was received by the licensee which was forwarded to the Director, related to resident #027. The written complaint stated resident #027 had not received the required level of assistance with activities of daily living due to a lack of staffing in the home, which resulted in the resident not receiving specified personal care.

During a telephone interview, the complainant verified to Inspector #570 that they had concerns regarding the staffing levels in the LTCH. The complainant felt that there was not enough staff working on the resident home area to consistently meet resident #027's care needs, which resulted in resident #027 not receiving specified personal care due to not having staff available to provide the level of assistance required.

During review of the written complaint submitted by resident #027's SDM, Inspector #672 observed the written response supplied to the complainant by the DOC. The written response stated resident #027 had not received specified personal care on several occasions and the nursing leadership team considered the staffing of the home a priority at all times.

Related to Log #001139-19:

A complaint was received by the Director related to resident #019, regarding personal care concerns due to the staffing levels in the home.

During a telephone interview, resident #019's SDM indicated to Inspector #672

that resident #019 passed away in the home after acquiring an area of altered skin integrity along with another medical diagnosis. Resident #019's SDM further indicated that the area of altered skin integrity had worsened significantly over a specified time period, which resulted in the nursing team putting specified interventions in place. Resident #019's SDM indicated a belief that resident #019 acquired the area of altered skin integrity as a result of the home not having enough staff members on duty during a specified period of time to ensure resident #019 received an intervention as required. The SDM indicated that as a result of the area of altered skin integrity, resident #019 was supposed to receive a specified intervention every hour, yet during visits to the home only observed resident #019 receive the intervention every two and a half to four hours, which they believed resulted in the area worsening. Resident #019's SDM further indicated a belief that resident #019 was not receiving the required time and level of assistance required to consume food and fluids as a result of the home not having enough staff members on duty, therefore the SDM hired a private PSW to assist resident #019 with specified interventions and consumption of food and fluids.

During review of resident #019's health care record, Inspector #672 observed resident #019 was observed to have an area of altered skin integrity which worsened over a specified period of time. Resident #019 developed several other areas of altered skin integrity during that time period.

During separate interviews, RN #160, RPN #134 and PSWs #123 and #140 indicated that following the observation of the initial area of altered skin integrity, resident #019 had an intervention put in place. RNs #144, #160 and #166, RPNs #132 and #134, and PSWs #123, #140, #174 and #175 all indicated that the home worked short staffed during the specified period of time, which could have resulted in resident #019 not receiving specified interventions as required.

Related to Log #027448-18:

A written complaint was received by the Director from resident #011's SDM, related to personal care and sufficient staffing in the home. The written complaint stated resident #011 had not received the required level of assistance with activities of daily living due to a lack of staffing in the home.

During a telephone interview, resident #011's SDM indicated to Inspector #672 that during an identified period of time, they would visit with the resident and

would find the resident had not received the required personal care. The SDM stated these concerns had been brought forward to the nursing staff on the unit, RCC #105, and the DOC and Administrator on multiple occasions, but continued to have concerns that resident #011 was not receiving the required assistance. Resident #011’s SDM indicated a belief this had led to the resident acquiring an area of altered skin integrity which required medical intervention. Resident #011’s SDM indicated a belief that resident #011 did not receive the required level of personal care to meet the resident’s needs as a result of the home being short staffed, especially during the identified time period, which they had shared with the nursing leadership team during a meeting to discuss their concerns.

While conducting the inspection in the home, resident #044 approached Inspector #672 and requested a meeting to discuss some concerns. During the interview, resident #044 indicated they did not feel there was enough staff working in the home, and would frequently have staff members inform them, or would hear staff members complaining, that the resident home area was working short staffed. Resident #044 further indicated that when the resident home areas were short staffed, resident care needs would either not be met in a timely manner, or not at all. Resident #044 indicated that when the resident home areas were short staffed there were long wait times for residents to receive the requested assistance to the bathroom.

During separate interviews, PSWs #104, #123, #158, #159, #170, #171, #174 and #175, RPNs #132 and #134, RNs #144 and #160, PT #103 and RCC #105 all indicated a belief that the home continued to not consistently have enough staff working on the resident home areas to meet each resident’s care needs in a timely manner.

During an interview, the DOC indicated to Inspector #672 that the home had worked short staffed over the two identified time periods. The DOC further indicated this negatively impacted resident care and resulted in some resident care needs not being met.

The licensee failed to ensure there was a staffing plan in the home which provided for a staffing mix that was consistent with residents' assessed care and safety needs over the two identified time periods. This was evidenced by residents #027, #019 and #011 not receiving the required level of assistance with activities of daily living due to a lack of staffing in the home. [s. 31. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is a written staffing plan for the nursing and personal support services programs in the home and that the staffing plan provides for a staffing mix that is consistent with residents' assessed care and safety needs, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident received proper nail care.

Related to Log #027448-18:

A written complaint was received by the Director from resident #011's SDM, related to personal care needs and sufficient staffing in the home.

During a telephone interview, resident #011's SDM indicated to Inspector #672 they still had concerns related to the nail care resident #011 was receiving in the home, and would often find the resident with dirty, jagged and unkempt fingernails. Resident #011's SDM further indicated this complaint had been brought forward to the nursing staff several times following the complaint submitted to the Director, but had not found any improvement.

On a specified date, Inspector #672 observed resident #011's fingernails, and found they were jagged and dirty, with brown material caught under the nails. This was reported to the staff on duty, who indicated they would provide resident #011 with nail care and hand hygiene.

On six further dates over a specified period of time, Inspector #672 observed resident #011's fingernails, and found they were jagged and dirty, with brown material caught under the nails. This was reported to a staff member on duty each time, who acknowledged the resident's nails continued to be jagged and dirty, and indicated that resident #011 would immediately be provided with nail care and hand hygiene.

Inspector #672 then expanded the scope of assessment related to nail care, to inspect two more residents, to assess if other residents had been provided nail care. On a specified date, Inspector #672 assessed resident #032's fingernails and observed the resident to have brown grime caked under the fingernails. RPN #134 and PSW #174 indicated that resident #032's nails would not be considered clean or well kempt, and PSW #174 would provide resident #032 with nail care and hand hygiene following the interview. Inspector #672 then assessed resident #043's fingernails, and observed the resident to have bilateral brown grime caked under the fingernails. RPN #134 and PSW #175 indicated that resident #043's nails would not be considered clean or well kempt, and PSW #175 would provide resident #043 with nail care and hand hygiene following the interview.

On a later specified date and time, Inspector #672 observed resident #011, #032 and #043's fingernails, and found each resident's nails to be jagged and bilaterally dirty, with brown material caught under the nails. This was reported to RPN #134, who acknowledged the resident's nails would not be considered clean or well kempt, and indicated they would assign a PSW to provide each resident with nail care and hand hygiene.

During separate interviews, the DOC and RCC #105 both indicated the expectation in the home was that each resident should receive nail care at a minimum of twice weekly during their bath days, and at any other time required, as staff were expected to assess the cleanliness of each resident's hand and nails when personal hygiene was being provided.

The licensee failed to ensure that residents #011, #032 and #043 received proper

nail care, when each resident was observed to have jagged and bilaterally dirty nails, with brown material caught under them on multiple occasions during the inspection. [s. 35. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure each resident receives proper nail care as required, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,
(a) the home lacks the physical facilities necessary to meet the applicant's care requirements; 2007, c. 8, s. 44. (7).
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or 2007, c. 8, s. 44. (7).
(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval. 2007, c. 8, s. 44. (7).

s. 44. (9) If the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out,
(a) the ground or grounds on which the licensee is withholding approval; 2007, c. 8, s. 44. (9).
(b) a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care; 2007, c. 8, s. 44. (9).
(c) an explanation of how the supporting facts justify the decision to withhold approval; and 2007, c. 8, s. 44. (9).
(d) contact information for the Director. 2007, c. 8, s. 44. (9).

Findings/Faits saillants :

1. Under the LTCHA, 2007, s. 44(7) the appropriate placement coordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43(6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless, (a) the home lacked the physical facilities necessary to meet the applicant's care requirements; (b) the staff of the home lacked the nursing expertise necessary to meet the applicant's care requirements; or (c) circumstances existed which were provided for in the regulations as being a ground for withholding approval.

Related to Log #003654-19:

A complaint was received by the Director, submitted by a case manager at the Central East Local Health Integration Network (CELHIN) indicating applicant #009 had been refused admission to the Long-Term Care Home. A second complaint was submitted to the Director by applicant #009. The complaints pertained to withholding approval for admission to Hillsdale Estates LTC Home, located in Oshawa, Ontario.

Review of the applicant's refusal letter for admission from the licensee indicated the applicant was refused admission because the home lacked the nursing expertise to meet the applicant's care requirements, and did not have the necessary resources to meet their needs. The letter was signed by the Social Worker.

During review of the admission intake, Inspector #672 observed that the applicant was residing in a retirement home at the time of the application. The applicant was having specified personal care needs managed related to an identified intervention through community visits once per month provided through the CELHIN, and agreed to attend the local hospital upon transfer to a long term care home to have specified personal care needs managed if required, until the long term care home was equipped with any supplies and/or education which may have been required to provide care specified personal care related to an identified intervention.

During a telephone interview, the case manager at the CELHIN indicated applicant #009 had moved into another long term care home, where their specified personal care needs related to the identified intervention were being managed by the long term care home staff. The case manager further indicated that the applicant was still seeking to transfer from the current long term care home, as they wanted to reside in the Oshawa area.

During an interview, the Social Worker indicated they forwarded a copy of the applicant's Placement Services Assessment Tool provided by the CELHIN to the DOC, who made the final decisions regarding admission to the LTCH. The Social Worker indicated the DOC had indicated the applicant was not appropriate for admission to the LTCH due to the nursing staff not being trained on how to provide specified personal care needs related to an identified intervention. The Social Worker further indicated that the applicant was not on the crisis placement list, and the home had a waiting list for admission, therefore the applicant would not have been imminently placed in the home.

During an interview, the DOC of Hillsdale Estates indicated they had declined the application due to the nursing staff not having the required training to provide the required care related to the identified intervention. The DOC further indicated awareness that this skill was within both the RPN and RN scope of practice, and that training could have been provided to the staff prior to the applicant's admission to the LTCH, but felt that task would have been “very difficult”, therefore declined the application.

The documented evidence provided by the licensee did not support how the home lacked the nursing expertise to meet applicant #009's care requirements, or how the licensee did not have the necessary resources to meet applicant #009’s care. [s. 44. (7)]

2. Under the LTCHA, 2007, s. 44(7) the appropriate placement coordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43(6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless, (a) the home lacked the physical facilities necessary to meet the applicant's care requirements; (b) the staff of the home lacked the nursing expertise necessary to meet the applicant's care requirements; or (c) circumstances existed which were provided for in the regulations as being a ground for withholding approval.

Related to Log #006865-19:

A complaint was received by the Director indicating an applicant had been refused admission to the Long-Term Care Home.

Review of the applicant's refusal letter for admission from the licensee indicated the applicant was refused admission because the home lacked the nursing expertise to meet the applicant’s care requirements, and did not have the necessary resources to meet their needs.

The explanation provided by the licensee in the refusal letter was that the applicant had exhibited responsive behaviours. These responsive behaviours had apparently increased, according to a Behavioural Assessment Tool provided by the CELHIN, when compared to a previously provided assessment to the licensee, when the applicant had been approved for admission to the LTCH. The

licensee further indicated in the letter that the exhibited responsive behaviours would require applicant #008 to reside on a secured unit due to safety reasons related to wandering behaviour. The letter was signed by the Social Worker.

During an interview, the Social Worker indicated they forwarded a copy of the applicant's Placement Services Assessment Tool provided by the CELHIN to the DOC, who made the final decisions regarding admission to the LTCH. The Social Worker indicated the DOC had indicated the applicant was not appropriate for admission to the LTCH due to the nursing staff not having the expertise to deal with the responsive behaviours exhibited by applicant #008. The Social Worker further indicated that the home had a secured specialized care unit, and the nursing staff had received education and training related to responsive behaviours.

During an interview, the DOC of Hillsdale Estates indicated that the home had a secured specialized care unit, and the nursing staff had received education and training related to responsive behaviours. The DOC further indicated the licensee had a previous history of non-compliance under the legislation related to responsive behaviours, and did not feel the staff were managing responsive behaviours well at the time, therefore declined the application.

The documented evidence provided by the licensee did not support how the home lacked the nursing expertise to meet the applicant's care requirements, or how the licensee did not have the necessary resources to meet the applicant's care. [s. 44. (7)]

3. The licensee has failed to ensure that when withholding approval for admission, the licensee shall provide to persons described in subsection (10) a written notice setting out, the ground or grounds on which the licensee was withholding approval; a detailed explanation of the supporting facts, as they related both to the home and to the applicant's condition and requirements for care; an explanation of how the supporting facts justified the decision to withhold approval; and contact information for the Director.

Related to Log #003654-19:

This inspection was initiated related to two complaints received by the Ministry of Health and Long Term Care. One complaint was submitted by the Central East Local Health Integration Network (CELHIN), related to applicant #009, and the

second was submitted by applicant #009. The complaints pertained to withholding approval for admission to Hillsdale Estates LTC Home.

An application for admission was made to the LTC home. A letter from the Social Worker on behalf of Hillsdale Estates LTC Home addressed to the applicant stated the licensee was withholding approval for admission due to the home lacking the nursing expertise to meet the care requirements related to a specified intervention.

During separate interviews, the Social Worker and DOC confirmed the reasons the application for admission was denied. The Social Worker further indicated awareness that when withholding approval for admission, the legislation in subsection (10) required a written notice setting out, the ground or grounds on which the licensee was withholding approval; a detailed explanation of the supporting facts, as they related both to the home and to the applicant's condition and requirements for care; an explanation of how the supporting facts justified the decision to withhold approval; and contact information for the Director. Following review of the letter, the Social Worker indicated the letter did not meet the requirements, as it did not provide for a detailed explanation of the supporting facts, how the supporting facts justified the decision to withhold approval, or contact information for the Director. [s. 44. (9)]

4. The licensee has failed to ensure that when withholding approval for admission, the licensee shall provide to persons described in subsection (10) a written notice setting out, the ground or grounds on which the licensee was withholding approval; a detailed explanation of the supporting facts, as they related both to the home and to the applicant's condition and requirements for care; an explanation of how the supporting facts justified the decision to withhold approval; and contact information for the Director.

Related to Log #006865-19:

This inspection was initiated related to a complaint received by the Ministry of Health and Long Term Care, submitted by the Central East Local Health Integration Network (LHIN), related to applicant #008. The complaint pertained to withholding approval for admission to Hillsdale Estates LTC Home.

An application for admission was made to the LTC home. A letter from the Social Worker on behalf of Hillsdale Estates LTC Home addressed to the applicant

stated the licensee was withholding approval for admission due to the licensee not having the necessary resources to meet the applicant's needs due to the home lacking the nursing expertise to meet their care requirements related to responsive behaviours.

During separate interviews, the Social Worker and DOC confirmed the reasons the application for admission was denied. The Social Worker further indicated awareness that when withholding approval for admission, the legislation in subsection (10) required a written notice setting out, the ground or grounds on which the licensee was withholding approval; a detailed explanation of the supporting facts, as they related both to the home and to the applicant's condition and requirements for care; an explanation of how the supporting facts justified the decision to withhold approval; and contact information for the Director. Following review of the letter, the Social Worker indicated it did not meet the requirements, as it did not provide for a detailed explanation of how the supporting facts justified the decision to withhold approval and contact information for the Director. [s. 44. (9)]

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 applicants are approved for admission to the home unless circumstances exist which are provided for in the regulations as being a ground for withholding approval; and if the licensee withholds approval for admission, the licensee provides to the persons described in subsection (10) a written notice setting out all of the requirements listed within the legislation, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents who were incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, where the condition or circumstances of the resident required.

Related to Log #027448-18:

A written complaint was received by the Director from resident #011's SDM, related to personal and continence care. Resident #011's SDM also submitted the written complaint to the licensee, which resulted in several conversations and one meeting between the management team and resident #011's SDM. Following the meeting, the licensee provided a written response to the complainant, which indicated resident #011's continence plan was assessed and the home would continue to monitor resident #011's continence care requirements to ensure resident #011's care was completed in accordance with their routines and preferences.

During a telephone interview, resident #011's SDM indicated they continued to have concerns related to resident #011's continence level, specifically related to the resident's continence decline over a specified period of time, and the continence care resident #011 received in the home.

During review of resident #011's health care record, Inspector #672 observed that resident #011 was on a scheduled toileting routine and the written plan of care indicated the resident required a specified number of staff members and level of assistance to assist with the task of toileting.

During an interview, PSW #124 indicated that during specified period of time, resident #011 had an identified level of continence, was on a scheduled toileting routine and required a specified number of staff members and level of assistance to assist with the task of toileting. PSW #124 further indicated that during a later specified period of time, resident #011's cognitive and physical status had declined, therefore their identified level of continence had changed, they were no longer on a scheduled toileting routine and required a specified number of staff members to provide a different level of assistance with the task of toileting. PSW #124 indicated these changes had been communicated to both the RPN and RN.

During an interview, RPN #132 indicated being aware that resident #011's continence level had declined and the specified number of staff members and level of assistance to assist with the task of toileting had changed due to resident #011's worsening cognitive and physical status. RPN #132 further indicated they had not completed or checked if a continence assessment had been completed for resident #011 when their continence level declined. RPN #132 indicated the expectation in the home regarding completion of resident continence assessments was that assessments were to be completed only upon admission to the home.

During an interview, the RAI Coordinator indicated that the expectation in the home was for continence assessments to be completed for each resident annually, and should be present in each resident's health care record, if one had been completed.

During an interview, RCC #176, who was in charge of the Continence Care and Bowel Management program in the home, indicated the expectation in the home was that continence assessments were to be completed for each resident upon admission to the home and annually thereafter, unless there were any changes related to the resident's continence status. If the resident experienced a change related to their continence status, the registered staff were expected to immediately complete another continence assessment, which included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions.

Inspector #672 reviewed resident #011's entire health care record, and could not observe a completed continence assessment. Inspector #672 then requested RN #160 and RPN #134 assist in searching resident #011's health care record and they also could not observe a completed continence assessment for resident

#011.

Inspector #672 then expanded the scope of assessment related to completion of resident continence assessments to inspect two more residents who experienced changes to their continence levels, to observe if continence assessments had been completed which included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, where the condition or circumstances of the resident required. On a specified date, RN #160 and RPN #134 indicated that residents #032 and #041 had experienced significant changes to their continence levels within a specified period of time, both due to declining physical and cognitive status.

Related to Resident #032:

During an interview, PSW #174 indicated that during a specified time period, resident #032 had exhibited a specified level of continence, and required the assistance from a specified number of staff members to provide a specified level of assistance with the task of toileting. PSW #174 further indicated that at a later period of time resident #032 exhibited a change in their level of continence of both bladder and bowel, and required a different level of assistance from a specified number of staff members to provide a specified level of assistance with the task of toileting. PSW #174 further indicated that registered staff were aware of resident #032's identified change in continence level.

Inspector #672 reviewed resident #032's entire health care record and observed the current written plan of care indicated the resident exhibited a specified level of continence of both bowel and bladder, and required the assistance from a specified number of staff members to provide a specified level of assistance with the task of toileting. Inspector #672 did not observe a completed continence assessment for resident #032 since their admission to the home.

Related to Resident #041:

During an interview, PSW #175 indicated that during a specified period of time, resident #041 had exhibited a specified level of continence of bowel and bladder; and required the assistance from a specified number of staff members to provide a specified level of assistance with the task of toileting. PSW #175 further indicated that currently resident #041 exhibited a differed level of continence of both bladder and bowel, and required a different level of assistance from a

specified number of staff members to provide a specified level of assistance with the task of toileting. PSW #175 indicated that registered staff were aware of resident #041's change in continence level, and current toileting needs.

Inspector #672 then reviewed resident #041's entire health care record and observed the current written plan of care indicated the resident exhibited a specified level of continence of bowel and bladder and required specified assistance to be toileted. Inspector #672 did not observe a completed continence assessment for resident #041 since their admission to the home.

During an interview, RPN #134 indicated being aware that residents #011, #032 and #041's continence levels had all changed over approximately the past six months, which was considered a significant change in status related to their continence level. RPN #134 further indicated being unaware of what the expectation in the home was regarding completion of continence assessments for residents, and as the full time RPN on residents #011, #032 and #041's home area, indicated they could not recall completing or being aware of continence assessment being completed for any of the residents.

During an interview, RCC #176 indicated being aware that continence assessments were "being completed in the home hit or miss upon admission only", and were not being completed at any other time. RCC #176 indicated all registered staff in the home had received education regarding the expectation in the home regarding completion of resident continence assessments, and was hopeful that with the change over to the Point Click Care (PCC) documentation system, continence assessments would begin to be completed as expected.

The licensee failed to ensure that when residents #011, #032 and #041 experienced a change in their continence levels, they received an assessment which included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions. [s. 51. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure ever resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, where the condition or circumstances of the resident requires, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every written complaint made to the licensee concerning the care of a resident received a response within 10 business

days of receipt of the complaint.

During review of the complaints received by the licensee during a specified period of time, Inspector #672 observed a written complaint submitted to the licensee by resident #045's SDM. The written complaint was related to an alleged incident of resident #045's pain not being treated, medication management and infection control practices in the home. The written complaint further stated that resident #045's SDM considered the written complaint a formal complaint and requested a written response.

Inspector #672 then reviewed the written response to the complaint provided by the licensee, which was more than 10 business days following receipt of the written complaint.

During an interview, the DOC indicated they were aware of the legislative requirements which stated every written complaint made to the licensee concerning the care of a resident must be investigated, resolved where possible, and a response provided within 10 business days of receipt of the complaint.

The licensee failed to ensure the written complaint made to the licensee by resident #045's SDM concerning the care of the resident received a response within 10 business days of receipt of the complaint. [s. 101. (1) 1.]

2. The licensee has failed to ensure that a documented record was kept in the home that included all of the information required under the legislation.

Related to Log #027448-18:

A written complaint was received by the Director from resident #011's SDM, related to personal care concerns for the resident and sufficient staffing in the home.

During a telephone interview, resident #011's SDM indicated they were very frustrated with the complaints procedures in the home as they indicated they had brought forward several verbal complaints in the past to the nursing leadership team, which they had not received responses for, despite making several follow up phone calls. Resident #011's SDM further indicated the most recent example of this was from a specified date, when the SDM indicated they had been notified of an incident involving resident #011. RCC #105 indicated an internal

investigation would be conducted into the cause of the incident and would inform resident #011's SDM of the outcome of the internal investigation. Resident #011's SDM indicated they had not received any follow up phone calls, despite leaving voice messages for both the DOC and RCC #105 on several occasions.

During an interview, RCC #105 verified that the incident involving resident #011 had occurred, they had spoken to the resident's SDM to inform them that an internal investigation into the incident would be completed, but had not gotten back to resident #011's SDM with the outcome. RCC #105 further indicated they were responsible for documenting, tracking, following up and responding to all complaints received related to residents who resided on specified resident home areas of the home and the expectation in the home was for all complaints received which could not be resolved within 24 hours and all written complaints to be documented. RCC #105 indicated they did not have time to document the complaints received as required, due to competing priorities.

On a specified date, Inspector #672 requested a copy of the licensee's documented complaints received during two separate periods of time. Approximately one week later, the DOC provided the internal complaints spreadsheet documents. The DOC indicated the nursing management team currently "did not do a good job with documenting verbal complaints received in the home", and indicated the documents may not be accurate or contain information related to all complaints received.

Inspector #672 reviewed the complaints documented for an identified time period. During that timeframe, seven complaints had been documented by the licensee. Of the seven complaints documented, all seven were missing some part of the documentation required under the legislation.

Inspector #672 then reviewed the complaints documented for the identified time period when the written complaints from residents #011 and #019's SDMs occurred. During that period of time, ten complaints were missing some part of the documentation required under the legislation.

During separate interviews, RCC #105 and the DOC indicated they were aware of the legislative requirements regarding documentation of complaints received. RCC #105 and the DOC further indicated that documentation of complaints in the home was an area the nursing management team needed to improve upon, as they were aware that the legislative requirements were not being met regarding

the documentation requirements.

The licensee failed to ensure that a documented record was kept in the home that included all of the information required under the legislation related to complaints received during two separate identified periods of time. [s. 101. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every written complaint made to the licensee concerning the care of a resident receives a response within 10 business days of receipt of the complaint and that a documented record of all complaints received is kept in the home that includes all of the information required under the legislation, to be implemented voluntarily.

WN #10: 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).

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

Findings/Faits saillants :

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

Related to Log #001139-19:

A complaint was received by the Director related to resident #019, regarding personal care and staffing levels in the home.

During a telephone interview, resident #019's SDM indicated to Inspector #672 that resident #019 passed away in the home after acquiring an area of altered skin integrity along with another medical diagnosis. Resident #019's SDM further indicated a belief that resident #019 was not receiving the required time and level of assistance required to consume food and fluids as a result of the home not having enough staff members on duty, therefore the SDM hired a private PSW to assist resident #019 with specified interventions and consumption of food and fluids. As a result of the allegations made during the telephone conversation, Inspector #672 observed nourishment passes which occurred in the home to ensure that all residents were offered a between meal snack and/or fluids, specific to their care plan.

On a specified date and time, Inspector #672 observed the morning nourishment pass on an identified resident home area, which was being completed by PSW #123. No hand hygiene was observed being completed by PSW #123, while the PSW was entering and exiting resident rooms to deliver food and fluids, and assisting resident #011 with activities of daily living, such as locomotion via wheelchair.

During an interview, PSW #123 indicated that the expectation in the home was that hand hygiene was to be completed upon entering and exiting each resident room, following incidents of assisting residents with activities of daily living and between serving nourishment to each resident.

On a specified date and time, Inspector #672 observed the residents on an identified resident home area being assisted into the dining room for lunch by Food Service Worker (FSW) #120, and no hand hygiene was performed. The Food Service Workers present in the kitchenette had begun to serve residents their first course, and fluids were already served on the dining room tables.

During an interview, FSW #120 indicated that the expectation in the home was that hand hygiene was to be completed on each resident upon entering the dining room for any meal. FSW #120 further indicated that hand hygiene had not been performed on any of the 22 residents seated in the dining room prior to entering

the dining room for the lunch meal.

On a specified date and time, Inspector #672 observed resident #018 from an identified resident home area being assisted into the dining room for the lunch meal by PSW #121, with no hand hygiene offered or performed.

During an interview, PSW #121 indicated that the expectation in the home was that hand hygiene was to be completed with each resident upon entering the dining room for any meal. PSW #121 further indicated that on the identified resident home area, resident #017 assisted other residents with completing hand hygiene prior to entering the dining room, until they entered the dining room themselves for their meal. After resident #017 entered the dining room for their meal, it was the responsibility of the staff to ensure resident hand hygiene was completed.

On a specified date and time, Inspector #672 observed three residents from an identified resident home area entering the dining room for the lunch meal. Two of the residents were being assisted into the dining room by family members/visitors, and one of the residents entered independently. No hand hygiene was offered or performed.

During an interview, PSW #122 indicated that the expectation in the home was that hand hygiene was to be completed on each resident upon entering the dining room for any meal.

On a specified date and time, Inspector #672 observed the afternoon nourishment pass on an identified resident home area, which was being completed by PSW #125. No hand hygiene was observed being completed by PSW #125, while the PSW was entering and exiting resident rooms to deliver food and fluids, nor prior to or following assisting residents to consume the nourishment.

During an interview, PSW #125 indicated the expectation in the home was that hand hygiene was to be performed each time food items were to be touched, and after physically assisting a resident. PSW #125 further indicated they had forgotten to perform hand hygiene between offering and/or serving nourishment items to each resident.

On a specified date and time, Inspector #672 observed the afternoon nourishment pass on an identified resident home area, which was being completed by PSW

#126. No hand hygiene was observed being completed by PSW #126, while the PSW was entering and exiting resident rooms to deliver food and fluids, nor prior to or following assisting residents to consume the nourishment.

During an interview, PSW #126 indicated the expectation in the home was that hand hygiene was to be performed between each resident using hand sanitizer, unless the resident had a communicable illness. In that instance, staff were expected to physically wash their hands at a sink with antibacterial soap. PSW #126 further indicated they did not complete hand hygiene between serving and assisting residents to consume their nourishment during this nourishment pass, due to forgetting.

On a specified date and time, Inspector #672 observed the morning nourishment pass on an identified resident home area, which was being completed by PSW #127. No hand hygiene was observed being completed by PSW #127, while the PSW was entering and exiting resident rooms to deliver food and fluids.

During an interview, PSW #126 indicated the expectation in the home was that hand hygiene was to be performed between each resident using hand sanitizer, but acknowledged this was not completed during the nourishment pass this morning.

On a specified date and time, Inspector #672 observed PSW #128 assisting residents from an identified resident home area into the dining room for the lunch meal, with no hand hygiene offered or performed. During an interview, PSW #128 indicated the expectation in the home was that hand hygiene was to be completed on each resident prior to sitting at the dining room table for the meal, but acknowledged they did not offer or perform hand hygiene to any of the residents they assisted into the dining room.

On a specified date and time, Inspector #672 observed PSW #129 assisting residents from an identified resident home area into the dining room for the lunch meal, with no hand hygiene offered or performed. During an interview, PSW #129 indicated the expectation in the home was that hand hygiene was to be completed on each resident prior to each meal. PSW #129 further indicated that hand hygiene had not been performed on any of the residents they assisted into the dining room because "they don't do anything anyway, so their hands can't be too dirty, so it's not really a big deal". PSW #129 was also observed to assist one resident into a bathroom prior to assisting them into the dining room for lunch, and

no hand hygiene was observed to be completed by either the resident or the PSW. During the interview, PSW #129 acknowledged they did not complete hand hygiene following assisting the resident in the bathroom and entering the dining room to assist other residents with the lunch meal.

On a specified date and time, Inspector #672 observed the afternoon nourishment pass on an identified resident home area, which was being completed by PSWs #131 and #110. No hand hygiene was observed being completed by PSW #131, while the PSW was entering and exiting resident rooms to deliver food and fluids, or after the PSW assisted a resident to consume their nourishment and blow their nose.

During an interview, PSWs #131 and #110 indicated the expectation in the home was for staff to sanitize their hands prior to initiating the nourishment cart, and then only after soiling their hands by removing dirty dishes or touching residents, otherwise hand hygiene did not need to be performed again. PSW #131 acknowledged they continued with the nourishment pass after assisting a resident to consume their nourishment and blow their nose, without completing hand hygiene, and went on to assist serving three more residents their afternoon nourishment.

On a specified date and time, Inspector #672 observed the morning nourishment pass on an identified resident home area, which was being completed by PSW #133. No hand hygiene was observed being offered or performed.

During an interview, PSW #133 indicated the expectation in the home was that hands were to be washed prior to starting the nourishment cart and then sanitized only after directly feeding a resident. PSW #133 acknowledged that hand hygiene was not performed between assisting each resident, or following the removal of dirty cups from residents/resident rooms during the morning nourishment pass.

On a specified date and time, Inspector #672 observed PSWs #137 and #139 and Recreation staff member #138 assisting residents into the dining room for the lunch meal on an identified resident home area, with no hand hygiene offered or performed. During separate interviews, each staff member indicated the expectations in the home was that hand hygiene was to be performed on each resident prior to each meal.

On a specified date and time, Inspector #672 observed the morning nourishment

pass on an identified resident home area, which was being completed by PSW #158. No hand hygiene was observed being offered to residents prior to their nourishment or performed by PSW #158, between specified resident bedrooms.

During an interview, PSW #158 indicated the expectation in the home was that hand hygiene was only required if staff were physically touching the food items.

On a specified date and time, Inspector #672 observed the morning nourishment pass on an identified resident home area, which was being completed by PSWs #121 and #159. No hand hygiene was observed being offered to residents prior to their nourishment or performed by PSWs #121 and #159 while in the short hall of the resident home area, or while serving residents who were sitting in the lounge area watching television.

During separate interviews, both PSWs indicated the expectation in the home was that hand hygiene was only required when entering resident rooms and touching the resident environment, but not when residents were sitting in common areas, or no items in the resident environment was touched.

During an interview, the Infection Control Nurse (ICN) indicated the expectation in the home was for hand hygiene to be completed by staff between each resident and offered to residents prior to accepting their nourishment, during each nourishment pass. Regarding hand hygiene during meal services, the ICN indicated that staff were expected to assist the resident with completing hand hygiene once the resident was seated at the dining room table, due to not being able to predict exactly what the resident may touch between the last time they had their hands cleaned and when they arrived at the dining room table. The ICN further indicated that all staff in the home received education regarding hand hygiene at a minimum of annually, and further education was provided during random hand hygiene audits and observations.

The licensee failed to ensure that all staff participated in the implementation of the licensee's infection prevention and control program, by not ensuring hand hygiene was performed during nourishment passes and prior to meal services. [s. 229. (4)]

2. The licensee has failed to ensure that staff recorded symptoms of infection in residents on every shift, as required.

Related to Log #001139-19:

A complaint was received by the Director related to resident #019 regarding personal care and staffing levels in the home.

During review of resident #019's progress notes, resident #019 was observed to have a specified type of infection. The Physician was notified, and an order was received for an oral antibiotic to be administered for seven days. Two days later there was a progress note which indicated the resident was assessed by the physician, and received another antibiotic order. Further review of the progress notes showed that four days later, resident #019 was again assessed by the physician, and two further new antibiotic orders were given.

Inspector #672 reviewed resident #019's progress notes during the period of time the resident was receiving antibiotic therapy and observed there was no documentation on eight shifts regarding the resident's infection symptoms or vital signs.

Inspector #672 then expanded the scope of assessment to include two more residents who had recently received antibiotics within the home, to assess if staff had recorded symptoms of infection in the residents on every shift, as required. On a specified date, Inspector #672 was provided with the names of residents #025 and #026 from RN #163, who indicated both residents had received antibiotics within the previous month.

Related to Resident #026:

Inspector #672 reviewed resident #026's progress notes from a specified one month period, and observed a progress note from an identified date, which indicated resident #026 was noted to have a specified type of infection.

Inspector #672 reviewed resident #026's physician's orders from the specified one month period, and observed the resident was ordered an antibiotic to be administered for seven days, along with one STAT dose.

Inspector #672 reviewed resident #026's progress notes and vital signs record during the period of time the resident was receiving antibiotic therapy and observed there was no documentation on 22 shifts regarding the resident's infection symptoms or vital signs.

Related to Resident #025:

Inspector #672 reviewed resident #025's progress notes, and observed a progress note from a specified one month period, and observed a progress note from an identified date, which indicated resident #025 was noted to have a specified type of infection.

Inspector #672 reviewed resident #025's physician's orders from the specified one month period, and observed the resident was ordered an antibiotic to be administered for seven days.

Inspector #672 then reviewed resident #025's progress notes and vital signs record during the period of time the resident was receiving antibiotic therapy and observed there was no documentation on one shift regarding the resident's infection symptoms or vital signs.

During separate interviews, RPNs #115, #132, and #134, and RNs #124, #160 and #163, along with the Infection Control Nurse, all indicated the expectation in the home was for staff to assess and document a resident's symptoms of infection on every shift, while the resident was actively ill and/or receiving an antibiotic.

The licensee failed to ensure that when resident's #019, #025 and #026 experienced identified infections, that symptoms of each of the infections were recorded on every shift, as required. [s. 229. (5) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that hand hygiene is performed on every resident prior to every intake of nourishment and meal and to ensure that staff record symptoms of infection in residents on every shift, as required, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a report to the Director regarding an allegation of staff to resident abuse included a description of the incident which included the area or location of the incident, the date and time of the incident, and the events leading up to the incident.

Related to Log #026117-18:

A Critical Incident Report was submitted to the Director regarding an allegation of staff to resident abuse, which was reported to the licensee by resident #011's SDM.

Inspector #672 reviewed the CIR, and observed the report indicated resident #011's SDM made an allegation of staff to resident abuse. The CIR further indicated that a PSW was interviewed related to the allegation. The CIR did not provide a description of the incident which led to resident #011's SDM bringing forward the allegation, did not include the area or location the incident occurred, the date and time of the incident, or the events leading up to the incident. The CIR had been amended, and did not add any of the above information into the report.

During an interview, the DOC indicated they had filed the CIR related to the allegation, and it had been an oversight to not include a description of the incident which included the area or location of the incident, the date and time of the incident, and the events leading up to the incident in the report. The DOC further indicated being aware of the legislative requirement that the information be included in each report to the Director.

The licensee failed to ensure that after resident #011's SDM brought forward an allegation of staff to resident abuse, the critical incident report to the Director included a description of the incident which included the area or location the incident occurred, the date and time of the incident and the events leading up to the incident. [s. 104. (1) 1.]

Issued on this 25th day of October, 2019 (A2)

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

Original report signed by the inspector.

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by JENNIFER BATTEN (672) - (A2)
Inspection No. / No de l'inspection :	2019_715672_0005 (A2)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	002061-18, 020792-18, 027448-18, 001139-19, 002757-19, 003184-19, 003654-19, 006865-19, 011869-19 (A2)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Oct 25, 2019(A2)
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. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Order / Ordre :

The licensee must be compliant with s. 6 of the LTCHA.

Specifically, the licensee shall ensure the following:

1) Develop and implement a plan to ensure that all front line staff members and others involved in the different aspects of the resident's care (RPNs, RNs, RDs, PTs, OTs, Wound Care Champions and physicians) collaborate with each other. A documented record of the process must be kept.

2) Create separate auditing processes and audit the health care records of residents who have new areas of altered skin integrity, signs and symptoms of an infection and/or have sustained falls with injuries on a monthly basis for a six month period of time to ensure collaboration within the multidisciplinary team has occurred.

3) Educate the relevant staff members on the expectations of how/when to collaborate within the multidisciplinary team and document.

4) Develop and implement a corrective action plan which outlines measures to
be taken and by whom, if staff fail to implement the interventions as identified, and educate direct care staff on the process. A documented record of the process must be kept.

Grounds / Motifs :

1. The licensee has failed to ensure that staff and others collaborated with each other in the assessment of resident #010.

Related to Log #003184-19:

A complaint was received by the Director regarding an incident on a specified date and time when resident #010 was found on the floor by staff.

Prior to the incident of being found on the floor, resident #010 used a specified mobility aid to ambulate in their room and a different mobility aid for longer distances, such as to the dining room.

A review of the progress notes from a specified time period included the following:

- On a specified date and time, RN #124 documented that the resident was found on the floor. No apparent injury was noted and the family was notified.

- The following day RN #142 documented a referral for OT was made as staff reported that resident was increasingly difficult to transfer and used another transfer device. Later that day RPN #153 documented that the resident denied pain and had no voiced concerns but several hours later RPN #143 documented that a follow-up assessment indicated the resident was noted to be lethargic, denied pain and staff used the specified transfer device for transfers. RPN #143 further documented that an OT referral was made due to identified concerns and requested an assessment for the staff to utilize another specified transfer device for the resident.

- The next day RN #148 documented that staff had reported to the nurse that the resident had a brief unresponsive episode. The resident's family member was informed and a note was left in the physician's book regarding the unresponsive episode. A few hours later, Physiotherapist #103 documented that the RN reported the resident had an unresponsive episode and the PSWs reported a specified concern during transfers over the past two days. The resident's physical condition was not stable enough at that moment for an assessment to be completed by the Physiotherapist. The Physiotherapist posted an identified transfer logo for transfers and notified staff. That evening, RN #156 documented that resident #010 was observed to be attempting to self-transfer. Health teaching was provided to the resident about the importance of waiting for assistance for transferring, especially since the resident's recent fall.

- The following day RPN #145 documented that the resident had no complaints of pain or discomfort related to the previous fall sustained. Extensive bruising was observed on an identified area of the resident.

- Two days later RN #157 documented they were called by staff to assess resident #010 and observed bruising to an identified area, along with two identified physical injuries. Resident #010 exhibited minimal grimacing on palpation and movement of the area and remained alert and calm with no voiced complaints. The resident was transferred to hospital for further assessment.

A review of the x-ray report from hospital indicated that there was an identified injury to the area. A review of the follow-up mobile x-ray report indicated also indicated an identified injury was present.

During an interview with Inspector #571, PSW #146 indicated that after the resident's fall, the resident was transferred to a chair via an identified transfer device. After the nurse assessed the resident, the resident was transferred to the toilet. PSW #146 assisted PSW #152 to transfer the resident off of the toilet. PSW #146 indicated that a specified concern was observed during the transfer so they informed RPN #143.

In an interview with Inspector #571, RPN #143 indicated that RN #124 had assessed the resident after the fall, and documented their findings. RPN #143 further indicated they had assumed that the RN had informed the physician of resident #010's fall.

In an interview with Inspector #571, RN #124 indicated they had assessed resident #010 after the fall, with RPN #143. No evidence of an injury was found during that assessment and the resident was transferred via an identified transfer device. RN #124 further indicated they had not been made aware of any specified concerns during further transfers with the resident.

In an interview with Inspector #571, RN #148 indicated that they informed physician #151 of the resident's unresponsive episode. RN #148 did not work on the date of resident #010's fall of the following day, and made an assumption that physician #151 had been informed of the fall that had occurred. The RN indicated if a resident sustained a minor fall with no injury observed, they might put a notation in the physician's communication book rather than calling the physician directly to inform of a resident fall. RN #148 further indicated that if there was a change in a resident's condition then the physician would be called directly to be informed of the incident. RN #148 indicated that they considered a change in a resident's ability to assist during a transfer to be a change in condition. The RN did not speak to physician #151 about resident #010's change in ability to assist during a transfer, as they were more focused on the resident's unresponsive episode from earlier that day.

In an interview with Inspector #571, physician #151 indicated that they did not recall being notified of the resident's fall or of the resident's change in ability to assist during a transfer. The physician further indicated that the staff should have realized that when the resident could no longer assist in their transfers there was an injury

present. Physician #151 indicated that resident #010 had sustained an identified injury, and the fact that the resident was not sent to the hospital sooner would not have changed the outcome, however, there could have been serious complications, which fortunately did not happen.

The staff failed to collaborate with the physician in their assessment of resident #010 after the resident fell and could no longer provide the same level of assistance during transfers. [s. 6. (4) (a)]
(571)

2. 3. The licensee has failed to ensure that staff involved in the different aspects of resident #019's care collaborated with each other so that their assessments were integrated, consistent with and complemented each other.

Related to Log #001139-19:

A complaint was received by the Director related to resident #019, regarding skin and wound care, nutrition and hydration, staffing levels and pain control.

During a telephone interview, resident #019's SDM indicated to Inspector #672, that resident #019 passed away in the home after acquiring an identified area of altered skin integrity along with another medical diagnosis. Resident #019's SDM further indicated that the area of altered skin integrity had worsened over a specified time period which resulted in the nursing team putting identified interventions in place.

A review of resident #019's progress notes for a specified time period revealed the following:

- Between a specified time period, resident #019 experienced an identified symptom on a number of occasions.

- Between another specified time period, resident #019 was noted to have experienced an identified symptom on a number of occasions, and received an identified intervention.

There was no documentation in resident #019's health care record that resident #019's primary physician, MD #162, was notified of resident #019's symptom for longer than one month, and had been exhibiting this symptom daily during a

specified time period.

During an interview, MD #162 indicated their expectation was that the registered staff would notify them directly if a resident was experiencing an identified symptom for "more than a day or two". MD #162 further indicated they could not recall being notified resident #019 had exhibited the identified symptom during the specified time period, or that the resident exhibited the identified symptom daily during another specified time period. MD #162 indicated if they had been notified of the resident's identified symptom, they would have documented about them in the "Physician's progress notes" section of resident #019's health care record. Following a review of their documentation in resident #019's health care record, MD #162 felt confident they were not notified of resident #019's identified symptoms. MD #162 further indicated they were "not surprised" they had not been notified of resident #019's changing condition, as there had been "longstanding communication issues" in the home between the nursing and medical staff, which MD #162 indicated they had spoken to the DOC about on several occasions. MD #162 further indicated they had recently changed the process of how communication occurred between the nursing staff and the physicians in the home, in the hope of assisting communication and physician notification, to help improve resident outcomes. MD #162 indicated if they had been aware of resident #019's changing condition, there may have been interventions which could have been implemented to assist in ensuring the resident's comfort.

During separate interviews, RPNs #132 and #134 indicated they could not recall notifying MD #162 of resident #019's changing condition, but had notified RNs #160 and #166, who would have been responsible for communicating with the physician. RNs #160 and #166 indicated they believed they had notified MD #162 of resident #019's changing condition by leaving a notation in the physician's book. Inspector #672 reviewed the physician's book with RNs #160 and #166 during the specified time period, and could not locate any documentation which indicated MD #162 had been notified of resident #019's increased temperatures.

During an interview, Resident Care Coordinator (RCC) #105 indicated the expectation in the home was for either the RPN or the RN to keep each resident's primary care physician up to date on the resident's current health condition, by contacting the physician directly. RCC #105 further indicated it was only appropriate to leave notes in the physician's book related to non-urgent information which was

not time sensitive, and should not include any information regarding a resident's condition.

The licensee failed to ensure that the nursing and medical staff collaborated with each other regarding resident #019's changing health condition, so that their assessments were integrated, consistent with and complemented each other. [s. 6. (4) (a)]

The severity of this issue was determined to be a level 3, as there was actual harm to residents #010 and #019. The scope of the issue was determined to be a level 2, as there was a pattern of staff not collaborating as required within the multidisciplinary team. The home had a level 3 compliance history, as non-compliance was observed under the following areas of the legislation related to s. 6 of the LTCHA.

A VPC was issued during the following inspection, under LTCHA, 2007, s.6 - Complaint Inspection (#2015_360111_0020), under s. 6 (4)(a).
(672)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Dec 16, 2019(A1)

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

Order / Ordre :

The licensee must be compliant with r. 8 of the LTCHA.

Specifically, the licensee shall ensure the following:

1) Educate all relevant members of the multidisciplinary team (RPNs, RNs, RDs, Wound Care Champions, PTs and OTs) on the internal policy entitled “Skin and Wound Care”; policy number: INTERD-03-06-01; last reviewed: November 2018. Test the retention of this knowledge and a documented record must be kept.

2) Create an auditing system to audit the health care records of residents who have new areas of altered skin integrity on a monthly basis for a six month period of time to ensure the internal policy is being followed. This is to include assessment of the weekly skin assessments, referrals to the appropriate members of the interdisciplinary team, ensuring pictures are being taken of the wounds as required, measurements are being completed during the wound assessments, and the resident's pain levels are being documented during/following the dressing changes, as directed in the internal policy. Keep a record of the audits completed.

3) Develop and implement a corrective action plan which outlines measures to
be taken and by whom, if staff fail to implement the interventions as identified by the internal policy, and educate direct care staff on the process. A documented record of the process must be kept.

Grounds / Motifs :

1. The licensee has failed to ensure that the internal policy related to skin and wound care was complied with.

In accordance with O. Reg. 79/10, r. 48 (1), the licensee was required to ensure that the following interdisciplinary programs were developed and implemented in the home: 2) A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.

Under O. Reg 79/10. s. 30 (1), every licensee of a long-term care home shall ensure

that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

Under O. Reg 79/10. r. 50 (2) (b) (iii), a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is to be assessed by the 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.

Under O. Reg 79/10. r. 50 (2) (b) (iv), a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is to be reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Inspector #672 reviewed the licensee's internal policy specific to areas of altered skin integrity, which directed that upon discovery of an area of altered skin integrity, registered staff were to initiate a baseline assessment using a clinically appropriate assessment instrument, send referrals to the dietitian, Skin and Wound Care Champion, occupational therapist and physiotherapist, ensure the plan of care was established outlining interventions and treatments, reassess the resident weekly and revise the care plan accordingly. The internal policy also directed what assessment tool(s) and documentation was to be completed and included in the resident's health care record on a weekly basis.

Related to Log #001139-19:

A complaint was received by the Director related to resident #019, regarding skin and wound care, nutrition and hydration, staffing levels and pain control.

During a telephone interview, resident #019’s SDM indicated to Inspector #672 that resident #019 passed away in the home after acquiring an area of altered skin integrity along with another medical diagnosis. Resident #019’s SDM further indicated that the area of altered skin integrity had worsened significantly over a

specified time period, which resulted in the nursing team putting specified interventions in place.

A review of resident #019's progress notes indicated the resident had acquired an area of altered skin integrity which was noted to have deteriorated over a specified time period. Resident #019 was further observed to have acquired three other areas of altered skin integrity approximately three weeks after the first area was observed, and two other areas of altered skin integrity approximately one week later.

Based on a review of resident #019's health care records, the first specified baseline assessment for resident #019 was completed four days after the initial observation of the area of altered skin integrity was observed.

Inspector #672 reviewed resident #019's skin and wound assessments completed during a specified approximate six week time period and noted that regarding the five areas of altered skin integrity observed after the initial area of altered skin integrity was found, Inspector #672 could not observe any assessments of the areas to have been completed by the registered staff. Regarding the initial area of altered skin integrity, Inspector #672 noted there appeared to be missing weekly assessments, and of the assessments which were completed, there appeared to be specified documentation missing, as per the instructions provided to the registered staff within the licensee's internal written policy specific to areas of altered skin integrity.

During an interview, the DOC indicated the expectation in the home was that every resident who exhibited altered skin integrity was to be reassessed at least weekly by a member of the registered nursing staff which was to be documented in a clinically appropriate wound assessment that included specified documentation as directed within the licensee's internal written policy.

Inspector #672 reviewed resident #019's health care record for a specified time period, regarding referrals to the dietitian, occupational therapist and physiotherapist related to the observed areas of altered skin integrity. No referrals were observed to have been completed and documented in resident #019's health care record during that time period. Inspector #672 then reviewed the health care record for referrals to the Skin and Wound Care Champion and did not observe any completed referrals related to any of resident #019's areas of altered skin integrity, outside of the initial area first observed.

During separate interviews, RPNs #132 and #134 indicated they were the regular part time and full time RPNs on resident #019's home area and completed the interventions for resident #019's areas of altered skin integrity most often. RPNs #132 and #134 indicated the expectation in the home was that every resident who exhibited altered skin integrity was to be reassessed at least weekly by a member of the registered nursing staff, which was to be documented in a clinically appropriate wound assessment that included specified documentation as directed within the licensee's internal written policy. RPNs #132 and #134 further indicated they did not routinely send referrals to the OT/PT when a resident was observed to have an area of altered skin integrity, and would only send a referral to the dietitian if the resident was not already being followed for another issue. RPNs #132 and #134 further indicated the referrals would sometimes be delivered verbally, either by calling the RD on the telephone or updating the RD in person during the RD's observation rounds during meals. RPNs #132 and #134 indicated if referrals were given verbally they should always be documented within the resident's progress notes and could not recall requesting any referrals for resident #019 related to the areas of altered skin integrity. RPNs #132 and #134 further indicated they were unaware of one of the specified assessment tools registered staff were directed to complete within the licensee's internal policy and had not completed some of the other instructions listed within the policy.

During separate interviews, OT#164, PT#103 and RD #135 indicated they had not received referrals regarding each of resident #019's areas of altered skin integrity. PT#103 indicated they never received referrals related to any resident's areas of altered skin integrity, unless the area was directly related to the resident's mobility device. RD #135 indicated they were aware that resident #019 had an area of altered skin integrity, but had not been informed or were aware the area had worsened. RD #135 further indicated they were unaware of resident #019's five other areas of altered skin integrity observed during the specified six week time period. RD #135 indicated if they were informed of resident #019's areas of altered skin integrity, there may have been further nutritional interventions which could have been implemented for the resident. OT#164 indicated they had not received any referrals regarding resident #019's areas of altered skin integrity, but was involved in a request for resident #019 to obtain a specified intervention following the observation of the first area of altered skin integrity but prior to the subsequent areas being observed.

After review of the licensee's internal written policy regarding areas of altered skin integrity, Inspector #672 observed several areas of non-compliance with the policy, specific to resident #019, therefore expanded the scope of assessment related to assessing compliance with the internal policy to include two more residents with exhibited areas of altered skin integrity. On a specified date, RN #163 indicated that residents #023 and #024 had experienced areas of altered skin integrity within a specified period of time.

Related to Resident #023:

During review of resident #023's health care record, Inspector #672 observed the resident's Treatment Administration Records (TARs) for a specified time period, which indicated in a specified month, the resident had an existing area of altered skin integrity. The following month, resident #023 was noted to have another area of altered skin integrity.

During review of resident #023's assessments completed during the specified time period related to both areas of altered skin integrity, Inspector #672 noted there appeared to be missing weekly assessments and of the assessments which were completed, there appeared to be documentation missing, as per the instructions provided to the registered staff within the licensee's internal written policy specific to areas of altered skin integrity.

Inspector #672 then reviewed resident #023's health care record related to referrals to the registered dietitian, Skin and Wound Care Champion, occupational therapist and physiotherapist regarding one of the areas of altered skin integrity from when it was first noted. No referrals were observed to have been completed and documented in resident #023's health care record during the specified time period.

Related to Resident #024:

During review of resident #024's health care record, Inspector #672 observed the resident's TARs for a specified time period, which indicated that in a specified month, the resident had two existing areas of altered skin integrity. Approximately two months later, resident #024 was noted to have four new areas of altered skin integrity. Inspector #672 reviewed resident #024's health care record for a specified

time period regarding referrals to the dietitian, occupational therapist and physiotherapist related to the areas of altered skin integrity. No referrals were observed to have been completed and documented in resident #024's health care record during that time period.

Review of the physician's orders indicated resident #024 had a physician's treatment order which specified assessments of the areas were to be completed weekly on a specified day and shift. Inspector #672 then reviewed resident #024's assessments completed during a specified time period, related to the areas of altered skin integrity and noted there appeared to be missing weekly assessments and of the assessments which were completed, there appeared to be documentation missing, as per the instructions provided to the registered staff within the licensee's internal written policy specific to areas of altered skin integrity.

During separate interviews, RPNs #132 and #134, RNs #160 and #166, RCCs #105 and #176, and the RAI Coordinator all indicated the expectation in the home was that each resident with exhibited areas of altered skin integrity was to be assessed and documented upon by a member of the registered nursing staff on a weekly basis, which was to include specified documentation as directed within the licensee's internal written policy.

During an interview, OT #164 indicated the expectation in the home was for staff to send referrals when a resident was noted to be at risk for pressure related injuries. OT #164 further indicated if a referral was not sent prior to the resident's skin breaking down, a referral should be sent once an area of altered skin integrity was observed. OT #164 stated that communication within the multidisciplinary team could be more collaborative and felt that the nursing team did not keep occupational therapy updated regarding resident's health care status, specifically related to areas of altered skin integrity. OT #164 indicated they were contacted if a device was requested for a resident, or was noted to be malfunctioning, and had not received any referrals related to residents #023 and #024's areas of altered skin integrity. OT #164 indicated they were only aware of some of resident #023 and #024's areas of altered skin integrity after speaking with the staff on the resident home areas during conversations regarding pressure relief interventions. OT #164 indicated they felt that "a lot more could have been done for (resident #024) to prevent their (areas of altered skin integrity)", if they had the opportunity to be involved in resident #024's care during the early stages, when specified interventions could have been

implemented when the resident was first observed to exhibit areas altered skin integrity.

During an interview, RD #135 indicated the expectation in the home was for a referral to be sent each time a resident's area of altered skin integrity was noted to improve or decline. RD #135 further indicated they did not receive any referrals related to resident #023's areas of altered skin integrity improving and declining during a specified time period. RD #135 indicated they did not receive any referrals related to resident #024's areas of altered skin integrity, and was only aware of two of the areas, but was not aware of the four newer areas of altered skin integrity.

During separate interviews, RCCs #105, #176 and the DOC indicated that the expectation in the home was for all staff members to follow each internal policy, including the internal policy related to areas of altered skin integrity. RCCs #105 and #176 further indicated they were aware that weekly skin assessments were not always being completed on a weekly basis, that referrals to the RD/OT/PT were not routinely being sent and that other specified directions and instructions provided for within the licensee's internal policy were not being followed.

The licensee failed to ensure that the internal policy related to areas of altered skin integrity was complied with, specific to residents #019, #023 and #024 receiving assessments on a weekly basis, referrals to the RD/OT/PT/Wound Care Champion following observation of areas of altered skin integrity; having a baseline assessment using a clinically appropriate assessment instrument completed upon discovery of each area of altered skin integrity; or having a 'Pressure Injury/Wound Assessment Record' completed, which was to include specified documentation related to each of the areas of altered skin integrity. [s. 8. (1) (a),s. 8. (1) (b)]

The severity of this issue was determined to be a level 3, as there was actual harm to residents #019, #023 and #024. The scope of the issue was determined to be a level 3, as the issue was noted to be widespread. The home had a level 3 compliance history, as previous VPCs were issued during the following inspections, under LTCHA, 2007, r.8 - during Resident Quality Inspection (#2018_643111_0007) and during Critical Incident Inspection (#2019_603194_0004).
(672)

Dec 16, 2019(A1)

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Order / Ordre :

(A2)
The licensee must be compliant with r. 52 of the LTCHA.

Specifically, the licensee shall ensure the following:

1) Educate all members of the registered nursing team on the internal pain management policy and the legislation under the LTCHA 2007, r. 52 (2) which directs that when a resident's pain is not relieved by initial interventions, the resident is to be assessed using a clinically appropriate assessment instrument
specifically designed for that purpose.

2) Test the staff member's knowledge of the internal pain management policy and the legislation under the LTCHA 2007, r. 52 (2) to ensure understanding of the expectations.

3) Keep a documented record of the education and testing completed.

4) Create an auditing system and audit the health care records of residents who have new complaints of pain on a monthly basis for a six month period of time to ensure the internal policy and legislation is being followed. A documented record of the audits must be kept.

5) Develop and implement a corrective action plan which outlines measures to be taken and by whom, if staff fail to implement the interventions as identified, and educate direct care staff on the process. A documented record of the process must be kept.

Grounds / Motifs :

1. The licensee has failed to ensure that when resident #019's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for that purpose.

Related to Log #001139-19:

A complaint was received by the Director related to resident #019, regarding skin and wound care, nutrition and hydration, staffing levels and pain control.

During a telephone interview, resident #019's SDM indicated to Inspector #672 that resident #019 passed away in the home after acquiring an area of altered skin integrity along with another medical diagnosis. Resident #019's SDM further indicated a belief that resident #019 had been experiencing pain, which had not been well controlled. As a result of the concerns that resident #019's pain was not being well managed, the SDM indicated they felt they did not have the opportunity to spend the resident's last days sharing time together and had to spend the time advocating for resident #019 to receive better pain management. Resident #019's SDM indicated they had brought these concerns forward to the nursing staff on resident #019's home area, to the attending physician and to RCC #105, which resulted in a palliative care conference being held. During the care conference, resident #019's SDM indicated the health care team assured them that resident #019's pain could be managed appropriately in the home and a hospital transfer was not necessary. Resident #019's SDM further indicated that resident #019's pain had not been well managed following the care conference.

A review of the physician's progress notes indicated that following an assessment of the resident and a conversation with the SDM, resident #019 was deemed palliative. The physician's progress notes indicated that resident #019 was frequently observed to be in pain, breakthrough pain medications were being "used frequently", and pain medication dosages would be increased to assist with resident #019's pain control.

Inspector #672 reviewed resident #019's medication list, and observed that over a specified period of time, pain medications were ordered or modified in an attempt to assist resident #019 with pain control.

A review of resident #019's health care record showed that between the date when resident #019 was deemed palliative, and the date resident #019 passed away in the home, there was no record of pain assessments being performed.

During separate interviews, RPNs #132 and #134, and RNs #160 and #166 could not recall completing any pain assessments to assess resident #019's pain during the specified period of time. RPNs #132 and #134, and RNs #160 and #166 further indicated the expectation in the home was that clinically appropriate pain assessment instruments specifically designed for the purpose of assessing the resident's pain

were to be used any time a resident had complaints of a new or different type of pain, or if their pain was not well controlled with current interventions.

Inspector #672 then expanded the scope of assessment related to completion of assessments using clinically appropriate pain assessment instruments, specifically designed for the purpose of assessing a resident's pain. The inspection was expanded to include two additional residents, residents #039 and #040, who experienced frequent pain and/or changes to their pain medications due to uncontrolled pain.

Related to Resident #039:

During an interview, resident #039 indicated they suffered from constant moderate to severe pain to an identified area on a daily basis, which worsened through the night time hours, therefore negatively affected their sleep cycle. Resident #039 further indicated they utilized pain medications on a daily basis, which were only moderately effective in relieving their pain symptoms. Resident #039 stated the nursing staff did not ask questions regarding their pain symptoms, other than asking about the location of the pain and if the pain medication was effective.

Inspector #672 reviewed resident #039's physician's orders for a specified period of time, related to pain control, which indicated pain medications were ordered for resident #039.

A review of resident #039's progress notes and physician's notes for the specified time period indicated that resident #039 continued to have complaints of pain during this time, which resulted in increases to the pain medications.

During separate interviews, RPN #134 and RN #160 indicated that resident #039 experienced pain on a daily basis, which was often not relieved by the current intervention of routine and breakthrough pain medications being utilized. RPN #134 and RN #160 further indicated they could not recall completing any assessment using clinically appropriate pain assessment instruments for the assessment of resident #039's pain, when the resident had complaints of pain, was exhibiting symptoms of pain, and had multiple changes to their pain medications.

Related to Resident #040:

During an interview, resident #040 indicated they suffered from generalized moderate to severe pain which was most often felt in specified areas of the body on a daily basis. Resident #040 further indicated they utilized pain medications on a daily basis, which were only moderately effective in relieving their pain symptoms, and could not recall if nursing staff asked questions regarding their pain symptoms prior to or following administration of the pain medications.

Inspector #672 reviewed resident #040's physician's orders from a specified time period, related to pain control which indicated resident #040 had no changes made to their pain medication orders during that time period and noticed breakthrough pain medications were administered frequently. Resident #040 had various pain medication orders during the specified time period, which included both short and long acting pain medications, which were administered both routinely and on an as needed basis.

Inspector #672 reviewed resident #040's electronic Medication Administration Records (eMARs) and progress notes for the specified time period, which indicated that resident #040 expressed daily complaints of pain and received both routine and breakthrough pain medications.

During separate interviews, RPN #134 and RN #160 indicated that resident #040 experienced pain on a daily basis, which was treated by routine and breakthrough pain medications. RPN #134 further indicated that resident #040 continued to have verbal complaints of pain following administration of the pain medications, along with exhibiting specified responsive behaviours. RPN #134 and RN #160 indicated they could not recall completing any pain assessments for resident #040 during the identified time period, despite the resident's continued expressed verbal complaints of pain and exhibited responsive behaviours when their pain was not relieved by interventions.

During separate interviews, RCC #105 and the RAI Coordinator indicated the expectation in the home regarding completion of pain assessments was that staff were expected to complete formal pain assessments any time a resident had complaints of a new or different type of pain, if the pain was not well controlled with current interventions, and during the RAI-MDS assessment, for residents who had pain listed as an issue within their written plan of care and/or MDS assessment.

The licensee failed to ensure that when residents #019, #039 and #040's pain was not relieved by initial interventions, the residents were assessed using a clinically appropriate assessment instrument specifically designed for that purpose.

The following findings of non-compliance were identified by Inspector #570 during a Critical Incident System Inspection (#2019_598570_0012) conducted concurrently with this Complaint Inspection (#2019_715672_0005) and issued under this report.

2) The licensee has failed to ensure that when the resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Related to Log #017363-18:

A Critical Incident Report was submitted to the Director related to an incident which involved resident #002.

A review of progress notes for resident #002 indicated that on a specified date and time the resident was observed by RPN #109 to have an injury on an identified area, and the resident complained of pain, therefore an identified pain medication was administered by RPN #109. Two days later, RPN #118 documented that resident #002 received an identified pain medication for ongoing complaints of pain and monitoring continued. Several hours after that, RPN #111 noted that the previous pain medication had been ineffective and resident #002 continued to complain of significant pain to the area. Routine pain medications were given with little effect, a notation was made in the doctor's book for the doctor to assess the resident's pain, and staff continued to monitor resident #002's condition. The next day, PSW staff stated that the resident was in severe pain when repositioned and breakthrough pain medications were given with little effect. Later that day, resident #002 continued to complain of pain and was assessed by RN #117. Resident #002 was then transferred to hospital, where they were diagnosed with an identified injury. The resident returned to the home from the hospital and an identified intervention was put in place.

Inspector #570 reviewed resident #002's health records. The record review did not indicate any documented evidence that pain assessments were completed using a

clinically appropriate assessment instrument when the resident complained of pain during the specified time period prior to being transferred to the hospital for assessment. A pain assessment was noted to be completed after the resident returned from hospital with the specified injury.

During an interview, RPN #106, indicated that on a specified date, resident #002's identified body part was observed to be swollen and the resident complained of pain. Interventions in an attempt to assist the pain were implemented with little effect. RPN #106 indicated that they assessed the resident's pain but could not locate any pain assessment tools completed for resident #002.

During an interview, RPN #111 indicated that on a specified date, resident #002's identified body part was observed to be swollen and the resident complained of pain as they rubbed the area. RPN #111 indicated they did not initiate the objective pain assessment tool although they had documented in the progress notes that the resident complained of severe pain in the area and pain medications had been provided with little effect.

During an interview, RPN #109 indicated they had not initiated a pain assessment tool when the resident complained of pain, but the resident had been given an identified intervention for the pain, with little effect.

During an interview, RCC #105 indicated that registered staff should have assessed resident #002's pain using the Objection Pain Assessment Tool but none could be found to have been completed for resident #002 when the resident complained of pain during the specified time period.

During an interview, the DOC indicated that the registered staff should have been using the Objective Pain Assessment Tool to assess resident's pain prior to the licensee implementing a new pain assessment tool in the Point Click Care (PCC) documentation system.

Resident #002 was not assessed using a clinically appropriate instrument when pain medications were noted to have been ineffective during a specified period of time. (Inspector #570)

3) Related to Log #018945-18:

A Critical Incident Report was submitted to the Director which indicated that on a specified date, resident #001 sustained an identified injury while utilizing a mobility aid. The resident was transferred to hospital due to increased pain related to the identified injury, where they received a specified diagnosis and returned to the home the following day.

A review of the progress notes for resident #001 indicated on a specified date and time, RPN #116 documented that PSW staff stated that resident #001 sustained an identified injury while utilizing a mobility aid and the resident complained of discomfort to the area. Three days later, RN #119 assessed resident #001. RN #119 documented that PSW staff stated that resident #001 complained of pain when the area was touched. The resident was assessed by the physician and was transferred to hospital. The next day the resident returned to the home with a confirmed diagnosis and an identified medical intervention. Shortly after returning to the home from the hospital, the resident was noted to be exhibiting non-verbal signs of pain. Specified medications were given with poor effect.

Inspector #570 reviewed resident #001's clinical records. The record review did not indicate any documented evidence that a pain assessment was completed using a clinically appropriate assessment instrument when the resident returned from hospital, complained of pain and was provided a specified pain medication, with poor effect.

During an interview, RPN #106, indicated that on a specified date, resident #001's injury was assessed. The resident did not complain of pain and there was no signs that could be associated with the injury observed at that time. The RPN indicated that PSW #107 reported that the resident had sustained an identified injury while using a mobility aid.

During an interview, RCC #105 indicated that registered staff should have assessed resident #001 for pain using the "Objective Pain Assessment Tool" but it was not completed for the resident when the resident complained of pain on the date the injury occurred and after the resident returned from hospital. The RCC further indicated that there was no documentation in the progress notes regarding pain until three days after the injury occurred.

During an interview, the DOC indicated that registered staff should have been using the Objective Pain Assessment Tool to assess resident's pain prior to the licensee implementing a new pain assessment tool on the new PCC documentation system in January 2019.

Resident #001's pain was not assessed using a clinically appropriate assessment instrument identified as the "Objective Pain Assessment Tool" after the resident received a confirmed medical diagnosis, and received a specified pain medication to assist with pain control with poor effect. (Inspector #570)

4) Related to Log #021231-18:

A Critical Incident Report was submitted to the Director which indicated that on a specified date, resident #016 complained of pain to an identified area. The resident continued to complain of pain over a specified period of time, therefore an assessment was completed by the RN and a mobile x-ray was taken. The x-ray confirmed resident #016 had an identified medical diagnosis and pain medications were administered to resident #016.

A review of the progress notes for resident #016 indicated that on a specified date and time, reside #016 reported pain in an identified area. RPN #183 attempted to reposition the resident slightly which increased the discomfort and a breakthrough pain medication was given.

On a specified date, a breakthrough pain medication was administered to resident #016 for complaints of pain to the identified area. Resident #016 continued to complain of pain, therefore their name was placed in the doctor's book for further assessment. Several days later the progress notes indicated that the resident had complaints of pain and received breakthrough pain medications. The physician was informed that the resident had continued ongoing complaints of pain. An x-ray of the identified area was ordered and indicated the resident had an identified medical diagnosis. The resident continued to complain of discomfort to the identified area. Breakthrough pain medications continued to be administered for the complaints of pain along with an identified intervention.

Inspector #570 reviewed resident #016's clinical health records including the electronic records and paper chart. The record review did not indicate any

documented evidence that pain assessments were completed using a clinically appropriate assessment instrument although the resident received a specified medical diagnosis and had ongoing complaints of pain to the identified area which breakthrough pain medications were observed to be ineffective to manage.

During an interview, RN #117, indicated that resident #016 had ongoing complaints of pain before the resident was diagnosed with the identified injury. Review of the progress notes for resident #016 with RN #117, indicated the resident complained of pain over a specified time period. RN #117 indicated the RPNs should have completed the Objective Pain Assessment Tool but could not locate any completed pain assessments. RN#117 confirmed that they did not complete a pain assessment after they assessed the resident.

During an interview, RPN #161, indicated that prior to using the Point Click Care (PCC) documentation system, staff used to document pain assessments using the Objective Pain Assessment Tool. Review of the progress notes for resident #016 with RPN #161 indicated that a pain assessment had not been initiated for resident #016 when the resident complained of pain to the identified area and continued to have complaints of pain over a specified time period.

The resident was not reassessed using a clinically appropriate assessment instrument after the pain medications were found to be ineffective. (Inspector #570) [s. 52. (2)]

The severity of this issue was determined to be a level 2, as there was minimal risk to residents #001, #002, #016, #019, #023, and #024. The scope of the issue was determined to be a level 3, as the issue was noted to be widespread with non-compliance observed related to 6 out of 6 residents inspected. The home had a level 2 compliance history, with previous non-compliance to different subsections of the legislation observed. (672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 16, 2019(A1)

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 25th day of October, 2019 (A2)

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Amended by JENNIFER BATTEN (672) - (A2)

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