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 sous la Loi de 2007 sur les foyers de soins de longue durée

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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 14, 2018	2018_714673_0006	007775-18	Resident Quality Inspection

Licensee/Titulaire de permis

Nisbet Lodge
740 Pape Avenue TORONTO ON M4K 3S7

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

Nisbet Lodge
740 Pape Avenue TORONTO ON M4K 3S7

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

BABITHA SHANMUGANANDAPALA (673), SUSAN SEMEREDY (501), VERON ASH (535)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 18-20, 23-27, April 30; and May 1-4, 2018.

Critical Incident System report (CIS) #C546-000005-17 related to resident to resident abuse and responsive behaviours was inspected concurrently with the RQI.

During the course of the inspection, the inspector(s) spoke with residents, substitute decision-makers (SDMs), resident's family, Director of Care (DOC), Chief Executive Officer (CEO), Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Scheduling Clerk (SC), Director of Environmental Services (DES), Maintenance Worker (MW), Housekeeping (HK), Social Worker (SW), Director of Finance (DOF), Physician (MD), Dietary Aide (DA), and Director of Food Services (DFS).

During the course of the inspection, the inspector(s) conducted a tour of the home; completed observations of the medication administration system, staff and resident interactions and the provision of care; reviewed health records, complaint and critical incident record logs, staff training records, meeting minutes for Residents' Council and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Sufficient Staffing

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

16 WN(s)
10 VPC(s)
3 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

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 residents were protected from abuse by anyone.

A Critical Incident Report with CIS #C546-000005-17 was submitted to the Ministry of Health and Long Term Care (MOHLTC) related to a physical altercation that took place between resident #015 and resident #010 on an identified date and time. Resident #010 was noted to have an identified cognitive impairment.

A progress note on the identified date of the incident stated that resident #010 was observed to be missing from their floor during an identified time and was later discovered on a different floor arguing with resident #015. Resident #010 and resident #015 engaged in a physical alteration resulting in resident #010 sustaining altered skin integrity to three identified locations. Resident #015 did not sustain any injuries as per their progress notes.

A review of resident #015's medical records did not identify any behavioural issues. Resident #015's progress note from the same identified date of their altercation with resident #010, indicated that resident #015 was capable of understanding that another resident was in their room and that engaging in the altercation was incorrect. Resident #015 also acknowledged that instead, they should have called staff for help. Resident #015's progress notes dated six days after the altercation, indicated that resident #015 had altered skin integrity on two identified areas, and that the resident stated they resulted from the altercation with resident #010.

A review of resident #010's medical records indicated that resident #010 had identified mood and behaviour patterns with these behaviours not being easily altered; however, resident #010 was not involved in any intervention programs for mood or behaviour.

A review of resident #010's progress notes indicated that throughout the month leading up to the identified date of the altercation, they displayed identified behaviours towards other residents, requested and attempted to leave the unit on some days, and displayed an identified behaviour almost daily during the same time of day that the incident occurred.

A review of resident #010's written plan of care did not indicate any interventions to address resident #010's identified behaviours.

In an interview, Personal Support Worker (PSW) #127 stated that on the identified shift, PSWs care for residents on three different floors, which includes more than 30 residents, and those that exhibited the identified behaviour were monitored every hour. PSW #127 stated that while they were completing rounds, resident #010 used to exhibit the behaviours previously described in the resident's progress notes. PSW #127 stated that resident #010 displayed other identified behaviours around people that they were not familiar with, and that the only intervention was to continue to monitor the resident.

In an interview, Registered Practical Nurse (RPN) #115 stated that the intervention in place at this time was to monitor resident #010 and document the behaviour using an identified tool.

Record reviews did not indicate that any monitoring documentation was completed during the last six months leading to the time of this inspection.

In an interview RPN #131 stated that although another intervention was to bring resident #010 to the nursing station to monitor them, this was not always possible if staff were busy. In an interview, RPN #125 stated that resident #010 was exhibiting the previously described behaviours more than one year ago from the time of the inspection, especially during an identified shift. RPN #125 further stated that physical abuse includes resident to resident altercations.

In an interview, Registered Nurse (RN) #103 confirmed that due to the lack of assessment and interventions for resident #010's behaviours, resident #010 was not protected from abuse by resident #015 on the identified date of the altercation. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

The licensee has failed to ensure that drugs were stored in an area or a medication cart that was secured and locked.

1. On an identified date during the RQI mandatory medication pass observation on an identified floor, the Inspector observed RPN #120 administer medication for resident #011 during an identified medication pass. The RPN opened the medication cart, which was placed outside of the medication room, then left the medication cart unlocked and went inside the medication room to retrieve an identified medication for the resident. The medication cart was outside the RPN's line of sight as they entered the medication room and closed the door.

During the same medication pass, the RPN transferred resident #011 to their room in order to administer the identified medication. The Inspector observed that the RPN left the medication cart unlocked again in the same location outside the medication room, with at least one resident seated in the area. The Inspector remained with the unlocked

medication cart while Inspector #501 observed the administration of the identified medication in the resident's room.

During an interview, RPN #120 verified that they had left the medication cart open on two occasions during the medication pass and confirmed that the medication cart should have been locked when it was out of their line of sight. Director of Care (DOC) #100 also verified during an interview that the medication cart should have been locked and secured on both occasions when RPN #120 was away from it and unable to monitor access to it.
[s. 129. (1) (a)]

2. On an identified date, during the mandatory medication observation, resident #011 was noted to have prescribed medicated creams. The Inspector was informed by RPN #120 that PSWs were trained by registered staff to apply prescribed topical creams and lotions, and the registered staff would confirm with the PSWs that the cream/lotion had been applied and then sign the residents' treatment administration records (TARs).

In an interview, PSW #107 indicated that the registered staff unlock the cupboard and provide them with the appropriate cream/lotion for administration when required.

Two days after the previously identified date, the Inspector conducted observations of the locations where prescribed topical creams/lotions were stored by registered staff in the home.

There were three nurses' stations located in the home on three identified floors. The Inspector observed that on one identified floor, the prescribed topical creams/lotions were stored in an unlocked cupboard inside the nurses' station, making them accessible to all staff in the home, as verified by PSW #106 and RPN #125. They were also observed to be stored in an unlocked cupboard in the nursing station of another identified floor as verified by RPN #120.

Director of Care (DOC) #100 verified during an interview that residents' prescribed topical creams/lotions were kept in the medication rooms, where they should be locked and secured at all times. Furthermore, the DOC stated that if the creams/lotion were kept in a cupboard for ease of access, the cupboard should have been locked with a key to ensure only registered staff have direct access to prescribed medications. [s. 129. (1) (a)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and reported to the resident, the resident's Substitute Decision Maker (SDM), if any, the DOC, the Medical Director, the prescriber of the drug, the resident's attending physician or RN in the extended class attending the resident and the pharmacy service provider.

As part of the RQI mandatory medication pass observation, the Inspector reviewed the Medication Incident and Adverse Drug Reaction folder provided by the DOC. The folder contained three completed Resident Incident Report forms; however, there was no adverse drug reaction form included for the last quarter. All medication incidents occurred during an identified month in 2018, and included the following information:

- Resident #019's identified medication was not administered to the resident on an identified date as prescribed. The Resident Incident Report form indicated that the physician was notified; however the resident's SDM was not notified.
- Resident #020's identified medication was not administered to the resident on an identified date as prescribed. The Resident Incident Report form indicated that the physician was notified; however, the resident's SDM was not notified.
- Resident #021's identified medication was not administered on two identified dates as prescribed. The Resident Incident Report form indicated that the physician and the SDM were not notified.

In an interview, DOC #100 verified that in relation to each of the the above mentioned medication incidents, the appropriate residents' SDMs were not notified. [s. 135. (1)]

2. The licensee has failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions.

On May 2, 2018, as part of the RQI, the Inspector reviewed the Medication Incidents and Adverse Drug Reactions folder provided by the DOC which indicated that there had been three medication incidents in the last quarter between January and March 2018, and that the last Professional Advisory Committee (PAC) meeting was held in April 2017. There were no documented medication incidents or adverse drug reactions in the quarters between April 2017 and January 2018.

The DOC confirmed that the last quarterly review of the medication incidents and adverse drug reactions had taken place during the PAC meeting held on Monday, April 20, 2017. The DOC acknowledged that the home had not completed a quarterly review of the medication incidents and adverse drug reactions for the last quarter between January 2018, and March 2018. [s. 135.]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

Resident #001 triggered from stage one of the inspection for low body mass index (BMI) and with no nutrition interventions to promote weight gain.

A review of resident #001's weight record indicated that the resident had a decrease of a specified amount of weight within an approximate one month time frame in 2017, representing a decrease of a specified per cent of body weight. Resident #001's weight recorded between an identified ten month time frame between 2017 and 2018, indicated continued weight loss.

A review of resident #001's written plan of care, indicated the resident was at an identified level of nutritional risk.

A review of their progress notes indicated that there was a quarterly dietary assessment completed by the Director of Food Services (DFS) #136 in a specified month in 2018. It identified that resident #001's current BMI was below their healthy goal weight and revised Ideal Body Weight Range (IBWR); however, the referral section of the assessment stated that the resident's weight was within a healthy range.

During an interview DFS #136 told the Inspector that they were unaware what the referral section was meant for and agreed that resident #001 should have been referred to the Registered Dietitian (RD) #137 due to ongoing weight loss and low BMI.

During an interview the RD #137 confirmed that it is the expectation of the home that the DFS #136 makes a referral for residents with low body weight and ongoing weight loss. In this case DFS #136 did not collaborate with the RD #137 so that their assessments of the resident were integrated, consistent with and complemented each other. [s. 6. (4) (a)]

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

Resident #001 triggered from stage one of the inspection for low BMI and with no nutrition interventions to promote weight gain.

A review of resident #001's most recent written plan of care indicated that the resident was to receive an identified number of portions of specified food items at lunch and dinner. According to a progress note by RD #137 on a specified date, a family member had requested an identified number of food portions and the RD had implemented this intervention.

The Inspector observed on a specified date, during lunch, that resident #001 did not receive the identified number of food portions. A review of the diet list in the servery stated resident #001 was to receive an identified number of portions of specified food items at lunch and dinner. During an interview, Dietary Aide (DA) #134 acknowledged that they had failed to serve resident #001 the identified number of portions as indicated on the diet list.

During interviews with the DFS #136 and RD #137 confirmed that the home failed to provide resident #001 with the identified number of portions as set out in their plan of care. [s. 6. (7)]

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 staff involved and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure there was at least one registered nurse, who is an employee of the licensee and a member of the regular nursing staff, is on duty and present in the home at all times, except as provided for in the regulations.

During the RQI, the Inspector became aware of a concern related to registered nurses being on duty and present in the home.

The Inspector interviewed the Scheduling Clerk (SC) #108 related to the home's scheduling practice when a registered nurse was not available to work a shift in the home. According to the SC #108, all registered nurses employed by the home are contacted for availability; then nursing agencies are contacted to request a registered nurse to work the shift; and if a registered nurse is not available, the home would schedule an RPN who is employed by the home and familiar with the residents to work the shift; and DOC #100 would remain available and on call to support the three RPNs working in the home that shift.

A review of the registered staff (RN/RPN) schedule from February to April 2018, indicated that there were nine scheduled shifts without registered nurse coverage in the home as listed below:

-Thursday, February 1, 2018 – day shift
-Friday, February 2, 2018 – day shift
-Saturday, February 17, 2018 – day shift and evening shift
-Friday, March 2, 2018 – day shift
-Saturday, March 24, 2018 – day shift
-Sunday, March 25, 2018 – day shift
-Monday, March 26, 2018 – day shift
-Wednesday, April 4, 2018 – evening shift

Each of the above listed shifts were covered with an RPN who regularly worked in the home, with DOC #100 listed as being on call.

DOC #100 verified the information above by reviewing the registered nurse schedule for the shifts identified above. [s. 8. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that at least one registered nurse, who is both an employee of the licensee and a member of the regular nursing staff of the home, is on duty and present in the home at all times, except as provided for in the regulations, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by residents, and locked when they were not being supervised by staff.

On April 18, 2018, while conducting the tour of the home during stage one of the RQI, the Inspector observed that the linen storage room door on an identified floor was left unlocked. During an interview, PSW #117 verified that the door should have been locked with the key; however, they were not aware of the location of the key at the time of observation.

Further observations were conducted by the Inspector on identified dates, and the following observations were noted:
- the waste disposal room door on an identified floor was unlocked as verified by RPN #102 who pushed the door and locked the keypad in place.
- the linen storage room door on an identified floor was unlocked and unsupervised and the key was hanging above the doorway. PSW #144 verified that the door should have been locked with the key at all times if the room is not in use.

During an interview, the DES #111 verified that the waste disposal room doors, and linen storage room doors should be locked at all times except when in use and supervised by staff.[s. 9. (1) 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 all doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by residents, and locked when they were not being supervised by staff., to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

On April 19, 2018, while conducting the tour of the home during stage one of the Resident Quality Inspection (RQI), the Inspector made the following observations:
- a small heater with sharp edges and the front of the heater separating as if becoming dislodged, in the hallway immediately to the left of the stairwell door on floors 5,7, and 11. These observations were verified by PSWs #142 and #145.
- scratches exposing drywall along the middle to bottom portions on the external surface of all the residents' bedroom doors located along each of the hallways on floors 3,6,7,8 and 9.

On April 24, 2018, while conducting observations during stage two of the RQI, the Inspector observed:
-the tracks for the bedside table drawer were broken and hanging off the hinge in resident #007's room as verified by PSW #104.
-a broken floor tile at the entrance of resident #008's washroom as verified by maintenance worker #112.
-a hole in the wall beside the bed with drywall exposure in residents #012 and #013's bedrooms.

During separate interviews, Maintenance Worker (MW) #112 and the Director of Environmental Services (DES) informed the Inspector that daily, weekly and monthly rounds are conducted in the home, and that preventative maintenance is scheduled for June 2018. Both staff stated that they could not observe all disrepair and maintenance issues in the home; therefore, they relied on staff and families to alert them to disrepair and broken surfaces by completing and placing work order forms located in the rack outside the three nurses' stations. MW #112 stated in the interview that they would consider placement of work orders on all floors in the home to increase access and convenience.

DES #111 stated that they would continue to request further assistance from staff, residents and families to identify maintenance concerns and issues; and also verified during the interview that the walls, heaters, flooring, and furnishing in the home should have been kept in a good state of repair for the residents residing in the home. [s. 15. (2) (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 the home, furnishings and equipment were maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 30. Protection from certain restraining

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff. 2007, c. 8, s. 30. (1).
2. Restrained, in any way, as a disciplinary measure. 2007, c. 8, s. 30. (1).
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident is not restrained by the use of barriers, locks or other devices or controls (except under the common law duty described in section 36), from leaving a room or any part of the home, including the grounds of the home or; from entering part of the home generally accessible to other residents.

A Critical Incident Report with CIS #C546-000005-17 was submitted to the Ministry of

Health and Long Term Care (MOHLTC) related to a physical altercation that took place between resident #015 and resident #010 on an identified date as a result of resident #010's identified behaviour.

Review of a progress note on a specified date in 2017, by a registered staff member who no longer works in the home, indicated that as resident #012 was coming out of their room, a Hoyer lift was placed across the door to prevent resident #010 from coming out to the lounge area and disturbing another resident. As a result, resident #010 remained in bed as there was no way of getting out of their room.

Review of the home's current policy titled Minimizing of Restraints, RCS 7.13.01, stated that no resident shall be restrained for the convenience of staff or as a disciplinary measure and that only legally approved environmental barriers or locks can and only be used when indicated on the resident's care plan.

Review of resident #010's medical records and written plan of care did not indicate a physician's order, signed consent form, or directions to restrain resident #010 from leaving their room.

In interviews, PSW #127, RPN #115, RPN #125, and RN #128 stated that resident #010 had behaviours in an identified month, and the intervention in place at the time was to monitor them. RPN #115 further stated that an environmental barrier for a resident with behaviours can make the behaviour worse.

In an interview, RPN #125 defined restraints as anything that would prevent a resident from moving between different locations. RPN #125 stated that putting a lift in front of a resident's room to prevent them from leaving is considered a restraint.

In an interview, Physician #129 stated that interventions for a resident displaying behaviours would include staff re-direction, monitoring of the resident, ruling out physiological causes through investigation, and involving them in activities. If these interventions were not successful, adjustments to medications, or a referral to psychiatry could be made. MD #129 stated that they would not resort to restraints for such a behaviour.

In an interview, DOC #100 defined a restraint as something that restricts freedom of movement for a resident. DOC #100 further stated that blocking a resident's doorway to prevent them from leaving is considered a restraint. They acknowledged that the licensee

had failed to ensure that resident #010 was not restrained by a barrier from leaving a room or any part of the home. [s. 30. (1) 5.]

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 resident is not restrained by the use of barriers, locks or other devices or controls (except under the common law duty described in section 36), from leaving a room or any part of the home, including the grounds of the home or; from entering part of the home generally accessible to other residents, to be implemented voluntarily.

WN #9: 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 are taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff through observation, which could potentially trigger such altercations.

A Critical Incident Report with CIS #C546-000005-17 was submitted to the Ministry of Health and Long Term Care (MOHLTC) related to a physical altercation that took place between resident #015 and resident #010 on an identified date and time.

A progress note on the identified date of the incident stated that resident #010 was observed to be missing from their floor during an identified time and was later discovered on a different floor arguing with resident #015. Resident #010 and resident #015 engaged in a physical alteration resulting in resident #010 sustaining altered skin integrity to three identified locations. Resident #015 did not sustain any injuries as per their progress notes.

A review of resident #010's progress notes indicated that during the four months leading up to the identified date of the altercation with resident #015, they had exhibited multiple behaviours. These behaviours were exhibited on 17 separate days, with 13 of them occurring during the same time of day that the incident occurred.

A review of resident #010's medical records indicated that resident #010 had identified mood and behaviour patterns with these behaviours not being easily altered; however, resident #010 was not involved in any intervention programs for mood or behaviour.

A review of resident #010's written plan of care with a specified date did not identify any interventions to address resident #010's identified behaviour.

In an interview, PSW #127 stated that during the identified shifts, PSWs care for residents on three different floors, which includes more than 30 residents, and those that exhibited an identified behaviour wandered were monitored every hour. PSW #127 stated that while they were completing rounds, resident #010 used to exhibit the behaviours previously described in the resident's progress notes. PSW #127 stated that resident #010 was displayed other identified behaviours around people that they were not familiar with.

In an interview RPN #131 stated that although another intervention was to bring resident #010 to the nursing station to monitor them, this was not always possible if staff were busy.

In an interview, RPN #115 stated that resident #010 had an identified behaviour and a tendency to get into altercations with other residents. RPN #115 stated that the intervention in place at this time was to monitor resident #010 and document the behaviour using the an identified tool.

Record reviews did not indicate that the identified monitoring tool related to resident #010's behaviour had been completed during the four month period leading to the

identified date of the altercation between resident #010 and #015

In an interview, Social Worker (SW) #122, stated they were the Behavioural Response Team lead during the four month period leading to the identified date of the altercation between resident #010 and #015. SW #122 further stated that the home's process for addressing behaviours was for them to first complete rounds for residents with behavioural concerns with their external behavioural consultant. SW #122 and the behavioural consultant would then discuss interventions and communicate these to the front line staff so that the appropriate interventions could be implemented. SW #122 stated that the behavioural consultant had recommended a specified type of monitoring for resident #010's behaviour after their rounds on an identified date approximately three months before the identified date of the altercation between resident #010 and #015, but it was never completed nor followed up with.

In interviews, SW #122 and DOC #100 confirmed that the licensee had failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between resident #010 and other residents by identifying factors, based on an assessment, that could potentially trigger such altercations. [s. 54. (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 steps are taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff through observation, that could potentially trigger such altercations, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001 with a weight change of 5 per cent of body weight, or more, over one month was assessed using an interdisciplinary approach.

Resident #001 triggered from stage one of the inspection for low BMI with no nutrition interventions to promote weight gain. A review of resident #001’s medical record indicated their identified BMI and that there were no nutritional supplements or special nourishments that the resident was to receive. Review of resident #001's progress notes indicated that the RD #137 had assessed resident #001 on an identified date, because the resident’s identified family member was concerned about the resident’s weight and wanted the resident to receive an identified number of portions.

A review of resident #001’s weight record from a two month period before the month in which RD #137 completed an assessment of the resident, indicated that the resident had a decrease of body weight within a specified one month period. There was no indication that this weight was assessed using an interdisciplinary approach.

A review of the home’s policy #Food 3.6.01 titled Monitoring Residents’ Weight and Height indicated if there is a significant unplanned weight change, a referral is made to the RD #137 as soon as possible, and no later than the fifteenth of the month.

During an interview RD #137 indicated that nursing staff usually send a referral for significant weight changes but did not do so in this case. During an interview, DOC #100 stated that it is the expectation of the home to have an interdisciplinary approach to unexplained weight loss and the nursing department should refer weight changes to the RD #137. The RD #137 confirmed that this weight change was not assessed using an interdisciplinary approach. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 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 residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status., to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that planned menu items were offered at each meal.

Residents #001, #002 and #003 triggered from stage one of the inspection for low BMI with no nutrition interventions to promote weight gain. The Inspector observed lunch meal service during the second seating on an identified date. According to the posted menu the two entrée options were baked beans and wieners or shaved beef sandwich.

The Inspector observed the show plate for the sandwich entrée had 4 triangular pieces of sandwich but dietary aides were plating only three pieces of sandwich. According to PSW #132 residents had not asked for four pieces of sandwich but could request it.

A review of the therapeutic spreadsheet for the menu indicated the portion size for the sandwich was two bread pieces with 75 grams of meat. During an interview with the DFS #136, they stated they were aware that dietary staff were serving three pieces of sandwich and confirmed that three pieces of a sandwich did not have the same nutritional value of four pieces or two pieces of bread with 75 grams of meat.

During an interview the RD #137 indicated that three pieces of a sandwich would equal three quarters of the portion size and confirmed that the staff should be offering and plating the portion size as planned. [s. 71. (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 the planned menu items are offered and available at each meal and snack, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee has failed to ensure that at least once in every calendar year, the evaluation made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences, considers the results of the analyses of every incident of abuse or neglect of a resident.

Critical Incident System #C546-000005-17 was submitted to the MOHLTC on an identified date related to resident to resident abuse.

Review of the home's most recent policy titled Zero Tolerance of Abuse and Neglect, RCS 7.7.45, stated that on an annual basis, the Zero Tolerance of Abuse and Neglect policy would be evaluated and the evaluation would include the analysis of all incidents of abuse or neglect.

Review of the home's documentation of evaluation of the Abuse, Neglect and Retaliation program, dated August 29, 2017, stated that there were no reportable incidents that the staff were aware of. The document did not contain an evaluation of the analysis of the incident described in CIS #C546-000005-17.

In an interview, DOC #100 confirmed that the annual evaluation did not include the results of the analysis undertaken of every incident of abuse or neglect of a resident at the home. [s. 99. (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 at least once in every calendar year, the evaluation made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences, considers the results of the analyses of every incident of abuse or neglect of a resident, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program (IPAC).

During the RQI, the Inspector conducted the mandatory medication administration observation of RPN #120 and observed the following:
-on an identified date, RPN #120 administered identified medications to resident #011, but did not perform hand hygiene before or after administering an identified injection.
-on an identified date, RPN #120 administered identified medications to resident #012 but did not perform hand hygiene before or after administering an identified injection.
-on May 2, 2018, RPN #120 administered identified medications to resident #016, but did not perform hand hygiene before or after administering an identified injection or another identified medication.

RPN #120 verified during the interview that they had forgotten to perform hand hygiene during both medication administrations because it was difficult to remember everything when they were being watched.

RN #103, who was also the home's IPAC lead, and DOC #100 verified during separate interviews that registered staff should perform hand hygiene during medication administration, especially if contact was made with the resident during the administration. The IPAC lead also added that there should be a hand sanitizer bottle with solution on the medication cart at all times and if not, there were hand sanitizers available on the wall in many locations throughout the home. Therefore, the home failed to ensure that RPN #120 participated in the implementation of the infection prevention and control program. [s. 229. (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 all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (1) Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations. 2007, c. 8, s. 79. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the required information was posted in the home, in a conspicuous and easily accessible location in a manner that complied with the requirements, if any established by the regulations.

On April 18, 2018, during the initial tour of the home, the Inspector observed that the home had one RQI report dated March 4, 2017 posted. A review of the home's compliance history indicated that the home was issued an RQI report on September 29, 2016. The home's DOC #100 and Administrator #123 acknowledged that the second inspection report should have been posted since it would be included in the two year period. [s. 79. (1)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

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

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were developed and implemented in accordance with manufacturer's specification, using at a minimum a low level disinfectant in accordance with evidence-based practices and, if there was none, with prevailing practices, for cleaning and disinfection of supplies and devices, including personal assistance services devices, assistive aids and positioning aids.

On April 19, 2018, while conducting interviews during stage one of the RQI, the Inspector observed resident #005 and #006 were using unclean ambulatory equipment. Both observations were confirmed by PSWs working on the respective units at the time of observation.

On April 24, 2018, the Inspector observed resident #004, #005 and #006 using unclean ambulatory equipment. During interviews, PSW #104 and #105 confirmed that the ambulatory devices were soiled, and stated that they should have been cleaned by the night PSW according to the cleaning schedule.

A review of the ambulatory devices cleaning schedules for the three nursing units in the home, on three identified floors indicated that the April 2018 ambulatory devices cleaning schedule was not posted on any of the three units. During separate interviews, PSW #104 and #105 stated that it was possible that residents' ambulatory devices were not being cleaned on the scheduled dates.

DOC #100 verified in the interview that the April 2018 schedule was not printed by the administrative assistant and posted by charge nurses for all nursing teams. The DOC #100 further stated that PSWs and registered staff who observed unclean ambulatory devices should have cleaned them right way on all shifts to support the home's infection control practices. [s. 87. (2) (b)]

2. The licensee has failed to ensure that procedures are developed and implemented for addressing incidents of lingering offensive odours. 87 (2) (d)

During stage one of the RQI, an offensive odour was noted during observations of resident #001's washroom. The offensive odour was noted during these initial and follow up observations as listed below:
-April 19, 2018, at approximately 1242hrs
-April 20, 2018, at approximately 1224hrs
-April 24, 2018, at approximately 1210 hours as witnessed by Housekeeping Staff (HK) #139
-April 24, 2018, at approximately 1230 hours as witnessed by DES #111 who identified the smell as dampness. Upon inspection, a leak from an unknown source was noted.
-April 26, 2018 at approximately 1530hrs

In an interview, HK #139 stated that the home's process in addressing offensive odours was to clean the room, and if the issue does not resolve, to report it to DES #111. HK #139 further stated that the odour had been present for two months, and that they had tried to clean it but had not reported it to DES #111.

In an interview, DES #111 stated that staff are to fill out a work order form, or call them to inform them of any issues related to odour, so that they could explore interventions to address the concern. DES #111 stated that they were not informed about a persistent offensive odour in resident #001's washroom. DES #111 later reported that upon inspection, a leak from the toilet commode had been identified and the commode was subsequently replaced.

In an interview, DOC #100 acknowledged that the home's procedure for addressing incidents of lingering offensive odours had not been implemented as staff had not reported the concern to DES #111, as per the home's procedural expectations. [s. 87. (2) (d)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 88. Pest control

Specifically failed to comply with the following:

s. 88. (2) The licensee shall ensure that immediate action is taken to deal with pests. O. Reg. 79/10, s. 88 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home takes immediate action to deal with pests.

During stage one of the RQI, multiple fruit flies were observed in resident #002's washroom:
-On April 19, 2018, at approximately 1247 hours
-On April 20, 2018, at approximately 1223 hours
-On April 24, 2018, at approximately 1150 hours
-April 24, 2018, at approximately 1210 hours as witnessed by HK #139
-April 24, 2018, at approximately 1230 hours as witnessed by DES #111
-April 26, 2018 at approximately 1530hrs

No food or fruits were observed in the washroom or its vicinity during the observations mentioned above.

In an interview, resident #002 stated that the fruit flies had been in their washroom for the last three months, and that they are coming through the walls. Resident #002 further stated that they had reported the concern to DOC #100 three months ago but there was no action taken by the home.

In an interview, HK #139 stated that the home's process in addressing pests including fruit flies was to inform DES #111. HK #139 stated that they had observed the fruit flies in

resident #002’s washroom once a week, but nothing was done as they did not have the proper equipment/tools to address the issue. HK #139 further stated that they had not informed DES #111 of this concern.

In an interview, DES #111 stated that staff are to fill out a work order form, or call them to inform them of any issues related to pests so that they could explore interventions to address the concern. DES #111 stated that they were not informed about a pest issue in resident #002’s washroom. DES #111 further stated that the fruit flies could be coming through the walls or the screen in the windows as there is a plumbing stack that runs from the kitchen through the back the wall in resident #002’s washroom.

In an interview, DOC #100 stated that they had not received any complaints from resident #002 or information from other staff related to a pest issue in resident #002. DOC #100 acknowledged that immediate action was not taken by staff to deal with the fruit flies as staff had not reported the concern to DES #111, as per the home’s procedural expectations. [s. 88. (2)]

Issued on this 27th day of August, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	BABITHA SHANMUGANANDAPALA (673), SUSAN SEMEREDY (501), VERON ASH (535)
Inspection No. / No de l'inspection :	2018_714673_0006
Log No. / No de registre :	007775-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 14, 2018
Licensee / Titulaire de permis :	Nisbet Lodge 740 Pape Avenue, TORONTO, ON, M4K-3S7
LTC Home / Foyer de SLD :	Nisbet Lodge 740 Pape Avenue, TORONTO, ON, M4K-3S7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Glen Moorhouse

To Nisbet Lodge, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

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

The licensee shall prepare, submit and implement a plan to ensure that resident #010 and any other residents with responsive behaviours that put themselves or others at risk of harm, are protected from abuse by all other residents, specifically resident #015. The plan must include, but is not limited to the following:

-an on-going auditing process to ensure that resident #010 specifically, and any resident exhibiting responsive behaviours that put themselves or others at risk or harm, is reassessed, new interventions initiated and plan of care reviewed and revised to minimize the risk of harm to other residents. Include who will be responsible for doing the audits and evaluating the results.

Please submit the written plan for achieving compliance for 2018_714673_0006 to Babitha Shanmuganandapala, LTC Homes Inspector, MOHLTC, by email to TorontoSAO.moh@ontario.ca by June 27, 2018.

Please ensure that the submitted written plan does not contain any Personal Information /Personal Health Information.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were protected from abuse by anyone.

A Critical Incident Report with CIS #C546-000005-17 was submitted to the Ministry of Health and Long Term Care (MOHLTC) related to a physical

altercation that took place between resident #015 and resident #010 on an identified date and time. Resident #010 was noted to have an identified cognitive impairment.

A progress note on the identified date of the incident stated that resident #010 was observed to be missing from their floor during an identified time and was later discovered on a different floor arguing with resident #015. Resident #010 and resident #015 engaged in a physical alteration resulting in resident #010 sustaining altered skin integrity to three identified locations. Resident #015 did not sustain any injuries as per their progress notes.

A review of resident #015's medical records did not identify any behavioural issues. Resident #015's progress note from the same identified date of their altercation with resident #010, indicated that resident #015 was capable of understanding that another resident was in their room and that engaging in the altercation was incorrect. Resident #015 also acknowledged that instead, they should have called staff for help. Resident #015's progress notes dated six days after the altercation, indicated that resident #015 had altered skin integrity on two identified areas, and that the resident stated they resulted from the altercation with resident #010.

A review of resident #010's medical records indicated that resident #010 had identified mood and behaviour patterns with these behaviours not being easily altered; however, resident #010 was not involved in any intervention programs for mood or behaviour.

A review of resident #010's progress notes indicated that throughout the month leading up to the identified date of the altercation, they displayed identified behaviours towards other residents, requested and attempted to leave the unit on some days, and displayed an identified behaviour almost daily during the same time of day that the incident occurred.

A review of resident #010's written plan of care did not indicate any interventions to address resident #010's identified behaviours.

In an interview, Personal Support Worker (PSW) #127 stated that on the identified shift, PSWs care for residents on three different floors, which includes more than 30 residents, and those that exhibited the identified behaviour were monitored every hour. PSW #127 stated that while they were completing rounds,

resident #010 used to exhibit the behaviours previously described in the resident's progress notes. PSW #127 stated that resident #010 displayed other identified behaviours around people that they were not familiar with, and that the only intervention was to continue to monitor the resident.

In an interview, Registered Practical Nurse (RPN) #115 stated that the intervention in place at this time was to monitor resident #010 and document the behaviour using an identified tool.

Record reviews did not indicate that any monitoring documentation was completed during the last six months leading to the time of this inspection.

In an interview RPN #131 stated that although another intervention was to bring resident #010 to the nursing station to monitor them, this was not always possible if staff were busy. In an interview, RPN #125 stated that resident #010 was exhibiting the previously described behaviours more than one year ago from the time of the inspection, especially during an identified shift. RPN #125 further stated that physical abuse includes resident to resident altercations.

In an interview, Registered Nurse (RN) #103 confirmed that due to the lack of assessment and interventions for resident #010's behaviours, resident #010 was not protected from abuse by resident #015 on the identified date of the altercation.

The severity of this issue was determined to be a level 2 as there was minimal harm/risk or potential for actual harm/risk to residents. The scope of the issue was isolated as it related to one of three residents reviewed. The home had a level 4 history as they had on-going noncompliance with this section of the LTCHA that included:

-voluntary plan of correction (VPC) issued August 16, 2016, (2016_398605_0017).
(673)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 13, 2018

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Order / Ordre :

Specifically the licensee must ensure that:

a) drugs are stored in an area or a medication cart that is secured and locked, particularly during medication administration when the medication cart is not being supervised by staff

b) prescribed medicated creams are stored in an area or a medication cart that is secured and locked.

c) audits are conducted on the 3rd and 9th floors and all other areas in the home where prescribed topical creams/lotions are stored to ensure these areas are secured and locked

d) audits are conducted during medication passes on the 3rd floor to ensure the medication cart is secured and locked when the medication cart is not being supervised by staff

e) documented records of the audits are maintained with the date of the audit, who conducted the audit and the outcome of the audit.

Grounds / Motifs :

1. The licensee has failed to ensure that drugs were stored in an area or a medication cart that was secured and locked.

On an identified date, during the mandatory medication observation, resident #011 was noted to have prescribed medicated creams. The Inspector was informed by RPN #120 that PSWs were trained by registered staff to apply prescribed topical creams and lotions, and the registered staff would confirm with the PSWs that the cream/lotion had been applied and then sign the residents' treatment administration records (TARs).

In an interview, PSW #107 indicated that the registered staff unlock the cupboard and provide them with the appropriate cream/lotion for administration when required.

Two days after the previously identified date, the Inspector conducted observations of the locations where prescribed topical creams/lotions were stored by registered staff in the home.

There were three nurses' stations located in the home on three identified floors. The Inspector observed that on one identified floor, the prescribed topical creams/lotions were stored in an unlocked cupboard inside the nurses' station, making them accessible to all staff in the home, as verified by PSW #106 and RPN #125. They were also observed to be stored in an unlocked cupboard in the nursing station of another identified floor as verified by RPN #120.

Director of Care (DOC) #100 verified during an interview that residents' prescribed topical creams/lotions were kept in the medication rooms, where they should be locked and secured at all times. Furthermore, the DOC stated that if the creams/lotion were kept in a cupboard for ease of access, the cupboard should have been locked with a key to ensure only registered staff have direct access to prescribed medications. [s. 129. (1) (a)] (535)

2. On an identified date during the RQI mandatory medication pass observation on an identified floor, the Inspector observed RPN #120 administer medication for resident #011 during an identified medication pass. The RPN opened the medication cart, which was placed outside of the medication room, then left the medication cart unlocked and went inside the medication room to retrieve an identified medication for the resident. The medication cart was outside the RPN's line of sight as they entered the medication room and closed the door.

During the same medication pass, the RPN transferred resident #011 to their room in order to administer the identified medication. The Inspector observed that the RPN left the medication cart unlocked again in the same location outside the medication room, with at least one resident seated in the area. The Inspector remained with the unlocked medication cart while Inspector #501 observed the administration of the identified medication in the resident's room.

During an interview, RPN #120 verified that they had left the medication cart open on two occasions during the medication pass and confirmed that the medication cart should have been locked when it was out of their line of sight. Director of Care (DOC) #100 also verified during an interview that the medication cart should have been locked and secured on both occasions when RPN #120 was away from it and unable to monitor access to it.
[s. 129. (1) (a)]

The severity of this issue was determined to be a level 2 as there was minimal harm/risk or potential for actual harm/risk. The scope of this issue was a level 2

as there was a pattern of this issue throughout the home. The home had a level 3 history as they had previous written notification (WN) in a similar area with this section of the LTCHA that included:

-WN issued August 16, 2016 (2016_398605_0017).
(535)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 13, 2018

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Order / Ordre :

The licensee must be compliant with r.135 (1) and r.135 (3) of the LTCHA.

Specifically the licensee must ensure that:

a) every medication incident involving a resident and every adverse drug reaction is reported to the resident, the resident's substitute decision maker (SDM), if any, the DOC, the Medical Director, the prescriber of the drug, the resident's attending physician, or RN in the extended class attending the resident, and the pharmacy service provider.

b) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions.

Grounds / Motifs :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and reported to the resident, the resident's Substitute Decision Maker (SDM), if any, the DOC, the Medical Director, the prescriber of the drug, the resident's attending physician or RN in the extended class attending the resident and the pharmacy service provider.

As part of the RQI mandatory medication pass observation, the Inspector reviewed the Medication Incident and Adverse Drug Reaction folder provided by the DOC. The folder contained three completed Resident Incident Report forms; however, there was no adverse drug reaction form included for the last quarter. All medication incidents occurred in an identified month in 2018, and included the following information:

- Resident #019's identified medication was not administered to the resident on an identified date as prescribed. The Resident Incident Report form indicated that the physician was notified; however the resident's SDM was not notified.
- Resident #020's identified medication was not administered to the resident on an identified date as prescribed. The Resident Incident Report form indicated that the physician was notified; however, the resident's SDM was not notified.
- Resident #021's identified medication was not administered on two identified dates as prescribed. The Resident Incident Report form indicated that the physician and the SDM were not notified.

In an interview, DOC #100 verified that in relation to each of the the above mentioned medication incidents, the appropriate residents' SDMs were not notified.

2. The licensee has failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions.

On May 2, 2018, as part of the RQI, the Inspector reviewed the Medication Incidents and Adverse Drug Reactions folder provided by the DOC which indicated that there had been three medication incidents in the last quarter between January and March 2018, and that the last Professional Advisory Committee (PAC) meeting was held in April 2017. There were no documented medication incidents or adverse drug reactions in the quarters between April 2017 and January 2018.

The DOC confirmed that the last quarterly review of the medication incidents and adverse drug reactions had taken place during the PAC meeting held on Monday, April 20, 2017. The DOC acknowledged that the home had not completed a quarterly review of the medication incidents and adverse drug reactions for the last quarter between January 2018, and March 2018.

The severity of this issue was determined to be a level two as there was minimal harm/risk or potential for actual harm/risk to residents. The scope of the issue was a level three as it related to three of three residents reviewed. The home had a level 2 history as they had previous unrelated noncompliances. (673)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 13, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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

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

Issued on this 14th day of June, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector / Nom de l'inspecteur : Babitha Shanmuganandapala

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