Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 8, 2019	2019_668543_0004	016584-18, 020197-18, 020926-18, 025216-18, 027576-18, 028813-18, 028822-18, 028911-18, 029296-18, 029894-18, 029931-18, 030267-18, 031547-18, 031679-18, 031777-18, 031806-18, 031935-18, 032641-18, 032748-18, 032821-18, 033150-18, 033419-18, 000485-19, 000723-19, 000746-19, 000839-19, 000845-19, 000941-19, 001028-19, 001601-19, 002040-19, 002041-19, 003922-19	Critical Incident System

Licensee/Titulaire de permis

2063412 Ontario Limited as General Partner of 2063412 Investment LP
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

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

Muskoka Shores Care Community
200 Kelly Drive GRAVENHURST ON P1P 1P3

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

TIFFANY BOUCHER (543), AMY GEAUVREAU (642), STEVEN NACCARATO (744), SYLVIE BYRNES (627)

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 11-15, 19-22, 25-28 and March 1, 2019.

A Complaint inspection #2019_668543_0006 and a Follow-up inspection #2019_668543_0005 were conducted concurrent with this inspection.

The following intakes were inspected during this inspection:

Twenty two intakes; related to resident to resident abuse,

Eight intakes; related to falls,

Two intakes; related to missing medications, and

One intake; related to improper care.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Nurse Managers, Physicians, Behavioural Support Service (BSS) Staff, Registered Nurses (RN), Registered Practical Nurses (RPN) and Personal Support Workers (PSW) and residents.

The Inspectors also observed resident care areas, the provision of care and services to residents, staff to resident interactions, reviewed relevant health care records, internal investigation documents and policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Personal Support Services
Responsive Behaviours

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

6 WN(s)
4 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident had the right to be treated with courtesy and respect in a way that fully recognized the resident's individuality and respected the resident's dignity.

A)A Critical Incident (CI) report was submitted to the Director regarding an incident of alleged abuse between resident #026 and resident #001.

Inspector #627 reviewed a progress note in resident #026's electronic medical record which indicated that resident #026 was leaning over a co-resident inappropriately touching and saying something to them. Nurse Manager #107, asked resident #026 what they had said and resident #026 stated that they had told the co-resident how they felt about them. The writer, Nurse Manger #107, responded to the resident in a manner that was hurtful to the resident.

Inspector #627 reviewed resident #026's care plan, in effect at the time of the incident. For the focus of specific behaviours, it further described how resident #026 expressed the specific behaviours towards other residents.

Inspector #627 interviewed Nurse Manager #107 who stated that the language they utilized and the attempt to redirect the resident was inappropriate, and that the resident

may have interpreted their comment differently. Nurse Manager #107 acknowledged that the comments may have been hurtful to resident #026.

B) Two CI reports were submitted to the Director alleging resident to resident abuse between residents #018 and #019. The CI report indicated that resident #018 and resident #019 were observed displaying inappropriate behaviours.

Inspector #627 reviewed resident #018's progress notes which revealed the following progress note:

On a specified date, Nurse Manager #107 approached resident #018 in the hallway. They were sitting with resident #019 in the presence of staff. The writer asked resident #018 specific questions about resident #019. Resident #019 stated that they felt embarrassed by the questions that Nurse Manager #107 asked.

Inspector #627 interviewed the DOC, who stated that the conversation was inappropriate and that the residents were to be treated with respect and dignity. They further stated that the comment may have made resident #019 and resident #018 feel ashamed and embarrassed, as the discussion had taken place in the hallway with staff and residents present, which should not have occurred. [s. 3. (1) 1.]

2. The licensee has failed to ensure that every resident had the right to form friendships and relationships and to participate in the life of the long-term care home.

Two CI reports were submitted to the Director related to alleged resident to resident abuse, between residents #018 and resident #019. The CI reports identified that resident #018 was observed inappropriately touching resident #019. The CI reports further identified that recently both residents had been seeking each other out and had voiced that they enjoyed spending time together. The two residents had a history of specific beahviours towards each other.

Inspector #627 reviewed resident #018's written care plan in effect at the time of the inspection which listed interventions for specific behaviours.

Inspector #627 reviewed resident #019's care plan, which listed interventions for specific behaviours.

Inspector #627 reviewed the home's policy related to specific behaviours, last revised

December 2017. The policy indicated that registered staff, upon becoming aware of a resident displaying specific behaviours, they were to assess the situation. If unwanted behaviours occurred or there was evidence of distress or injury noted and /or inappropriate for the surrounding environment, immediately intervene to ensure safety of resident(s) and report to the Director of Care/charge nurse.

Inspector #627 reviewed the electronic progress notes of resident #018 and identified 31 progress notes indicating that resident #018 displayed inappropriate behaviours towards resident #019; none of the progress notes indicated that either residents had expressed fear or distress during the observations.

A progress note indicated that Nurse Manager #107 approached resident #018 in the hallway; who was sitting with resident #019, in the presence of staff. The writer asked them specific questions about resident #019. Resident #019 stated that they felt embarrassed by the questions asked.

A progress note indicated that writer (RPN #134) found resident #018 and resident #019 sitting together. RPN #134 told resident #018 that their specific behaviour was inappropriate and could get them in trouble.

A progress note written by RPN #124 indicated the following: writer had been notified that resident #018 was sitting with resident #019 and that the residents may be acting socially inappropriately.

A progress note indicated the following:

A meeting was held with a team of interdisciplinary members who discussed incidents that had occurred between resident #018 and #019.

Inspector #627 interviewed resident #018 who stated that resident #019 was their friend and that they were "very nice". When Inspector #627 asked if it bothered them (resident #018), when resident #019 spent time with them, to which resident #018 replied "no, I really don't think about it".

Inspector #627 interviewed resident #019 who stated that they enjoyed spending time with resident #018 and that they wished the home stop intervening in their friendship.

Inspector #627 interviewed PSW #129 who stated that they had been told to keep

resident #018 and #019 completely apart, and the reason why. PSW #129 stated that resident #018 enjoyed resident #019's company. PSW #129 stated that they had not received any training in regards to specific beahviours. PSW #129 further stated that it was the residents' right to form friendships, unless their families had not wanted that.

Inspector #627 interviewed RPN #131 who stated that when residents demonstrated specific behaviours towards another resident, they were to be immediately separated for their safety, and that staff tried to keep residents away from each other. They stated that it was an ongoing issue between resident #018 and resident #019, because they kept seeking each other out. The RPN stated that appropriate assessments were completed.

Inspector #627 interviewed RPN #134, who stated that staff were confused in regards to resident #018 and resident #019's interest towards each other, as management told the staff to keep the residents separated. RPN #134 stated that they completed a specific assessment, which was given to management and they informed us on how to proceed. RPN #134 stated that when they questioned resident #018, they denied any relationship.

Inspector #627 interviewed RN #106, who stated that resident #018 and resident #019 sought each other out. The RN stated that when two residents were displaying interest towards each other, the residents were separated and questioned separately. RN #106 stated that they determined if it was a pattern or a first occurrence. As well, specific assessment were completed, and a decision tree was utilized to determine if the resident was capable of consenting to relationships. RN #136 stated that they completed the forms, however, management made the decision in regards to the residents being allowed to demonstrate interest towards each other. RN #136 stated that two days ago, it was determined that the residents would be allowed to sit together and spend time together; however, they were unsure how specific interactions would be addressed.

Inspector #627 interviewed Physician #133 who stated that when they were informed of specific behaviours between two residents, they assessed the residents.

Inspector #627 interviewed Nurse Manager #107, who stated that when residents demonstrated interest towards each other, the residents' were assessed. Nurse Manager #107 stated that the resident interaction would be stopped until the assessments were completed. Nurse Manager #017 stated that staff followed the home's policies which had not included asking the residents, at the time of the alleged incident, if they wanted the activity to continue.

Inspector #627 interviewed the DOC, who stated that when specific behaviours were observed between two residents, specific assessments were utilized. The DOC further discussed the interactions between resident #018 and #019. The DOC stated that perhaps the home was concerned about protecting the residents and ensuring that abuse had not occurred, that they had disregarded the "human factor". [s. 3. (1) 18.]

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 every resident has the right to be treated with courtesy and respect in a way that fully recognizes the resident's individuality and respects the resident's dignity and that every resident has the right to form friendships and relationships and to participate in the life of the long-term care home, to be implemented voluntarily.

WN #2: 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. (3) The licensee shall ensure that the plan of care covers all aspects of care, including medical, nursing, personal support, nutritional, dietary, recreational, social, restorative, religious and spiritual care. 2007, c. 8, s. 6 (3).

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 has failed to ensure that there was a written plan of care for each resident that sets out clear directions to staff and others who provided direct care to the residents.

A CI report was submitted to the Director on a specific date in 2018, for a fall which caused a significant injury to resident #005.

Inspector #627 reviewed resident #005's fall history which indicated that the resident had six falls during a specific time frame in 2018. The Inspector reviewed the "Post Fall Incident Forms" for the aforementioned falls and noted that three of the six falls, (or 50 per cent of the falls) were related to when resident #005 attempted to transfer independently.

Inspector #627 reviewed the resident's care plan and Kardex, in effect at the time of the inspection, and noted under a specific foci, the interventions included that resident needed one staff member to assist with a specific ADL, and that the resident was able to

perform specific ADLs independently.

Inspector #627 reviewed the home's policy titled "Documentation-Plan of Care" (VII-C-10.70-SSLI), last revised April 2018, which indicated that the care plan was a document tool that communicated and directed the plan to team members for specific care approaches not established in standard operating procedures.

Inspector #627 interviewed PSW #100, who stated that resident #005 needed assistance with specific ADLs. PSW #100 and the Inspector reviewed the current Kardex and care plan. The PSW acknowledged that the interventions for resident #005's ADL needs were not clear.

Inspector #627 interviewed Nurse Manger #108, who acknowledged that the resident's care plan and Kardex had not provided clear directions related to resident #005's care needs. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the plan of care covered all aspects of care, including medical, nursing, personal support, nutritional, dietary, recreational, social, restorative, religious and spiritual care.

A CI report was submitted to the Director on a day in 2018, for a fall which caused a significant change to resident #004's health status.

Inspector #627 reviewed resident #004's admission "Fall Risk Assessment", from a specific date, which indicated that the resident was at a moderate risk for falls. Resident #004's last annual Minimal Data Assessment (MDS), and the resident's assessment protocol (RAP) indicated that the resident was at risk for falls.

Inspector #627 reviewed resident #004's care plan in effect, at the time of the incident, and it failed to identify a foci for the prevention of falls.

The Inspector reviewed the home's "Documentation-Plan of Care" policy (VII-C-10.70-SSLI) which indicated that the plan of care is comprised of more than one document; and includes but is not limited to, medical diagnosis, and any other information in the chart pertinent to care delivery to the resident. This policy defined "care plan" as a documentation tool that communicates and directs the plan to team members for specific care approaches not established in standard operating procedures.

Inspector #627 interviewed PSW #100, who stated that they would review a resident's care plan to know what care was required, as well as, what their risk of falling was, and what interventions were in place to prevent falls.

In separate interviews with RN #106 and RN #109, they stated that if a resident was at risk of falls, interventions should be listed in the resident's care plan.

Inspector #627 interviewed the DOC, who stated that if a resident was at risk for falls, their care plan should indicate their risk for falls, and the interventions in place to reduce the risk of falling. The DOC and the Inspector reviewed the resident's care plan in effect at the time of the incident, and the DOC acknowledged that there was no foci to identify resident #004's risk of falls in the care plan. [s. 6. (3)]

3. A CI report was submitted to the Director on a day in 2019, related to resident #024 having a fall that resulted in the resident being transferred to the hospital and being diagnosed with significant injuries.

Inspector #543 reviewed the resident's health care record, and was unable to identify that the resident had specific contributing factors related to falls. However, the resident's physician's orders included an order for a specific medication to be given as indicated for a specific medical diagnosis. There was no indication in the resident's care plan that communicated and directed any care for the resident, related to contributing factors related to falls.

The Inspector interviewed RPN #139 who indicated that the resident's plan of care should have identified contributing factors related to falls, and this information should also be included in the medical diagnosis tab and in the care plan.

The Inspector interviewed RN #106 who verified that a specific diagnosis should have been identified in the medical diagnoses within the resident's electronic health record. The RN verified that the resident's care plan did not identify that the resident had specific contributing factors related to falls.

Inspector #543 interviewed the DOC who indicated that resident #024's contributing factors related to falls should be indicated within the diagnoses tab in the electronic health record, as well as documented in the care plan. They further indicated that resident #024 has had significant injuries as a result of a fall from specific contributing factors, as well as identifying that the resident required medication to manage a specific

diagnosis. The DOC verified that the resident's plan of care did not identify the resident had specific contributing factors related to falls. [s. 6. (3)]

4. 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.

A CI report was submitted to the Director on a day in 2019, related to resident #024 having a fall that resulted in the resident being transferred to the hospital and diagnosed with significant injuries.

Inspector #543 reviewed the resident's health care record which identified that the resident sustained 12 falls between specific dates in 2018 and 2019.

Inspector #543 reviewed the following additional information:

-the resident's care plan implemented after the fall that occurred on a day in 2019, identified a focus of being at moderate risk for falls,
-progress note, titled "assessment SPN", identified the resident was a high risk for falls.

The Inspector interviewed PSW #141, who identified the resident was at a high risk for falling, as a result of their numerous falls.

The Inspector interviewed RPN #122 and RN #108 who indicated that resident #024 was at a high risk for falling.

The Inspector interviewed RN #106 who indicated that resident #024 was at a high risk for falling, and that their care plan should have been updated after their fall.

Inspector #543 interviewed the DOC who verified that a resident's care plan should be updated at least quarterly and with any MDS changes. The DOC indicated that when there are any changes in the resident's condition the care plan should be updated immediately. [s. 6. (10) (b)]

5. 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 care set out in the plan had not been effective.

A CI report was submitted to the Director on a day in 2018, regarding an altercation between resident #016 and resident #017. Resident #017 wandered into resident #016's room. Resident #016 confronted resident #017, which resulted in resident #017 injuring the other resident.

Inspector #744 reviewed the home's policy, titled: "Documentation – Plan of Care" (VII-C-10.70-SSLI), last revised date of April 2018, which indicated that the Executive Director and Director of Care will: "Reassess and update the care set out in the plan of care as required if the care is no longer necessary or it has not been effective".

Inspector #744 reviewed resident #016's care plan, which indicated that the resident expressed specific behaviours when other residents entered their room. As of December 2018, an identified intervention was to be applied on resident #016's room door to deter other residents from entering.

Multiple observations by Inspector #744 on February 14, 15, and 19, 2019, identified resident #016 in their room without the identified intervention applied on their door.

Inspector #744 interviewed PSW #114 who indicated that they had not seen the identified intervention on the resident's door and were not certain if it was needed.

In an interview with RPN #113, they indicated that the identified intervention not effective for resident #016.

During an interview with Nurse manager #107, they confirmed that the identified intervention to resident #016's room door was no longer effective and the plan of care for the resident should have been revised. [s. 6. (10) (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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the residents and 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 change or care set out in the plan is no longer necessary, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A CI report was submitted to the Director on a day in 2018, related to a missing medication, identified during a medication count.

A) In accordance with O.Reg 79/10, s. 114 (1) (2), the licensee was required to ensure that written policies and protocols were developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration,

and destruction and disposal of all drugs used in the home.

A review of Medical Pharmacies policy, titled: "The Medication Pass" (3-6), last revised date of January 2018, indicated that "borrowing of one resident's medication for use by another is not permitted".

Inspector #744 reviewed resident #030's Individual Monitored Medication Record from specific dates in 2018, and identified that RPN #125 had borrowed a specific medication on seven separate occasions, from resident #030 to administer to resident #031 who had the same medication order.

Inspector #744 interviewed RPN #125, who stated they had borrowed a prescribed medication from resident #030 to administer to resident #031 because they needed the medication in a hurry, and confirmed they did not follow the direction as outlined in the home's policy.

Inspector #744 interviewed ADOC #124, who confirmed that registered staff should not "borrow" medication, as directed by the home's policy.

B) In accordance with O.Reg 79/10, s. 136. (1) Every licensee of a long-term care home shall ensure, as part of the medication management system, that a written policy is developed in the home that provides for the ongoing identification, destruction and disposal of drugs.

A review of Medical Pharmacies policy, titled: "Discontinued Medications" (4-10), dated February 2017, indicated that "All discontinued medications to be processed properly, checked for accuracy and removed from the active medication in cart/med room in accordance with the current legislation".

Inspector #744 reviewed the investigation notes, an order for a specific medication was discontinued for resident #030 on a date in 2018, but the medication remained in the medication room.

Inspector #744 reviewed resident #030's Medication Administration Record (MAR) for specific dates in 2018, which described that a specific medication was discontinued for resident #030 on a specific date in 2018.

Inspector #744 interviewed RPN #103, who acknowledged that the discontinued

medication should have been discarded upon their discovery of the discontinued medication.

Inspector #744 interviewed ADOC #124, who confirmed that the discontinued medication should have been immediately discarded by the first nurse who counted the discontinued medication. [s. 8. (1) (b)]

2. A) A CI report was submitted to the Director on a date in 2019, related to resident #024 having a fall that resulted in the resident being transferred to the hospital and diagnosed with significant injuries.

Inspector #543 reviewed resident #024's progress notes related to the fall that occurred on a date in 2019. The notes described how RN #106 had received the resident.

Inspector #543 reviewed the home's "Falls Prevention" (VII-G-30.00) policy which indicated that registered staff would complete a Falls Risk Assessment, within 24 hours of admission, as triggered by the Minimum Data Set (MDS) resident assessment protocol and any significant change in a resident's status.

Inspector #543 reviewed the resident #024's health care record, and identified that in the last six months, the resident had two Falls Risk Assessments completed prior to their fall. There was no Falls Risk Assessment completed after the resident fell, and sustained significant injuries on the date in 2019.

Inspector #543 interviewed RPN #131, who indicated that any resident who sustained a fall should have a "Fall Risk Assessment" completed at least quarterly, and more often, if the resident had a history of falling or a change in their health condition.

The Inspector interviewed the DOC, who indicated that a Falls Risk Assessment must be completed within 24 hours of admission, quarterly if triggered by MDS, annually if triggered by MDS, any with any change in status and any return from hospital. The Inspector and the DOC reviewed the resident's "Falls Risk Assessments" together, and the DOC acknowledged and verified that this resident had no "Falls Risk Assessment" completed after they fell on the date in 2019.

B) A CI report was submitted to the Director on a day in 2018, for an incident that caused an injury to resident #004, for which the resident was taken to the hospital. The CI report indicated that resident #004 had an unwitnessed fall on a date in 2018, whereby, they

were found lying on the floor, complaining of pain and requesting pain medication. The resident was later identified as having a fracture.

Inspector #627 reviewed the home's policy titled "Falls Prevention" (VII-G-30.00), last revised January 2015, which indicated that the registered staff were not to move the resident if there was suspicion or evidence of injury. The physician should be contacted and/or arrange for immediate transfer to the hospital; the substitute decision maker was to be notified.

Inspector #627 reviewed resident #004's electronic progress notes that indicated that on a day in 2018, "the resident had an unwitnessed fall. The resident was complaining of pain during range of motion (ROM), and requested pain medication. Two other progress notes indicated that the resident complained of pain on and off throughout the shift, saying "ouch it hurts". A progress note indicated that resident #004, continued to complain of pain and was refusing to stand. The writer informed the Nurse Practitioner of a change in the resident's vital signs. A progress note indicated that the Nurse Practitioner assessed resident #004, whereby they sent the resident to the hospital for further diagnostic testing.

Inspector #627 interviewed PSW #100, who stated that when a resident had a fall, the RPN decided if the resident was able to transfer with staff members and if they were able to weight bear. If not, a mechanical lift would be used to transfer the resident.

Inspector #627 interviewed RN #106, who stated that they were working with RN #109, at the time of resident #004's fall. They stated that when a resident exhibited pain after a fall, the substitute decision-maker and the physician on call were to be notified.

Inspector #627 interviewed RN #109, who stated that if a resident complained of pain after a fall during ROM, that it would be a reason for the resident to be sent to hospital for further assessment and that, "If they required [a certain number] people to transfer them, and they were complaining of pain, the resident should have been sent to the hospital".

Inspector #627 interviewed RN #110, who stated that if a resident had a fall, and was complaining of pain, they would ask them to try and move. If they were given pain medication, and continued to complain of pain and refused to weight bear, they would send them to the hospital for further assessment. The RN stated that the resident should have been transferred using an assistive device, not with [a certain number] staff members.

Inspector #627 interviewed the DOC who stated that by looking at the progress notes, the resident should have been sent to the hospital to be evaluated. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the " Falls Prevention", policy is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident who was incontinent had an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan was implemented.

A CIS report was submitted to the Director on a day in 2018, related to a fall which caused a significant injury to resident #005. Please see WN #2-1.

Inspector #627 reviewed resident's #005 fall history which indicated that the resident had six falls between specific dates in 2018. The Inspector reviewed the "Post Fall Incident Forms" for the aforementioned falls and noted that three of the six falls, (or 50 per cent of the falls) were related to when resident #005 attempted to transfer independently.

Inspector #627 reviewed resident #005's last two continence assessments between 2018 and 2019, which clearly defined treatment options related to the continence assessments.

Inspector #627 reviewed resident #005's care plan and Kardex in effect at the time of the inspection and could not identify any specific interventions related to the defined treatment options.

Inspector #627 reviewed the home's policy titled, "Continence Program-Promoting Continence", last revised January 2015, which identified that all nursing staff were to adhere to resident's individualized care plan, which included scheduled times providing care and assisting residents with ADLs, and at the scheduled time, staff were to remind residents that it was time to perform specific ADLs.

Inspector #627 interviewed PSW #100 on two separate occasions. The PSW stated that the resident often tried to perform specific ADLs independently; however, this was no longer safe for them. PSW #100 further stated that they were not aware of resident #005 having specific interventions related to specific their continence needs.

Inspector #627 interviewed RPN #125 who stated that a continence assessment was completed annually and anytime when a resident had a change in their status. Upon review of resident #005's continence assessments, RPN #125 acknowledged that the resident's care plan and Kardex should have been reviewed and revised to reflect that staff were to provide specific assistance related to ADLs by the staff member who completed the assessment.

Inspector #627 interviewed the Nurse Manager #108 who acknowledged that resident #005's care plan and Kardex should have included specific interventions, as was indicated in their two previous assessments. [s. 51. (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 each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented, 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 ensure that the home's "Falls Prevention" (VII-G-30.00) policy, was evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

A CI report was submitted to the Director on a day in 2018 for a fall which caused a significant change to resident #004.

Inspector #627 reviewed the home's policy titled "Falls Prevention" (VII-G-30.00) policy, and identified the policy had not been evaluated or updated since January, 2015.

Inspector #627 interviewed the Administrator, who stated that they had called the Corporate office and verified that the home's "Fall Prevention" (VII-G-30.00) had not been evaluated or updated since January, 2015. [s. 30. (1) 3.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A CI report was submitted to the Director on a day in 2019, which alleged that PSW #105 had transferred resident #021 alone. The CI report identified that PSW #105 had transferred the resident without using a safe transferring device; and that there should have been two staff members present and an assistive device in use, while assisting the resident.

Inspector #642 reviewed the home's investigation notes, and an interview had been completed with PSW #105 on a day in 2019, who had admitted to transferring resident #021 alone, and had not used an assistive device as required, per resident #021's care plan.

Inspector #642 reviewed resident #021's care plan implemented at the time of the

incident. The care plan indicated that the resident required two staff members to assist, and an assistive device for specific ADLs.

Inspector #642 interviewed PSW #104, who had witnessed the incident that occurred on a date in 2019, and they stated that PSW #105 was with resident #021, and there had been no assistive device observed in the room, nor another staff member present for the transfer of resident #021.

The Inspector interviewed PSW #105, who stated they had transferred resident #021 without an assistive device or another staff member.

Inspector #642 interviewed PSW #127, RPN #128, and RN #109, who stated that when a transfer was required with an assistive device, there should be two staff to assist the resident for a proper transfer.

The Inspector reviewed the home's policy, titled, "Zero Lift & Protocol" (IV-M-10.10) last revised October, 2018. The policy stated, the team member would comply with the Zero Lift & Protocol policy, procedures, and plan of care/service plan at all times by utilizing appropriate body mechanics, available lift devices, and seeking additional assistance where required. The policy also indicated that two qualified team members must be present at all times when operating specific equipment.

Inspector #642 interviewed Nurse Manager #108, who had investigated the incident. They stated PSW #105, had transferred resident #021 without the assistance of another staff member or an assistive device, as required at that time for the safety of the resident. [s. 36.]

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 11th day of April, 2019

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

Original report signed by the inspector.