Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

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

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

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jun 11, 2018;	2018_633577_0006 (A1)	005841-18	Resident Quality Inspection

Licensee/Titulaire de permis

St. Joseph's Care Group
35 North Algoma Street P.O. Box 3251 THUNDER BAY ON P7B 5G7

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

Hogarth Riverview Manor
300 Lillie Street THUNDER BAY ON P7C 4Y7

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

Amended by DEBBIE WARPULA (577) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The Licensee has requested and been granted an extension to Compliance Order #001, and #002 to ensure sustained compliance with each respective provision.

Issued on this 11 day of June 2018 (A1)

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

Original report signed by the inspector.

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Amended by DEBBIE WARPULA (577) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): April 30, 2018, and May 1-4, 7-11, 2018.

The following intakes were inspected during this inspection:

-Three Critical Incident System (CIS) reports related to allegations of resident neglect;

-One CIS report related to a resident fall;

-Two CIS reports related to missing narcotics;

A Complaint inspection #2018_740621_0014 was conducted concurrently with this RQI inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Directors of Care (ADOC), Maintenance, Resident Assessment Instrument (RAI) Coordinator, Resident Engagement Coordinator, Clinical Managers, Registered Nurses (RNs),

Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Environmental Service Supervisor, Registered Dietitian, Staff Educator, Infection Prevention and Control Facilitator, Staffing Coordinator, Laundry Aide, residents and families.

The inspector(s) also conducted daily tours of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed health care records, internal investigations and policies, procedures and programs.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Laundry

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Residents' Council

Responsive Behaviours

Skin and Wound Care

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

10 WN(s)
5 VPC(s)
2 CO(s)
0 DR(s)
0 WAO(s)

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 s. 20.	CO #001	2018_655679_0005	577

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident was taking any drug or combination of drugs, including psychotropic drugs, there was monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

Resident #009 was identified as experiencing unrelieved pain through a resident interview.

In an interview with Inspector #679, resident #009 identified that they experienced a specific pain all over their body. Resident #009 identified that the pain was experienced "pretty well steady" and that the prescribed medication did not relieve the pain.

Inspector #679 reviewed the electronic Medication Administration Record (eMar) for a two week period. It was identified that the resident received their PRN medication on 13 occasions. A review of the "Follow-Up Notes" report identified that the effectiveness of the medication was documented on two occasions.

In an interview with RPN #112 they identified that resident #009 complained of pain "a lot" and that they had pharmaceutical interventions, including PRN medication, which was effective for managing their pain. RPN #112 identified that when a PRN

medication was administered, the follow up for the effectiveness would be documented in the electronic notes. Inspector #679 and RPN #112 reviewed the electronic "Follow-Up Notes" report, and identified that a follow up note was not completed on a number of occasions. RPN #112 identified that a follow up note was to be completed after the administration of any PRN medication.

In an interview with Inspector #679, the Director Of Care identified that all PRN analgesic medications were to be followed up to determine the effectiveness and documented as per the home's policy. Inspector #679 and the DOC reviewed the "Follow-Up Notes" report. The DOC indicated every PRN administration was supposed to have a re-evaluation to determine the effectiveness. [s. 134. (a)]

2. During an interview with resident #003, they had reported to Inspector #577 that they experienced pain to a specific area in their body.

A review of the physician orders indicated that the resident was prescribed two PRN pain medications.

Inspector #577 reviewed the electronic Medication Administration Record (eMar) for a two month period, and found that the resident received prn medication for pain on 12 occasions. A review of the "Follow-Up Notes" report identified that the response of effectiveness to the medication was documented on four occasions.

In an interview with RPN #150 they reported to the Inspector that resident #003 had complained of pain to a specific area in their body and was prescribed regularly scheduled pain medication and prn medication. They further reported that staff documented the response to pain medication on the eMAR within an hour.

During an interview with RN #151 they reported to the Inspector that a follow up note to a PRN medication should be documented on the eMAR or electronic note.

During an interview with the DOC, Inspector #577 reviewed the "Follow-Up Notes" report. They confirmed that the follow up documentation was inconsistent and staff were required to document the effectiveness of PRN pain medication on the eMAR within an hour. [s. 134. (a)]

3. During an interview with resident #011, they had reported to Inspector #577 that they experienced frequent pain to a specific area in their body.

A review of the physician orders indicated that the resident was prescribed PRN medication for pain.

Inspector #577 reviewed the electronic Medication Administration Record (eMar) over a five week period and found that the resident received PRN medication for pain on 23 occasions. A review of the "Follow-Up Notes" report identified that the response of effectiveness to the medication was documented on two occasions.

A review of the policy titled "Janzen's Pharmacy Administration of Medications-General Guidelines" last revised January 2017, identified that when PRN (as needed) medications were administered, residents were assessed to determine medication effectiveness and that the effects of the medication were to be documented in the resident's record.

In an interview with RPN #149 they reported that the documentation related to response to pain medication had been inconsistent and should be documented in an electronic note.

During an interview with Clinical Manager #129 they reported to the Inspector that staff were required to be documenting effectiveness or ineffectiveness of PRN pain medication within an hour on the eMAR.

During an interview with the DOC, Inspector #577 reviewed the "Follow-Up Notes" report. They confirmed that the follow up documentation was inconsistent and staff were required to document the effectiveness of prn pain medication on the eMAR within an hour. [s. 134. (a)]

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

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care
Specifically failed to comply with the following:

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

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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 the written plan of care for each resident set out clear directions to staff and others who provided direct care to the resident.

Resident #008 was identified as having had weight loss and a low body mass index (BMI) from their past to most recent minimum date set (MDS) assessment.

On a day in May 2018, at 0941 hours, Inspector #627 observed resident #008 sitting at the side of their bed. The resident was eating peanut butter and jam toast and drinking a glass of a cold brown beverage. At 1006 hours, a staff member was observed to have entered the room and asked the resident if they were done their meal. At 1239 hours, the resident was observed sitting in the dining room for the lunch meal service. The resident had eaten approximately a quarter to a third of their plate and drinking a beverage. The resident was not receiving assistance. A staff member approached the resident and asked if they were done eating and

removed their plate.

Inspector #627 reviewed resident #008's care plan in effect at the time of the inspection and noted for the focus of eating and nutrition, resident #008 required specific assistance at meal time.

Inspector #627 interviewed PSW #137 who stated that the resident often ate breakfast in their room as they displayed responsive behaviours in the morning. They stated that the resident was able to eat on their own most of the time; however, there were times when they needed assistance. They further stated that the care plan was not indicative of their care needs.

Inspector #627 interviewed RPN #135 who stated that the specific care plan intervention meant that the resident needed specific assistance from a staff member. RPN #135 stated that resident #008 was able to eat on their own; however, at times they needed assistance. RPN #135 acknowledged that the care plan was not reflective of the resident's care needs.

Inspector #627 interviewed Registered Dietitian (RD) #136 who stated that they had been made aware that the resident ate better with the assistance of staff; therefore, they had updated the care plan. The goal was for the resident to eat on their own when they could and to receive assistance when they could not. They indicated that they did not think that the resident needed assistance if they were eating toast on their own, and that they would update the care plan to indicate assist the resident as required, which was more reflective of their care needs. [s. 6. (1) (c)]

2. A Critical Incident (CI) report was submitted to the Director in January 2018, which alleged neglect of resident #018's skin condition. The CI report revealed that the resident developed altered skin integrity in the fall of 2017, and two months later, the altered skin integrity had progressed.

Inspector #577 conducted a record review of the physician orders for wound care over a three month period from the fall of 2017 to the winter of 2018. The treatment orders were initiated in a specific month in 2017, to be done PRN (as necessary). Six days later, treatment orders were initiated for a different area of altered skin integrity. And specifically, dressing changes to the both areas were to be done three times a week. Three weeks later, treatment orders for both areas of altered skin integrity were changed to twice weekly.

A record review of resident #018's care plan in effect during the time of altered skin integrity, from the fall of 2017 to the winter of 2018, did not indicate any focus or interventions related to altered skin integrity. The care plan was updated to include altered skin integrity to a specific area of their body 12 weeks later, after the onset of altered skin integrity. An intervention which identified a specific skin treatment was updated 14 weeks later.

A review of the home's policy titled "Care Planning – RC-05-01-01" last revised April 2017, indicated that as the resident's status changes, members of the interdisciplinary team were to update the plan of care so that at any point in time the care plan continued to be reflective of the current needs and preferences of the resident. Additionally, the care plan was to be revised when appropriate to reflect the resident's current needs, based on evaluation of response to care and treatment; and significant changes in the resident's status.

During an interview with the DOC, they confirmed that the care plan for resident #018 was not updated to include altered skin integrity with specific interventions until three months after the onset of their condition. They further confirmed that the altered skin integrity to another area of their body was not identified in the care plan at all. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the substitute decision maker (SDM) if any, and any other persons designated by the resident or SDM were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

During a family interview, resident #007's family member indicated that they had not been notified when the resident was removed from a special precautions for a particular outbreak. They had found out when they had come to visit the resident. They stated that they believed the outbreak had been over, however they were not sure.

Inspector #627 reviewed the resident's electronic progress notes and noted an entry for an event that had occurred in March 2018, which indicated that "the floor was currently on an outbreak. Substitute decision maker notified regarding outbreak and given contact numbers to contact for additional information if required". There was no progress note that identified when the outbreak had been declared over or whether the SDM and family had been notified.

Inspector #627 interviewed RPN #105 who stated that families were notified when a resident was placed on special precautions and when an outbreak occurred in the home; however, the families were not notified when the outbreak was over. They acknowledged that the families should be called when the outbreak and special precautions were over. The family typically found out when they called to inquire or came to visit.

Inspector #627 interviewed the Infection Prevention and Control (IPAC) Facilitator who stated that the particular outbreak on the floor had occurred over a 16 day period in 2018. They stated that the SDMs and families were notified when the residents were placed on special precautions and an outbreak was declared; however, they were not notified when the residents were taken off special precautions and the outbreak was over. When the Inspector asked how the families would know when they could visit their family members, they stated that this information was posted at the Public Health Unit and online and family could obtain their information there.

Inspector #627 interviewed the DOC who stated that the families were not called when an outbreak was over and the families found out when they visited or called, the signage would be removed, and it was published in the community. [s. 6. (5)]

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

A Critical Incident (CI) report was submitted to the Director which alleged staff to resident neglect. The report indicated that PSW #101 and #122 had not provided care to residents #022, #023, #024 and #025 for a period of four to five hours.

Inspector #627 reviewed resident #025's care plan in effect at the time of the incident which indicated for the focus of toileting, the resident was to be toileted at specific times. For the focus of locomotion on unit, the care plan indicated that the resident ambulated with a mobility aid and limited assistance from one staff member.

Inspector #627 reviewed the "Daily Check List of Duties-PSW Eight Hour Day", provided by the DOC which indicated that safety checks were to be completed hourly on every resident.

Inspector #627 interviewed PSW #101 who stated that they were only assigned to resident #025 during the shift where the allegations of neglect were brought forth. PSW #101 stated that they had a busy shift, and felt that resident #025 was able to toilet themselves, ambulate independently and that they looked fine sitting in the dining room. For this reason, they had focused on toileting the other residents who needed more assistance. PSW #101 acknowledged that resident #025 was not provided care as specified in their plan of care.

Inspector #627 interviewed RPN #126 who stated that they had noticed at 1400 hours, that the residents remained in the dining room and television room, and that PSW #101 and #122 were sitting at the desk reviewing the schedule. Although they had not worked frequently on this unit, they were aware that residents should be toileted after a meal. They had asked PSW #101 and #122 to provide residents #022, #023, #024 and #025 with the care required, however the PSWs had not and they had reported the incident to RN #127.

Inspector #627 interviewed the DOC who acknowledged the home's procedures had not been followed and that care had not been provided to resident #024 as indicated in their plan of care. [s. 6. (7)]

5. A Critical Incident (CI) report was submitted to the Director alleging staff to resident neglect. The report indicated that PSW #101 and #122 had not provided care to residents #022, #023, #024 and #025 for a period of four to five hours.

Inspector #627 reviewed the care plans in effect at the time of the incident for residents #023 and #024. For the focus of toileting, resident #024's care plan indicated that they needed specific assistance and were to be toileted at specific times to ensure that they were clean and dry. Resident #023's care plan revealed for the focus of toileting that the resident had continence issues and needed assistance from staff members to be toileted. For the focus of skin, the care plan indicated that the resident was to be repositioned at certain times.

Inspector #627 reviewed the "Daily Check List of Duties-PSW Eight Hour Day", provided by the DOC which indicated that safety checks were to be completed hourly on every resident.

Inspector #627 interviewed PSW #122 who stated that they were assigned to resident #024 and #023 on the day of the alleged incident. They stated that they were at the nursing desk completing their charting when PSW #128 (afternoon

shift) noted that resident #024 had an odor of incontinence. PSW #122 further stated that they would never neglect residents consciously, and had they been informed that resident #024 and #023 required care, they would have provided them with care. PSW #122 stated that they were new to the unit and were not familiar with the residents.

Inspector #627 interviewed RPN #126 who stated that they had noticed after lunch, that resident #022, #023, #024 and #025 were left in the dining room and in the television room. They had then asked PSW #101 and #122 to provide them with care. After their 1400 hour medication pass, they noted that the residents remained where they last were; resident #023 remained in the television room sleeping and resident #025 was in the dining room was visibly incontinent. RPN #126 had asked the oncoming afternoon PSW #128 to assist them and they had provided care to the four residents.

Inspector #627 interviewed the DOC who acknowledged that resident #024 should have been toileted at specific times, and resident #023 should have been checked and repositioned at specific times and that care was not provided to the residents as per the home's process and the resident's plan of care. [s. 6. (7)]

6. A Critical Incident (CI) report was submitted to the Director in January 2018, which alleged neglect of resident #018's specific skin condition. The CI report revealed that the resident developed altered skin integrity during the fall of 2017. Further, three months later, the altered skin integrity had progressed.

Inspector #577 conducted a record review of the wound care orders over a three month period, from the fall of 2017, to the winter of 2018. On a specific month in 2017, the treatment orders were initiated for an area of altered skin integrity, to be done three times a week. Three weeks later, the skin treatment orders were changed to twice weekly.

A review of resident #018's treatment record for the area of altered skin integrity revealed the following:

-a month in 2017, 9/13 or 69% of the dressing changes were completed;
-another month in 2017, 2/10 or 20% of the dressing changes were completed;
-a month in 2018, 1/10 or 10% of the dressing changes were completed; and
-another month in 2018, there was no treatment record.

A record review of the care plan in place over a three month period from the fall of 2017, to the winter of 2018, did not identify the area of altered skin integrity.

During an interview with RPN #149 they reported that every dressing change was documented on the treatment sheet and on the Wound Assessment Tool.

During an interview with RPN #152 they reported that resident #018 had wound dressing changes and staff would document on the treatment record.

In an interview with RPN #153 they reported that with every dressing change, a treatment sheet, a wound assessment tool and a progress note was completed with every dressing change.

Inspector #577 conducted an interview with the DOC, and together, reviewed resident #018's treatment records for their altered skin integrity to the specific area of their body. They confirmed that the area of altered skin integrity had not been assessed and treated as per the treatment orders. They further confirmed that the documentation and dressing changes were inconsistent. [s. 6. (7)]

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

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A Critical Incident (CI) report was submitted to the Director in January 2018, which alleged neglect of resident #018's skin condition. The CI report revealed that the resident developed altered skin integrity in the fall of 2017, and three months later, the altered skin integrity had progressed.

Inspector #577 conducted a record review of the physician orders for wound care over a three month period from the fall of 2017 to the winter of 2018. The treatment orders were initiated in a specific month in 2017, to be done PRN (as necessary). That same month, treatment orders were initiated for a different area of altered skin integrity. And specifically, dressing changes to the both areas were to be done three times a week. Three weeks later, treatment orders for both areas of altered skin integrity were changed to twice weekly.

A review of the home's policy titled "Skin and Wound Care Program" dated July

2016, indicated that after a dressing change, staff were to complete the Woundtracker documentation (Appendix F-Wound Assessment Tool). Weekly documentation included size-circumference and depth of the wound, discharge from the wound, appearance, progression, pain, nutrition, and equipment being used.

During a record review, the Inspector found a Wound Assessment Tool completed for one area of altered skin integrity for two out of 16 weeks or 12 % (per cent) of the time. Documentation on the Wound Assessment Tool for another area of altered skin integrity was completed 11 out of 16 weeks or 68 % of the time.

In an interview with RPN #154 they reported that following each dressing change, staff would initial the treatment record and document on the Wound Assessment Tool.

In an interview with RPN #155 they reported that a wound treatment record, Wound Assessment Tool and progress note were required with every dressing change.

During an interview with the DOC, they reported that staff were required to document weekly wound assessments on the Wound Assessment Tool. The Inspector and the DOC reviewed together the Wound Assessment Tools for both wounds and they confirmed that the documentation was not consistently completed. [s. 50. (2) (b) (iv)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that all hazardous substances at the home were kept inaccessible to residents at all times.

During the initial tour of the home, Inspector #679 observed that the door to the housekeeping closet on one of the home units was unlatched, which allowed the door to be opened. Inspector #679 opened the door to the housekeeping closet and observed one 4 liter (L) bottle of Virox concentrated surface cleaner and disinfectant general Virucide solution.

In a separate observation on a day in May 2018, Inspector #679 observed that the door was unlatched. The inspector observed that the closet contained a 4L bottle of Virox concentrated surface cleaner/disinfectant general Virucide solution, which had a corrosive Workplace Hazardous Materials Information System (WHMIS) symbol and a 1L bottle of Bestuff Cream Cleanser, which had a hazard and corrosive WHMIS symbol.

In separate interviews with Inspector #679, RPN #134 and RPN #132 both indicated that the door to the housekeeping closet was to remain closed.

A review of the policy entitled "Housekeeping Equipment and Supplies" date approved January 2017, identified that the housekeeping supply rooms, housekeeping utility rooms and housekeeping carts were to be locked at all times. A review of the Extendicare Policy entitled "Housekeeping Cart" last updated December 2017, identified that chemicals required on the cart were to be locked and inaccessible to residents.

In an interview with Clinical Manager #129, they indicated that the housekeeping closets were to be locked. They further indicated that all closets or doors that were not a resident room, with the exception of the entries were to be locked.

In an interview with the Environmental Service Supervisor #116 they indicated that all doors to the housekeeping closets were to be locked, and that a maintenance request had been sent to fix the door. [s. 91.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all hazardous substances at the home are kept inaccessible to residents at all times, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area or a medication cart, (i) that was used exclusively for drugs and drug-related supplies, (ii) that it was secured and locked and (iv) that complied with manufacturer's instructions for the storage of the drugs.

Inspector #679 and RN #118 observed the government stocked medication cabinet on a home unit. It was identified during the observation that the following medications were expired:

- Two bottles of Soflax expired December, 2017;

- 14 bottles of Soflax expired April, 2018;
- Three bottles of Diphenhydramine 25mg expired October, 2017;
- 23 bottles of Entrophen expired February 2018;
- Four bottles of Gravol liquid expired March, 2018;
- Three boxes of Glycerin Suppositories expired on March 2018; and,
- Four bottles of Mucillium expired December 2017.

In an interview with Inspector #679, RN #118 identified that it may have been the responsibility of the unit clerk, or the registered staff to check for expired medications. RN #118 identified that the expired stock should have been removed from the medication cupboard and disposed of.

In an interview with the DOC they identified that the Registered Nurses (RNs) were responsible for checking the government stock and the expiry dates as part of their monthly duties. The DOC identified that the expired medications should have been removed from the medication cabinet. [s. 129. (1) (a)]

2. The licensee has failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area, or stored in a separated locked area within the medication cart.

a) During an observation of the narcotic storage area on a home unit, RPN #117 identified to Inspector #679 that narcotic medications were kept in a locked drawer at the bottom of the medication cart, with the exception of one resident's Ativan which was kept in the medication room's refrigerator.

Inspector #679 observed RPN #117 unlock the refrigerator, and observed the vial containing Ativan in a basket on the refrigerator shelf. The refrigerator had one lock.

b) Inspector #679 observed the medication cart within the medication room on a home unit. RPN #117 identified to Inspector #679 that the narcotic medications were kept in a locked drawer at the bottom of the medication cart, which was locked by turning a knob on the side of the cart.

RPN #117 demonstrated to Inspector #679 that the medication cart was locked by turning a knob on the side of the medication cart. RPN #117 did not require a key to unlock the medication cart.

Inspector #679 reviewed the home's policy entitled "Narcotic and Controlled Drugs Control", date approved January 30, 2017, which identified that narcotics and controlled drugs are obtained, stored, recorded, counted, wasted and documented in compliance with the Controlled Drugs and Substances Act, the Narcotic Control Act, the Food Drug Regulations and the Benzodiazepine and Other Targeted Substances Regulations.

In an interview with Clinical Manager #143 they identified that controlled substances were to be double locked. Clinical Manager #143 indicated that the drawer to the controlled substances were locked and the medication cart was to be locked. Clinical Manager #143 identified that that the medication cart had a turning knob with a key hole, and that it should be locked/unlocked with a key. [s. 129. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are stored in an area or a medication cart that complies with manufacturer's instructions for the storage of the drugs, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that on every shift the symptoms were recorded and that immediate action was taken as required.

Resident #008 was identified as having had a specific infection from their previous to most recent minimal data assessment (MDS).

Inspector #627 reviewed resident #008's electronic progress notes which revealed a note dated in March 2018, documented by the Nurse Practitioner (NP), which indicated that the resident had experienced a specific exacerbation of a medical condition and was ordered four different medication treatments for their symptoms.

Inspector #627 reviewed the resident's electronic records, which included the vital sign assessment record and the progress notes and identified that the resident's vital signs had been taken once daily for six days in March 2018. Progress notes documenting the resident's health status were noted to have been completed daily for five days in March 2018.

The inspector interviewed RPN #135 who stated that resident #007 became ill in March 2018, and was ordered medication treatments at that time. The RPN stated that when a resident was ill, they were to be monitored at least on every shift; vital signs and a specific assessment should have been completed for every shift. Upon review of the resident's vital signs and progress notes, the RPN stated that it was only done once a day, mostly on the night shift, however, it should have been done every shift.

Inspector #627 interviewed the Infection and Prevention Control (IPAC) Facilitator who stated that when a resident was experiencing symptoms of infection, they were to be monitored on every shift until the symptoms subsided. The symptoms were to be documented in the electronic notes. The IPAC Facilitator substantiated that the resident's symptoms were not documented every shift in the electronic notes. [s. 229. (5) (b)]

2. Resident #001 was identified as experiencing a specific infection through their Minimum Data Set (MDS) assessment.

Inspector #679 reviewed the physician order sheet which identified that in January 2018, the resident was prescribed medication treatments for their symptoms.

Inspector #679 reviewed the electronic progress notes and identified a progress note from a specific date in January 2018, which indicated that resident #001 was placed on special precautions for their symptoms. Inspector #679 observed that on 24 shifts over 19 days, symptoms indicating the presence of infection were not documented within the e-notes.

In an interview with RPN #112 they identified that when a resident was experiencing a specific infection, symptoms were to be monitored every shift. RPN #112 identified that the symptoms would be documented within the electronic notes. Inspector #679 and RPN #112 reviewed the electronic progress notes, and identified that the resident's symptoms were not documented on each shift.

In an interview with the Infection Prevention and Control (IPAC) Facilitator they identified that when a resident was experiencing symptoms of infection their symptoms were to be monitored every shift until resolved. The IPAC Facilitator identified that the symptoms would be documented within the electronic notes, and that any resident experiencing new symptoms would be placed onto the "Daily 24-hour Symptom Surveillance Form". [s. 229. (5) (b)]

3. Resident #003 was identified as experiencing a specific infection through their Minimum Data Set (MDS) assessment.

Inspector #577 reviewed the physician order's dated March 2018, which identified that resident #003 was prescribed three medication treatments for their symptoms. An additional order that same month, indicated other and additional medication treatments as symptoms had not improved.

During a record review of the electronic progress notes, Inspector #577 found a progress note dated March 2018, which had identified resident #003 as having received medication treatments for their symptoms. A progress note dated April 2018, identified that the resident's health had improved and was not having any further symptoms. The Inspector further determined that over a three week period, symptoms were not monitored and recorded for 14/25 shifts or 56 per cent of the time.

During an interview with RN #156 they reported that an electronic note should be documented every shift until symptoms resolve.

In an interview with RN #151 they reported that the "Daily 24-hour Surveillance

Form" was initiated for the onset of symptoms and an electronic note was documented every shift until the symptoms resolved.

During an interview with the Infection Prevention and Control (IPAC) Facilitator, they identified that there was no record of the "Daily 24 - hour Symptom Surveillance Form" for this resident. They further reported that the surveillance form was utilized for residents exhibiting onset of symptoms. Any residents experiencing symptoms of infection, were to be monitored every shift and documented in the electronic notes, until the symptoms were resolved. [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 on every shift, the symptoms are recorded and that immediate action is taken as required, to be implemented voluntarily.

WN #7: 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 where the Act or the Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system that the policy was complied with.

According to O. Reg 114 (2)(3)a, the licensee is required to "ensure that written policies and protocols, are developed for the medication management system to ensure the accurate acquistion, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home. The written policies and protocols must be developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices".

A Critical Incident (CI) report was submitted to the Director for a missing or unaccounted for controlled substance. The CI report identified that in April 2018, RN #120 reported that they were missing a 2 milligram (mg) tablet of Dilaudid.

a) A further review of the CI report identified that in April 2018, at 0700 hours RN #120 reported that during their previous day shift in April 2018, at the 1900 hours shift count they were missing a 2 mg tablet of Dilaudid.

In an interview with Inspector #679, RN #120 identified that they noticed the medication was missing during their end of shift narcotic count. RN #120 identified they were unable to determine how the narcotic went missing. RN #120 identified that they completed the safety report the following date.

A review of the home's internal documentation regarding the CI report identified a written note which indicated that the "second issue" was that the incident was not reported until "this AM".

Inspector #679 reviewed the home's policy entitled "Narcotic and Controlled Drug Control (LTC): LTC-5-30", date approved February 2017, which identified that when a discrepancy was identified, the nurse was to complete two procedures immediately: the nurse reports any discrepancy to the charge RN/manager and the nurse initiates an investigation and completes the LTC Narcotic and Controlled Drugs Count-Discrepancy Report form for submission to the manager.

In an interview with RPN #142 they identified that when a controlled substance was

identified as missing, staff were to report to the RN, complete a search of the medication room, review the documentation and fill out a safety report immediately.

b) Inspector #679 reviewed a copy of the "Narcotic/Controlled Drug Inventory Record" for April 2018, on a particular unit, and observed that a nurse's signature was missing for the shift count on a day in April 2018, at 1900 hours.

In an interview with Inspector #679, RN #120 identified that the narcotic shift count was to be completed at the beginning of their shift, if they left the building during their shift and when they ended their shift. RN #120 identified that the pink narcotic count sheet was to be signed when the count was completed.

A review of the home's internal documentation regarding the CI report identified a written note which indicated that the "first issue" was that there was no signature on the incoming/outgoing section for the narcotic count.

Inspector #679 reviewed the home's policy entitled "Narcotic and Controlled Drug Control (LTC): LTC-5-30", date approved February 2017, which identified that all shift counts were to be completed by two registered staff. The policy further identified that the nurse was to document the narcotic count at shift change.

In an interview with Clinical Manager #143 they identified that the process when completing a narcotic count was for staff to perform the narcotic count and sign the narcotic sheets at the beginning and end of their shift. Clinical Manager #143 identified that when a controlled substance was noted missing, staff were to report to the RN and the manager, and that staff were to remain in the home until the medication was found. Clinical Manager #143 identified that RN #120 did not follow the home's policy related to the narcotic count and reporting procedure. [s. 8. (1) (a)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's policy to promote zero tolerance of abuse and neglect of residents was complied with.

A critical incident (CI) report was submitted to the Director alleging neglect of residents #022, #023, #024 and #025, in February 2018. The CI report indicated that three residents were left in the dining room in the same position with no care being provided for a three to four hour period and a fourth resident had not been repositioned for five hours since lunch.

Inspector #627 reviewed the home's policy titled "Zero Tolerance of Resident Abuse and Neglect Program", #LTC 5-50, last reviewed February 22, 2018, which indicated that in cases where allegations of abuse or neglect were made against an employee, management immediately advised the employee that they were being removed from the work schedule with pay pending investigation.

Inspector #627 was provided with documentation from Staff Coordinator #125 which indicated that PSW #122 had worked from 0700 to 1500 hours on that day in February 2018, and had been placed on a leave of absence for their next two following shifts. The documentation also indicated that PSW #101 had worked on that day in February 2018, and the following day, from 0700 to 2300 hours.

Inspector #627 reviewed the personal file of PSW #101 and noted a letter dated in February 2018, from Manager #123 indicating that the allegations of neglect brought forth on a day in February 2018, had been substantiated, this constituted neglect of residents under their care, and that they would receive disciplinary action.

Inspector #627 interviewed PSW #101 who stated that they had been scheduled for a double shift (days and evenings) on the day of the alleged incident which had occurred on the day shift. They further stated that they were approached the next day to discuss what had occurred and that they were sent home at that time. PSW #101 stated that when they had arrived home, they received a call telling them to come in the next day at 1300 hours, "and that was the end of it". There was no follow up; no one discussed with them why they were sent home. PSW #101 informed the Inspector that they had completed their shift on the day of the alleged incident after a discussion with RN #127.

Inspector #627 interviewed RPN #126 who stated that they had reported the alleged neglect to RN #127. They stated that PSW #122 had finished their shift and had left. RN #127 had spoken to PSW #101 and the PSW had returned to complete their shift.

Inspector #627 interviewed RN #127 who stated that they had been made aware of the allegations of neglect from PSW #126 and had reported it immediately to the on call Manager #124. They further stated that they had been directed by the on call Manager #124 to complete teaching with PSW #101 and they were to return to work. RN #127 stated that they were not sure why PSW #101 was not sent home and perhaps it was because they were scheduled to work a double shift.

Inspector #627 interviewed the DOC who stated that when allegations of abuse or neglect were made against a staff member, they were to be sent home immediately pending the results of the investigation. The DOC acknowledged that their process and policy was not followed, PSW #101 worked for the rest of the shift and the following shift after the incident, prior to receiving disciplinary action. [s. 20. (1)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (2) The licensee shall ensure that each resident receives assistance, if required, to insert dentures prior to meals and at any other time as requested by the resident or required by the resident's plan of care. O. Reg. 79/10, s. 34 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #007 received assistance, if required, to insert dentures prior to meals and at any time when requested by the resident or required by the resident's plan of care.

During a family interview, resident #007's family member stated that they often visited the resident and found them not to be wearing their dentures on multiple occasions.

On a specified day, at 1113 hours, Inspector #627 observed resident #007 in bed sleeping. Their top denture were soaking in a cup at the bedside. On the same day at 1249 hours, the resident was observed sitting in the dining room at the lunch meal service. They were not wearing their top dentures.

Inspector #627 reviewed the resident's care plan in effect at the time of the inspection and noted for the focus of dental that the resident wore upper dentures. Staff were to assist with oral hygiene by providing prompting and cuing. The top denture were to be soaked overnight.

Inspector interviewed PSW #146 who acknowledged that they had provided care to resident #007 on this day. They stated that the resident was to wear their dentures at every meal. The PSW did not reply when the Inspector inquired why they were not wearing their dentures during the lunch meal service.

Inspector #627 interviewed RPN #147 who indicated that the resident was to wear their top denture during the day as specified in her care plan. [s. 34. (2)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 232. Every licensee of a long-term care home shall ensure that the records of the residents of the home are kept at the home. O. Reg. 79/10, s. 232.

Findings/Faits saillants :

1. The licensee has failed to ensure that the records of the residents of the home were kept at the home.

Resident #003 was identified as experiencing a specific infection through their Minimum Data Set (MDS) assessment.

A record review had identified that the resident had specific symptoms in March 2018, and their symptoms had resolved in April 2018. During that three week period, the resident had been prescribed seven different medication treatments.

In an interview with RN #151 they reported that the "Daily 24-hour Surveillance Form" was initiated for the onset of symptoms.

During an interview with the Infection Prevention and Control (IPAC) Facilitator, they identified that the "Daily 24 - hour Symptom Surveillance Form" was utilized for residents exhibiting onset of symptoms. They further confirmed that there was no record of the "Daily 24 - hour Symptom Surveillance Form" for this resident as they kept those records for four weeks and then discarded them.

During an interview with the DOC, they confirmed that the "Daily 24 - hour Symptom Surveillance Forms" should not have been discarded. [s. 232.]

Issued on this 11 day of June 2018 (A1)

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

Ministère de la Santé et des Soins de longue durée

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

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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : Amended by DEBBIE WARPULA (577) - (A1)

Inspection No. / No de l'inspection : 2018_633577_0006 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 005841-18 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Jun 11, 2018;(A1)

Licensee / Titulaire de permis : St. Joseph's Care Group
35 North Algoma Street, P.O. Box 3251, THUNDER BAY, ON, P7B-5G7

LTC Home / Foyer de SLD : Hogarth Riverview Manor
300 Lillie Street, THUNDER BAY, ON, P7C-4Y7

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

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

To St. Joseph's Care Group, 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 :

O.Reg 79/10, s. 134. Every licensee of a long-term care home shall ensure that,

(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;

(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and

(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Order / Ordre :

The licensee must be in compliance with O. Reg. 134. Specifically the licensee must;

a) ensure that resident #003, #009, and #011 are being monitored to determine the response and effectiveness of their as needed medication

b) conduct routinely scheduled audits of residents' electronic medication administration records and "Follow-Up Notes" to ensure that staff are monitoring the effectiveness of as needed pain medication

Grounds / Motifs :

1. The licensee has failed to ensure that when a resident was taking any drug or combination of drugs, including psychotropic drugs, there was monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

During an interview with resident #011, they had reported to Inspector #577 that they experienced frequent pain to a specific area in their body.

A review of the physician orders indicated that the resident was prescribed PRN medication for pain.

Inspector #577 reviewed the electronic Medication Administration Record (eMar) over a five week period and found that the resident received PRN medication for pain on 23 occasions. A review of the "Follow-Up Notes" report identified that the response of effectiveness to the medication was documented on two occasions.

A review of the policy titled "Janzen's Pharmacy Administration of Medications-General Guidelines" last revised January 2017, identified that when PRN (as needed) medications were administered, residents were assessed to determine medication effectiveness and that the effects of the medication were to be documented in the resident's record.

In an interview with RPN #149 they reported that the documentation related to response to pain medication had been inconsistent and should be documented in an electronic note.

During an interview with Clinical Manager #129 they reported to the Inspector that staff were required to be documenting effectiveness or ineffectiveness of PRN pain medication within an hour on the eMAR.

During an interview with the DOC, Inspector #577 reviewed the "Follow-Up Notes" report. They confirmed that the follow up documentation was inconsistent and staff were required to document the effectiveness of prn pain medication on the eMAR within an hour. [s. 134. (a)] (577)

2. During an interview with resident #003, they had reported to Inspector #577 that they experienced pain to a specific area in their body.

A review of the physician orders indicated that the resident was prescribed two PRN pain medications.

Inspector #577 reviewed the electronic Medication Administration Record (eMar) for a two month period, and found that the resident received prn medication for pain on 12 occasions. A review of the "Follow-Up Notes" report identified that the response of effectiveness to the medication was documented on four occasions.

In an interview with RPN #150 they reported to the Inspector that resident #003 had complained of pain to a specific area in their body and was prescribed regularly scheduled pain medication and prn medication. They further reported that staff documented the response to pain medication on the eMAR within an hour.

During an interview with RN #151 they reported to the Inspector that a follow up note to a PRN medication should be documented on the eMAR or electronic note.

During an interview with the DOC, Inspector #577 reviewed the "Follow-Up Notes" report. They confirmed that the follow up documentation was inconsistent and staff were required to document the effectiveness of PRN pain medication on the eMAR within an hour. [s. 134. (a)] (577)

3. Resident #009 was identified as experiencing unrelieved pain through a resident interview.

In an interview with Inspector #679, resident #009 identified that they experienced a specific pain all over their body. Resident #009 identified that the pain was experienced "pretty well steady" and that the prescribed medication did not relieve the pain.

Inspector #679 reviewed the electronic Medication Administration Record (eMar) for a two week period. It was identified that the resident received their PRN medication on 13 occasions. A review of the "Follow-Up Notes" report identified that the

effectiveness of the medication was documented on two occasions.

In an interview with RPN #112 they identified that resident #009 complained of pain "a lot" and that they had pharmaceutical interventions, including PRN medication, which was effective for managing their pain. RPN #112 identified that when a PRN medication was administered, the follow up for the effectiveness would be documented in the electronic notes. Inspector #679 and RPN #112 reviewed the electronic "Follow-Up Notes" report, and identified that a follow up note was not completed on a number of occasions. RPN #112 identified that a follow up note was to be completed after the administration of any PRN medication.

In an interview with Inspector #679, the Director Of Care identified that all PRN analgesic medications were to be followed up to determine the effectiveness and documented as per the home's policy. Inspector #679 and the DOC reviewed the "Follow-Up Notes" report. The DOC indicated every PRN administration was supposed to have a re-evaluation to determine the effectiveness. [s. 134. (a)]

The decision to issue a Compliance Order (CO) was based on the home's ongoing non-compliance with this section of the legislation, the severity was minimal harm or potential for actual harm, the scope was widespread. The home has a history of non-compliance in this area of the legislation as follows:

-a Voluntary Plan of Correction (VPC) during the Critical Incident Inspection #2017_509617_0017
(679)

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

Jun 30, 2018(A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be in compliance with s. 6 (7) of the LTCHA. Specifically the licensee must;

a) conduct routinely scheduled audits of residents' plans of care to ensure they are providing care as specified in each residents' plans of care

b) ensure all residents' plans of care are followed specifically related to the physician's wound care orders

c) ensure resident #023's and #024's plans of care are followed specifically, but not limited to their continence care assistance and repositioning.

Grounds / Motifs :

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

A Critical Incident (CI) report was submitted to the Director in January 2018, which alleged neglect of resident #018's specific skin condition. The CI report revealed that the resident developed altered skin integrity during the fall of 2017. Further, three months later, the altered skin integrity had progressed.

Inspector #577 conducted a record review of the wound care orders over a three month period, from the fall of 2017, to the winter of 2018. On a specific month in 2017, the treatment orders were initiated for an area of altered skin integrity, to be done three times a week. Three weeks later, the skin treatment orders were changed

to twice weekly.

A review of resident #018's treatment record for the area of altered skin integrity revealed the following:

-a month in 2017, 9/13 or 69% of the dressing changes were completed;
-another month in 2017, 2/10 or 20% of the dressing changes were completed;
-a month in 2018, 1/10 or 10% of the dressing changes were completed; and
-another month in 2018, there was no treatment record.

A record review of the care plan in place over a three month period from the fall of 2017, to the winter of 2018, did not identify the area of altered skin integrity.

During an interview with RPN #149 they reported that every dressing change was documented on the treatment sheet and on the Wound Assessment Tool.

During an interview with RPN #152 they reported that resident #018 had wound dressing changes and staff would document on the treatment record.

In an interview with RPN #153 they reported that with every dressing change, a treatment sheet, a wound assessment tool and a progress note was completed with every dressing change.

Inspector #577 conducted an interview with the DOC, and together, reviewed resident #018's treatment records for their altered skin integrity to the specific area of their body. They confirmed that the area of altered skin integrity had not been assessed and treated as per the treatment orders. They further confirmed that the documentation and dressing changes were inconsistent. [s. 6. (7)] (577)

2. A Critical Incident (CI) report was submitted to the Director alleging staff to resident neglect. The report indicated that PSW #101 and #122 had not provided care to residents #022, #023, #024 and #025 for a period of four to five hours.

Inspector #627 reviewed the care plans in effect at the time of the incident for residents #023 and #024. For the focus of toileting, resident #024's care plan indicated that they needed specific assistance and were to be toileted at specific

times to ensure that they were clean and dry. Resident #023's care plan revealed for the focus of toileting that the resident had continence issues and needed assistance from staff members to be toileted. For the focus of skin, the care plan indicated that the resident was to be repositioned at certain times.

Inspector #627 reviewed the "Daily Check List of Duties-PSW Eight Hour Day", provided by the DOC which indicated that safety checks were to be completed hourly on every resident.

Inspector #627 interviewed PSW #122 who stated that they were assigned to resident #024 and #023 on the day of the alleged incident. They stated that they were at the nursing desk completing their charting when PSW #128 (afternoon shift) noted that resident #024 had an odor of incontinence. PSW #122 further stated that they would never neglect residents consciously, and had they been informed that resident #024 and #023 required care, they would have provided them with care. PSW #122 stated that they were new to the unit and were not familiar with the residents.

Inspector #627 interviewed RPN #126 who stated that they had noticed after lunch, that resident #022, #023, #024 and #025 were left in the dining room and in the television room. They had then asked PSW #101 and #122 to provide them with care. After their 1400 hour medication pass, they noted that the residents remained where they last were; resident #023 remained in the television room sleeping and resident #025 was in the dining room was visibly incontinent. RPN #126 had asked the oncoming afternoon PSW #128 to assist them and they had provided care to the four residents.

Inspector #627 interviewed the DOC who acknowledged that resident #024 should have been toileted at specific times, and resident #023 should have been checked and repositioned at specific times and that care was not provided to the residents as per the home's process and the resident's plan of care. [s. 6. (7)] (627)

3. A Critical Incident (CI) report was submitted to the Director which alleged staff to resident neglect. The report indicated that PSW #101 and #122 had not provided care to residents #022, #023, #024 and #025 for a period of four to five hours.

Inspector #627 reviewed resident #025's care plan in effect at the time of the incident which indicated for the focus of toileting, the resident was to be toileted at specific times. For the focus of locomotion on unit, the care plan indicated that the resident ambulated with a mobility aid and limited assistance from one staff member.

Inspector #627 reviewed the "Daily Check List of Duties-PSW Eight Hour Day", provided by the DOC which indicated that safety checks were to be completed hourly on every resident.

Inspector #627 interviewed PSW #101 who stated that they were only assigned to resident #025 during the shift where the allegations of neglect were brought forth. PSW #101 stated that they had a busy shift, and felt that resident #025 was able to toilet themselves, ambulate independently and that they looked fine sitting in the dining room. For this reason, they had focused on toileting the other residents who needed more assistance. PSW #101 acknowledged that resident #025 was not provided care as specified in their plan of care.

Inspector #627 interviewed RPN #126 who stated that they had noticed at 1400 hours, that the residents remained in the dining room and television room, and that PSW #101 and #122 were sitting at the desk reviewing the schedule. Although they had not worked frequently on this unit, they were aware that residents should be toileted after a meal. They had asked PSW #101 and #122 to provide residents #022, #023, #024 and #025 with the care required, however the PSWs had not and they had reported the incident to RN #127.

Inspector #627 interviewed the DOC who acknowledged the home's procedures had not been followed and that care had not been provided to resident #024 as indicated in their plan of care. [s. 6. (7)]

The decision to issue a Compliance Order (CO) was based on the home's ongoing non-compliance with this section of the legislation, the severity was actual harm/risk, the scope was a pattern affecting five residents. The home has a history of non-compliance in this area of the legislation as follows:

-a Written Notification (WN) during Compliant Inspection #2018_655679_0005,
-a Written Notification (WN) during Compliant Inspection #2018_657681_0002,
-a Voluntary Plan of Correction (VPC) during the Complaint Inspection #2017_509617_0020,

- a CO during the Follow Up Inspection #2017_616542_0002 issued on March 7, 2017, and complied on April 18, 2017,
- a CO with a Director's Referral (DR) during the Follow Up Inspection #2016_391603_0024 issued on November 25, 2016, and complied on February 27, 2017,
- a CO during the Follow Up Inspection #2016_333577_0010 issued on July 13, 2016, and complied on November 7, 2017,
- a Voluntary Plan of Correction (VPC) during the Follow Up Inspection #2016_246196_0006 issued on March 29, 2016,
- a VPC during the Complaint Inspection #2016_246196_0005 issued on March 17, 2016,
- a CO during the Complaint Inspection #2016_264609_0006 issued on March 7, 2016, and complied on July 6, 2016,
- a Written Notice (WN) during the Resident Quality Inspection #2015_333577_0012 issued on June 15, 2015, and
- a VPC during the Resident Quality Inspection #2014_246196_0016 issued on September 2, 2014. (627)

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

Jun 30, 2018(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
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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

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

Issued on this 11 day of June 2018 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by DEBBIE WARPULA - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Service Area Office / Bureau régional de services : Sudbury