Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 20, 2018	2018_624196_0030	025214-18, 025230-18, 026195-18, 026465-18, 026612-18, 028099-18, 028712-18, 029606-18, 030666-18	Complaint

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

LAUREN TENHUNEN (196), KATHERINE BARCA (625), MELISSA HAMILTON (693)

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): November 19 - 23, 2018.

The following intakes were inspected upon during this Complaint inspection:

- Two with an associated Critical Incident System (CIS) report regarding a fall with injury;
- Three regarding alleged incidents of staff to resident abuse and neglect, the provision of care, and medication incidents;
- One regarding an alleged medication incident;
- One regarding falls, and the provision of care; and
- Two regarding alleged staff to resident abuse and neglect, and the provision of care.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Clinical Managers (CMs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Occupational Therapist (OT), a Physician, Resident Assessment Instrument (RAI) Coordinators, Resident Home Workers (RHW), Staff Educator, Staffing Coordinator, complainants, substitute decision makers (SDMs), family members and residents.

The Inspectors also conducted daily tours of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, home's internal investigation notes and complaints, and reviewed numerous licensee policies, procedure and programs.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Skin and Wound Care

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

- **8 WN(s)**
- **6 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

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

Specifically failed to comply with the following:

s. 6. (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. (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).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care of the resident collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

A complaint was submitted to the Director regarding falls experienced by resident #002.

Inspector #625 reviewed a Critical Incident System (CIS) report submitted to the Director for a fall involving resident #002 that occurred in 2018. The report identified that the resident was found by staff and had sustained a significant injury.

The Inspector reviewed resident #002's health care record which included MED e-care progress notes. The notes identified that resident #002 fell on two separate dates in a month in 2018; both falls had occurred in a specific location, and had not been witnessed. A progress note dated on a particular date in 2018, identified that staff had assisted the resident with an activity of daily living and the resident was observed to have difficulty.

During interviews with resident #002's family member, they stated that they had spoken to CM #108, and requested an occupational therapy referral for an assistive aide. The family member stated that, if the home did not provide the assistive aide, they would have to go and purchase one for the resident to use as the resident had difficulty with a specific activity of daily living.

Inspector #625 reviewed a Referral Form for an occupational therapy assessment for resident #002 dated a specific date in 2018. The assessment was requested by CM #111 and the reason for the referral was to assess for the use of a particular assistive aide.

During an interview with CM #108, they stated that they recalled a discussion with resident #002's family member about obtaining an assistive aide for the resident. The CM stated that they had informed an RN to submit an occupational therapy referral for an assessment for an assistive aide but that the Occupational Therapist (OT) was busy with a workload seeing 500 people. When the Inspector identified that it had been greater than two months since resident #002's second fall, the CM indicated that the resident may have to wait for two or more months for an assessment, as the OT prioritized the assessments and maintained their own prioritized list, independent of the home.

During an interview with OT #112, they stated that they had received a referral on a later date for resident #002 for an assistive aide which indicated that the resident was having difficulty with an activity of daily living and may benefit from an assistive aide.The OT stated that staff had stopped them on the unit at one time and had asked if the OT could speak to the resident's substitute decision-maker [family member] about the assistive aide. The OT was not able to locate a referral for an assistive aide for resident #002 dated on a particular date in 2018, and stated that the OT referral process was electronic using an icon on the home's computers, and that sometimes staff didn't electronically submit the referral but would lock it or print it off and slide it under the OT's door. The OT stated that they suspected, for the referral dated on the earlier date, that staff had printed out a paper referral and they didn't know what would have become of the referral as

there had been times when staff had slid referrals under their door and a custodian had thrown it out. The OT stated that they received referrals for items such as adaptive utensils and, if the risk was not clear, or if the items was not noted as needed as soon as possible, they would not be prioritized. The OT further stated that sometimes they would not even see the resident for the referral, as they worked two days per week and received approximately 20 referrals per week plus required follow-up. The OT identified that they did the best they could with urgent referrals, but that if residents were waiting for equipment for activities of daily living, it was unfortunate. The OT indicted that, unless the referral identified that the resident was at risk for falls or that the referral was urgent, they would not know to prioritize it.

During an interview with CM #111, they stated that they had assisted one of the Clinical Managers to complete the OT referral dated on a specific date in 2018. CM #111 stated that they had generated the Referral Form on the computer, printed it off and gave it to the Clinical Manager to scan to the OT. CM #111 stated that they had been informed that a fall had occurred when they had completed the OT referral, but that they did not have a lot of information about the fall. The CM had stated that the OT referral must not have been scanned to the OT, if the OT had not received it. [s. 6. (4) (b)]

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

A complaint was submitted to the Director regarding allegations of abuse, neglect and improper care towards resident #007 which resulted in an injury.

In addition, a Critical Incident System (CIS) report had been received by the Director for alleged staff to resident neglect. The report indicated that resident #007 had sustained a injury on a date in 2018, and the family was not notified of the injury until four days after it had become evident.

During an interview with the complainant, they reported to Inspector #196 that they had not been made aware of the injury to resident #007 until four days after it had occurred.

A review of the home's policy "Extendicare; Management of Skin Tears" last updated February 2017, indicated "the Nurse will report skin tears to the Wound Care Lead/Champion, Physician/NP, and the family/SDM" and the nurse was to "Document in

the interdisciplinary progress notes: b) communication to POA/SDM/family"

A review of the MED e-care progress notes identified that the injury had been discovered on a date in 2018, and four days later, there was an entry which indicated the SDM had been notified.

During an interview with CM #104, they reported that the SDM had not been notified of the injury at the time of the discovery on a date in 2018, and acknowledged that they had been notified four days later.

During an interview, the Administrator reported that the SDM should have been notified as soon as possible after an injury and confirmed this was not done. [s. 6. (5)]

3. 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 complaint was received by the Director, on a date in 2018, related to the provision of personal care.

The CIS report was submitted to the Director by the home, which indicated that resident #001's SDM had submitted a complaint to CM #104 on a date in 2018. The report indicated that resident #001 had not been provided with personal care until after a specified time on two consecutive dates in 2018. The CIS also indicated that the SDM met with the Director of Care (DOC) three days later. The complainant brought forward their concerns; that resident #001 had not been provided with personal care prior to meal time and that a meal was not provided for five consecutive days in 2018.

Inspector #693 met with the SDM and another family member on a date during the inspection. The SDM showed the Inspector evidence that showed that during five consecutive dates, resident #001 was not provided with personal care until after a specified time, on each of these days. The SDM stated that on three of these days, resident #001 was not brought provided a meal as included in their plan of care.

A review of resident #001's care plan, that was current during the period of the five consecutive days in 2018, revealed that if resident #001 refused to go to the dining room for a specific meal, staff were to provide a particular intervention.

In an interview with PSW #101, they stated that if resident #001 refused to come to the

dining room for a specific meal, the assigned PSW would provide a particular intervention, as included in the plan of care.

A review of the home's investigation notes relating to this complaint and CIS indicated that they had concluded, through evidence, that resident #001 was not provided with a particular intervention on three consecutive dates in 2018.

A review of the home's policy "Extendicare; Care Planning and Assessments", last updated in April 2017, indicated that a care plan was a guide that directed care that was provided to the resident.

In an interview with CM #104, they confirmed that on three consecutive dates in 2018, resident #001 was not provided with a particular intervention and the care set out in the plan was not provided. [s. 6. (7)]

4. A complaint was submitted to the Director regarding allegations of abuse, neglect and improper care towards resident #007 which resulted in an injury.

a) During observations on a date during the inspection, resident #007 had a positioning device in place on a specific area, there was a pillow under another specific area, and there were no interventions in place on two other areas.

During observations on another date during the inspection, resident #007 had a positioning device in place on a specific area, the same pillow under another specific area, and interventions were in place on two other areas.

The current care plan indicated under the focus of "comfort" that a positioning device was to be placed on a specific area of the resident to provide comfort. A pillow under another specific area was to be provided for support. Under the focus of "dressing" there was an intervention to ensure a pillow was under another specific area, and to apply interventions to one area and then a positioning device appropriately.

During an interview, RPN #102, reported to the Inspector that the PSW had applied the positioning device; that the intervention was to be applied to two areas, and the positioning device on another area.

During an interview, PSW #101, reported that on a specific date during the inspection, they had applied the positioning device and interventions to both areas on resident #007.

On another date during the inspection, PSW #119, confirmed to the Inspector that a pillow was not positioned under a specific area of resident #007. The PSW located a pillow from another area under the resident's body and proceeded to place it under the area as indicated in the care plan.

During an interview with CM #104, they reported to the Inspector that the interventions to two areas and the application and removal of the positioning device had been assigned in the eMAR as a task for the RPNs. They further reported that the RPN was to apply these; however, if they had delegated the task to the PSWs that would be fine; the RPNs would need to ensure proper application.

The licensee had failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan; specifically, the interventions to two areas were not in place on the resident on one date during the inspection and the pillow was not positioned under a specific area, on two dates during the inspection.

b) A Critical Incident System (CIS) report had been received by the Director for alleged staff to resident neglect. The report indicated that resident #007 had sustained an injury on a specific date in 2018. The report also noted the positioning device was reported to be missing, and the family was not notified of the injury until four days after it had become evident.

The Point of Care flow sheets for a month in 2018, in which the PSWs were to document the application and removal of the positioning device, noted one application and removal of the positioning device on one date and did not identify the use of the device on the date of the injury.

During an interview, CM #104 reported to the Inspector that staff were expected to follow the care plan for care that was to be provided to the residents. They further reported that staff were to apply the positioning device and interventions on resident #007 as indicated in the care plan, and it was assumed this had not been done on the date of the injury.

The licensee had failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan, specifically that resident #007 had not had the positioning device applied on a date in 2018. [s. 6. (7)]

5. A complaint was received by the Director related to the provision of personal care on a

date in 2018. Additional complaints were received by the Director on two other dates the following month, in 2018, outlining multiple care issues, including an allegation that the plan of care had not been followed.

A review of resident #001's current care plan, indicated that resident #001 was at risk for falls and had interventions in place to prevent falls: The interventions included: the use of two different mobility devices, a falls prevention device, and the use of one of the mobility devices was not to be done unless supervised and the use of a falls prevention device in place.

During an interview with CM #104, the Inspector and the CM became aware of an incident in which resident #001 was unsupervised in a mobility device and the falls prevention device was not in place.

In an interview with PSW #103, they stated that they and another PSW had placed resident #001 in their mobility device and brought resident #001 to the common area for a particular reason. PSW #103 stated that a falls prevention device was not in place as resident #001 did not have or use a falls prevention device.

In an interview with CM #104, they stated that the staff had not provided care as set out in resident #001's most current plan of care as resident #001 was left unsupervised in their mobility device and a falls prevention device was not in place. [s. 6. (7)]

6. A complaint was submitted to the Director regarding falls experienced by resident #002.

Inspector #625 reviewed a CIS report, submitted to the Director for a fall involving resident #002 that occurred on a date in 2018, which identified that the resident had sustained a significant injury as a result of the fall.

The Inspector reviewed resident #002's health care record which included MED e-care progress notes which identified resident #002 fell on two dates in a month in 2018. The notes identified that both falls were unwitnessed by staff.

The Inspector reviewed the resident's current care plan, which identified the resident had a falls prevention device on their bed and on their specific type of chair, a similar falls prevention device beside their bed and on their mobility device. The care plan indicated that staff were to ensure that all fall prevention devices were on and functioning when in

use.

On a date during the inspection, the Inspector observed that the resident's falls prevention device on their mobility device was not clipped to their shirt, as was required.

During an interview with PSW #117, they confirmed that resident #002's falls prevention device was not clipped to their shirt, but should have been. The PSW stated that the staff who had provided care to the resident may not have applied it when the resident had been assisted with care.

During an interview with RN #118, they acknowledged that resident #002 required, and should have had attached to their clothing, a falls prevention device.

CO #001 was issued during inspection #2018_624196_0022 pursuant to LTCHA 2007, c.8, s.6.(7) with a compliance due date of December 19, 2018. As the compliance date was not yet due at the time of this inspection, this finding will be issued as a WN to further support the order. [s. 6. (7)]

7. The licensee has failed to ensure that the provision of care set out in the plan of care was documented.

A complaint was received by the Director related to the provision of personal care on a date in 2018. Additional complaints were received by the Director on two other dates the following month, in 2018, outlining multiple care issues, including an allegation that the plan of care had not been followed.

A review of resident #001's current care plan, indicated that staff were to report changes to regular bowel continence patterns and routines, identify any contributing factors; and that resident #001 was to be provided with continence assistance before meals and mid-afternoon and asked hourly if they need to use the toilet.

A review of resident #001's flowsheet from a two month time period in 2018, specifically the bowel monitoring record, indicated that on eight dates in one month and six dates the following month, the section relating to the number of bowel movements the resident had, was left blank.

In an interview with PSW #100 they stated that for resident #001, the PSWs were responsible for monitoring bowel function on each shift and reporting any abnormalities

to the RPN, for example, if the resident did not have a bowel movement. PSW #100 stated that the number of bowel movements was to be documented each shift, on each day, by the PSW, in Point of Care (POC).

In an interview with RPN #102, they stated that the PSW staff were responsible for charting the "number of bowel movements" resident #001 had; if there were any changes they should have been reported to the RPN. RPN #102 reviewed the same two months flowsheets for resident #001 and stated that there were several dates where this section was left blank; and so, the care was either not provided or the care that was provided was not documented as per the plan of care.

In an interview with CM #104, they stated that the PSWs should document on each shift if resident #001 had a bowel movement or not. Together with the Inspector, CM #104 reviewed the same two months flowsheets for resident #001; they stated that there were days where the "number of bowel movements" section was left blank. CM #104 confirmed that the care provided as set out in the plan was not documented for resident #001. [s. 6. (9) 1.]

8. A complaint was received by the Director related to the provision of personal care on a date in 2018. Additional complaints were received by the Director on two other dates the following month, in 2018, outlining multiple care issues, including an allegation that the plan of care had not been followed.

The CIS report indicated that resident #001's SDM had submitted a complaint to CM #104 on a date in 2018, indicating that resident #001 had not been provided with personal care until after a specified time on two consecutive dates in 2018. The CIS also indicated that the SDM met with the DOC three days later and brought forward their concerns; that resident #001 had not been provided with personal care prior to meal time and that a meal was not provided for five consecutive days in 2018.

In an interview with resident #001's SDM and another family member, they stated that resident #001 was not provided with personal care until after a specified time, on five consecutive days in 2018, and showed Inspector #693 evidence. The evidence also indicated that at a particular time on two consecutive days in 2018, a PSW was attempting to get resident #001 up and out of bed.

A review of resident #001's current care plan indicated that resident #001 was to be provided with continence care at specific times throughout the day, and asked hourly if

they needed to use the toilet; as well, resident #001 required a specific type of assistance with an activity of daily living.

In an interview with PSW #101 they stated that for resident #001, the PSWs were responsible for documenting all care that they provided in POC, this included Activities of Daily Living (ADLs) and personal care. They stated that they were to document in POC if the resident refused care.

A review of resident #001's flowsheet from the same five consecutive days in 2018, indicated that the section identified as "Toileted" was left blank on the day shifts of three of those days, and the section identified as "Number of Times Toileted" was left blank on the day shifts of four of those days.

A review of the home's investigation, indicated that on five consecutive days, PSW and Nursing staff entered resident #001's room multiple times between specified hours of the day.The evidence did not provide evidence that care was, or was not provided to resident #001.

In an interview with CM #104, they stated that it was their expectation that PSWs documented on each shift, all care that they had provided to residents as per the plan of care. Together with the Inspector, CM #104 reviewed the flowsheet from the five consecutive days. CM #104 verified that there was no charting of whether resident #001 was toileted on the day shift of four of those days and that the care provided was not documented as per the care set out in the plan. [s. 6. (9) 1.]

9. A complaint was received by the Director related to the provision of personal care on a date in 2018. Additional complaints were received by the Director on two other dates the following month, in 2018, outlining multiple care issues, including an allegation that the plan of care had not been followed.

The CIS report indicated that a meal had not been provided to resident #001 on five consecutive dates in 2018.

Inspector #693 met with the SDM and another family member on a date during the inspection. The SDM showed the Inspector evidence that showed that during five consecutive dates, resident #001 was not provided with personal care until after a specified time, on each of these days. The SDM stated that on three of these days, resident #001 was not brought provided a meal as included in their plan of care.

A review of resident #001's care plan, that was current during the period of the five consecutive days in 2018, revealed that if resident #001 refused to go to the dining room for a specific meal, staff were to provide a particular intervention.

In an interview with PSW #101, they stated that if resident #001 refused to come to the dining room for a specific meal, the assigned PSW would provide a particular intervention, as included in the plan of care. PSW #101 stated that the resident's meal consumption as well as the provision of the intervention would be documented on the meal consumption record and then documented in POC.

Inspector #693 reviewed the home's investigation notes; wherein, CM #104 interviewed staff and documented that PSW staff who worked days on three consecutive days indicated that resident #001 did not get a breakfast tray as they had refused.

A review of the dietary report for resident #001 for five consecutive days, indicated that resident #001 was documented as asleep for a meal on one date, no charting or documentation was completed for a meal for resident #001 on the following date, and resident #001 was documented as asleep for the same meal on the following date.

In an interview with CM #104, they stated that on three dates, resident #001 did not receive a meal intervention and that PSW staff should have accurately documented this on the flowsheet. CM #104 confirmed that the care provided for resident #001 was not documented as per the care set out in the plan.

CO #003 was issued during inspection #2018_624196_0024 pursuant to LTCHA 2007, c.8, s.6.(9)1 with a compliance due date of December 19, 2018. As the compliance date was not yet due at the time of this inspection, this finding will be issued as a WN to further support the order. [s. 6. (9) 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 that ensures staff and others involved in the different aspects of care of the resident collaborated with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complemented each other, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury. O. Reg. 79/10, s. 48 (1).
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. O. Reg. 79/10, s. 48 (1).
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. O. Reg. 79/10, s. 48 (1).
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a falls prevention and management program to reduce the incidence of falls and the risk of injury was developed and implemented in the home.

A complaint was submitted to the Director regarding falls experienced by resident #002.

Inspector #625 reviewed a CIS report submitted to the Director for a fall involving resident #002 that occurred on a date in 2018. The report identified that the resident was

found by staff who responded to the resident's calls for help. The report also identified that the resident had sustained a significant injury as a result of the fall.

Inspector #625 reviewed the home's policy titled, "Falls Management – LTC 3-60", approved March 21, 2018, which identified that, if a fall was unwitnessed, staff were to complete a Clinical Monitoring Record.

The Inspector also reviewed the Post-Fall Procedure Checklist that identified staff were to initiate a Clinical Monitoring Record, which, when completed, became a permanent resident record and was stored in the resident's chart under assessments.

The Inspector reviewed a Clinical Monitoring Record which identified that staff were to monitor the resident's neurological vital signs, vital signs, pain and changes in behaviour every hour for four hours, then every eight hours for 72 hours.

The Inspector reviewed resident #002's health care record which included:
- MED e-care progress notes which identified resident #002 fell on two dates in a month in 2018. The notes identified that both falls were unwitnessed by staff; and
- Clinical Monitoring Records for the falls on the same two dates in 2018.

The Inspector noted that the Clinical Monitoring Record, for the first fall, did not include documentation in entirety for the required areas.

The Inspector also noted that the Clinical Monitoring Record, for the second fall, did not include documentation in entirety for the required areas.

During an interview with RPN #106, they stated that resident #002 should have had Clinical Monitoring Records completed for the falls that occurred on both dates in 2018. The RPN was not able to locate a Clinical Monitoring Record for the first fall. The RPN identified that the Clinical Monitoring Record for the second fall had not been completed in its entirety.

During an interview with RN #107, they indicated that Clinical Monitoring Records should have been completed for the falls resident #002 had on the two dates in 2018. The RN was not able to locate a Clinical Monitoring Record for the first fall and acknowledged that the record for the second fall was incomplete. The RN identified that, in addition to having missing entries, the entries indicating the resident had been "sleeping" should not have been recorded as such, but should have been completed with the assessment

documented on the record.

During an interview with CM #108, they confirmed that Clinical Monitoring Records should have been completed for resident #002's falls on both dates in 2018. They indicated that the Clinical Monitoring Record for the second fall had not been completed in full, and they were unable to locate a Clinical Monitoring Record for the first fall. The Clinical Manager (CM) stated that staff were expected to wake residents up if monitoring for an injury, as per the Clinical Monitoring Record.

During an interview with CM #109, they stated that a Clinical Monitoring Record had been initiated for resident #002's second fall, but they could not locate a Clinical Monitoring Record for the first fall. They acknowledged that the Clinical Monitoring Record for the second fall was incomplete.

During an interview with the Staff Educator #110, they provided a Clinical Monitoring Record for the fall that resident #002 had on the first date in 2018. They stated that the document had been located [on the last day of the inspection] in a filing cabinet by a Ward Clerk. The Staff Educator acknowledged that the Clinical Monitoring Record had not been completed as required.

The home has failed to ensure that its falls prevention and management program, specifically completion of the Clinical Monitoring Record as directed, was implemented in the home. [s. 48. (1) 1.]

2. A complaint from resident #003's family member was forwarded to the Director regarding falls experienced by resident #003.

The Inspector reviewed resident #003's health care record which included:
- MED e-care progress notes which identified resident #003 fell on four dates in 2018. The notes identified the falls and the incidents; and
- Clinical Monitoring Records for the falls. The records for all of the falls had not been completed in their entirety.

The Inspector noted that the Clinical Monitoring Records for all of resident #003's falls did not include documentation in entirety for the required areas.

During interviews with CM #104, they acknowledged that the expectation was that the Clinical Monitoring Record was to be completed in its entirety. They reviewed the Clinical

Monitoring Records for the falls experienced by resident #003 and acknowledged that they had not been completed in their entirety, as required, and as detailed in the home's Falls Management policy.

The home has failed to ensure that its falls prevention and management program, specifically completion of the Clinical Monitoring Record, was implemented in the home. [s. 48. (1) 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 that ensures the falls prevention and management program to reduce the incidence of falls and the risk of injury is developed and implemented in the home, 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 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 complaint was submitted to the Director regarding an injury to resident #007, which had occurred on a specific date in 2018.

A review of the home's policy "Extendicare; Management of Skin Tears" last updated February 2017, indicated that the nurse was to complete an assessment, “a minimum of every seven (7) days until closed, including that dressing is intact and there are no signs of infection".

During an interview with the complainant, they reported to Inspector #196 that they were informed of the injury four days after it was first evident. In addition, they told the Inspector that after viewing the injury that was covered by a dressing on a specific date in 2018, a family member had brought forward to staff their concern about the area.

The MED e-care progress notes on a specific date in 2018, documented by RPN #115, outlined the family member’s concern about the injury area. The notes also included an initial progress note outlining the injury on a date in 2018; there were no further notes outlining an assessment of the injured area until approximately 11 days later.

The Wound assessment tool, for the injured area was initiated on a specific date in 2018, the next entry was approximately 11 days later, then again five days later and then noted as "healed" on the date of the last assessment.

During an interview with CM #104, they reported to the Inspector that staff were required to conduct a weekly skin/wound assessment of the impaired skin integrity area using the impaired skin integrity assessment tool in MED e-care. They further reported that the weekly assessment had not been completed as required after the injury was first identified. [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 that ensures 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. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

a) Complaints were received by the Director on two dates in 2018, that stated that medication errors had occurred in the medication administration process for resident #001.

The physician's orders for resident #001 included an order for a type of medication, ordered on a specific date in 2018, with directions for administration.

The flowsheets for resident #001, from a two month time period in 2018, identified on a specific record that the resident did not have a type of bodily function for:
- six days over a time period;
- six days over another time period;
- four days over another time period;
- four days over another time period;
- five days over another time period;

- four days over another time period; and
- eight days over another time period.

A review of resident #001's, Electronic Medication Administration Record (eMAR), for the same two month time period in 2018, identified that the resident was given the prescribed medication on five separate dates in 2018.

In an interview with RPN #102, they stated that there was a valid order for resident #001, to have been administered a prescribed medication. RPN #102 stated that it was the responsibility of the RPN who worked at night to have reviewed the specific records and to have administered the prescribed medication as ordered. They stated that if the prescribed medication was not given as prescribed it would be considered a medication incident.

Together with the Inspector, RPN #102 reviewed the flowsheets and the eMARs for resident #001, for a two month time period in 2018. There were seven occasions where resident #001 went four or more days without having had a bodily function and did not receive the prescribed medication as ordered by the prescriber. RPN #102 stated that as per the home's policy, these seven incidents would be considered a medication error.

A review of the home's policy titled, "Medication Administration: 5.5 Administration of Medications-General Guidelines" last updated September 2018, identified that the nurse administering medications was to review the MAR to ascertain that all necessary doses were administered and that all administered doses were documented. The policy also stated that the nurse administering was to administer following the eight rights of medication administration: right resident, right medication, right dose, right time, right route, right reason, right response and right documentation.

In an interview with Clinical Manager #104, Inspector #693 and CM #104 reviewed resident #001's specific records and eMARS for resident #001. CM #104 stated that it looked as though the prescribed medication was not given as ordered, but that to their knowledge, some of the times, the Substitute Decision Maker (SDM) had directed that the prescribed medication was not to be administered. CM#104 stated that if the prescribed medication was not given because of refusal, this should have been documented on the eMAR. A review of the eMAR for the two month time period in 2018, for resident #001 did not produce any documentation of refusals for the prescribed medication. CM #104 stated that the seven incidences where the prescribed medication was not administered would then be considered a medication incident as the medication

was not administered to resident #001 as ordered by the prescriber. [s. 131. (2)]

2. b) In an interview with resident #001's SDM and another family member, the SDM provided Inspector #693 with an electronic mail (email) letter they sent CM #104 on a date in 2018, indicating that on a specific date, the RPN gave resident #001 medication at a particular time and again at another time, on the same day. The SDM stated to the Inspector, that the order for the medication was at specific times.

A review of the physician's orders for resident #001, identified an order from a physician for a specific medication to be given at specific times.

A review of resident #001's eMAR, indicated that the medication was administered to resident #001 at one time and again approximately 2.5 hours later.

In an interview with RPN #102, they stated that there was a valid order from a prescriber for a specific medication to be given at specific times for resident #001. They stated that sometimes resident #001 refused their medications so the nurses administered the medications later in the day, when the SDM was present; in this case, the process was to stagger the doses or mark refused for the the first dose of the day. They stated that if the prescribed medication was given at a specific time and again at another time it would have been considered a medication incident.

Together with the Inspector, CM #104 reviewed resident #001's eMAR from a date in 2018, and stated that a medication error occurred when the prescribed medication was administered at the one time and again 2.25 hours later. CM #104 stated they had received an email from the SDM for resident #001 that outlined this incident. CM #104 confirmed that the prescribed medication was not administered to resident #001 in accordance with the directions for use specified by the prescriber on a date in 2018. [s. 131. (2)]

3. A complaint was submitted to the Director regarding falls experienced by resident #002. The complainant alleged that the home had failed to properly assess the resident's level of pain after the falls.

Inspector #625 reviewed resident #002's health care record which included:
- MED e-care progress notes which identified resident #002 fell on two dates in 2018;
- the electronic Medication Administration Record (eMAR) for a specific month in 2018, which identified that the resident was administered a prescribed medication as needed

on one date at a specific time and the following day at another time. The directions for use indicated the medication was to be taken when a condition was evident; and
- the most recent physician's order for the specific medication, as needed, listed on a Medication Reconciliation physician review dated in 2018, was consistent with the order on the eMAR.

The Inspector also reviewed a report titled Follow up List which listed the effectiveness of the as needed medications administered. The list identified that resident #002 had been administered the prescribed medication on a date in 2018 for a condition and again the following day for a similar condition.

During an interview with CM #109, they acknowledged the as needed prescribed medication, administered to resident #002 on two dates in 2018, for a condition, had not been administered in accordance with the prescriber's directions.

During an interview with Staff Educator #110, they acknowledged that they had reviewed resident #002's chart and determined that the as needed medication, administered on the two dates in 2018, for a condition, had not been administered in accordance with the prescriber's directions. [s. 131. (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 that ensures drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #5: 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.

A complaint was submitted to the Director regarding falls experienced by resident #002. The complainant alleged that the home had failed to properly assess the resident's level of pain after the falls.

The Inspector reviewed the home's, "Pain Management Toolkit Long-Term Care Bethammi Nursing Home", dated May 2016, which was identified as in place at the time of both falls. The toolkit identified that registered nursing staff were to implement strategies to effectively manage pain including pharmacological … interventions and were to document the effectiveness of the interventions in the eMAR with written follow up in the electronic notes (enotes).

Inspector #625 reviewed resident #002's health care record which included:
- MED e-care progress notes which identified resident #002 fell on two dates in 2018;
- the eMAR for the month in which the falls had occurred, which identified the resident had been administered a type of medication as needed six times that month.

The Inspector also reviewed a report titled Follow up List which listed the effectiveness of the as needed medications, administered. The list identified that resident #002 had been administered a type of medication which required follow up, which had not been completed. The list did not include an entry corresponding with the administration of the same type of medication on another date and time in 2018.

The Inspector further reviewed MED e-care progress notes and identified two notes which identified that scheduled medication had not been administered at a specific time and had been "held as PRN (pro re nata) given". The other note indicated that the medication had been administered for a particular reason and no follow up was required.

During an interview with Staff Educator #110, they reviewed resident #002's health care record and acknowledged that follow-up had not been documented on the effectiveness of the as needed medication that was administered to resident #002 on two different dates in 2018, in either the resident's eMAR or in the enotes, but that documentation of the effectiveness of the medication would have been required. [s. 134. (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 that ensures 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, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Complaints were received by the Director on two dates in 2018, that stated that medication errors had occurred in the medication administration process for resident #001.

A review of the home's policy titled, "Client Safety Incident Reporting and Management", last updated in January 2018, indicated that a safety report involving clients was to be completed by the most involved staff as soon as possible following an incident.

Inspector #693 obtained the medication incidents for resident #001 from CM #104 for three different months in 2018. There was no medication incident report for the administration of a medication that was given on a specific date, twice, within an approximate 2.75 hours time period. A review of the progress notes did not indicate that this incident occurred.

Together with the Inspector, CM #104 reviewed resident #001's eMAR from a particular date in 2018, and stated that a medication error occurred when the medication was administered at a specific time and again 2.25 hours later. CM #104 stated they had received an email from the SDM for resident #001 that outlined this incident and that they provided coaching to the identified RPN but, an incident report was not completed and there was no written documentation of this incident from the home. [s. 135. (1)]

2. Complaints were received by the Director on two dates in 2018, that stated that medication errors had occurred in the medication administration process for resident #001. Please refer to WN #4- a) for further details.

Inspector #693 obtained the medication incidents for resident #001 from CM #104 for three different in months 2018. There were no medication incident reports completed for resident #001 relating to the prescribed medication. A review of progress notes did not indicate that these incidents occurred or that the medication was refused.

In an interview with Inspector #693, CM #104 stated that the seven incidences where the medication was not administered would be considered a medication incident and that a medication incident report should have been completed and was not. [s. 135. (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 that ensures every medication incident involving a resident is documented together with a record of the immediate actions taken to assess and maintain the resident's health, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

A complaint was submitted to the Director regarding falls experienced by resident #002. The complainant stated that the resident had sustained a significant injury from a fall and had required a positioning device, which the staff had not known how to apply and had placed on the resident incorrectly.

Inspector #625 reviewed the manufacturer's instruction pamphlet for the specific positioning device, located in the resident's chart. The pamphlet instructed the user to place the positioning device in a certain way and included a diagram illustrating this.

Inspector #625 reviewed the home's, "Falls Management – LTC 3-60" policy, approved March 21, 2018, including Appendix 3 "Ways to Reduce Fall Risk – Tip Sheet for Staff", last updated February 2017. The tip sheet indicated that, to address resident transfer and mobility needs, staff were to always follow safe handling procedures (e.g. right devices/equipment, correct positioning and transfer techniques).

The Inspector reviewed resident #002's health care record which included MED e-care

progress notes that identified the resident required the use of a positioning device following a fall on a date in 2018, where they sustained a significant injury.

During an interview with PSW #114, they stated that they had worked shortly after resident #002 had the injury and had incorrectly applied the resident's positioning device on backwards. The PSW further stated that the resident's family member had identified the positioning device was on incorrectly, had notified the nursing staff and had discussed the issue with a Clinical Manager. The PSW identified that the "instruction manual" on how to apply the positioning device was provided to the staff after the device had been incorrectly positioned and that they had not been provided with instructions or training on how to apply the device prior to that time.

During an interview with RPN #106, they stated that resident #002's positioning had been applied backwards. The RPN stated that the home did not provide training to the staff on how to apply the device; initially there had been no direction as to who was to apply the device and that they were familiar with the application of the device from personal experience.

During an interview with CM #108, they acknowledged that staff had not applied resident #002's positioning device properly as it was put on backwards. [s. 23.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that, when a resident had fallen, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that

was specifically designed for falls.

A complaint from resident #003's family member was forwarded to the Director regarding falls experienced by resident #003.

Inspector #625 reviewed the home's "Falls Management – LTC 3-60" policy, approved March 21, 2018, which identified that staff were to complete a post fall assessment as soon as possible after a fall.

The Inspector reviewed resident #003's health care record which included:
- MED e-care progress notes which identified resident #003 fell on four dates in 2018;
- A hardcopy Post-Fall Assessment Tool dated on the first fall, which had not been completed in its entirety as it did not identify if the fall had been witnessed or not, how the fall may have been prevented and post fall huddle participants; and
- An electronic St. Joseph's Care Group (SJCG) Post Fall Assessment Tool.

The Inspector was not able to locate a hardcopy or an electronic post fall assessment for the fall that occurred on one of the dates in 2018, or the fall that occurred on another date in 2018, which had resulted in an injury to the resident.

During an interview with RPN #115, they reviewed resident #003's electronic chart and was not able to locate a post fall assessment for that falls that had occurred on two of the dates in 2018. The RPN stated that they believed that the assessments may have been completed in paper as they were not aware of the requirement to complete an electronic post fall assessment for residents.

During an interview with RN #116, they stated that the completion of a post fall assessment was required after every fall. The RN stated that the home had previously completed a hard copy post fall assessment tool but currently completed electronic post falls assessments. The RN reviewed the hard copy chart and was not able to locate a post fall assessment for resident #003 for the falls that occurred on two of the dates in 2018.

During an interview with CM #104, they stated that staff were required to complete a post fall assessment after each fall and that the home had completed hard copy post falls assessments until June or July of 2018, when the home switched to electronic post fall assessments. The CM was not able to locate a hard copy post fall assessment for the falls which occurred on two of the dates in 2018. The CM acknowledged that post falls

assessments should have been completed for resident #003's falls that occurred on both dates in 2018, but had not been completed. [s. 49. (2)]

2. A complaint was submitted to the Director regarding falls experienced by resident #002.

Inspector reviewed a CIS report submitted to the Director for a fall that occurred on a date in 2018. The report identified that the resident was found by staff who responded to the resident's calls for help. The report also identified that the resident had sustained a significant injury as a result of the fall.

The Inspector reviewed resident #002's health care record which included MED e-care progress notes which identified that resident #002 fell on two dates in 2018, and a SJCG Post Fall Assessment Tool for the resident's second fall in 2018. The Inspector was not able to locate a post fall assessment completed for the resident's first fall that occurred in 2018.

During an interview with RPN #106, they stated that resident #002 should have had a post fall assessment completed for the falls that occurred on both dates in 2018. The RPN was not able to locate a post fall assessment for the fall that occurred on the first date in 2018.

During an interview with RN #107, they stated that a post fall assessment should have been completed for a fall that occurred on the first date in 2018. The RN was not able to locate a post fall assessment and stated that one had not been completed for resident #002's fall.

During an interview with CM #108, they stated that a post fall assessment should have been completed, for resident #002's fall.

During an interview with CM #109, they stated that resident #002 should have had a post fall assessment completed for the first fall, but that one had not been completed. [s. 49. (2)]

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Issued on this 21st day of December, 2018

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

Original report signed by the inspector.