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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

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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
Oct 26, 2018	2018_606563_0015	005400-18	Resident Quality Inspection

Licensee/Titulaire de permis

Sharon Farms & Enterprises Limited
108 Jensen Road LONDON ON N5V 5A4

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

Kensington Village
1340 Huron Street LONDON ON N5V 3R3

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

MELANIE NORTHEY (563), AMIE GIBBS-WARD (630), CASSANDRA ALEKSIC (689), DONNA TIERNEY (569)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 27 and 28, October 1, 2, 3, 4, 5, 9, 10, 11, 12 and 15, 2018

The following Critical Incident (CI) and Complaint intakes were completed as part of the Resident Quality Inspection:

Related to the Prevention of Abuse and Neglect:
Log #009080-18 / CI #2729-000011-18

Log #023925-18 / CI #2729-000019-18
Log #023321-18 / CI #2729-000018-18
Log #025233-17 / Complaint IL-51964-LO
Log #016500-17 / Complaint IL-51964-LO

Related to Falls Prevention:
Log #000675-18 / CI #2729-000001-18
Log #018134-17 / CI #2729-000002-17
Log #014528-18 / CI #2729-000014-18

Related to Plan of Care:
Log #010209-18 / Complaint IL-56992-LO

Related to Medication Management System:
Log #010393-18 / Complaint IL-57008-LO

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Resident Assessment Instrument Coordinator, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Behavioural Supports Ontario Personal Support Worker, the Nutrition Manager, a Dietary Aide, the Residents' Council president, the Family Council Representative, residents and family members.

The inspectors also observed resident rooms and common areas, observed medication storage areas, observed a medication administration, observed meal and snack service, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, reviewed policies and procedures of the home, reviewed various meeting minutes and written records of program evaluations.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

- **11 WN(s)**
- **7 VPC(s)**
- **3 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 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 the plan, policy, protocol, procedure, strategy or system was complied with.

The home's policy related to pain management was reviewed since the licensee failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The Sharon Village Care Homes (SVCH) Pain Management policy with index: PM-N-20 last revised January 2018 documented the use of appendixes and screening:
- "conduct the full pain assessment utilizing a clinically appropriate instrument (Appendix A: Pain Assessment Tool),
- "Evaluate policy effectiveness annually" and "may include trends in data on internal tools such as Appendix B: Pain Assessment Tool",
- "Appendix C: Pain Indicator List for the Cognitively Impaired",
- "Appendix D: Pain Monitoring Flow Sheet will be used to monitor pain and determine effectiveness of pain strategies over time",
- "Notify physician using SBAR Communication Tool (Appendix E) if pain is not resolved (< or = 4) within 72 hours",
- "The interdisciplinary team will screen for the presence of pain every shift using the appropriate tool considering factors such as age and level of cognition under the following circumstances: Admission and Readmission", and
- "If pain is identified, screening will be completed q4h x 3days as well as in the following circumstances: change in condition with the onset of pain, RAI-MDS Pains Score of 2 or more and following initiation or any changes in pain medication".

The Registered Practical Nurse (RPN) #113 stated they were the Pain and Palliative Team Lead for Kensington Village since December 2017. RPN #113 was asked if the Sharon Village Care Homes (SVCH) Pain Management policy with index: PM-N-20 last revised January 2018 was the updated pain policy used in the home and the RPN stated the pain policies as part of the current resources available in the pain and palliative binder included the SVCH Pain Management policy with index: PM-N-10 last revised September 2017, and the SVCH Pain Assessment and Symptom Management Implementation policy with index: PM-N-20 last revised September 2017 with a "PM-N-20 a Pain Management" chart. RPN #113 stated they did not know the difference between Appendix A and B for the same "Pain Assessment Tool'. The RPN stated they did use the Pain Indicator List for the Cognitively Impaired or a Pain Monitoring Flow Sheet to monitor pain. RPN #113 did not know what the SBAR Communication Tool was or what screening tool was used every four hours for three days if pain was identified. RPN #113 was asked what was meant by "The interdisciplinary team will screen for the presence of pain every shift using the appropriate tool considering factors such as age and level of cognition under the following circumstances: Admission and Readmission". The RPN stated it might be the "Pain Assessment" but did not know why factors such as age or cognition would be a factor when screening for the presence of pain in a resident. The RPN also verified that registered staff were not completing a pain assessment when the Resident Assessment Instrument – Minimum Data Set (RAI-MDS) Pain Scale score was "2" or more and stated that staff only initiate a pain assessment on re-admission and not on admission.

The Director of Care (DOC) #101 stated that the screening and tools documented as part of the SVCH Pain Management policy with index: PM-N-20 last revised January 2018 were not used by the Kensington Village registered staff. The DOC stated it was a corporate policy and the appendixes outlined in the policy were not used, but the "PAINAD – Pain Assessment in Advanced Dementia", the "PAINAD Item Definitions" and the "Pain Assessment" are the only three tools used by the home. The DOC also verified that screening was not being completed every four hours for three days when pain was identified on admission and re-admission or when the RAI-MDS pain Scale was greater than "2". The DOC also acknowledged that the January 2018 Pain Assessment policy PM-N-20 was the pain policy currently used by the home.

The licensee failed to ensure that SVCH Pain Management policy with index: PM-N-20 last revised January 2018 was complied with.

2. The licensee failed to ensure that the plan, policy, protocol, procedure, strategy or

system put in place was complied with.

The home's policy related to pain management was reviewed since the licensee has failed to ensure that controlled substances were administered to a resident in accordance with the directions for use specified by the prescriber for pain management.

The SmartMeds Pharmacy Narcotic and Controlled Drug Count & Ward Count Policy 6-6 documented that "when a narcotic medication is administered, the nurse must document the following information on the form: date, time, quantity administered, quantity remaining, and the nurse's initials." "Each Resident's Narcotic/Controlled Drug Count for accompanying the medication is individualized with the prescription label that contains the prescription number, resident's name, physician's name, medication, directions, strength, quantity dispensed and date dispensed."

The Director of Care (DOC) #101 and Inspector #563 reviewed the SmartMeds Pharmacy "Resident's Narcotic/Controlled Drug Count/Ward Count" for a resident:
- Of the 31 documented doses of a specific controlled substance administered during a specific time period, 51.6 per cent of the dates did not document a year and multiple dates were illegible. The DOC verified that the documentation was illegible and was not recorded with the full date.
- Of the 29 documented doses administered during a specific time, 20.7 per cent of the dates did not document a year and multiple dates were illegible. On two specific dates the quantity administered was not documented and on another date the count had blank documentation where there was no date, time, dose administered or a staff signature. The DOC verified that the documentation was illegible and the registered staff did not document the appropriate information when a controlled substance was administered.
- The May 2018 electronic Medication Administration (eMAR) in PCC documented that a specific medication was administered and the DOC verified that the administration was not documented as part of the "Resident's Narcotic/Controlled Drug Count/Ward Count" and the documentation was confusing. The count was missing the quantity dispensed and the date dispensed.
- The "Resident's Narcotic/Controlled Drug Count/Ward Count" was not individualized with the prescription number, physician's name, and medication directions. The DOC also stated that there was missing information required on all drug count sheets.
- The "Resident's Narcotic/Controlled Drug Count/Ward Count" was not individualized with the prescription number, physician's name, medication directions and strength. The eMAR documented that the medication was administered and DOC #101 verified that the count record did not document this dose.

The Director of Care (DOC) #101 and Inspector #563 reviewed the Narcotic Ward Drug Counts and for six separate shift counts there was a missing date. The DOC verified that the narcotic ward counts were not documented with the date during multiple shift counts. DOC #101 also stated that the monthly audit of the controlled substance count sheets were of the ward drug counts only and not the individual resident counts of controlled substances. The DOC stated that only discrepancies in the count of narcotics would be followed up on.

The SmartMeds Pharmacy Narcotic and Controlled Drug Count & Ward Count Policy 6-6 documented that "all narcotic and controlled medications must be accounted for at the end of each shift. Both the nurse handing over (Nurse 1) and taking over (Nurse 2) will sign with the date and time and the Narcotic Ward Drug Count sheet".

The Director of Care #101 stated it was the expectation that the registered nursing staff comply with the Narcotic and Controlled Drug Count & Ward Count Policy when a narcotic medication was administered, the nurse would document the date, time, and quantity administered and the documentation be legible. The DOC also verified that for all stock emergency controlled substance medications used for a resident, that the Narcotic and Controlled Drug Count & Ward Count include the prescription number, resident's name, physician's name, medication, directions, strength, quantity dispensed and date dispensed. The DOC stated that the expectation was for registered nursing staff to complete the Narcotic Ward Drug Count with the date documented at each shift count.

The licensee failed to ensure that the SmartMeds Pharmacy Narcotic and Controlled Drug Count & Ward Count Policy 6-6 was complied with. [s. 8. (1) (b)]

Additional Required Actions:

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

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

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep 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, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment; and a resident exhibiting altered skin integrity had been reassessed at least weekly by a member of the registered nursing staff.

A) During stage one of the Resident Quality Inspection (RQI) a resident was identified in a review of clinical documentation as having developed an area of altered skin integrity within the first 30 days of admission.

The Director of Care (DOC) #101 and Inspector #563 reviewed the skin assessments completed in Point Click Care (PCC) for a resident. The DOC stated that there should be progress note charting and an assessment completed in PCC when any resident has

developed an area of altered skin integrity. There were "KV Skin/Wound Assessment V 1.0" assessments completed in PCC for a resident. The DOC verified that there was no stage or measurements indicated as part of the assessments and this should be documented as part of this assessment and measured weekly. The assessments documented that the "Skin/Wound Area Unhealed (requires further assessment weekly until healed)". The assessments also identified multiple different areas of altered skin integrity where there were no assessments or weekly reassessments completed consistently. The DOC stated that the assessment documented "Skin/Wound Area Unhealed (requires further assessment weekly until healed)" and verified that the expectation was that weekly wound assessments were to be completed for all areas of altered skin integrity for a resident.

The Prevention, Management, Monitoring of Pressure Injuries policy index: SW-Q-30 last revised January 16, 2018 documented wound assessment guidelines where "a wound assessment is the first step in wound management." Any wound "is to have an initial wound assessment completed and then a weekly follow-up." The policy documented that the assessment will contain the following elements:
- Classification of the wound (staging of wounds),
- Anatomical location of the wound,
- Size of the wound including length, width and depth,
- Exudate amount, type and colour,
- Necrotic tissue colour, amount and type,
- Undermining and tunneling,
- Evidence of infection,
- Pain

Ongoing evaluation was documented as a wound treatment principle and if a wound has been noted as not healing "within 2-4 weeks" then "the treatment plan will be re-evaluated. Worsening wounds should be referred to the Wound Care Specialist."

The Registered Practical Nurse (RPN) #124 stated they were the Wound Care Lead for Kensington Village. RPN #124 shared that it was the role of the Wound Care Lead to coordinate that the registered staff were completing their skin assessments on time, and provide education on how to assess and manage wounds. The RPN stated that the process in place when a resident developed an area of altered skin integrity included assessment and measurement of the wound in PCC and a progress note would be completed depending on the wound protocol and type of wound. Then the registered staff were to complete a weekly skin assessment until healed. RPN #124 and Inspector #563 reviewed the Monthly Skin and Wound Management Tracking since there were

documented inconsistencies related to a resident's areas of altered skin integrity. RPN #124 stated the Wound Care Lead was responsible for maintaining the tracking sheet.

The Monthly Skin and Wound Management Tracking did not accurately document all areas of altered skin integrity for a resident. RPN #124 verified the tracking sheet documented incorrect healed wounds and did not document the skin areas and dates correctly. The RPN also stated that not all areas of altered skin integrity were reviewed monthly and should have been.

The Prevention, Management, Monitoring of Pressure Injuries policy index: SW-Q-30 last revised January 16, 2018 documented the role of the Registered Nurse Manager/Skin Wound Clinical Lead was to "assess the wound weekly depending on dressing change schedule, not greater than 7 days between assessments." The role of the Director of Resident Care/designate was to ensure "audits of skin and wound assessments will be conducted monthly to ensure documentation is completed appropriately."

The licensee failed to ensure that a resident exhibiting altered skin integrity received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment when the wound was initially observed and at least weekly by a member of the registered nursing staff.

B) During stage one of the Resident Quality Inspection (RQI), a resident was identified through a resident observations as having two areas of altered skin integrity.

The progress notes in Point Click Care (PCC) for the resident showed a referral to the registered dietitian (RD) for two areas of altered skin integrity. Another referral to the RD was shown in the progress notes for multiple areas of skin breakdown. The physician's progress note stated that the resident was seen and had an area of altered skin integrity.

The Orders in PCC showed physician's orders for treatments and dressings to be applied. The Treatment Administration Records (TARs) were reviewed and showed that weekly skin assessments were to be completed until healed.

The Assessments in PCC for the resident showed that a weekly skin/wound assessment was started which identified an area of altered skin integrity with no measurements indicated. Inspector #689 reviewed the weekly skin and wound assessments in PCC which showed that no skin assessments were identified for six different weeks. Inspector

#689 reviewed the Assessments and no weekly skin/wound assessment was completed on a specific date for the identified areas of altered skin integrity.

The Registered Practical Nurse (RPN) #124 stated that the resident had two area of altered skin integrity. The RPN stated that if a resident was identified as having altered skin integrity, the registered staff would assess the resident, document a progress note, and complete an initial skin and wound assessment in PCC. The RPN stated that ulcers, skin tears, bruises or dry skin were types of altered skin integrity that would require the registered staff to complete a clinically appropriate weekly skin and would assessment. RPN #124 reviewed Assessments in PCC and confirmed that an initial skin/wound assessment was documented for the two areas of altered skin integrity. RPN #124 reviewed the weekly skin/wound assessments for the resident and confirmed that no skin assessments were completed for the second area of altered skin integrity for several weeks. The RPN stated that if an area of skin breakdown was healed, then the skin and wound assessment should have been done to indicate it was healed.

The Director of Care (DOC) #101 stated that weekly skin and wound assessments should be completed in PCC for areas of altered skin integrity. The DOC reviewed the resident's records and confirmed that an initial skin and wound assessment should have been completed when the areas were first identified. The DOC reviewed the weekly skin/wound assessments for the resident and stated that the assessments were not completed and had omitted areas of altered skin integrity that were assessed initially.

The licensee failed to ensure that a resident who exhibited altered skin integrity received a skin assessment and was reassessed at least weekly. [s. 50. (2) (b)]

2. The licensee failed to ensure that the resident who was dependent on staff for repositioning been repositioned every two hours or more frequently as required depending on the resident's condition and tolerance of tissue load, and while asleep if clinically indicated.

The current care plan in Point Click Care (PCC) documented that a resident required physical assistance for bed mobility and repositioned every two hours while in bed. The transferring focus documented that the resident required total assistance with transfers using the sit-stand mechanical lift as able and to provide total assist with use of Hoyer lift from two staff with all transfers.

The "MONITOR- TURNING AND REPOSITIONING PROGRAM" task in PCC for the

resident documented that the task was scheduled for nights. DOC #101 verified that this does not match the resident's care needs since the resident was non-ambulatory and required physical assistance for bed mobility. The DOC stated the resident would require turning and repositioning on all shifts. The DOC verified that the Point of Care (POC) task for turning and repositioning was completed by the Personal Support Workers (PSWs) on evenings only and stated there was no prompt for the PSWs to turn and reposition the resident on days and nights.

The POC task "MONITOR- TURNING AND REPOSITIONING PROGRAM" for "Question 1 – Resident Repositioned Every 2 Hours?" was documented as "yes" between approximately 1555 and 2154 hours once per evening shift that the resident was turned and repositioned. DOC #101 explained the task should be documented at the end of the shift because the staff would not know at 1555 hours that the resident was turned and repositioned every two hours until 2200 hours. The DOC further stated that a staff member could go home sick half way through their shift and the task would appear completed for their replacement.

The POC task "MONITOR- SKIN CONDITION" was scheduled as needed (PRN). "Question 1- Skin Observation" documented "No Data Found" and "Question 2 – Is this a new or worsening skin condition?" documented "No Data Found". DOC #101 stated the expectation for PSWs include documenting the resident's skin status if there's a change and reporting it verbally to the registered staff. The DOC verified that the resident was identified as having multiple areas of skin impairment and there should have been a task for this resident where the PSWs would routinely check skin status since there was an identified alteration.

The "POC Response History" for "Monitor- Turning and Repositioning Program" documented "No" for "Resident Repositioned Every 2 Hours?" for the resident on five separate dates. The documentation for this assigned task to turn a reposition the resident every two hours per shift was not documented by the PSWs at the end of the shift as expected by the Director of Care.

The Resident Assessment Instrument Coordinator (RAI-C) #103 provided a copy of the "POC Response History" for "Monitor- Turning and Repositioning Program" related to the resident. The RAI-C verified that on five occasions staff documented "No" for "Resident Repositioned Every 2 Hours?" and that the resident should always be turned and repositioned "every 2 hours" as indicated in POC.

The Prevention, Management, Monitoring of Pressure Injuries policy index: SW-Q-30 last revised January 16, 2018 documented the role of the Personal Support Worker was to "reposition any resident who is dependent on staff for repositioning every 2 hours according to turning schedule and document on repositioning record in POC." The role of the Registered Practical Nurse /Registered Nurse was to "determine turning schedule for high/very high residents (Pressure Ulcer Risk Scale (PURS) 4 and greater) and residents with any alteration in skin integrity." The role of the Registered Nurse Manager/Skin Wound Clinical Lead was to "ensure the resident is on a turning and repositioning schedule, and ensure documentation for this is set up in POC."

The licensee failed to ensure that the resident was repositioned every two hours or more frequently as required. The resident had ongoing issues of altered skin integrity with a wound present and tissue offloading was required. [s. 50. (2) (d)]

Additional Required Actions:

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

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

The Medication Incident Report documented that a resident did not receive a medication at bedtime. The medication strip pack was found in the morning by the day nurse with the medication still packed from the previous evening.

The physician's order in Point Click Care documented that the resident was to receive a medication at bedtime.

The Director of Care (DOC) #101 verified that the medication incident involving the resident was an omission and therefore the medication was not administered in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

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

The Ministry of Health and Long Term Care (MOHLTC) Infoline - Complaint Information Report documented that a resident had not been given required pain medication for almost twenty-four hours before the resident's death.

The May 2018 electronic Medication Administration Record (eMAR) for the resident was reviewed by the Director of Care (DOC) #101 and Inspector #563. The resident had an order for a controlled substance and the DOC #101 verified that the medication should have been administered earlier if the dose had poor effect and there was an order for pain medication as needed (PRN) every two hours available for administration. The DOC stated that the pain medication every two hours was not administered to the resident in accordance with the directions for use as needed.

A Health Status progress note stated the resident required pain medication but that there was no PRN available to give. DOC #101 verified that injectable pain medication was available as part of the emergency nursing stat box the resident should have been administered this pain medication as ordered and was not.

A Health Status progress note documented the resident had displayed agitation. The DOC #101 verified that no pain medication was administrated and the resident could very well have been in pain. The DOC verified that the eMAR documented that pain medication was not administered for approximately 21 hours prior to the resident`s death. The medication was not administered subcutaneously as ordered for palliation to keep the resident comfortable.

The eMAR for the resident documented a medication order with a code of "10" = "Drug Not Available" on a specific date and time. DOC #101 verified that the medication was available as part of the emergency nursing stat box and the resident should have been administered this medication as ordered and was not.

A Medical Director (MD) progress note documented that the resident had taken a turn for

the worse and that the resident had not received pain medication throughout the day and then by the evening had deteriorated. The resident did not get any pain medication every two hours as needed for approximately 8 hours with a documented resident decline stated in the progress notes by the physician. DOC #101 verified that the resident should have received the pain medication on the day shift since the dose effectiveness was documented as unknown and nothing was given until the evening shift. The DOC stated that the staff did not know whether the pain medication was effective and should have administered the pain medication as ordered. The DOC also stated that the resident was deemed palliative and was to remain comfortable.

The Palliative & End of Life Care Processes policy index: EOL-M-20 stated, "Quality and timely symptom management is one of the keys to excellence in palliative care while moving towards the end of life stage."

The Registered Practical Nurse (RPN) #118 stated that the home has a stat box for PRN pain medications that were required for administration but have not arrived yet from pharmacy. The RPN verified that the pain medication was available in the emergency stat box for administration. Inspector #563 and RPN #118 reviewed the progress note where resident required pain medication but that there was no PRN available to give and the RPN acknowledged that this was their note and that the resident should have received the medication as ordered for pain management to remain comfortable.

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

Additional Required Actions:

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

WN #4: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident; the goals the care was intended to achieve; and clear directions to staff and others who provided direct care to the resident.

During stage one of the Resident Quality Inspection (RQI), a resident was observed with a Personal Assistance Services Device (PASD) in use.

The progress notes in point Click Care (PCC) did not document the use of the PASD. The current care plan in PCC did not document interventions related to the use of the PASD.

The Personal Support Worker (PSW) #115 stated the resident had an areas of altered skin integrity and that the resident used a PASD. The PSW stated that the resident could communicate their needs and would ask the PSW staff to engage the PASD.

The Director of Care (DOC) #101 verified that the resident used a PASD. The DOC acknowledged that interventions related to the use of the PASD was not added to the

current care plan for the resident and the plan of care should have been updated to include the PASD when it was put in use. The DOC also stated that the PASD was not new and the resident did not have freedom of movement and required two staff physical assistance for all transfers and bed mobility.

The PSW #119 shared that the resident required assistance for bed mobility and the resident was not able to move in bed or the wheelchair without help. The PSW also stated that the resident would tell the staff that they needed the PASD engaged.

The Sharon Village Care Homes Resident Plan of Care policy with index: NAM-C-15 last revised September 2017 documented that the "Resident Plan of Care must be individualized, provide clear guidance and direction to all care providers in the provision of care and services." The initial plan of care must include PASDs.

During a telephone conversation, DOC #101 stated that the resident's name was just added to the Restraint/ Personal Assistance Services Device (PASD) tracker list and there was no documentation as to when the PASD was put in place for the resident. The DOC also verified there was no written plan of care for the resident that set out the planned care related to the PASD and there were no interventions or clear direction to staff and others who adjust the PASD as needed for the resident.

The licensee failed to ensure that there was a written plan of care for the resident that set out the planned care for the resident related to the use of a PASD. [s. 6. (1)]

2. 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 resident was observed with a PASD engaged and appropriately applied.

A Family Communication progress note in Point Click Care (PCC) stated there was a conversation with the residents Power of Attorney (POA) related to the use of the PASD and it was not to be used as there was no Personal Assistance Services Device (PASD)/Restraint consent in place.

The RPN #128 stated they had observed the resident attempting to remove the PASD in place. The RPN reviewed the resident's plan of care and stated that there was no intervention in place directing staff to apply the PASD when the resident was up in their chair. Registered Nurse #115 arrived on the unit and assisted RPN #128 in looking for

the PASD in PCC and verified the PASD was not a part of the plan of care for the resident. RN #115 verified that there was only consent for the use of the one PASD by the POA, but that the other PASD would be a part of the plan of care in Point of Care (POC) and this task would trigger the PSW staff to apply it and document. RPN #128 verified there was no task for PASD application in POC and stated the only task was for the one PASD in use.

The Registered Practical Nurse (RPN) #113 stated that the resident was not supposed to use the PASD because there was no consent in the chart for its use. The RPN stated that they would come on shift for evenings and would notice the PASD in place, remove it and remind staff not to use the PASD. The RPN verified that there was consent in place for the use of the one PASD in use. RPN #113 acknowledged that the use of the PASD was not set out in the plan of care, but was provided to the resident.

The current care plan in Point Click Care documented a focus related to the use of one PASD, and not the other that was applied in error.

The licensee has failed to ensure that the care set out in the plan of care related to the use of PASDs was provided to the resident as specified in the plan. There was only one PASD to be used for the resident and staff were applying both, which was not a part of the planned care. [s. 6. (7)]

3. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

During stage one of the Resident Quality Inspection (RQI), a resident was observed with a pressure relieving surface in use.

The progress notes documented that the pressure relieving surface was in use since the first day of admission and there were concerns by family that the device was not being monitored to ensure proper air flow and/or leaks which may impact the resident`s comfort.

The "Task History" in PCC related to the use of the therapeutic surface documented that the task was added to the plan of care one month after the device and monitoring were put in place.

The Director of Care (DOC) #101 verified that the resident had used this surface since admission and it was not added to the plan of care for monitoring until a month later.

The Sharon Village Care Homes Resident Plan of Care policy with index: NAM-C-15 last revised September 2017 documented that the resident plan of care would be revised when the resident's care needs change.

The licensee has failed to ensure that the resident`s plan of care was reviewed and revised when the resident's care needs changed. The surface was documented as deflating and a family member of the resident reported that the staff did not know these surfaces were to be checked regularly for proper air flow and/or air leaks. The plan of care was updated to include the use of the surface one month later. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written plan of care for each resident that set out the planned care for the resident; the goals the care is intended to achieve; and clear directions to staff and others who provide direct care to the resident; to ensure that the care set out in the plan of care is provided to the resident as specified in the plan; and to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee has failed to keep a written record relating to each evaluation under paragraph 3 that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

Section 30(1) 3 of the Ontario Regulation 79/10 states, "The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices."

The Skin and Wound Care Management Program Evaluation was dated January 17, 2018 for the documented time frame from January 1, 2017 to December 31, 2017. The review was completed by Registered Practical Nurse (RPN) #124 and former Director of Care (DOC) #131. The "Summary of changes made over the past year with dates of change" included the following:

- "Updated policies and procedures (SVCH) reviewed",
- "Updated protocol spring/summer",
- "re-started monthly meetings", and
- "increase education opportunities".

There were no documented dates that those changes were implemented.

The RPN #124 stated they were the Wound Care Lead for Kensington Village. RPN #124 shared that every month they would meet with the DOC and review how the wounds were healing and any new wounds were present or if there were any concerns or Wound Care Specialist referrals. RPN #124 also stated that they attended and participated in the annual review of the skin and wound care program with former DOC #131. RPN #124 verified that the updated policies were added to the skin and wound binder for staff to refer to and the resources for staff were there. The RPN did not remember when that was implemented and verified there was no date documented as part of the evaluation. The RPN also stated there were no changes to the policies and procedures related to skin and wound care. When asked what "updated protocol spring/summer" meant as part of the skin and wound care management program evaluation, RPN #124 stated they did not know and again verified there was no documented date of implementation. The RPN could not state when the monthly meetings were re-started and verified the date was absent from the evaluation for this change. RPN #124 clarified that the increased education opportunities were for them and stated they went to education sessions related to skin and wound management in April 2017.

The licensee has failed to keep a written record relating to the skin and wound care evaluation that included a summary of the changes made and the date that those changes were implemented.

2. The Pain Management Program Evaluation was dated January 19, 2018 for the documented time frame from January 1, 2017 to December 31, 2017. The review was completed by Registered Practical Nurse (RPN) #113 and former Director of Care (DOC) #131. The "Summary of changes made over the past year with dates of change" included "change of champion" and "updated policy and procedures". There were no documented dates that those changes were implemented.

On October 12, 2018, RPN #113 stated they were the Pain and Palliative Team Lead for Kensington Village since December 2017. RPN #113 shared the former Director of Care (DOC) #131 and RPN #113 created a pain and palliative binder to organize the pain

assessments. RPN #113 stated they would review the pain assessments and progress notes in the binder and add the information to the tracker. RPN #113 stated that the binder has the updated policies. The RPN also shared that they were a part of the annual evaluation of 2017 that took place on January 19, 2018 and verified that there were no dates documented as part of the summary of changes for 2017. RPN #113 was asked if the Sharon Village Care Homes (SVCH) Pain Management policy with index: PM-N-20 last revised January 2018 was the updated pain policy as indicated in the pain program evaluation and the RPN stated the pain policies as part of the current resources available in the pain in palliative binder included:
- SVCH Pain Management policy with index: PM-N-10 last revised September 2017, and
- SVCH Pain Assessment and Symptom Management Implementation policy with index: PM-N-20 last revised September 2017 with a "PM-N-20 a Pain Management" chart.
RPN #113 acknowledged that they were unfamiliar with the Pain Management policy with index: PM-N-20 last revised January 2018, and was using outdated policies as part of the program. The RPN verified that the "summary of changes made over the past year with dates of change" that included "updated policy and procedures" was not shared with the Pain and Palliative Team Lead.

The licensee has failed to keep a written record relating to the pain management evaluation that included a summary of the changes made and the date that those changes were implemented. The Pain Management policy with index: PM-N-20 was last revised January 2018 but was not implemented as part of the resources available to the Pain and Palliative Team Lead. [s. 30. (1) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to keep a written record relating to each evaluation under paragraph 3 that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home received oral care to maintain the integrity of the oral tissue that included an offer of an annual dental assessment and other preventative dental services.

During stage one of the Resident Quality Inspection (RQI), two residents were identified as having oral/dental problems from the most recent full Minimum Data Set (MDS) assessment, and a third resident was identified as having no oral hygiene assist from a resident interview, and the Ministry of Health and Long-Term Care (MOHLTC) received a complaint regarding oral care not being provided for a fourth resident.

The Resident Assessment Instrument Coordinator (RAI-C) #103 provided Inspector #689 the "Kensington Consent Form, Samaritan Senior Dental Service, Dental Assessment and Oral Wellness Program" documents for three residents. There was no document provided to Inspector #689 for the fourth resident. RAI-C #103 stated that the consent forms were completed by the resident or their Power of Attorney (POA) upon admission to the home. The RAI-C said that the consent forms were not re-distributed each year to the resident. When asked by Inspector #563 what the home would do if a resident had dental concerns after admission, the RAI-C said that the resident would be assessed and a referral for dental services would be completed.

The consent form titled "Kensington Consent Form, Samaritan Senior Dental Service, Dental Assessment and Oral Wellness Program" indicated the resident's preference to consent, or not to consent, in the participation in the "Dental Assessment and Oral

Wellness Program" in the home. The form stated the cost of the "initial" dental assessment, however, the form did not indicate an offer or mention of an annual dental assessment.

The Administrator #102 reviewed the "Kensington Consent Form, Samaritan Senior Dental Service, Dental Assessment and Oral Wellness Program" form with Inspector #689. The Inspector asked the Administrator if the form that the home provided to residents had mentioned an offering of an annual assessment, the Administrator stated that it did not. When asked if the details of the "Dental Assessment and Oral Wellness Program" as stated in the consent form, contained information related to an offering of an annual dental assessment, the Administrator stated that they did not know, as the information was not provided to the residents by the home and was not discussed on admission. When asked by the Inspector if an annual offering for dental services would be documented elsewhere, the Administrator stated that it was not.

The licensee has failed to ensure that four residents of the home received oral care to maintain the integrity of the oral tissue that included an offer of an annual dental assessment and other preventative dental services. [s. 34. (1) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident of the home received oral care to maintain the integrity of the oral tissue that included an offer of an annual dental assessment and other preventative dental services, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The Ministry of Health and Long Term Care (MOHLTC) Infoline - Complaint Information Report form documented that a resident had not been given required pain medication for almost twenty-four hours before the resident's death.

The electronic Medication Administration Record (eMAR) for the resident was reviewed by the Director of Care (DOC) #101 and Inspector #563. DOC #101 verified that a pain assessment should been completed since there was a change in medication and it was ineffective. The DOC also reviewed progress notes where the resident was documented as exhibiting behaviours.

A Medical Director (MD) progress note documented that the resident had taken a turn for the worse and that the resident had not received pain medication throughout the day and then by the evening had deteriorated. The resident did not get any pain medication every two hours as needed for approximately 8 hours with a documented resident decline stated in the progress notes by the physician. DOC #101 verified that the resident should have received the pain medication on the day shift since the dose effectiveness was documented as unknown and nothing was given until the evening shift. The DOC also stated that the resident was deemed palliative and was to remain comfortable and that a pain assessment would be completed when the resident exhibited a change in status.

The progress notes in PCC were reviewed by Inspector #563 with the Director of Care (DOC) #101 where the DOC verified that a pain assessment should have been completed when pain was not relieved by initial interventions on three separate occasions.

The eMAR documentation in PCC for as needed (PRN) pain management effectiveness noted that a pain medication was documented as ineffective. The DOC verified that all pain assessments were completed on paper and kept in a Pain and Palliative Care binder at the nursing station and stated that the resident did not have any pain assessments completed in 2018 and there were no completed pain assessments for the resident when pain management interventions were not effective to relieve the pain.

The Palliative & End of Life Care Processes policy index: EOL-M-20 stated, "Pain assessment will be completed on a regular basis using the pain assessment tool when the presence of pain is identified."

The Registered Practical Nurse (RPN) #118 stated that a pain assessment would be completed when staff noticed an increase in a resident's pain, for a change in medication, after falls, for a new admission, and on readmission. RPN #118 also stated that it was the RPN who was in the primary care role for the resident who was responsible to complete a pain assessment. The RPN stated that palliative meant a resident was reaching the end of life and they were to be kept comfortable and pain free. RPN #118 stated that to ensure the palliative resident remained comfortable, the registered nursing staff would give PRN pain medications closer together as ordered. The RPN also stated that pain assessments were not typically completed for palliative residents because they should not be having pain, those residents should be pain free. RPN #118 verified that there was no pain medication administered for up to 21 hours prior to the resident's death. RPN #118 shared that the resident would have been administered a PRN pain medication if the resident was assessed for pain, but also acknowledged that the resident did not have a pain assessment completed during their palliation to determine level of comfort and was to remain comfortable. RPN #118 also stated that the resident was yelling out more and although that was not unusual for the resident, the resident was also restless when they yelled out and they were making more noises than usual. The RPN stated that this behaviour could indicate pain and a pain assessment should have been completed.

The licensee failed to ensure that when the resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose. [s. 52. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when the resident's pain is not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that as part of the organized program of housekeeping under clause 15 (1) (a) of the Act, that procedures were developed and implemented for cleaning and disinfection of the personal assistance services devices in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

During Stage 1 of the RQI Inspector #563 observed that a resident had dried splatter on their wheelchair frame as well as dried food debris on the wheelchair seatbelt.

During Stage 1 of the RQI Inspector #689 observed that another resident had dirt and debris on their wheelchair frame and wheel frames.

During Stage 1 of the RQI Inspector #689 observed that another resident had dust and debris on their wheelchair frame.

Inspector #635 and #735 observed that a resident's wheelchair had dust and debris build-up on the frame and wheel frame. The other resident was observed to have multiple white/yellow residue on the right and left arm rests, multiple dried spots of a yellow substance near and around the buckle area of the seat belt and the frame had dust build-up and dirt and debris on the frame and wheel frames. Another resident was observed to have white residue on right side front corner of wheelchair cushion as well as dirt and debris on the frame.

Inspector #630 observed that a resident's wheelchair had dust and debris build-up on the frame and wheel frame. Another resident was observed to have multiple dried spots of a yellow substance near and around the buckle area of the seat belt and the frame had dust build-up and dirt and debris on the frame and wheel frame. Another resident was observed to have cigarette ashes on the front wheelchair frame and cushion.

One resident told Inspector #630 that they did not think their wheelchair had been cleaned for a long time.

The clinical record for all three residents indicated that they used a wheelchair for all mobility. The Point of Care (POC) task showed that the last documented date that the resident's wheelchairs were cleaned was in September 2018.

The RN #115 said that wheelchairs were cleaned by the night shift according to a schedule and they thought that the staff used a steamer to clean the chairs. RN #115 said they were not sure how frequently the chairs were cleaned and thought it was the expectation in the home that staff would be cleaning chairs as needed if they were noted to be soiled or dirty.

The home's "Mobility Devices" policy revised January 19, 2018, stated that the Director of Care/designated would: "Ensure all assistive devices related to mobility (wheelchairs, walkers, scooters, other mobility equipment) are properly cleaned and maintained."

The Director of Care (DOC) #101 said that Resident Assessment Instrument Coordinator (RAI-C) #103 was the lead for organizing the cleaning of wheelchairs in the home and they would be the best person to speak with regarding the procedures and practices.

The RAI-C #103 said that most wheelchairs were cleaned monthly based on the schedule set-up in POC. When asked how it was decided to be a monthly task, RAI-C #103 said that it had always been done that way in the home. RAI-C #103 said that it was the expectation that if a wheelchair was found to be heavily soiled then the staff would leave a note for the night shift to clean the chairs. RAI-C #103 said they thought staff cleaned the chairs by wiping them down with a disinfectant spray. RAI-C #103 said that the home's "Mobility Devices" policy dated January 19, 2018, stated that staff were to ensure that all assistive devices related to mobility were to be properly cleaned and maintained. RAI-C #103 said that they thought the specific procedures for cleaning were in a separate policy but did not have that policy. At the request of Inspector #630, RAI-C #103 observed the wheelchairs for the three residents and said that they had dust on the frames. RAI-C #103 also acknowledged that one resident's seat belt was visibly soiled. RAI-C #103 said that they thought that resident's wheelchair needed to be cleaned for sure, but they were not sure about the other two as they did not seem visibly soiled.

The Administrator #102 told Inspector #630 that the "Mobility Devices" policy was the only policy or procedure in place in the home regarding the cleaning of wheelchairs and mobility devices. Administrator #102 acknowledged that the current policy did not include procedures to direct the staff regarding the cleaning of wheelchairs.

Based on these observations, interviews and record reviews, three resident's mobility devices were observed on multiple occasions during the inspection to be visibly soiled. The home's policy identified that it was the expectation that mobility devices would be properly cleaned and did not include the procedures for cleaning the devices according to the manufacturer's specifications. The licensee has failed to ensure that procedures were developed and implemented for cleaning and disinfection of the personal assistance services devices in the home. [s. 87. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that as part of the organized program of housekeeping under clause 15 (1) (a) of the Act, that procedures were developed and implemented for cleaning and disinfection of the personal assistance services devices in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1.The licensee has failed to ensure that the Director was informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4) subject to subsection (3.1), an incident that causes an injury to a resident for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition.

The Critical Incident (CI) System report was submitted to the Ministry of Health and Long Term Care (MOHLTC). The CI documented that a resident had an incident that caused an injury to the resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status where the resident sustained a fall and a significant injury.

The Director of Care (DOC) #101 stated they were not employed with the home at the

time of the submission of the CI report, but verified that the CI was submitted five days after the fall and injury. The progress note was reviewed and the DOC acknowledged that the submission to the MOHLTC was not within one business day after the occurrence of the incident. [s. 107. (3) 4.]

2. The licensee has failed to inform the Director of an incident under subsection (1), (3) or (3.1) within 10 days of becoming aware of the incident, or sooner if required by the Director, and make a report in writing to the Director setting out the following with respect to the incident: the outcome or current status of the individual or individuals who were involved in the incident.

Section 107(4) of the Ontario Regulation 79/10 states, "The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition."

The Critical Incident (CI) System report was submitted to the Ministry of Health and Long Term Care (MOHLTC). The CI documented that a resident had an incident that caused an injury to the resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status where the resident sustained a fall and a significant injury. The CI documented that the outcome/current status of the individual included one significant injury.

The progress notes documented the current status of the resident's injuries from the fall that included another significant injury not documented as part of the CI report.

The Director of Care (DOC) #101 stated they were not employed with the home at the time of the submission of CI, but verified that the Director was not the informed within 10 days of the current status of the resident's injuries. [s. 107. (4) 3. v.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the Director was informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4) subject to subsection (3.1), an incident that causes an injury to a resident for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition; and to inform the Director of an incident under subsection (1), (3) or (3.1) within 10 days of becoming aware of the incident, or sooner if required by the Director, and make a report in writing to the Director setting out the following with respect to the incident: the outcome or current status of the individual or individuals who were involved in the incident, to be implemented voluntarily.

WN #10: 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. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that all medication incidents and adverse drug reactions were documented, reviewed and analyzed, corrective action was taken as necessary, and a written record was kept of everything.

The "Medication Analysis documented medication incidents that occurred each month and documented the type of error, cause of the error, interventions and severity of risk of harm for each incident. All Medication Incident Reports (MIR) were kept in a binder and organized by month. The number of MIRs per month were reviewed against the "Medication Analysis" to ensure accuracy of the documentation. In April 2018, the analysis accounted for five medication incidents that were reviewed and there were seven MIRs documented by staff in April 2018. The analysis did not include a completed MIR for two residents.

A) The Medication Incident Report for the first resident documented that the resident did not receive noon dose of a medication and the resident refused to take the medication. The report noted that the medication was not removed from blister pack.

The electronic Medication Administration Record (eMAR) documented that the resident refused the medication.

An eMAR-Medication Administration Note in Point Click Care (PCC) documented that the resident refused after several attempts including crushing and the resident still adamantly refused. The next day, a Health Status note in PCC documented that the resident did not receive their scheduled medication and that it was treated as a medication incident in error because the medication was actually refused.

The Registered Practical Nurse (RPN) #118, stated that they were present for the discovery of the medication incident for the resident. The RPN verified that the medication was still in the blister pack for the count at shift change. The shift count was not correct because there was one more tablet than there should have been. RPN #118 stated this was a medication error because the resident did not receive it as prescribed, it was not offered and it was still available in the blister card. The RPN shared that the medication was charted as refused, but it was never offered and there was no documentation that the medication was wasted.

B) The Medication Incident Report for the second resident documented that the resident's medications were held for physician clarification.

The resident’s medications were not available for administration in the medication cart according to the MIR. The incident report made no reference as to what happened to the medications due for administration.

The electronic Medication Administration Record (eMAR) documented that three medications were coded "10=Drug Not Available". Then approximately three hours late, two of the three medications were administered to the resident.

The Medication Incident Report documented "due to situation, not considered med error. Orders after situation/use of clinical judgement" with no corrective action taken to prevent the recurrence of missing medications for the resident.

The SmartMeds Pharmacy Medication Incident Report Policy 9-1 last revised April 2016, documented that the policy was in place to "immediately identify, investigate and correct medication errors". The policy defined a medication incident as a preventable event associated with prescribing, ordering, dispensing, storing, labelling, administering or

distributing of a drug, or the transcribing of a prescription, and included an act of omission whether or not it results in harm to a resident. The policy also included a near miss event where an incident does not reach a resident but had it done so, harm could have resulted.

The Director of Care (DOC) #101 stated it was their expectation that the registered nursing staff must pour, prepare and present the medication for it to be refused by a resident and since the medication was still in the blister pack it was not offered. The DOC also verified that the Medication Incident Report for the resident did not document any action taken to prevent recurrence. The DOC stated that the incident should have been analyzed to know what occurred and what the home did to prevent it from happening again and that included corrective action taken with the registered staff member involved. The DOC reviewed the progress note documentation and eMAR related to the missed medication dose and stated that this was clearly a medication error, but because the Medication Incident Report documented "no med error", the incident was not analyzed and corrective action was not taken. The DOC also stated that medication incident for the second resident should have been analyzed to determine if corrective action was necessary.

The licensee has failed to ensure that all medication incidents and adverse drug reactions analyzed and corrective action was taken as necessary and a written record was kept of everything. [s. 135. (2)]

2. The licensee has failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, any changes and improvements identified in the review were implemented, and a written record was kept of everything.

The "Medication Analysis documented medication incidents that occurred each month and documented the type of error, cause of the error, interventions and severity of risk of harm for each incident. All Medication Incident Reports (MIR) were kept in a binder and organized by month. The number of MIRs per month were reviewed against the "Medication Analysis" to ensure accuracy of the documentation. In April 2018, the analysis accounted for five medication incidents that were reviewed and there were seven MIRs documented by staff in April 2018. The analysis did not include a completed MIR for two residents.

The Director of Care (DOC) #101 stated that the pharmacist, Medical Director and the DOC review the MIRs quarterly and the most recent quarterly analysis was of all medication incidents that occurred between March 1 to June 30, 2018. The DOC verified that the two MIRs completed should have been included in the Medication Analysis and were not for the most recent quarterly review.

The licensee failed to ensure that the quarterly review was undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review. There were 17 medication incidents during this time frame and only 15 incidents were reviewed for changes and improvements. [s. 135. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance failed to ensure that all medication incidents and adverse drug reactions were documented, reviewed and analyzed, corrective action is taken as necessary, and a written record was kept of everything, and, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (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 to the extent possible in the development and implementation of the resident's care plan, and in reviews and revisions of the care plan. O. Reg. 79/10, s. 24 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was given an opportunity to participate to the extent possible in the development and implementation of the resident's care plan, and in reviews and revisions of the care plan.

The Ministry of Health and Long-Term Care (MOHLTC) received a complaint which included a concern related to a resident not being informed or explained a new medication order.

The resident stated that they refused to take a new medication because they were never informed or had any staff explain the medication to them prior to being provided the medication dose.

The Orders in Point Click Care (PCC) showed an order for the medication described by the resident.

The Medication Administration Record (MAR) in PCC showed documentation where the resident refused the medication on multiple occasions.

The Multidisciplinary Progress Notes in the resident's chart documented by RPN #127 stated that the resident refused to take the medication order. The RPN documented that the resident said that no one explained to them the new order. The writer documented that they explained to the resident afterwards, and the resident said that they were still not going to take the medication. The RPN documented that they were aware, will continue to monitor and inform this to the oncoming staff.

The Registered Practical Nurse (RPN) #121 stated that if there was a change in the care plan for the resident, then the resident or their Power Of Attorney (POA) should be notified of the change. The RPN stated that the resident was their own POA. When asked by Inspector #689 who would be responsible for informing the resident or their POA of a new medication order, the RPN stated that it was the registered staff's responsibility. The RPN stated that if a resident was prescribed a new medication, this would indicate a revision or change in their plan of care. When asked if they would expect that the resident should be given the opportunity to participate in the development and implementation of their care plan, the RPN stated that the resident should be aware and know the changes in their care plan. RPN #121 said that the expectation for documenting the notification of a change in medication to the resident or their POA was mandatory, and would be documented in the progress notes. The RPN reviewed the progress notes in PCC for the resident and stated that there was no note to indicate that the resident was informed or explained of the medication. RPN #121 reviewed the Multidisciplinary Progress Note documented by RPN #127 and stated that after reading the note, they believed that the resident probably did not want to take the medication, as no one explained it to them. When asked by the Inspector if they would expect that the

resident should have been provided the opportunity to participate in the development and implementation of their care plan, including being informed of new medication orders, the RPN stated yes.

The progress notes in PCC for the resident showed no documentation that the registered staff informed the resident of the order for medication.

The Director of Care (DOC) #101 stated that when there was a change in care plan for a resident, the resident or the POA should be notified. The DOC stated that the resident was their own Power of Attorney (POA) and would be informed of changes to their care needs. When asked whose responsibility it was to inform a resident or their POA of a new medication, the DOC stated that it was the responsibility of the registered staff between days and evenings. DOC #101 stated that it was their impression that registered staff would complete a progress note to document that the resident or their POA was notified of a change in medication. When asked if a resident was prescribed a new medication, would it indicate a revision or change in their care plan, the DOC stated yes. DOC #101 reviewed documentation in PCC and confirmed that the medication was prescribed for the resident. When asked if there was documentation showing that the resident was informed of the new medication order, the DOC said no. The DOC reviewed the Multidisciplinary Progress Note documented by RPN #127 dated for the resident and when asked if they would expect that the RPN who documented the note informed and explained the medication to the resident, the DOC confirmed that it was not explained until after the resident had stated that they were not explained of the new medication. When asked if they would expect that the resident should have been provided the opportunity to participate in the development and implementation of their care plan, including medication changes, DOC #101 stated yes.

The licensee has failed to ensure that the resident was given an opportunity to participate to the extent possible in the development and implementation of the resident's care plan, and in reviews and revisions of the care plan related to medication changes. [s. 24. (5)]

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 14th day of November, 2018

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MELANIE NORTHEY (563), AMIE GIBBS-WARD (630), CASSANDRA ALEKSIC (689), DONNA TIERNEY (569)
Inspection No. / No de l'inspection :	2018_606563_0015
Log No. / No de registre :	005400-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Oct 26, 2018
Licensee / Titulaire de permis :	Sharon Farms & Enterprises Limited 108 Jensen Road, LONDON, ON, N5V-5A4
LTC Home / Foyer de SLD :	Kensington Village 1340 Huron Street, LONDON, ON, N5V-3R3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Tracie Klisht

To Sharon Farms & Enterprises Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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 Ontario Regulation r. 8(1)(b).

Specifically, the licensee shall ensure that:
a) Ensure the Sharon Village Care Homes (SVCH) Pain Management policy with index: PM-N-20 last revised January 2018 is reviewed and updated.
b) Ensure that all direct care staff receive education related to the Pain Management policy and all associated assessment tools and forms as described in the policy.

Grounds / Motifs :

1. The licensee failed to ensure that the plan, policy, protocol, procedure, strategy or system was complied with.

The home's policy related to pain management was reviewed since the licensee failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The Sharon Village Care Homes (SVCH) Pain Management policy with index: PM-N-20 last revised January 2018 documented the use of appendixes and screening:
- "conduct the full pain assessment utilizing a clinically appropriate instrument (Appendix A: Pain Assessment Tool),

- "Evaluate policy effectiveness annually" and "may include trends in data on internal tools such as Appendix B: Pain Assessment Tool",
- "Appendix C: Pain Indicator List for the Cognitively Impaired",
- "Appendix D: Pain Monitoring Flow Sheet will be used to monitor pain and determine effectiveness of pain strategies over time",
- "Notify physician using SBAR Communication Tool (Appendix E) if pain is not resolved (< or = 4) within 72 hours",
- "The interdisciplinary team will screen for the presence of pain every shift using the appropriate tool considering factors such as age and level of cognition under the following circumstances: Admission and Readmission", and
- "If pain is identified, screening will be completed q4h x 3days as well as in the following circumstances: change in condition with the onset of pain, RAI-MDS Pains Score of 2 or more and following initiation or any changes in pain medication".

The Registered Practical Nurse (RPN) #113 stated they were the Pain and Palliative Team Lead for Kensington Village since December 2017. RPN #113 was asked if the Sharon Village Care Homes (SVCH) Pain Management policy with index: PM-N-20 last revised January 2018 was the updated pain policy used in the home and the RPN stated the pain policies as part of the current resources available in the pain and palliative binder included the SVCH Pain Management policy with index: PM-N-10 last revised September 2017, and the SVCH Pain Assessment and Symptom Management Implementation policy with index: PM-N-20 last revised September 2017 with a "PM-N-20 a Pain Management" chart. RPN #113 stated they did not know the difference between Appendix A and B for the same "Pain Assessment Tool'. The RPN stated they did use the Pain Indicator List for the Cognitively Impaired or a Pain Monitoring Flow Sheet to monitor pain. RPN #113 did not know what the SBAR Communication Tool was or what screening tool was used every four hours for three days if pain was identified. RPN #113 was asked what was meant by "The interdisciplinary team will screen for the presence of pain every shift using the appropriate tool considering factors such as age and level of cognition under the following circumstances: Admission and Readmission". The RPN stated it might be the "Pain Assessment" but did not know why factors such as age or cognition would be a factor when screening for the presence of pain in a resident. The RPN also verified that registered staff were not completing a pain assessment when the Resident Assessment Instrument – Minimum Data Set (RAI-MDS)

Pain Scale score was "2" or more and stated that staff only initiate a pain assessment on re-admission and not on admission.

The Director of Care (DOC) #101 stated that the screening and tools documented as part of the SVCH Pain Management policy with index: PM-N-20 last revised January 2018 were not used by the Kensington Village registered staff. The DOC stated it was a corporate policy and the appendixes outlined in the policy were not used, but the "PAINAD – Pain Assessment in Advanced Dementia", the "PAINAD Item Definitions" and the "Pain Assessment" are the only three tools used by the home. The DOC also verified that screening was not being completed every four hours for three days when pain was identified on admission and re-admission or when the RAI-MDS pain Scale was greater than "2". The DOC also acknowledged that the January 2018 Pain Assessment policy PM-N-20 was the pain policy currently used by the home.

The licensee failed to ensure that SVCH Pain Management policy with index: PM-N-20 last revised January 2018 was complied with.

2. The licensee failed to ensure that the plan, policy, protocol, procedure, strategy or system put in place was complied with.

The home's policy related to pain management was reviewed since the licensee has failed to ensure that controlled substances were administered to a resident in accordance with the directions for use specified by the prescriber for pain management.

The SmartMeds Pharmacy Narcotic and Controlled Drug Count & Ward Count Policy 6-6 documented that "when a narcotic medication is administered, the nurse must document the following information on the form: date, time, quantity administered, quantity remaining, and the nurse's initials." "Each Resident's Narcotic/Controlled Drug Count for accompanying the medication is individualized with the prescription label that contains the prescription number, resident's name, physician's name, medication, directions, strength, quantity dispensed and date dispensed."

The Director of Care (DOC) #101 and Inspector #563 reviewed the SmartMeds Pharmacy "Resident's Narcotic/Controlled Drug Count/Ward Count" for a

resident:
- Of the 31 documented doses of a specific controlled substance administered during a specific time period, 51.6 per cent of the dates did not document a year and multiple dates were illegible. The DOC verified that the documentation was illegible and was not recorded with the full date.
- Of the 29 documented doses administered during a specific time, 20.7 per cent of the dates did not document a year and multiple dates were illegible. On two specific dates the quantity administered was not documented and on another date the count had blank documentation where there was no date, time, dose administered or a staff signature. The DOC verified that the documentation was illegible and the registered staff did not document the appropriate information when a controlled substance was administered.
- The May 2018 electronic Medication Administration (eMAR) in PCC documented that a specific medication was administered and the DOC verified that the administration was not documented as part of the "Resident's Narcotic/Controlled Drug Count/Ward Count" and the documentation was confusing. The count was missing the quantity dispensed and the date dispensed.
- The "Resident's Narcotic/Controlled Drug Count/Ward Count" was not individualized with the prescription number, physician's name, and medication directions. The DOC also stated that there was missing information required on all drug count sheets.
- The "Resident's Narcotic/Controlled Drug Count/Ward Count" was not individualized with the prescription number, physician's name, medication directions and strength. The eMAR documented that the medication was administered and DOC #101 verified that the count record did not document this dose.

The Director of Care (DOC) #101 and Inspector #563 reviewed the Narcotic Ward Drug Counts and for six separate shift counts there was a missing date. The DOC verified that the narcotic ward counts were not documented with the date during multiple shift counts. DOC #101 also stated that the monthly audit of the controlled substance count sheets were of the ward drug counts only and not the individual resident counts of controlled substances. The DOC stated that only discrepancies in the count of narcotics would be followed up on.

The SmartMeds Pharmacy Narcotic and Controlled Drug Count & Ward Count

Policy 6-6 documented that "all narcotic and controlled medications must be accounted for at the end of each shift. Both the nurse handing over (Nurse 1) and taking over (Nurse 2) will sign with the date and time and the Narcotic Ward Drug Count sheet".

The Director of Care #101 stated it was the expectation that the registered nursing staff comply with the Narcotic and Controlled Drug Count & Ward Count Policy when a narcotic medication was administered, the nurse would document the date, time, and quantity administered and the documentation be legible. The DOC also verified that for all stock emergency controlled substance medications used for a resident, that the Narcotic and Controlled Drug Count & Ward Count include the prescription number, resident's name, physician's name, medication, directions, strength, quantity dispensed and date dispensed. The DOC stated that the expectation was for registered nursing staff to complete the Narcotic Ward Drug Count with the date documented at each shift count.

The licensee failed to ensure that the SmartMeds Pharmacy Narcotic and Controlled Drug Count & Ward Count Policy 6-6 was complied with. [s. 8. (1) (b)]

The severity of this issue was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of the issue was widespread. The home had a level 3 compliance history since there is one or more related non-compliance (NC) in the last 36 months that included:
- April 25, 2016 Voluntary Plan of Correction (VPC) during Resident Quality Inspection (RQI) #2016_326569_0010.
- January 3, 2017 VPC during Complaint Inspection #2017_536537_0001. (563)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2018

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(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;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee must be compliant with Ontario Regulation r. 50(2)(b).

Specifically, the licensee shall ensure that:
a) Resident #012, resident #002 and any other resident who is exhibiting altered skin integrity 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.
b) Develop and implement a tracking and auditing system for all altered skin integrity to ensure all residents exhibiting altered skin integrity receives a skin assessment and are reassessed weekly by a member of the registered nursing staff.
c) Educate the registered nursing staff to accurately measure and document altered skin integrity as part of the "KV Skin/Wound Assessment V 1.0".

Grounds / Motifs :

1. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment; and a resident exhibiting altered skin integrity had been reassessed at least weekly by a member of the registered nursing staff.

A) During stage one of the Resident Quality Inspection (RQI) a resident was identified in a review of clinical documentation as having developed an area of altered skin integrity within the first 30 days of admission.

The Director of Care (DOC) #101 and Inspector #563 reviewed the skin assessments completed in Point Click Care (PCC) for a resident. The DOC stated that there should be progress note charting and an assessment completed in PCC when any resident has developed an area of altered skin integrity. There were "KV Skin/Wound Assessment V 1.0" assessments completed in PCC for a resident. The DOC verified that there was no stage or measurements indicated as part of the assessments and this should be documented as part of this assessment and measured weekly. The assessments documented that the “Skin/Wound Area Unhealed (requires further assessment weekly until healed)”. The assessments also identified multiple different areas of altered skin integrity where there were no assessments or

weekly reassessments completed consistently. The DOC stated that the assessment documented "Skin/Wound Area Unhealed (requires further assessment weekly until healed)" and verified that the expectation was that weekly wound assessments were to be completed for all areas of altered skin integrity for a resident.

The Prevention, Management, Monitoring of Pressure Injuries policy index: SW-Q-30 last revised January 16, 2018 documented wound assessment guidelines where "a wound assessment is the first step in wound management." Any wound "is to have an initial wound assessment completed and then a weekly follow-up." The policy documented that the assessment will contain the following elements:
- Classification of the wound (staging of wounds),
- Anatomical location of the wound,
- Size of the wound including length, width and depth,
- Exudate amount, type and colour,
- Necrotic tissue colour, amount and type,
- Undermining and tunneling,
- Evidence of infection,
- Pain

Ongoing evaluation was documented as a wound treatment principle and if a wound has been noted as not healing "within 2-4 weeks" then "the treatment plan will be re-evaluated. Worsening wounds should be referred to the Wound Care Specialist."

The Registered Practical Nurse (RPN) #124 stated they were the Wound Care Lead for Kensington Village. RPN #124 shared that it was the role of the Wound Care Lead to coordinate that the registered staff were completing their skin assessments on time, and provide education on how to assess and manage wounds. The RPN stated that the process in place when a resident developed an area of altered skin integrity included assessment and measurement of the wound in PCC and a progress note would be completed depending on the wound protocol and type of wound. Then the registered staff were to complete a weekly skin assessment until healed. RPN #124 and Inspector #563 reviewed the Monthly Skin and Wound Management Tracking since there were documented inconsistencies related to a resident's areas of altered skin integrity. RPN #124 stated the Wound Care Lead was responsible for

maintaining the tracking sheet.

The Monthly Skin and Wound Management Tracking did not accurately document all areas of altered skin integrity for a resident. RPN #124 verified the tracking sheet documented incorrect healed wounds and did not document the skin areas and dates correctly. The RPN also stated that not all areas of altered skin integrity were reviewed monthly and should have been.

The Prevention, Management, Monitoring of Pressure Injuries policy index: SW-Q-30 last revised January 16, 2018 documented the role of the Registered Nurse Manager/Skin Wound Clinical Lead was to "assess the wound weekly depending on dressing change schedule, not greater than 7 days between assessments." The role of the Director of Resident Care/designate was to ensure "audits of skin and wound assessments will be conducted monthly to ensure documentation is completed appropriately."

The licensee failed to ensure that a resident exhibiting altered skin integrity received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment when the wound was initially observed and at least weekly by a member of the registered nursing staff.

B) During stage one of the Resident Quality Inspection (RQI), a resident was identified through a resident observations as having two areas of altered skin integrity.

The progress notes in Point Click Care (PCC) for the resident showed a referral to the registered dietitian (RD) for two areas of altered skin integrity. Another referral to the RD was shown in the progress notes for multiple areas of skin breakdown. The physician's progress note stated that the resident was seen and had an area of altered skin integrity.

The Orders in PCC showed physician's orders for treatments and dressings to be applied. The Treatment Administration Records (TARs) were reviewed and showed that weekly skin assessments were to be completed until healed.

The Assessments in PCC for the resident showed that a weekly skin/wound

assessment was started which identified an area of altered skin integrity with no measurements indicated. Inspector #689 reviewed the weekly skin and wound assessments in PCC which showed that no skin assessments were identified for six different weeks. Inspector #689 reviewed the Assessments and no weekly skin/wound assessment was completed on a specific date for the identified areas of altered skin integrity.

The Registered Practical Nurse (RPN) #124 stated that the resident had two area of altered skin integrity. The RPN stated that if a resident was identified as having altered skin integrity, the registered staff would assess the resident, document a progress note, and complete an initial skin and wound assessment in PCC. The RPN stated that ulcers, skin tears, bruises or dry skin were types of altered skin integrity that would require the registered staff to complete a clinically appropriate weekly skin and would assessment. RPN #124 reviewed Assessments in PCC and confirmed that an initial skin/wound assessment was documented for the two areas of altered skin integrity. RPN #124 reviewed the weekly skin/wound assessments for the resident and confirmed that no skin assessments were completed for the second area of altered skin integrity for several weeks. The RPN stated that if an area of skin breakdown was healed, then the skin and wound assessment should have been done to indicate it was healed.

The Director of Care (DOC) #101 stated that weekly skin and wound assessments should be completed in PCC for areas of altered skin integrity. The DOC reviewed the resident's records and confirmed that an initial skin and wound assessment should have been completed when the areas were first identified. The DOC reviewed the weekly skin/wound assessments for the resident and stated that the assessments were not completed and had omitted areas of altered skin integrity that were assessed initially.

The licensee failed to ensure that a resident who exhibited altered skin integrity received a skin assessment and was reassessed at least weekly.

The severity of this issue was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of the issue was a pattern. The home had a level 3 compliance history since there is one or more related non-compliance (NC) in the last 36 months that included:

- April 25, 2016 Voluntary Plan of Correction (VPC) during Resident Quality Inspection (RQI) #2016_326569_0010.
- March 6, 2017 Compliance Order (CO) #001 during RQI #2017_606563_0003. (563)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2018

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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).

Order / Ordre :

The licensee must be compliant with Ontario Regulation r. 131(2).

Specifically, the licensee shall ensure that:
a) All residents in the home who have been deemed (or identified by the physician) as "palliative care" receive medications in accordance with the directions for use specified by the prescriber for pain management.

Grounds / Motifs :

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

The Medication Incident Report documented that a resident did not receive a medication at bedtime. The medication strip pack was found in the morning by the day nurse with the medication still packed from the previous evening.

The physician's order in Point Click Care documented that the resident was to receive a medication at bedtime.

The Director of Care (DOC) #101 verified that the medication incident involving the resident was an omission and therefore the medication was not administered in accordance with the directions for use specified by the prescriber. (563)

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

The Ministry of Health and Long Term Care (MOHLTC) Infoline - Complaint Information Report documented that a resident had not been given required pain

medication for almost twenty-four hours before the resident's death.

The May 2018 electronic Medication Administration Record (eMAR) for the resident was reviewed by the Director of Care (DOC) #101 and Inspector #563. The resident had an order for a controlled substance and the DOC #101 verified that the medication should have been administered earlier if the dose had poor effect and there was an order for pain medication as needed (PRN) every two hours available for administration. The DOC stated that the pain medication every two hours was not administered to the resident in accordance with the directions for use as needed.

A Health Status progress note stated the resident required pain medication but that there was no PRN available to give. DOC #101 verified that injectable pain medication was available as part of the emergency nursing stat box the resident should have been administered this pain medication as ordered and was not.

A Health Status progress note documented the resident had displayed agitation. The DOC #101 verified that no pain medication was administrated and the resident could very well have been in pain. The DOC verified that the eMAR documented that pain medication was not administered for approximately 21 hours prior to the resident`s death. The medication was not administered subcutaneously as ordered for palliation to keep the resident comfortable.

The eMAR for the resident documented a medication order with a code of "10" = "Drug Not Available" on a specific date and time. DOC #101 verified that the medication was available as part of the emergency nursing stat box and the resident should have been administered this medication as ordered and was not.

A Medical Director (MD) progress note documented that the resident had taken a turn for the worse and that the resident had not received pain medication throughout the day and then by the evening had deteriorated. The resident did not get any pain medication every two hours as needed for approximately 8 hours with a documented resident decline stated in the progress notes by the physician. DOC #101 verified that the resident should have received the pain medication on the day shift since the dose effectiveness was documented as unknown and nothing was given until the evening shift. The DOC stated that the

staff did not know whether the pain medication was effective and should have administered the pain medication as ordered. The DOC also stated that the resident was deemed palliative and was to remain comfortable.

The Palliative & End of Life Care Processes policy index: EOL-M-20 stated, "Quality and timely symptom management is one of the keys to excellence in palliative care while moving towards the end of life stage."

The Registered Practical Nurse (RPN) #118 stated that the home has a stat box for PRN pain medications that were required for administration but have not arrived yet from pharmacy. The RPN verified that the pain medication was available in the emergency stat box for administration. Inspector #563 and RPN #118 reviewed the progress note where resident required pain medication but that there was no PRN available to give and the RPN acknowledged that this was their note and that the resident should have received the medication as ordered for pain management to remain comfortable.

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

The severity of this issue was determined to be a level 3 as there was actual harm/risk. The scope of the issue was a pattern. The home had a level 2 compliance history since there is one or more unrelated non-compliance (NC) in the last 36 months. (563)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 26th day of October, 2018

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Melanie Northey

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