Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

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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
May 26, 2020	2020_526645_0005	019026-19, 019433-19, 019671-19, 019824-19, 021411-19, 022953-19, 023068-19, 023597-19, 023938-19, 000013-20, 000611-20, 001205-20, 002875-20	Critical Incident System

Licensee/Titulaire de permis

City of Toronto
c/o Seniors Services and Long-Term Care 365 Bloor Street East, 15th Floor TORONTO ON M4W 3L4

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

Kipling Acres
2233 Kipling Avenue ETOBICOKE ON M9W 4L3

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

DEREGE GEDA (645), GORDANA KRSTEVSKA (600)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): February 19, 21, 22, 24, 26, 28, March 2, 3, 4, 5, 6, 2020.

During this inspection the following intakes were inspected:
- Log #021411-19 (CIS #545-000066-19), Log #000013-20 (CIS #545-000001-20), Log #001205-20 (CIS #545-000007-20) and Log #019433-19 (CIS #545-000061-19), related to prevention of abuse and neglect,

- Log #023938-19 (CIS #545-000078-19), Log #000611-20 (CIS #M545-000003-20), Log #019026-19 (CIS #545-000058-19), Log #023068-19 (CIS #545-000073-19), Log #002875-20 (CIS #545-000009-20) and Log #019824-19 (CIS #545-000065-19), related to Fall prevention and management, and

- Log #023597-19 (CIS #545-000076-19), Log #022953-19 (CIS #M545-000072-19), and Log #019671-19 (CIS #545-000063-19), related to fracture with unknown cause.

One Voluntary Plan of Correction (VPC) related to LTCHA, 2007, c.8, s. 6(7), identified in a concurrent complaint inspection #2020_526645_0004 (Log # 023553-19), is issued in this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Operational Nurse manager (ONM), Clinical Nurse Manager (CNM), Behavioural Support Ontario (BSO), Resident Assessment Instrument (RAI) Coordinators, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) and Residents.

During the inspection, the inspectors performed observations of staff and resident interactions, provision of care, reviewed residents' clinical records, medication administration records (MAR), staff training records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Admission and Discharge
Falls Prevention
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Skin and Wound Care

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

- **9 WN(s)**
- **7 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

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

Specifically failed to comply with the following:

s. 6. (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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

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

A Critical Incident System (CIS) report was submitted to the Ministry of Long Term Care (MLTC) regarding a complaint of a family member alleging staff to resident abuse. A review of the CIS indicated that PSW #100 reported to RPN #102 that resident #004 had large skin injuries on an identified part of their body. On an identified date, one of resident #004's family members who came to visit the resident, called the police when they identified the skin injuries. The family member alleged physical abuse.

A review of resident's plan of care indicated that resident #004 needed an identified type of care with two staff assistance.

A review of the progress notes, and interview with RPN #103 indicated that the plan of care for resident #004 indicated not to have a specific gender type provide care as per family request because the resident had expressed discomfort.

A review of the PSW Daily Documentation record indicated that PSW #100 who identified the skin injuries, was assigned and worked on the identified date.

An interview with PSW #100 indicated that they have worked with the resident many times before, always with another staff but they were not aware of the resident's preference not to be cared by the identified gender type.

In an interview, RPN #102 indicated that they worked on the identified date and assisted PSW #100 provide care to the resident. RPN #102 stated that they knew that the family requested not to have a staff of specific gender provide care to the resident, but they thought it was only for one shift and did not review the plan of care. The RPN also stated that they did not clarify with the family or the resident if the request was for an ongoing basis, or one-time request; and they did not communicate to the PSW or other team members of the family member's request.

In an interview, Operational Nurse Manager (ONM) #119, stated that on the identified date the family wish the and the plan of care was not followed when care was provided to resident #004 by a staff member of a specific gender type. [s. 6. (7)]

2. The licensee has failed to ensure that if the resident was being reassessed and the plan of care is being revised because care set out in the plan had not been effective, different approaches were considered in the revision of the plan of care.

A CIS report was submitted to the home regarding an incident that caused an injury to resident #003 for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.

Review of resident #003’s health record indicated that the resident had identified diagnosis and conditions and required an identified level of assistance with an activity of daily living. On an identified date, the resident had an incident that caused injury. Following the incident, the home conducted a through investigations to identify antecedent causes of the incident and unmet care needs were identified.

A review of the resident’s plan of care indicated a number of interventions in place to prevent further incidents, however, following the incident, they were not incorporated in the current plan of care and the plan of care was not revised with the new interventions.

In an interview, the Clinical Nurse Manager (CNM) #115, acknowledged that, when resident #003 was reassessed after the incident, the plan of care was not revised and there were no alternative approaches or new interventions included in the plan of care. [s. 6. (11) (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 the care set out in the plan of care was provided to the resident as specified in the plan, and that if the resident was being reassessed and the plan of care is being revised because care set out in the plan had not been effective, different approaches been considered in the revision of the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #011 was protected from abuse by resident #001 in the home.

A review of the CIS record and resident #001's progress notes indicated that on an identified date, resident #001 had touched resident #011's body part and resident #001 screamed for help. RPN #107 responded and when resident #001 saw the RPN, they let go of resident #011, turned around and walked away. Resident #011 was removed from the area and assessed, and there was no injury identified.

A review of resident #011's clinical records indicated that resident #011 had an identified type of cognitive impairment and exhibited responsive behaviours.

The resident had been identified to have responsive behaviours that were not easily altered. Review of the resident's plan of care indicated that the intervention developed was to monitor both residents for safety or potential altercation.

An interview with PSW #105 and RPN #107 indicated that the staff try to monitor the residents very closely. However, they indicated that it is not possible to monitor each resident all the time. They indicated that the residents were not being monitored when the incident occurred.

In an interview, RPN #116 indicated that resident #011 had been exhibiting responsive behaviours since they moved in the home.

An interview with RN #113 indicated that resident #011 had exhibited this behaviour for a long time, and staff would refer them to BSO team for reassessment, but BSO did not reassess or review the intervention in the plan of care.

In an interview, CNM #114 indicated that resident #001 had unpredictable responsive behaviours and they have communicated the concerns with BSO but there were no new approaches developed in the plan of care. The NM acknowledged that resident #011 was not protected from by resident #001 in the above mentioned incident. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are protected from abuse and neglect, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's pain management program to identify and manage pain in residents was implemented in the home.

Review of the home's policy titled "Pain Management Program, #RC-0518-01" last reviewed on January 2019, directed staff members to provide ongoing pain assessments to optimally control and manage pain and document effectiveness of pain medications. The policy directed staff members to complete pain assessment when a resident is a new admission, when there is a significant change with the resident condition, and when pain is not relieved following the initial pain treatment. The policy also directed staff members to complete pain assessment using Abbey pain assessment tool. The home's pain management policy also states that when a resident has altered skin condition,

registered staff should complete pain assessment and to observe non verbal pain markers such as guarding, facial expressions and tensions.

A review of the CIS report and complaint letter from resident #010's family indicated that the resident exhibits signs and symptoms of pain most of the time and staff at the home do not administer pain medications.

Review of the progress notes on three different identified dates, indicated that the resident sustained multiple altered skin conditions.
A review of the medication administration record (MAR) indicated that the Physician ordered an identified type of pain medication per required needed (PRN), for pain management. Record review of the progress notes and Abbey pain assessment tool indicated that resident #010 verbalized pain level on pain scale that required pain treatment, during skin assessment on one of the above identified date. The progress notes also indicated that the resident verbalized pain on a different occasion and needed pain treatments. On both occasions, the MAR did not indicate that pain medication was administered.

Interview with RN #112 confirmed that the resident verbalized pain on both occasions during skin assessment . The RN indicated that on both occasions, the prescribed pain medication was not administered.

Interviews with DOC confirmed that the registered staff did not administer pain medications after the resident verbalized pain on both occasions mentioned above. The DOC reiterated that pain assessment and management affect the quality of the residents' life and it is important to manage pain immediately. The DOC acknowledged that the registered staff did not implement the home's pain management program for resident #010 and indicated that they will re-educate staff members on pain management and interventions. [s. 48. (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 ensure that a pain management program to identify and manage pain is developed and implemented at the home, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents 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 is specifically designed for skin and wound assessment.

A CIS report was submitted to the MLTC regarding an alleged incident of improper/incompetent treatment of resident #010 by staff members.

The home's policy titled "Skin and Wound Care program Management #RC-0518-02", revised on January 2019, directed registered staff members to conduct a head to toe and initial skin assessments, when a resident has altered skin conditions and when there is a significant change in health conditions. The policy also directed staff members to initiate weekly wound assessments and develop interventions to promote healing.

Record review of the resident's admission assessments and the Local Health Integration Network (LHIN) assessments indicated that the resident did not have altered skin conditions upon admission. Record review of the progress notes and skin assessments completed on different occasions, indicated that resident #010 had multiple skin injuries following admission.

Review of the records indicated that the resident was not feeling well, less responsive and confused on the identified date and was sent to the hospital. Review of the ER assessment indicated that the resident had large skin injuries localized to different parts of their body.
Review of the records indicated that there were no skin assessments completed for a skin injury. Further review of the records did not indicate that if there were any initial wound and weekly skin assessments completed; there was no evidence to verify if the wound was assessed by a registered dietitian, there were no treatments ordered or administered; there was no documentation available describing the type, color, size, and drainage type of the wounds.

Interviews with RN #112 and RN #117 confirmed that there were no skin and head to toe assessments completed for the identified skin injury, and no dietitian assessments were completed.

Interview with the DOC indicated that it was the home’s expectation that registered staff complete skin assessments using the home’s skin assessment tool when a resident has altered skin conditions, initiate treatments and confirmed that the registered staff did not use the assessment tool and document findings as expected. The DOC further indicated that they were not sure how staff members would miss the skin injury identified on the same day of admission in the hospital. [s. 50. (2) (b) (i)]

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 residents 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 is specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

A review of the CIS record and resident #001's progress notes indicated that on an identified date, resident #001 had touched resident #011's body part and resident #001 screamed for help. RPN #107 responded and when resident #001 saw the RPN, they let go of resident #011, turned around and walked away. Resident #011 was removed from the area and assessed, and there was no injury identified.

Review of the plan of care indicated that when resident #001 was admitted to the home, the staff assessed the resident and identified responsive behaviours related to their cognitive status. Interventions to manage the resident's behaviours were set out in the plan of care and directed staff to complete an identified type of observation/monitoring, administer medications and document observations.

A review of resident #001's health record indicated that the resident had been exhibiting responsive behaviours towards other residents and the staff members. The progress notes on the identified date, indicated that BSO staff identified the triggers for the responsive behaviours and recommendations were made.

A review of resident #001's written plan of care indicated that the identified and recommended interventions by BSO team were not documented in the written plan of care.
An interview with the RPN #107 indicated that the written plan of care did not include the recommendations from the BSO. The RPN indicated that they aware of the recommended interventions by BSO but they were unable to provide the interventions and no staff members were available to do observations on the identified date.

The BSO lead who followed the resident was not available for an interview.

In an interview, the CNM #114 and DOC acknowledged that the BSO team had identified triggers for resident #001's responsive behaviour, and recommended interventions, but the identified recommended intervention were not included in the plan of care and they were not implemented. [s. 54. (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 steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 114 (3).
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff implemented the home's safe medication administration, reconciliation and dispensing protocol and policy.

The home's policy, "Medication Management: Admission/readmission and Medication Reconciliation, #MM-0105-00" revised on July 4, 2019, defined medication reconciliation and outlined specific processes to gather best possible medication history (BPMH). The definition and processes are as follows:

Medication reconciliation is a systematic and comprehensive review of medications to ensure accuracy and continuity of residents' medication orders. At the time of admission, the registered staff are expected to:
- Gather accurate list of medications that the resident currently taking and history of previous medications that were discontinued (BPMH) including name, dosage, frequency, and route.

- Obtain information on active and non active medications from the resident, resident's family or placement coordinators, or hospitals.
- Transcribe and complete the medication list from sources and mark the current medication as "current" and discontinued medications as "discontinued".
- Complete a "double-check" with a second nurse and the two nurses sign the BPMH document and
- Contact the physician to discuss and obtain the admission/readmission orders.

A CIS report was submitted to the MLTC regarding a medication administration incident and an alleged improper/incompetent treatment of resident #010 by staff members. The report indicated that resident #010 was given incorrect medications for ten days following admission.

Record review of the progress notes indicated that resident #010 was admitted to the home on an identified date. Record review of the home's investigation notes indicated that RPN #118 made a medication reconciliation error on the day of admission. The notes indicated that the RPN completed the resident's BPMH and contacted the family (SDM) to identify the current and discontinued medications. The notes indicated that the RPN forgot to mark the discontinued medications as discontinued and instead marked them as current. On the same day, the physician gave a telephone order to continue with the current medications.
Eleven days later, the family noticed that the resident was receiving medications that were discontinued prior to admission and raised concerns to the nurse manager. The investigation notes indicated that the resident was receiving the identified medications since admission. According to the notes, these medications were discontinued prior to the resident's admission to the home. Record review of the medication reconciliation form from admission also indicated that there was no signature from a second nurse confirming the BPMH and transcriptions were accurate. Review of the physician assessment notes on the above identified date, indicated that the physician was aware about the medication incident. The physician notes indicated that there was no injury to the resident and discontinued the above-mentioned medications.

Interview with RPN #118 confirmed that they forgot to mark the discontinued medications obtained from the family member as discontinued. They indicated that they made an error of marking all the BPMH as current. The RPN indicated that the admission came at the end of their shift and they were in a rush to finish and go home. The RPN revealed that they did the transcription alone and called the physician to confirm admission orders to expedite the process. The RPN indicated that they learned a big lesson and received a

disciplinary counselling regarding medication reconciliation.

The DOC confirmed during an interview that the RPN made medication reconciliation and transcription errors related to resident #010. They indicated that it was the expectation of the home that registered staff complete accurate BPMH and get them verified by a second nurse to prevent medication errors and adverse drug events. They indicated that the home has a process and policy in place to complete BPMH and confirmed that RPN #118 did not implement the program. The DOC indicated that the RPN was disciplined, and appropriate training was provided to mitigate the risk of medication incidents. [s. 114. (3) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's written safe medication administration and management policies are developed, implemented and updated in accordance with evidence based practices, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A CIS report was submitted to the MLTC regarding a medication administration incident and an alleged improper/incompetent treatment of resident #010 by staff members.

Review of the medical records indicated that resident #010 was admitted to the home on

an identified date. Review of the progress note indicated that the resident sustained multiple skin injuries to different parts of their body following admission:

A review of the complaint letter from resident #010's family indicated that the resident shows signs and symptoms of pain most of the time and staff at the home do not administer pain medications.

A review of the medication administration record (MAR) indicated that the Physician ordered an identified pain medication PRN, for pain management. Record review of the progress notes and Abbey pain assessment tool indicated that resident #010 verbalized pain on two identified dates. The records did not indicate if pain medication was administered.

Interview with RN #112 confirmed that the resident verbalized pain on two occasions during skin assessment and indicated that on both occasions, the prescribed pain medication was not administered. The RN confirmed that the pain medication was not administered as specified by the prescriber.

2. Review of the home's Quarterly Medication Review and Adverse Drug Reaction documentation indicated that there were medication administration incidents that involved residents #014, #015 and #016. The records indicated the following incidents:
- On an identified date, a prescribed pain medication was not administered for resident #014 at specific hours. The incident report indicated that the medication was not given as prescribed.

- On an identified date,a prescribed pain medication was not administered for resident #015 at specific hours. The incident report indicated that the medication was not given as prescribed.

- On an identified date, a prescribed pain medication was not administered for resident #016 at identified hours. The incident report indicated that the medication was not given as prescribed.

The DOC confirmed during an interview that it was the expectation of the home and the College of Nurses of Ontario (CNO) that registered staff administer medications as prescribed by the prescriber. The DOC indicated that registered staff were always to check and recheck the physician's order and administer medications accordingly. The

DOC indicated that the staff members involved in the above mentioned incidents were disciplined, and appropriate training was provided to mitigate the risk of medication incidents. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any policy and procedure the home had, instituted or otherwise put in place was complied with.

The home's policy titled "Resident Incident Management, #HC-0114-00" last reviewed on January 2019, provided direction to staff members on how to deal with incidents. The policy directed staff members to do the following:
- to complete incident reports whenever a resident is involved in a harmful or potentially harmful incident.
- Complete an environmental scan and provide a thorough description of the incident
- Notify MD and SDM
- Complete appropriate assessment, and ensure ongoing monitoring and evaluation is completed.
- Investigate the incident, complete a root cause analysis and determine the antecedent causes and update the plan of care.

A CIS report was submitted to the MLTC and indicated that resident #002 sustained an injury to an identified part of their body.

Further review of the home records did not indicate if the incident was investigated. There were no root cause analysis and assessments completed to determine the antecedent cause of the injury.

Inspector #645 reviewed two additional critical incident reports, that resulted in injury to residents #005 and #006, to increase the resident sample due to identified non-compliance. Review of these two incidents indicated that the home completed initial assessments, root cause analysis to determine antecedent causes, determined the cause of injury and updated the plan of care for both residents. No concerns were identified within the increased sample size.

Interview with the ONM #118, indicated that they did not complete incident investigation as they were not aware about the above mentioned incident involving resident #002. They indicated that they normally investigate every harmful or potentially harmful incidents thoroughly and update the plan of care to prevent recurrences. The ONM stated they were not sure how they missed this incident. [s. 8. (1) (b)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that an alleged improper or incompetent treatment and neglect of a resident, was reported to the MLTC immediately.

A CIS report was submitted to the MLTC, regarding an alleged improper/incompetent treatment of resident #010 by staff members.

Review of an email correspondence between the DOC and the complainant indicated that the home received verbal and written complaints regarding the alleged incident on an identified date. A review of the email correspondence between the DOC and the complainant indicated that the complainant wanted to have face to face meeting to discuss their concerns in detail and an appointment was arranged. The records indicated that the meeting was held on an identified date for the alleged incident of abuse and neglect of resident #010. Review of the CIS report indicated that the MLTC was not notified regarding the alleged incident of abuse immediately.

During the interview, the DOC confirmed that this incident was not reported to MLTC immediately. [s. 24. (1)]

Issued on this 30th day of June, 2020

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

Original report signed by the inspector.