Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
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Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jun 17, 2020	2019_555506_0012 (A2)	014878-19, 014879-19, 014880-19, 014881-19, 014883-19, 014887-19, 014890-19	Follow up

Licensee/Titulaire de permis

Idlewyld Manor
449 Sanatorium Road HAMILTON ON L9C 2A7

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

Idlewyld Manor
449 Sanatorium Road HAMILTON ON L9C 2A7

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

Amended by STACEY GUTHRIE (750) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

See extension of Compliance Due Date for s.76 to October 31, 2020.

Issued on this 17th day of June, 2020 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Amended by STACEY GUTHRIE (750) - (A2)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): November 4, 5, 6, 7, 14, 15, 18, 19, 20, 21 and 22, 2019.

Follow-up inspection log #014878-19- related to plan of care

Follow-up inspection log #014879-19- related to abuse and neglect

Follow-up inspection log #014880-19- related to immediately investigating any alleged, witnessed or suspected abuse

Follow-up inspection log #014881-19- related to training and orientation

Follow-up inspection log #014883-19- related to policy and procedures

Follow-up inspection log #014887-19- related to medication administration

Follow-up inspection log #014890-19- related to skin and wound

This inspection was completed concurrently with critical incident inspection report #2019_555506_0011.

A Voluntary Plan of Correction related to LTCHA, 2007, c. 8, r. 229. (4) was identified in this inspection and has been issued in Inspection Report 2019_555506_0011, November 2019, which was conducted concurrently with this inspection.

A Written Notice and Compliance Order related to LTCHA, 2007, c.8, s. 19 (1) and s. 8 (1) (b), identified in a concurrent inspection #2019_555506_0011 (Log # 020036-19, CIS #2931-000029-19 and Log #013758-19, CIS #2931_000024-19 Log #014601-19, CIS #2931_000025-19) were issued in this report.

During the course of the inspection, the inspector(s) spoke with During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nurses (DON's), Special Projects Administrator, Nursing Administration Assistant, Manager of Recreation and Volunteer Services, Resident Assessment Instrument (RAI) Co-ordinator, Registered Dietitian (RD), Agency support staff, Agency registered nurses, registered practical nurses personal support workers (PSW), Food Service Manager (FSM), Assistant Food Service Manager, Corporate Staff, Manager of Resident Services, registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), residents and families.

During the course of the inspection, the inspector observed the provision of care and services, medication administration, reviewed clinical records, policies and procedures, investigative notes, reviewed licensee's compliance plans, reviewed training material content, documentation of training completed and conducted interviews.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Medication
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care
Training and Orientation

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

- **3 WN(s)**
- **0 VPC(s)**
- **3 CO(s)**
- **1 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
O.Reg 79/10 s. 131. (2)	CO #001	2019_661683_0009	129
LTCHA, 2007 S.O. 2007, c.8 s. 23. (1)	CO #003	2019_661683_0008	506
O.Reg 79/10 s. 50. (2)	CO #001	2019_661683_0007	130
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2019_661683_0008	130

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. 19. Duty to protect

Findings/Faits saillants :

The licensee failed to ensure that resident #001 was not neglected by the licensee or staff.

The Ontario Regulation 79/10, section 5 defined “neglect” as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and included inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

The licensee submitted a CIS report #2931-000029-19 on an identified date in October 2019, identifying an unexpected death of resident #001 on an identified date in October 2019. A review of the CIS that was submitted and a review of the licensee’s investigation notes and interviews conducted determined that resident #001 was neglected by staff in the home.

A review of progress notes and the licensee's investigation notes identified in October 2019, during three consecutive shifts, resident #001 started to have complaints of feeling unwell and requested specific interventions. In an interview with RN #109 and RN #104 on identified dates in November 2019, they confirmed that they did not complete any assessments when the resident complained of feeling unwell and confirmed they did not provide an intervention when the resident requested. Interviews were also completed with PSW #124, #125 and #126 who all confirmed in an interview on an identified date in November 2019, that resident #001 was expressing they were feeling unwell and wanted specific interventions and this was reported to RPN #104 on several occasions and RPN #104 did not come and assess the resident immediately or provide the resident with the specified interventions that were requested.
Interview with DON#101 and the Administrator confirmed on an identified date in November 2019, that the staff’s failure to provide the resident with treatment and the pattern of inaction of not assessing the resident symptoms met the definition of neglect. [s. 19.]

Additional Required Actions:

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

DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (1) Every licensee of a long-term care home shall ensure that all staff at the home have received training as required by this section. 2007, c. 8, s. 76. (1).

Findings/Faits saillants :

The licensee failed to ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training as required by this section.

A. In accordance with O. Reg. 79/10, s. 222 (2), "the licensee shall ensure that the persons described in clauses (1) (a) to (c) are provided with information about the items listed in paragraphs 1, 3, 4, 5, 7, 8 and 9 of subsection 76 (2) of the Act before providing their services".

While completing a follow-up inspection it was noted that the licensee failed to comply with compliance order #006 from inspection #2019_661683_008, served on July 16, 2019 with a compliance due date of October 31, 2019, specifically:

The licensee was ordered to be compliant with s. 76 of the LTCHA related to: Training provided to all staff who work in the home pursuant to a contract or agreement between the licensee and an employment agency or other third party, in the areas identified below under LTCHA s. 76 (2), before performing their responsibilities:
• The Residents' Bill of Rights
• The long-term care home's policy to promote zero tolerance of abuse and neglect of residents

- The duty under section 24 to make mandatory reports
- The protections afforded by section 26
- Fire prevention and safety
- Emergency and evacuation procedures
- Infection prevention and control

Administrative staff #110 provided a list of staff who worked pursuant to a contract with an employment agency between an identified date in October 2019 and the time of the request on an identified date in November 2019. They identified RPN #115 worked specific hours on an identified date in November 2019, as well as worked specific hours on another date in November 2019. It was also identified that RPN #132 worked from specific hours on an identified date in November 2019 and from specific hours on an identified date in November 2019.

During a discussion on an identified date on November 2019, between Inspector #506 and the Administrator, DON #101 and DON #102, they indicated that verification of training provided to agency staff was documented on an Orientation Checklist. At the time, they were asked to provide the Orientation Checklists to verify that agency RPN #115 and agency RPN #132 were provided with orientation before performing their responsibilities on the above noted dates. DON #101 stated that they were unable to provide the Orientation Checklists for the above noted staff because the "Agency" had not initiated the training protocol that was via email by the home, on an identified date in October 2019, and they verified that this training had not been provided to the above noted staff while in the home.

The Administrator, DON #101 and DON #102 confirmed that agency RPN #115 and agency RPN # 132 had not receive the required orientation prior to performing their responsibilities.

The above noted previously issued compliance order #006 was not complied with when the licensee failed to provide the required orientation to staff who work in the home pursuant to a contract with an employment agency or third party, before the above noted staff performed their responsibilities.

The licensee failed to ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the other areas as provided for in the regulations.

B. In accordance with O. Reg. 79/10, s. 221(1) 3, for the purposes of paragraph 6 of subsection 76 (7) the licensee is to ensure that all staff who provide direct care to residents receive training in relation to the Continence and Bowel Management Program.

While completing a follow up inspection it was identified that the licensee failed to comply with compliance order #006 from inspection #2019_661683_008, served on July 16, 2019 with a compliance due date of October 31, 2019, specifically:

The licensee was ordered to be compliant with s. 76 of the LTCHA related to:
All staff who provide direct care to residents are trained on:
• Abuse Recognition and Prevention
• Mental Health Issues, including care for persons with dementia
• Behaviour Management
• Any other areas provided for in the regulations, including: falls prevention and management, skin and wound management, continence care and bowel management and pain management.

On an identified date in November 2019, during a meeting with staff #121 (Lead for Training and Orientation), they indicated that the home had identified Personal Support Workers (PSW), Registered Practical Nurses (RPN) and Registered Nurses (RNS) as staff who provided direct care to residents and at this time training completion records were reviewed.
Staff #121 indicated that a course identified as "OANHSS Continence Care and Bowel Management - Registered Nurse" was required related to continence care and bowel management program training. Training completion records were reviewed and verified that all registered staff that were required to be trained based on the compliance date of the above noted compliance order, had received the training.
Staff #121 was asked what training was provided to staff who provide direct care to residents other than the registered staff, specifically PSW staff . They reviewed the training material available in Surge and were unable to provide course material or training records to verify that the 135 PSWs had received the training required in the area of the licensee's Continence and Bowel Management program.

The above noted previously issued compliance order #006 was not complied with when the licensee failed to provide training to 135 PSW staff related to the

licensee's continence care and bowel management program. [s. 76.]

Additional Required Actions:

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

(A2)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 002

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that where the Act or this Regulation required the licensee of long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

i. Ontario Regulation 79/10 s. 114 (2) states, "The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage,

administration, and destruction and disposal of all drugs used in the home."

Specifically, staff did not comply with the licensee's policy "Medication Administration and Documentation" policy number 4.1, (revised date August 15, 2018). Which stated all medication administration must be documented on the Electronic Medication Administration Record (EMAR) at the point of administration by the registered staff administering the medication and the health care staff must be logged in under their own user name.

During a review of CIS #2931-000029-19 that was submitted to the Director it was identified during the licensee's investigation of the incident that on an identified date in October 2019, that RPN #116 worked at the facility from an agency and the RPN did not have an individualized or confidential user name and password to the home's electronic documentation system. In an interview with RN #106 on an identified date in November 2019, confirmed that they gave the RPN their password so they could give medications as they felt there was no other option and that they did make DON #002 aware that they had given the RPN their password on that day. In an interview with DON #002 on an identified date in November 2019, they confirmed that the RN did report that they had given the agency RPN their password and confirmed that they did not provide any direction to the RN. DON #002 confirmed on an identified date in November 2019, that the policy for medication administration and documentation was not complied with as the staff who was administering medications did not have their own facility password. [s. 8. (1) (b)]

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

The licensee failed to ensure staff complied with the following policies:

i. The licensee's policy "Medication Incidents", identified as #4.12 with a revised date of August 15, 2019.
This policy identified that "failure to administer/take a medication within a predefined time frame from its administration time" was a medication administration incident.
This policy directed staff that "all medication incidents or near misses (Home or Pharmacy derived must be reported and documented on the Medication

Incident/Near Miss Report".

ii. The licensee's policy "Medication Administration and Documentation Overview", identified as #4.1 with a revised date of August 15, 2019.
This policy directed under the heading of "Documentation" that "any early or late administrations are supported with proper documentation in the progress notes and the actual time of administration is recorded".

iii. The licensee's policy "Medication Administration Pass", identified as #4.6 with a revised date of August 15, 2019.
This policy directed that "The failure to administer or take medications within the acceptable "window" of the scheduled administration time is considered a medication incident. If administering the medication late, initial the paper MAR and record the actual time of the administration on the MAR. The eMAR automatically records the time medication is provided.

While reviewing resident #017's and resident #016's Medication Administration Record (MAR) it was noted that several medication were documented as not having been administered within the predefined time frame from its administration time.

On an identified date in November 2019, DON #101 and RPN #138 verified that medications are to be administered an hour prior to the identified administration time and can be administered up to an hour following the identified administration time. At this time RPN #138 also confirmed that a medication administered outside of those time parameters would be considered a medication incident.

On the above noted date, DON #101 was made aware of what appeared to be a trend related to the late administration of medications and this was demonstrated by a review of residents MARs.

Resident #017's October 2019, MAR was reviewed and it was noted that medications were not consistently administered within the predefined time period. A random review of the clinical record for two dates in October 2019 indicated there was no documentation to support the late administration of this medication.

Resident #016's October 2019 MAR was reviewed and it was noted that medications were not consistently administered within the predefined time period. A random review of the four dates identified the medication was administered

between 18 minutes and 27 minutes beyond the predefined time period.

During a discussion with DON #101 on an identified date in November 2019, they verified that since the start of their position in March 2019, they have not received any medication incidents related to the late administration of medications.

Staff administering medications failed to comply with the licensee's policies #4.12, #4.4 and #4.6, when they did not to submit medication incident reports and did not document support for late administration of medications when those medications were administered at times that were not consistent with the predefined time frame from the time the medications were to be administered. [s. 8. (1) (b)]

3. The licensee failed to ensure that where the Act or this 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 was complied with in accordance with Ontario Regulation 79/10 s. 48 (1) (1), that required a long term care home to ensure that there was a falls prevention and management program to reduce the incidence of falls and the risk of injury.

The home's policy titled Fall Prevention and Management Program, section: RC-11-01-01, revised September 4, 2019, indicated: (2) All residents will be assessed for risk of falls on admission, quarterly, with a significant change in status and after each fall episode. Fall risk will be determined through assessment and discussions with the resident and/or Substitute Decision Maker (SDM) and the interprofessional team.

Resident #004 sustained falls on identified dates in July 2019, both of which resulted in a significant change in status. A review of the point click care (PCC) assessment history indicated that the resident was assessed for fall risk at the time of admission,which identified the resident as a moderate risk for falls. The resident was not reassessed for fall risk until sometime in September 2019, at which time the resident was identified as high risk.

RN #017 confirmed in an interview that the resident was not reassessed for fall risk after each fall July 2019, which resulted in significant changes in condition.

Please note: This evidence further supports compliance order (CO) #005, that was issued on July 16, 2019, related to the same section, of the O. Reg. 79/10, s. 8 (1) (b), with a compliance due date of October 4, 2019.

This non-compliance occurred prior to the compliance due date. [s. 8. (1) (b)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 003

Issued on this 17th day of June, 2020 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère 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 Operations Division
Long-Term Care Inspections Branch

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Inspection de soins de longue durée

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by STACEY GUTHRIE (750) - (A2)
Inspection No. / No de l'inspection :	2019_555506_0012 (A2)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	014878-19, 014879-19, 014880-19, 014881-19, 014883-19, 014887-19, 014890-19 (A2)
Type of Inspection / Genre d'inspection :	Follow up
Report Date(s) / Date(s) du Rapport :	Jun 17, 2020(A2)
Licensee / Titulaire de permis :	Idlewyld Manor 449 Sanatorium Road, HAMILTON, ON, L9C-2A7
LTC Home / Foyer de SLD :	Idlewyld Manor 449 Sanatorium Road, HAMILTON, ON, L9C-2A7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Susan Hastings

Ontario

Ministry of Long-Term Care

Ministère 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 Idlewyld Manor, you are hereby required to comply with the following order(s) by the date(s) set out below:

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 # / No d'ordre: 001

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

Linked to Existing Order / Lien vers ordre existant: 2019_661683_0008, CO #002;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Order / Ordre :

The licensee must be compliant with s. 19 (1) of the LTCHA.

Specifically, the licensee must:

1. Protect all residents from neglect.

2. Review with all registered staff the Ontario Regulation 79/10, section. 5 definition of neglect and what constitutes neglect. All records are to be maintained.

2. Provide mandatory education to all registered staff on the signs and symptoms of respiratory distress or abnormal breathing. All records are to be maintained.

3. Ensure the CPR/DNR directives and medical wishes are followed.

4. Complete and document all assessments in residents' clinical records.

Grounds / Motifs :

1. The licensee has failed to comply with the following compliance order CO #002 from inspection #2019_661683_0008 issued on July 16, 2019, with a compliance date of September 13, 2019. The licensee was ordered to be compliant with s. 19 (1) of Ontario Regulation 79/10. Specifically, the license was ordered to:

1. Protect resident #031 and all other residents from abuse by resident #041 or

any other resident.
2. Revise and implement policy #AM-02-01-08, titled "Zero Tolerance of Abuse and Neglect," dated July 24, 2017, to include:
i) procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected,
ii) procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents
3. Provide training/education to all direct care staff and management that includes the application and implementation of the revised policy. Attendance records and training content are to be maintained related to this training.

The licensee completed all steps in CO #002
The licensee failed to comply with s. 19 (1).

The licensee failed to ensure that resident #001 was not neglected by the licensee or staff.

The Ontario Regulation 79/10, section 5 defined “neglect” as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and included inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

The licensee submitted a CIS report #2931-000029-19 on an identified date in October 2019, identifying an unexpected death of resident #001 on an identified date in October 2019. A review of the CIS that was submitted and a review of the licensee’s investigation notes and interviews conducted determined that resident #001 was neglected by staff in the home.

A review of progress notes and the licensee's investigation notes identified in October 2019, during three consecutive shifts, resident #001 started to have complaints of feeling unwell and requested specific interventions. In an interview with RN #109 and RN #104 on identified dates in November 2019, they confirmed that they did not complete any assessments when the resident complained of feeling unwell and confirmed they did not provide an intervention when the resident requested. Interviews were also completed with PSW #124, #125 and #126 who all confirmed in an interview on an identified date in November 2019, that resident #001 was expressing they were feeling unwell and wanted specific interventions and this

was reported to RPN #104 on several occasions and RPN #104 did not come and assess the resident immediately or provide the resident with the specified interventions that were requested.
Interview with DON#101 and the Administrator confirmed on an identified date in November 2019, that the staff's failure to provide the resident with treatment and the pattern of inaction of not assessing the resident symptoms met the definition of neglect. [s. 19.]

The severity of this issue was determined to be a level 3 as there was actual harm to the resident. The scope of the issue was a level 1 as it related to one of three residents reviewed. The home had a level 5 compliance history as they had on-going non-compliance with this section of the LTCHA and four or more compliance orders that included:
- compliance order (CO) #002 served on July 16, 2019, (2019_661683_0008
- compliance order (CO) #001 served on September 11, 2018, (2018_743536_0006) (506)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 07, 2020

Ontario

Ministry of Long-Term Care

Ministère 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 # / No d'ordre: 002

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

Linked to Existing Order / Lien vers ordre existant: 2019_661683_0008, CO #006;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Order / Ordre :

The licensee must be compliant with s. 76 of the LTCHA.

Specifically, the licensee must:

1. Provide the required orientation to all staff who work in the home pursuant to a contract or agreement between the licensee and an employment agency or other third party, before performing their responsibilities. Records of the completion of this training are to be maintained in the home.
2.Provide training to Personal Support Workers related to the Continence and Bowel Management Program. Records of the completion of this training are to be maintained in the home.

Grounds / Motifs :

1. The licensee failed to ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training as required by this section.

A. In accordance with O. Reg. 79/10, s. 222 (2), "the licensee shall ensure that the persons described in clauses (1) (a) to (c) are provided with information about the items listed in paragraphs 1, 3, 4, 5, 7, 8 and 9 of subsection 76 (2) of the Act before providing their services".

While completing a follow-up inspection it was noted that the licensee failed to comply with compliance order #006 from inspection #2019_661683_008, served on July 16, 2019 with a compliance due date of October 31, 2019, specifically:

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

The licensee was ordered to be compliant with s. 76 of the LTCHA related to: Training provided to all staff who work in the home pursuant to a contract or agreement between the licensee and an employment agency or other third party, in the areas identified below under LTCHA s. 76 (2), before performing their responsibilities:

- The Residents' Bill of Rights
- The long-term care home's policy to promote zero tolerance of abuse and neglect of residents
- The duty under section 24 to make mandatory reports
- The protections afforded by section 26
- Fire prevention and safety
- Emergency and evacuation procedures
- Infection prevention and control

Administrative staff #110 provided a list of staff who worked pursuant to a contract with an employment agency between an identified date in October 2019 and the time of the request on an identified date in November 2019. They identified RPN #115 worked specific hours on an identified date in November 2019, as well as worked specific hours on another date in November 2019. It was also identified that RPN #132 worked from specific hours on an identified date in November 2019 and from specific hours on an identified date in November 2019.

During a discussion on an identified date on November 2019, between Inspector #506 and the Administrator, DON #101 and DON #102, they indicated that verification of training provided to agency staff was documented on an Orientation Checklist. At the time, they were asked to provide the Orientation Checklists to verify that agency RPN #115 and agency RPN #132 were provided with orientation before performing their responsibilities on the above noted dates. DON #101 stated that they were unable to provide the Orientation Checklists for the above noted staff because the "Agency" had not initiated the training protocol that was via email by the home, on an identified date in October 2019, and they verified that this training had not been provided to the above noted staff while in the home.

The Administrator, DON #101 and DON #102 confirmed that agency RPN #115 and agency RPN # 132 had not receive the required orientation prior to performing their responsibilities.

The above noted previously issued compliance order #006 was not complied with when the licensee failed to provide the required orientation to staff who work in the home pursuant to a contract with an employment agency or third party, before the above noted staff performed their responsibilities.

The licensee failed to ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the other areas as provided for in the regulations.

B. In accordance with O. Reg. 79/10, s. 221(1) 3, for the purposes of paragraph 6 of subsection 76 (7) the licensee is to ensure that all staff who provide direct care to residents receive training in relation to the Continence and Bowel Management Program.

While completing a follow up inspection it was identified that the licensee failed to comply with compliance order #006 from inspection #2019_661683_008, served on July 16, 2019 with a compliance due date of October 31, 2019, specifically:

The licensee was ordered to be compliant with s. 76 of the LTCHA related to:
All staff who provide direct care to residents are trained on:
• Abuse Recognition and Prevention
• Mental Health Issues, including care for persons with dementia
• Behaviour Management
• Any other areas provided for in the regulations, including: falls prevention and management, skin and wound management, continence care and bowel management and pain management.

On an identified date in November 2019, during a meeting with staff #121 (Lead for Training and Orientation), they indicated that the home had identified Personal Support Workers (PSW), Registered Practical Nurses (RPN) and Registered Nurses (RNS) as staff who provided direct care to residents and at this time training completion records were reviewed.
Staff #121 indicated that a course identified as "OANHSS Continence Care and Bowel Management - Registered Nurse" was required related to continence care and bowel management program training. Training completion records were reviewed and verified that all registered staff that were required to be trained based on the

compliance date of the above noted compliance order, had received the training. Staff #121 was asked what training was provided to staff who provide direct care to residents other than the registered staff, specifically PSW staff . They reviewed the training material available in Surge and were unable to provide course material or training records to verify that the 135 PSWs had received the training required in the area of the licensee's Continence and Bowel Management program.

The above noted previously issued compliance order #006 was not complied with when the licensee failed to provide training to 135 PSW staff related to the licensee's continence care and bowel management program. [s. 76.]

The severity of this issue was determined to be a level 2 as there was a minimal risk of harm. The scope of the issue was a level 3 as it related to all 135 Personal Support Workers and two of two agency staff. The home had a level 5 history as a CO is being re-issued related to the same subsection and four or more COs complied or not; same or different that included:
• Compliance Order (CO) served September 11, 2018 (2018_743536_0006) -closed with link
• Compliance Order (CO) served July 16, 2019 (2019_661683_0008)
• In additions the licensee had been served with 18 COs in the last 36 months. (506)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2020(A2)

Ontario

Ministry of Long-Term Care

Ministère 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 # / No d'ordre: 003

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

Linked to Existing Order / Lien vers ordre existant: 2019_661683_0008, CO #005;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 8 (1) (b) of Ontario Regulation 79/10.

Specifically, the licensee must:

1. To ensure that all employees and agency staff that are working at the home have an individualized or confidential user name and password to access the home's electronic documentation system and electronic Medication Administration Records as per the home's policy.

2. To ensure that all employees and agency staff do not share their individualized or confidential user name and password to access the home's electronic documentation system and electronic Medication Administration Records.

3. The licensee shall ensure all staff who administer medications to residents comply with directions related to the timing of medication administration included in the following licensee's policies: Medication Incidents #4.12 -with a revised date of August 15, 2019, Medication Administration and Documentation Overview #4.1 - with a revised date of August 15, 2019 and Medication Administration Pass #4.6 - with a revised date of August 15, 2019.

Grounds / Motifs :

1. The licensee has failed to comply with the following compliance order CO #005 from inspection #2019_661683_0008 issued on July 16, 2019, with a compliance date of October 4, 2019.

The licensee was ordered to be compliant with s. 8 (1) (b) of Ontario Regulation 79/10.
Specifically, the license was ordered to:
1. Complete and document Head Injury Routine (HIR) assessments for every unwitnessed fall as per the home's policies #RC-11-01-05 titled ³Post Fall Assessment and Management,´dated February 22, 2019, and #RC-10-01-07, titled ³Head Injury Routine,´dated February 23, 2019, for resident #003, #017 and all other residents requiring HIR assessments.
2. Complete and document fall risk assessments for resident #003 and all other residents as per the home's policy #RC-11-01-02, titled ³Falls Prevention and

Management Program: The Interdisciplinary Team Roles and Responsibilities," dated February 15, 2017.
3. Complete training for all registered staff regarding HIR and fall risk assessments including the frequency that the assessments are to be completed and what to do when residents are sleeping for the HIR assessments. The home is to maintain documentation of who completed the training, when the training was completed and the material covered in the training.
3. Ensure that a referral is sent to the RD when resident #005 or any other resident consumes 50 per cent or less of their meals in three or more days, as per the policy #RC-08-02, titled "Hydration Monitoring," last revised on January 25, 2017.
4. Develop and implement an audit, at a frequency and schedule as determined by the licensee, to ensure that HIR and fall risk assessments are completed as per the home's policies. Audit records and documentation are to be maintained by the home.
5. Develop and implement an audit, at a frequency and schedule as determined by the licensee, to ensure that a referral is sent to the RD when residents consume 50 per cent or less of their meals in three or more days. Audit records and documentation are to be maintained by the home.

The licensee completed all steps in CO #005.
The licensee failed to comply with s. 8 (1) (b).

The licensee failed to ensure that where the Act or this Regulation required the licensee of long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

i. Ontario Regulation 79/10 s. 114 (2) states, "The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home."

Specifically, staff did not comply with the licensee's policy "Medication Administration and Documentation" policy number 4.1, (revised date August 15, 2018). Which stated all medication administration must be documented on the Electronic Medication Administration Record (EMAR) at the point of administration by the registered staff administering the medication and the health care staff must be

logged in under their own user name.

During a review of CIS #2931-000029-19 that was submitted to the Director it was identified during the licensee's investigation of the incident that on an identified date in October 2019, that RPN #116 worked at the facility from an agency and the RPN did not have an individualized or confidential user name and password to the home's electronic documentation system. In an interview with RN #106 on an identified date in November 2019, confirmed that they gave the RPN their password so they could give medications as they felt there was no other option and that they did make DON #002 aware that they had given the RPN their password on that day. In an interview with DON #002 on an identified date in November 2019, they confirmed that the RN did report that they had given the agency RPN their password and confirmed that they did not provide any direction to the RN. DON #002 confirmed on an identified date in November 2019, that the policy for medication administration and documentation was not complied with as the staff who was administering medications did not have their own facility password. [s. 8. (1) (b)]

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

The licensee failed to ensure staff complied with the following policies:

i. The licensee's policy "Medication Incidents", identified as #4.12 with a revised date of August 15, 2019.
This policy identified that "failure to administer/take a medication within a predefined time frame from its administration time" was a medication administration incident.
This policy directed staff that "all medication incidents or near misses (Home or Pharmacy derived must be reported and documented on the Medication Incident/Near Miss Report".

ii. The licensee's policy "Medication Administration and Documentation Overview", identified as #4.1 with a revised date of August 15, 2019.
This policy directed under the heading of "Documentation" that "any early or late administrations are supported with proper documentation in the progress notes and the actual time of administration is recorded".

iii. The licensee's policy "Medication Administration Pass", identified as #4.6 with a revised date of August 15, 2019.
This policy directed that "The failure to administer or take medications within the acceptable "window" of the scheduled administration time is considered a medication incident. If administering the medication late, initial the paper MAR and record the actual time of the administration on the MAR. The eMAR automatically records the time medication is provided.

While reviewing resident #017's and resident #016's Medication Administration Record (MAR) it was noted that several medication were documented as not having been administered within the predefined time frame from its administration time.

On an identified date in November 2019, DON #101 and RPN #138 verified that medications are to be administered an hour prior to the identified administration time and can be administered up to an hour following the identified administration time. At this time RPN #138 also confirmed that a medication administered outside of those time parameters would be considered a medication incident.

On the above noted date, DON #101 was made aware of what appeared to be a trend related to the late administration of medications and this was demonstrated by a review of residents MARs.

Resident #017's October 2019, MAR was reviewed and it was noted that medications were not consistently administered within the predefined time period. A random review of the clinical record for two dates in October 2019 indicated there was no documentation to support the late administration of this medication.

Resident #016's October 2019 MAR was reviewed and it was noted that medications were not consistently administered within the predefined time period. A random review of the four dates identified the medication was administered between 18 minutes and 27 minutes beyond the predefined time period.

During a discussion with DON #101 on an identified date in November 2019, they verified that since the start of their position in March 2019, they have not received any medication incidents related to the late administration of medications.

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

Staff administering medications failed to comply with the licensee's policies #4.12, #4.4 and #4.6, when they did not to submit medication incident reports and did not document support for late administration of medications when those medications were administered at times that were not consistent with the predefined time frame from the time the medications were to be administered. [s. 8. (1) (b)]

The severity of the issue was determined to be a level 2 as there was minimal risk to residents. The scope of the issue was a level 2 as it related to three of eight policies reviewed. The home had a level 5 compliance history as they had on-going non-compliance with this section of the LTCHA and four or more CO's complied or not; same or different that included:
-compliance order (CO) #005 served on July 16, 2019 (2019_661683_0008
-compliance order (CO) #003 served on November 13, 2018 (2018_695156_0007
- voluntary plan of correction (VPC) issued April 12, 2019 (2017_57610a_0006)
(506)

2.

(129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 13, 2020(A1)

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

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 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:

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

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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 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

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

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

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

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

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère 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 17th day of June, 2020 (A2)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur :

Amended by STACEY GUTHRIE (750) - (A2)

Ontario

Ministry of Long-Term Care

Ministère 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

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Service Area Office / Bureau régional de services : Hamilton Service Area Office