Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Central East District
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Oshawa, ON, L1H 1A1
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Original Public Report

Report Issue Date: May 9, 2023	
Inspection Number: 2023-1498-0001	
Inspection Type: Complaint Critical Incident System	
Licensee: Royal Canadian Legion District 'D' Care Centres	
Long Term Care Home and City: Tony Stacey Centre for Veterans' Care, Toronto	
Lead Inspector Elaina Tso (741750)	**Inspector Digital Signature**
Additional Inspector(s) Nicole Lemieux (721709) Moses Neelam (762) Maria Paola Pistritto (741736) Suzanna McCarthy (000745) was present during the inspection.	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 29 to 31, and April 3 to 6, 11 to 14, 2023.

The following intake(s) were inspected:

- Seven intakes related to alleged staff to resident abuse.
- One intake of a complaint related to plan of care, resident care and services, neglect, pain management and skin and wound concerns.
- One intake related to falls prevention and management.
- Nine intakes were completed in this inspection related to falls prevention and management.
- One intake related to alleged staff to residents' neglect.
- One intake related to an alleged resident to resident abuse.
- One intake related to improper care of a resident.
- Two intakes related to medication incidents.
- One intake related to an injury in which a resident was taken to hospital.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: MEDICATION MANAGEMENT

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with O. Reg. 246/22 s. 123 (2).

The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that their written policy related to management of drugs for a resident is complied with.

Specifically, staff did not comply with the “Control of Narcotics – Count” policy on a specific date which indicated that the totals of controlled drugs must reflect the actual number of it in the locked medication cabinet.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director for a medication incident involving a missing controlled substance. The home’s policy confirmed that controlled substance counts were to be completed on each shift to reflect the number of controlled substances on hand. A Registered Practical Nurse (RPN) confirmed that a controlled substance count was not completed at the beginning of the shift. Furthermore, two RPNs confirmed that the controlled substance was not identified to be missing until a medication count was completed at the end of the shift. The Director of Care (DOC) confirmed that the nurses were to complete a controlled substance count at the beginning and ending of each shift.

By the nurse not following the control of substance count policy, the resident was at risk of not receiving scheduled medications.

Sources: Interviews with staff, resident's MAR, Control of Narcotics - Count policy, narcotic count sheet. [741736]

WRITTEN NOTIFICATION: FALLS PREVENTION AND MANAGEMENT

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 79/10, s. 49 (2)

The licensee has failed to ensure that when a resident had a fall, a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Rationale and Summary

A CIR was submitted to the Director for an unwitnessed fall of a resident which resulted in a transfer to hospital. An RPN indicated that the resident experienced a change in condition requiring a post fall assessment using the post-fall assessment tool. Assessments and progress notes for the resident indicated that a post fall assessment was not completed using an appropriate instrument designed for falls. The home's falls management policy confirmed that a post fall assessment instrument was to be completed post fall. An RPN, Registered Nurse (RN) and the DOC confirmed a post fall assessment instrument was not completed.

By the home not completing the post falls assessment instrument, the resident was at risk for unidentified injuries related to the fall.

Sources: Falls Prevention and Management Program policy, a resident's health records, interviews with staff. [741736]

WRITTEN NOTIFICATION: RESPONSIVE BEHAVIOURS

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 79/10, s. 53 (4) (a)

The licensee has failed to ensure that a resident, who was exhibiting responsive behaviors, had triggers identified.

Rationale and Summary

A CIR was submitted to the Director related to inappropriate responsive behaviors between two residents. One resident's care plan had identified triggers for an inappropriate responsive behavior and was first initiated following the submission of this CIR. The resident's progress notes indicated that the

resident had several incidents of the responsive behaviors involving staff prior to the incident identified in the CIR. The DOC indicated that the triggers should have been identified after the first incident. Furthermore, the care plan did not address such responsive behaviors, prior to the incident identified in the CIR.

As such there was a risk of the resident's behaviors escalating as their needs were not addressed or identified until the incident identified in the CIR.

Sources: Interview with the DOC and electronic health records. [762]

WRITTEN NOTIFICATION: RESPONSVIE BEHAVIOURS

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 79/10, s. 53 (4) (b)

The licensee has failed to ensure that a resident, who was exhibiting responsive behaviors had strategies developed and implemented to respond to these behaviours.

Rationale and Summary

A CIR was submitted to the Director related to an inappropriate responsive behaviour between two residents. The resident's care plan identified strategies to respond to the responsive behaviors was first initiated following the incident identified in the CIR. The resident's progress notes indicated that the resident had three incidents of inappropriate expressive behaviors involving staff prior to the incident identified in the CIR. The DOC indicated that the strategies should have been initiated after the first incident. Furthermore, the care plan did not address the inappropriate responsive behaviors, prior to the incident identified in the CIR.

As such there was a risk of the resident's behaviors escalating as their needs were not addressed or strategies developed and implemented until the incident identified in the CIR.

Sources: Interview with the DOC and electronic health records. [762]

WRITTEN NOTIFICATION: LICENSEES WHO REPORT INVESTIGATIONS UNDER s. 23 (2) of Act

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 79/10, s. 104 (1) 2. i.

The licensee has failed to ensure that the report made to the Director when alleged abuse has occurred, included the name of a resident, who was involved in the incident.

Rationale and Summary

A CIR was submitted to the Director indicating alleged physical abuse of a resident. The CIR did not contain the name of the resident involved in the incident. The DOC indicated that the process of the Long-Term Care Home (LTCH) is to include the resident name in the CIR, and that this CIR did not contain that information.

There was no risk to the resident as a result of submitting a CIR without the name of the resident.

Sources: CIR and interview with the DOC. [762]

WRITTEN NOTIFICATION: LICENSEES WHO REPORT INVESTIGATIONS UNDER s. 23 (2) of Act

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 79/10, s. 104 (1) 2. ii.

The licensee has failed to ensure that the report made to the Director when alleged abuse had occurred, included the names of any staff members present at the incident.

Rationale and Summary

A CIR was submitted to the Director indicating alleged physical abuse of a resident. The CIR did not contain the names of any staff members who were present at the incident. The DOC indicated that the process of the LTCH is to include the names of any staff members who were present at the incident in the CIR, and that this CIR did not contain that information.

There was no risk to the resident as a result of submitting a CIR without the names of any staff members who were present at the incident.

Sources: CIR and interview with the DOC. [762]

WRITTEN NOTIFICATION: DIRECTIVES BY MINISTER

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-Compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to ensure that where the Act required the licensee of a LTCH to carry out every operational Minister’s Directive that applies to the LTCH, the operational Minister’s Directive was complied with.

In accordance with the Minister's Directive, COVID-19 guidance document for LTCH's in Ontario, dated June 29, 2022, licensee was required to conduct weekly Infection Prevention and Control (IPAC) self-audits when the home was in COVID-19 outbreak.

Rationale and Summary

The home was in a COVID-19 outbreak for a period of time in 2022. The IPAC lead stated that the home was to complete IPAC audits weekly when in outbreak. The home did not have records of the IPAC audits for two weeks during this period of the outbreak. The DOC confirmed the same and they could not verify if the IPAC audits were completed during that time.

Sources: The COVID-19 Guidance Document for Long-Term Care Homes in Ontario, the home's IPAC self-audit records and interviews with the IPAC Lead and the DOC. [741750]

WRITTEN NOTIFICATION: GENERAL REQUIREMENTS

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 34 (1) 2.

The licensee has failed to ensure that the assistive aids used for a resident were appropriate for the resident's condition.

Rationale and Summary

In accordance with O. Reg 246/22, s.53 (1) 1., LTCH is required to develop and implement an organized program for falls prevention and management. Under this program, any assistive aides used with respect to the resident must be appropriate based on the resident's condition.

A CIR was submitted to the Director for an incident involving a resident which resulted in a significant change in status. Progress notes, a physiotherapy referral, and the CIR, indicated that the incident occurred in conjunction with a malfunction assistive device. The resident's care plan indicated that they were independent with an assistive device and the Physiotherapist (PT) confirmed the same.

Further review of the resident's progress notes, indicated that prior to the incident identified in the CIR, that their assistive device was not fully functioning following a previous incident and required maintenance. Documents and records were unavailable to indicate what repairs were completed. The PT identified that the resident's assistive device was "not completely gone" and were functioning at "75-80%" capacity following the initial incident prior to the incident identified in the CIR. Documentation, records, and an interview with the PT indicated that the resident continued to use the same assistive device for approximately three months. The PT confirmed that the assistive aid was not in proper

functioning condition at the time of the incident in the CIR and was removed from the resident's use following that incident.

Failing to ensure that the resident's assistive device was functioning appropriately for their condition put the resident at an increased risk to fall.

Sources: Resident's progress notes, care plan, assessments and referrals, Motion Repair and Maintenance Log for first floor, CIR, and interview with the PT. [721709]

WRITTEN NOTIFICATION: GENERAL REQUIREMENTS

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 34 (1) 4.

The licensee has failed to ensure that a written record was kept for each evaluation of the fall's prevention and management program.

Rationale and Summary

As a result of a resident's fall, the LTCH falls prevention and management program was reviewed. Review of the program indicated that the home did not have a written record for the evaluation of the fall's prevention and management program for three years including 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. Both the DOC and Administrator indicated that an evaluation was currently in progress for the current year but was not yet completed. Additionally, both the DOC and Administrator confirmed that an evaluation of the fall's prevention and management program for the above-mentioned years could not be located within the home and a written record could not be provided.

Failing to evaluate the falls prevention and management program puts all residents at an increased risk of falling.

Sources: Interviews with the DOC and Administrator. [721709]

WRITTEN NOTIFICATION: NOTIFICATION RE PERSONAL BELONGINGS, ETC.

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with O. Reg. 246/22 s. 42 (b)

The licensee failed to notify a resident's Substitute Decision Maker (SDM) when the resident required new personal belongings.

Rationale and Summary

A complaint was made to the Director related to an incident of inappropriate dressing of a resident. While visiting the resident on a specific date, the SDM witnessed the resident in bed with their clothing not appropriately adorned, taking and providing a photograph as evidence. The resident's health record indicated that they had significant health changes prior to the incident.

Personal Support Worker (PSW) stated that the resident had health changes and did not have appropriate fitting clothing and that this was first reported to the registered staff when the incident happened. An RPN also confirmed that the resident's clothing was not fitting and that the SDM was only notified when the incident happened, that the resident required new clothing.

Failing to notify the SDM when resident required new clothing affected the resident's dignity and comfort.

Sources: Resident's health records, photograph of the resident and interviews with PSW and RPN. [741750]

WRITTEN NOTIFICATION: DRESS

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with O. Reg. 246/22 s. 44

The licensee has failed to ensure that a resident was dressed appropriately during the daytime.

Rationale and Summary

A complaint was made to the Director related to an incident of inappropriate dressing of a resident. The resident's clinical record noted a concern from the SDM that the resident was not dressed appropriately during the daytime. Progress notes also documented that the resident was not dressed appropriately in an afternoon on a specific date. Both PSW and RPN stated that it was not appropriate for the resident to be dressed in such clothing during the daytime, but they did not have enough suitable clothing. The resident's care plan was updated after this incident to ensure that such clothing was only to be worn during the nighttime

Failing to dress resident appropriately during the daytime did not put them at risk however impacted their appearance and dignity.

Sources: Resident's health record and interviews with PSW and RPN. [741750]

WRITTEN NOTIFICATION: SKIN AND WOUND CARE

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with O. Reg. 246/22 s. 55 (2) (a) (ii)

1) The licensee has failed to ensure that a resident received a skin and wound assessment upon return from the hospital.

Rationale and Summary

An incident was submitted through the afterhours line to the Director related to a resident's injury resulting to a transfer to hospital. Progress notes documented that the resident had surgery and returned from the hospital with a surgical wound. There was no evidence in the documentation records that a skin and wound assessment was completed for the resident after their return from hospital. The Assistant Director of Care (ADOC) confirmed that when a resident returns from the hospital with altered skin integrity, a skin and wound assessment should be done and that no skin and wound assessment was completed for the resident upon their return from hospital.

Failing to complete a skin and wound assessment for the resident posed a potential risk to miss signs of infection which could result in a delay in treatment.

Sources: Resident's health records and interview with the ADOC. [741750]

Non-compliance with O. Reg. 246/22 s. 55 (2) (a) (ii)

2) The licensee has failed to ensure that a resident received a skin and wound assessment upon return from hospital.

Rationale and Summary

A CIR was submitted to the Director for an incident involving a resident who had a significant change in health status in which they were transferred to hospital. The resident's care plan indicated that they were at risk for altered skin integrity. Progress notes and assessments indicated that a skin and wound assessment was not completed upon return from hospital. An RN indicated that a skin and wound assessment was to be completed on return from hospital and confirmed that such assessment was not completed for the resident after their return from hospital.

Failing to complete a skin and wound assessment upon return from hospital places the resident at risk for complications related to unidentified skin issues.

Sources: Resident's progress notes and assessments, and interviews with RPN and RN. [721709]

WRITTEN NOTIFICATION: SKIN AND WOUND CARE

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with O. Reg. 246/22 s. 55 (2) (b) (iv)

The licensee has failed to ensure that a resident's altered skin integrity was assessed at least weekly by a member of the registered nursing staff.

Rationale and Summary

A complaint was made to the Director related to altered skin integrity for a resident that were identified on two separate occasions. Initial skin and wound assessments were completed utilizing the home's skin and wound application on both areas of altered skin integrity by registered nursing staff. However, there was no documentation available to indicate weekly assessments were completed until the skin concerns were resolved several months later.

An RN stated that a weekly assessment was to be completed for any resident who had altered skin integrity until it was resolved. The RN also confirmed that it was clinically indicated for this resident to receive weekly skin and wound assessments but there was no record of documentation.

Failing to complete a weekly skin and wound assessment of altered skin integrity of the resident put them at risk for further skin breakdown.

Sources: Resident's health records and interview with RN. [741750]

WRITTEN NOTIFICATION: REPORTS RE CRITICAL INCIDENTS

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22 s.115 (5)

The licensee has failed to submit a CIR to the Director regarding an incident that resulted in an injury and significant change to a resident's health status for which they were taken to the hospital.

Rationale and Summary

A complaint was made to the Director related to an incident that caused injury resulting in significant health changes to a resident for which they were taken to the hospital. The LTCH documentation showed that the home had called the afterhours line on a specific date to report a critical incident resulting in an injury for a resident. A CIR was to be submitted to the Director afterwards. The DOC stated that their expectation was to submit the CIR following a call to the afterhours line. No evidence was available to indicate that the home had submitted the CIR to the Director and the DOC confirmed the same.

Failing to submit the CIR to the Director did not have impact or risk to the resident.

Sources: After hour report, resident's health records and interview with the DOC. [741750]

WRITTEN NOTIFICATION: ADMINISTRATION OF DRUGS

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-Compliance with O. Reg. 246/22, s. 140 (1)

1) The licensee has failed to ensure that no drug was administered to a resident in the home unless the drug has been prescribed for the resident.

Rationale and Summary

A CIR was submitted to the Director for an incident involving medication administration to the incorrect resident resulting in a transfer to hospital. The medication incident report and resident's MAR both confirmed that the wrong medication was given to the resident. There was no physician order for medications administered by an RPN to the resident. The RPN confirmed the incorrect medication was administered to the resident.

By the RPN not administering the correct medication the resident was at risk for adverse effects of medication.

Sources: Interviews with staff, resident's progress notes, MAR, physician's order and medication incident report. [741736]

Non-Compliance with O. Reg. 246/22, s. 140 (1)

2) The licensee has failed to ensure that no drug was administered to a resident in the home unless the drug has been prescribed for the resident.

Rationale and Summary

A CIR was submitted to the Director for an incident involving another medication administration to the incorrect resident resulting in a transfer to hospital. The medication incident report and the resident's MAR both confirmed that the wrong medication was given to the resident. There was no physician order for medications administered by an RPN to the resident. The RPN confirmed the incorrect medication was administered to the resident.

By the home not administering the correct medication the resident was at risk for adverse effects of medication.

Sources: Interviews with staff, resident's progress notes, MAR, physician's order, and medication incident report. [741736]

WRITTEN NOTIFICATION: MEDICATION INCIDENTS AND ADVERSE DRUG REACTIONS

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-Compliance with O. Reg. 246/22, s. 147 2 (c)

The licensee has failed to ensure that a written record of a medication incident was kept.

Rationale and Summary

A CIR was submitted to the Director for a medication incident involving missing controlled substance. An RPN confirmed that a controlled substance was missing on a specific date for a resident and reported to the Nurse Manager and the DOC on the same day. The DOC confirmed the pharmacy was contacted regarding this incident and was not able to produce the incident report. The DOC confirmed an investigation was completed but could not produce documentation of the review or analysis of the incident.

As a result of the incident, there was no risk to the resident.

Sources: Interviews with staff, resident's health record and narcotic count sheet. [741736]

WRITTEN NOTIFICATION: ADDITIONAL TRAINING - DIRECT CARE STAFF

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with O. Reg. 246/22, s. 261 (2) 1.

The licensee has failed to ensure that all staff who provide direct care to residents received falls prevention and management training.

Rationale and Summary

As a result of an incident occurred to a resident, the LTCH's falls prevention program was reviewed. The 2022 education records for all staff who provide direct care to residents were reviewed and it was noted that several staff did not receive their annual falls prevention and management training. The DOC confirmed that staff did not receive their training and it was an expectation that all staff would have received the education as per the Act.

Failing to educate all staff on the falls prevention and management program puts the resident's safety at risk as the staff were not up to date with the most current falls prevention education.

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Sources: The home’s falls prevention and management training records, and interview with the DOC.
[721709]