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

Division des foyers de soins de longue durée
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
Aug 8, 2018	2018_661683_0013	005508-18	Resident Quality Inspection

Licensee/Titulaire de permis

Liuna Local 837 Nursing Home (Hamilton) Corporation
44 Hughson Street South HAMILTON ON L8N 2A7

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

Queen's Garden
80 Queen Street North HAMILTON ON L8R 3P6

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

LISA BOS (683), BERNADETTE SUSNIK (120), DIANNE BARSEVICH (581), GILLIAN HUNTER (130), PHYLLIS HILTZ-BONTJE (129)

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): June 15, 18, 19, 20, 21, 22, 25, 26, 27, 28, July 3, 4, 5, 6, 9, 11, 12, 13, 16, 17, 18, 19 and 20, 2018.

The following intakes were completed concurrently with the Resident Quality Inspection:

Critical Incidents:
016937-16, CIS #2853-000024-16 – related to falls prevention and management

020116-16, CIS #2853-000029-16 – related to falls prevention and management
025849-16, CIS #2853-000037-16 – related to safe and secure home
033130-16, CIS #2853-000044-16 – related to medication management
003933-17, CIS #2853-000008-17 – related to the prevention of abuse and neglect
006583-17, CIS #2853-000016-17 – related to falls prevention and management
007686-17, CIS #2853-000019-17 – related to falls prevention and management
012038-17, CIS #2853-000028-17 – related to the prevention of abuse and neglect
017745-17, CIS #2853-000032-17 – related to the prevention of abuse and neglect
022234-17, CIS #2853-000036-17 – related to falls prevention and management
023634-17, CIS #2853-000040-17 – related to the prevention of abuse and neglect
027583-17, CIS #2853-000044-17 – related to the prevention of abuse and neglect
003092-18, CIS #2853-000004-18 – related to the prevention of abuse and neglect
003625-18, CIS #2853-000005-18 – related to falls prevention and management
008081-18, CIS #2853-000008-18 – related to falls prevention and management
009908-18, CIS #2853-000009-18 – related to infection prevention and control
015845-18, CIS #2853-000010-18 – related to falls prevention and management
015806-18, CIS #2853-000011-18 – related to falls prevention and management

Complaints:
028653-17 – related to falls prevention and management, nutrition and hydration, personal support services
003518-18, IL-55576-HA/IL-55711-HA - related to falls prevention and management, bed rails, skin and wound, pain
011784-18, IL-57229-HA – related to falls prevention and management, personal support services
002345-18, IL-55264-HA – related to accommodation services/maintenance/housekeeping

Follow Ups:
000139-18 – related to Compliance Order #001, O.Reg 79/10 s. 69, nutrition and hydration
000136-18 – related to Compliance Order #002, O.Reg 79/10 s. 51 (2)(a), continence
000201-18 – related to Compliance Order #003, O.Reg 79/10, s. 15 (1)(a),(b), bed rails
000210-18 – related to Compliance Order #006, LTCHA, 2007, s. 19. (1), prevention of abuse and neglect
000211-18 – related to Compliance Order #007, O.Reg 79/10, s. 50. (2)(b) (ii), skin and wound

Inquiries:
009372-17, CIS #2853-000024-17 – related to medication management
009623-17, CIS #2853-000025-17 – related to falls prevention and management
022030-17, CIS #2853-000035-17 – related to the prevention of abuse and neglect
023217-17, CIS #2853-000039-17 – related to the prevention of abuse and neglect
025641-17, CIS #2853-000041-17 – related to the prevention of abuse and neglect
026557-17, CIS #2853-000045-17 – related to the prevention of abuse and neglect
027031-17, CIS #2853-000043-17 – related to the prevention of abuse and neglect
003537-18, CIS #2853-000006-18 – related to falls prevention and management

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Resident Care and Services Nursing Consultant, Regional Nursing Consultant, Nursing Unit Clerk, Program and Support Service Manager, Resident Assessment Instrument (RAI) Coordinator, Environmental Supervisor/Maintenance, Registered Dietitian, Physiotherapist, Physiotherapist Assistant (PTA), Registered Staff, Personal Support Workers (PSW), residents and families.

During the course of the inspection the inspectors toured the home, observed resident bed systems, took air temperature and humidity measurements, reviewed resident clinical records, reviewed policies and procedures, reviewed investigation notes, reviewed training records and observed residents during the provision of care.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **11 WN(s)**
- **9 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 15. (1)	CO #003	2017_546585_0018	120
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #006	2017_546585_0018	581 683
O.Reg 79/10 s. 50. (2)	CO #007	2017_546585_0018	129
O.Reg 79/10 s. 51. (2)	CO #002	2017_546585_0018	683
O.Reg 79/10 s. 69.	CO #001	2017_546585_0018	683

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. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

A review of Critical Incident (CI) log #003625-18, 2853-000005-18, submitted to the Director on an identified date, indicated that while care was being provided, resident #008 complained of increased pain in an identified area post fall on an identified date. The resident fell again an identified number of days later and both falls were from the same position. An identified diagnostic procedure was completed an identified number of days after the first fall and the report showed an identified injury.

A review of the written plan of care identified that resident #008 was at a high risk for falls and identified specific falls prevention interventions that were in place.

In an interview with PSW #121 on an identified date, they stated the resident had two specific falls prevention interventions in place along with all of the interventions identified in their written plan of care.

In an interview with the Administrator on an identified date, they confirmed that two specific falls prevention interventions were being applied by the PSW staff; however, they were not set out as planned care for the resident in the written plan of care.

Please note: This non-compliance was issued as a result of CI inspection: 003625-18 related to 2853-000005-18, which was conducted concurrently with the RQI.

2. The licensee failed to ensure that the written plan of care for each resident provided clear directions to staff and others who provided direct care to the resident.

A) On an identified date, resident #007's room door was observed to have contact precaution signage on the door. Staff #108 was asked what the signage was for and they were not certain.

On an identified date, Registered Nurse (RN) #110 was interviewed and was unable to confirm why there were contact precautions in effect until they completed a search through progress notes.

A review of the progress notes identified that on an identified date, resident #007 was assessed by the Nurse Practitioner; the assessment identified the resident had an identified infection.

Staff #110 reviewed the plan of care revised on an identified date, and confirmed, the plan of care did not provide clear directions to direct care staff on the need for contact

precautions when providing care to resident #007. (#130).

B) Resident #064's written plan of care did not provide clear directions to staff and others in relation to positioning/repositioning the resident when in bed and when sitting in the identified mobility device.

Observations made by the inspector on two consecutive dates indicated the resident demonstrated limited function of specific body parts which affected the resident's body position and posture.

During an interview, PSW #114 said that resident #064 did not like to be positioned in a specific way because it was not comfortable for them.

During an interview, PSW #115 confirmed that they provided care to resident #064 and identified the specific interventions they used to provide positioning support when the resident was repositioned in bed. PSW #115 also said that when sitting in the identified mobility device they repositioned the mobility device and used the same interventions as when the resident was in bed.

A review of resident #064's written plan of care indicated that staff were directed to reposition the resident at specific time intervals when in bed and reposition the resident when sitting in their identified mobility device.

During the above noted interview with PSW #115, they reviewed the written plan of care and confirmed that the specific care related to the positioning/repositioning needs of resident #064 when in bed or in their mobility device was not included in the written plan of care.

A review of resident #064's written plan of care and interviews with direct care staff confirmed that the resident's written plan of care did not provide clear directions for staff in relation to positioning/repositioning the resident when in bed or when sitting in their mobility device.

3. The licensee failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

A review of CI log #015845-18, 2853-000010-18 identified that on an identified date, resident #070 was being transferred using an identified mechanical lift, as per their plan

of care, by Personal Support Worker (PSW) #136 and Registered Practical Nurse (RPN) #135. According to review of the CI, review of internal investigation notes, and interviews with PSW #136 and RPN #135, during the transfer, the resident sustained a fall. The resident was sent to the hospital for an assessment with no major injuries identified.

A review of the clinical record for resident #070 identified that after the resident's fall on the identified date, a Morse Fall Risk assessment was completed by RPN #135, which identified that the resident had a specific fall risk score. The resident was previously identified at a lower risk of falls.

A review of the written plan of care for resident #070 on an identified date did not identify anything related to resident #070's falls risk.

In an interview with RPN #135 on an identified date, and in an interview with the Director of Care (DOC) the next day, they acknowledged that resident #070's written plan of care did not include their newly updated falls risk and acknowledged that it should be in their written plan of care.

The home did not ensure that the care set out in the plan of care was based on resident #070's falls risk assessment.

Please note: This non-compliance was issued as a result of CI inspection: 015845-18 related to 20454 / 2853-000010-18, which was conducted concurrently with the RQI.

4. The licensee failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

A review of Complaint Incident IL-55576-HA/IL-55711-HA submitted to the Director on an identified date, indicated multiple care concerns which included the substitute decision-maker (SDM) was not notified when a specific diagnostic procedure was ordered post fall.

On an identified date, resident #008 had an identified fall and the post fall assessment in the progress notes identified there were no injuries. A review of the clinical record indicated that the resident was complaining of increased pain in a specific area the next day and three days after the fall a specific diagnostic procedure was ordered by the

physician.

In an interview with the Administrator on an identified date, they stated that the specific diagnostic procedure was ordered by the physician; however, confirmed after they reviewed the clinical record that the SDM was not notified and they were not given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Resident #008's SDM was not allowed to fully participate in the development and implementation of the resident's plan of care when they were not notified of a diagnostic procedure that was ordered for the resident.

This non-compliance was issued as a result of complaint inspection: 003518-18 related to IL-55576-HA/IL-55711-HA, which was conducted concurrently with the RQI.

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

A) A review of Complaint Incident IL-57229-HA, identified concerns about falls prevention and management. On an identified date at a specific time, resident #030 was observed sitting in their room, in their wheelchair with an identified wheelchair attachment in place.

A review of the written plan of care identified that at identifies times during the day the resident was to be seated in their wheelchair without the identified wheelchair attachment in place.

In an interview with PSW #133, on an identified date, they verified that the identified wheelchair attachment was to be removed at identified times during the day and took them off.

RPN #102 was interviewed on an identified date, and stated that the resident was not to have the identified attachment on the wheelchair unless they were being transported. They confirmed that the care set out in the plan of care was not provided to the resident as specified in the plan.

B) The licensee did not ensure that care set out in the plan of care was provided to the resident as specified in the plan when resident #008 fell and complained of increased

pain.

A review of Complaint Incident IL-55576-HA/IL-55711-HA, identified multiple care concerns with one related to falls management.

A review of the clinical record identified that on an identified date, the resident fell from an identified location and was assessed with no injuries identified. The following day, the resident was complaining of increased pain in an identified area and three days after the fall, the physician ordered a specific diagnostic test to be taken in the home. A review of the physician's order identified that the specific diagnostic test was to be taken of the identified area related to pain in the area while care was provided and to rule out an identified injury.

A review of the clinical record with the Administrator on an identified date indicated that six days after the original fall, the resident sustained another fall from the same identified location and was assessed with no injuries. The diagnostic procedure was provided to the resident 10 days after the original fall and the diagnostic test results that were faxed to the home the next day indicated that the resident had an identified injury in an identified area. The Administrator said that the diagnostic test should have been taken within two days after it was ordered by the physician.

In an interview with RPN #129 on an identified date, they said that when a specific diagnostic test was ordered by the physician, it was the home's expectation that it would be taken within 24 to 48 hours. They verified that the diagnostic test was ordered but was not taken until one week later.

The Administrator confirmed that the care set out in the plan of care was not provided to the resident as specified in the plan for seven days after the physician ordered the specific diagnostic test.

This non-compliance was issued as a result of complaint inspection: 003518-18 related to IL-55576-HA/IL-55711-HA, which was conducted concurrently with the RQI.

6. The licensee failed to ensure that the provision of care set out in the plan of care was documented.

The provision of care set out in resident #064's plan of care related to assisting the resident to reposition while in bed and in their identified mobility device as well as the

monitoring and provision of care related to continence were not documented.

i) A review of resident #064's plan of care confirmed that PSW staff were directed to document in the computerized documentation system that the resident was assisted to turn and reposition at specific time intervals while in bed. Resident #064 and PSW #115 confirmed that the resident was assisted from bed at a specific times each day. During an interview with staff #130 and RPN #118 a copy of the documentation record for a 16 day period was printed from the computerized record and reviewed. Staff #130 and RPN #118 reviewed the documentation record printed and confirmed that there was no documentation to verify that resident #064 was repositioned every two hours when in bed at a specific time of day on all 16 of the identified days.

ii) During this inspection staff who provided care to resident #064, including; PSW #114, PSW #115, RPN #117, RPN #109 and staff who identified they were aware of the care needs of the resident, including; the DOC and RPN #118, confirmed that the resident was unable to reposition themselves while sitting in their identified mobility device and experienced changes in skin integrity on specific pressure areas.

Resident #064's written plan of care directed staff to reposition the resident as needed while the resident was sitting in their identified mobility device.

During an interview with staff #130 and RPN #118, they confirmed that a documentation form had not been set up for PSWs who provided care to the resident to document that they had assisted the resident to reposition while sitting in their identified mobility device and there was no documentation that this care had been provided.

iii) A review of resident #064's plan of care confirmed that the plan of care included a care focus related to alterations in skin integrity that the resident experienced and directed staff that the resident should be changed every two hours throughout the day to ensure that their skin was not exposed to moisture.

During an interview with staff #130 and RPN #118, they confirmed that a documentation form had not been set up for PSWs who provided care to the resident to document that the resident was changed every two hours throughout the day and there was no documentation to confirm that this care had been provided.

Staff #130, RPN #118 and documentation records confirmed that the provision of care included in resident #064's plan of care related to assistance to reposition in bed,

assistance to reposition while sitting in their identified mobility device and care identified related to continence management was not documented.

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

A) The plan of care for resident #007, revised on an identified date, identified the resident had alterations in skin integrity and indicated the resident required a specific intervention on their bed to prevent skin alterations and to reduce the risk of bed entrapment.

The resident was observed in bed on an identified date with the specific intervention on one side of their bed only. They stated in an interview, that it was their request to have the intervention on one side of their bed only.

RN #110 confirmed in an interview on an identified date that the plan of care for resident #007 was not updated when the intervention to remove the intervention on a specific side was discontinued. (#130).

B) In an interview with resident #003 by Inspector #129 on an identified date, during stage one of the RQI, they identified that they did not get to choose when and how to bathe and they identified that they were not okay with it. In the interview with Inspector #129, resident #003 identified that they got a shower, but preferred a bath. In a follow up interview with the resident on an identified date, they clarified what they meant when they identified that they wanted a bath. After some discussion regarding the available facilities in the home they confirmed that they wished to continue to receive a shower.

A review of the written plan of care for resident #003 on an identified date indicated that the resident was to receive a bath. A review of the bath and shower schedule for the identified home area also identified that resident #003 was to receive a bath.

In an interview with PSW #104 on an identified date, they indicated that they always gave resident #003 a shower and identified that they had never given the resident a bath. They indicated that they were not aware that the resident's plan of care identified that they were to receive a bath. In an interview with PSW #111 on an identified date, they identified that they always gave resident #003 a shower.

In an interview with the DOC on an identified date, they confirmed that resident #003's plan of care was not reviewed and revised when the care set out in the plan was no longer necessary, related to bathing. (#683)

C) A review of Complaint Incident IL-57229-HA identified concerns about falls prevention and management.

A review of the current written plan of care identified that resident #030 was at high risk for falls and had specific falls prevention interventions in place. The resident was observed on an identified date and one of the specific falls prevention interventions was not in place.

In an interview with PSW #133 on an identified date, they stated that the resident did not have the identified falls prevention intervention in place as they refused it and it caused the resident increased agitation. They stated that the resident had not had the identified falls prevention intervention in place for a long time.

In an interview with RPN #102 on an identified date, they verified the resident did not use the identified falls prevention intervention and confirmed that the plan of care was not reviewed and revised when the care was no longer necessary.

D) Resident #064's plan of care was not reviewed and revised when the their care needs changed in relation to toileting and assistance required for personal hygiene and daily activity routines.

i) Resident #064's plan of care included a care focus related to the resident's required assistance for toileting and identified directions for staff that the resident required an identified mechanical lift for toileting only. This care focus also included a toileting routine that directed staff to assist the resident to toilet at specific times of the day.

During interviews with PSW #115, RPN #118, the Administrator and RPN #109 it was confirmed by all identified staff that the resident used to be assisted to the toilet using the identified mechanical lift and staff used to assist the resident to the toilet based on an identified schedule, but the resident's care needs changed and the care directions identified above were no longer necessary. Staff interviewed were unable to identify when the resident's care needs changed related to the assistance to toilet and the use of a toileting schedule, but said their care needs had been this way for some time.

Resident #064's plan of care was not reviewed and revised when staff interviewed confirmed that at the time of this inspection the identified mechanical lift and the identified toileting schedule were no longer appropriate for the resident. A review of clinical documentation confirmed that the resident's plan of care had not been reviewed or revised when the resident's care needs changed and the care related to assistance to toilet was no longer necessary.

ii) Resident #064's plan of care included a care focus related to bathing and directions for staff included specific care that was to be provided.

During an interview with PSW #115, who at the time of this inspection was assigned to provide care to the resident, the plan of care was reviewed and they said the specific care was no longer appropriate as the resident's condition had changed.

PSW #115 and clinical documentation confirmed that the resident's plan of care had not been reviewed or revised when the resident's condition had changed.

iii) Resident #064's plan of care was not reviewed and revised when the resident's pattern of daily activity changed. At the time of this inspection resident #064 and PSW #114 confirmed that the resident was assisted into and out of their identified mobility device at specific times of the day. Resident #064's plan of care directed staff to assist the resident into and out of their identified mobility device at different times of the day.

Resident #064, PSW #114 and clinical documentation confirmed that the resident's plan of care was not reviewed and revised when the resident's pattern of daily activity changed.

8. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the care set out in the plan was not effective.

A review of Complaint Incident IL-55576-HA/IL-55711-HA identified multiple care concerns which included but was not limited to what interventions were being put in place to prevent future falls.

Resident #008 was identified as high risk for falling, had fallen multiple times and the resident's care plan was not reviewed and revised when the falls interventions were not effective.

A review of the plan of care identified that resident #008 was at high risk of falls and had fallen an identified number of times in an 86 day period. A diagnostic report confirmed on an identified date, that the resident had sustained an identified fracture.

In an interview with RPN #129 on an identified date, they verified that the resident had multiple falls and stated that they had specific falls interventions in place. RPN #129 confirmed there were no new falls interventions put in place until after the most recent fall that resulted in an identified fracture.

RPN #129 confirmed that the resident was not reassessed when the care set out in the plan had not been effective related to falls management.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, that the care set out in the plan of care is provided to the resident as specified in the plan and that the resident is reassessed and the plan of care reviewed and revised at least every six months and any other time when the resident's care needs change, care set out in the plan is no longer effective or the care set out in the plan has not been effective, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

In accordance with O. Reg. 79/10, s. 30 (1), the long term care home was required to ensure that each of the organized programs required under section 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of the Regulation were complied with. In accordance with O. Reg. 79/10, r.48 (1) 1, the home was required to have a Falls Prevention and Management Program.

Specifically, staff did not comply with the licensee's policy LTC-CA-WQ-200-07-04, regarding Head Injury Routine (HIR), last revised on an identified date, which was part of the licensee's falls prevention and management program. The policy identified that any resident who may have sustained an injury to their head as a result of a fall or other such incident where the resident's head may have come in contact with a hard surface was to have a head injury routine initiated and identified that there did not have to be an observable injury. Under procedures, the policy directed registered staff to perform the HIR every 15 minutes for the first hour, every 30 minutes for the next two hours, every hour for the next four hours, then every four hours until 72 hours post fall was reached.

A) A review of CI log #015845-18, 2853-000010-18 identified that on an identified date, resident #070 was being transferred using an identified mechanical lift, as per their plan of care, by Personal Support Worker (PSW) #136 and Registered Practical Nurse (RPN) #135. According to review of the CI, review of internal investigation notes, and interviews with PSW #136 and RPN #135, during the transfer, the resident sustained a fall. The resident was sent to the hospital for an assessment with no major injuries identified.

A review of the clinical record for resident #070 identified a Head Injury Flow Sheet from the date of the fall, with three entries at 15 minute intervals, after the fall had occurred. A second Head Injury Flow Sheet was identified, dated 3 days after the fall, with two entries identified. There were no other Head Injury Flow Sheets identified in the resident's clinical record.

In an interview with RPN #135 on an identified date, they indicated that it was approximately 45 minutes after the fall when the resident left for the hospital. They identified that they started the Head Injury Flow Sheet for the resident after their fall on the identified date, and indicated that they had assessed the resident three times within the 45 minutes and documented it on the Head Injury Flow Sheet. In the interview with RPN #135, they reviewed the resident's clinical record and identified that the resident returned from hospital at an identified time, on the same date as their fall. RPN #135 reviewed resident #070's chart and identified the Head Injury Flow Sheet from three days after the resident's fall, but did not identify any other Head Injury Flow Sheets in the resident's clinical record.

In an interview with the DOC on an identified date, they confirmed that the Head Injury Routine was not completed every four hours upon resident #070's return from hospital until 72 hours post fall was reached, as per the home's policy.

Please note: This non-compliance was issued as a result of CI inspection: 015845-18 related to 20454 / 2853-000010-18, which was conducted concurrently with the RQI.

B) Staff did not comply with the licensee's procedure when they did not complete a HIR after resident #030 sustained three unwitnessed falls on three identified dates.

In an interview with the DOC on an identified date, they verified that it was the home's expectation that registered staff were to complete a HIR on all unwitnessed falls. During the interview the DOC provided the Inspector with the document titled "Document Guide," which included direction that staff were to document on the HIR form for any resident that had an unwitnessed fall or had evident head injury.

A review of the clinical record identified that resident #030 had three falls within a 41 day time period and all falls were unwitnessed. The second fall resulted in the resident being transferred to hospital with an identified injury.

A review of the Head Injury Flow Sheet after the first fall on an identified date, indicated that registered staff did not complete the HIR every 30 minutes for two hours, every hour for the next four hours and every four hours for the next 72 hours.

A review of the Head Injury Flow Sheet after the second and third falls on identified dates indicated that registered staff did not complete HIR every four hours until 72 hours post fall.

In an interview with RPN #102 on an identified date, they confirmed that the HIR was not completed as directed by the licensee's HIR policy for the three falls listed above.

This non-compliance was issued as a result of complaint inspection: 011784-18 related to IL-57229-HA, which was conducted concurrently with the RQI.

C) A review of the clinical record identified that resident #008 had three unwitnessed falls. One of the last two falls resulted in an identified fracture.

A review of the Head Injury Flow Sheet post fall on all three of the identified falls indicated that registered staff did not complete the HIR every 30 minutes for two hours, every hour for the next four hours and every four hours for the next 72 hours.

In an interview with RPN #120 on an identified date, they stated that the Head Injury Flow Sheet should be completed by registered staff according to the direction in the licensee's HIR policy and confirmed that the HIR was not completed for the three falls listed above.

This non-compliance was issued as a result of complaint inspection: 003518-18 related to IL-55576-HA/IL-55711-HA, which was conducted concurrently with the RQI.

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 where the Act or Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 20. Cooling requirements

Specifically failed to comply with the following:

s. 20. (1) Every licensee of a long-term care home shall ensure that a written hot weather related illness prevention and management plan for the home that meets the needs of the residents is developed in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices and is implemented when required to address the adverse effects on residents related to heat. O. Reg. 79/10, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that their written hot weather related illness prevention and management plan was developed in accordance with prevailing practices and implemented when required to address the adverse effects on residents related to heat.

Prevailing practices related to hot weather include guidelines established by the Ministry of Health and Long Term Care entitled "Prevention and Management of Hot Weather Related Illness in Long Term Care Homes," 2012. The document includes guidance related to monitoring the indoor building environment to ensure that when indoor air and humidity levels rise above outdoor values during extreme heat days, that designated cooling areas are established indoors. The term "designated cooling area," although no specific ideal temperature or humidity level has been determined, as per the guideline, the indoor designated cooling area must be cooler and more comfortable than the other spaces in the building or the outside. When the Humidex [a calculation of the air

temperature and humidity] outside is in the range of 30 to 39 (uncomfortable), residents may begin to experience one or more heat related symptoms. In order to determine the difference between indoor and outdoor values, temperature and humidity values must be taken using a hygrometer.

The licensee's policy entitled "Heat Prevention – Hot Weather," from an identified date, failed to include any information or direction about the monitoring of the indoor building environment, especially when cooling systems fail. No guidance was given as to how and when to take air temperatures and humidity levels, and where to take them. The policy did not identify where the designated cooling areas were located and that each space could accommodate up to 40 residents [as per s. 20(2)]. Under procedure #5 of the policy, an intervention included to "increase cool air circulation;" however, how this was to be achieved was not explained. No other interventions for cooling a designated space were offered.

The home was equipped with central air conditioning for the main floor (entrances, offices), first, second and third floor dining rooms and lounges/activity rooms and the chapel and banquet room located in the basement. Resident rooms and corridors were not air conditioned, but were tempered [some humidity removed]. During the inspection, the central air conditioning system was not functioning for the dining rooms on the east side of the building. Various staff members were asked about the temperatures in the home on an identified date, when the Humidex was 35 [As per Environment Canada]. Registered staff from all three floors reported that the dining rooms (on both east and west sides) were very hot with no relief and that residents complained about the heat. The staff reported that the first floor near the two entrances were cooler, but that the majority of the home was very warm.

According to service records from an identified date, provided by the Environmental Services Supervisor (ESS) on an identified date, two roof top units responsible for cooling certain areas of the building were inspected and found to have leaks and were out of refrigerant gas. The repair work was not submitted to their corporate office for approval by the ESS or the Administrator until after the inspection began on an identified date. According to the ESS, who had taken their vacation shortly after the date the service records were documented, the follow up was not made by anyone who was acting in their place and the repairs were not initiated. The ESS reported that the two roof top units were responsible for cooling the east side dining rooms on the third and second floors. Other smaller roof top units were allocated to cool the second and third floor west side dining rooms and lounge/activity rooms, but the ESS felt that they were

insufficient to operate adequately during extreme hot weather. No documentation could be provided related to internal temperatures or humidity levels to determine the difference between indoor and outdoor values and to determine where the designated cooling areas were located.

For an identified period of three days, the indoor environment felt uncomfortable and stuffy and the outdoor environment was cooler and more comfortable. No windows were open to increase air circulation and cool off interior spaces. Designated cooling area could not be determined as all spaces, especially on second and third floors felt the same temperature.

On an identified date, the outdoor air temperature throughout the day was between 19 and 22.5 degrees Celcius (C) with a humidity of 55-80% for a Humidex of 25 [as per Environment Canada's Hamilton weather station]. A tour of the building was made on the same date and the temperatures felt the same throughout resident rooms, dining rooms and lounge/activity rooms on the second and third floors.

In the first and second floor dining rooms, a hygrometer was posted with readings of 27C and 48% humidity (Humidex 30) at approximately 1315 hours. No thermometers or hygrometers were posted at the nurse's station or in any of the other common spaces in these two home areas.

On an identified date, beginning at 0930 hours, the outdoor air temperature was 17C with a Humidex of below 25. The hygrometer values for the Durrand dining room on the first floor were 26C and 44% (Humidex 28). The hygrometer values for the Dundurn dining room on the second floor were 24C and 46% (Humidex 26). When other common areas were checked using a hygrometer by inspector #120, the air temperature was approximately 25C with humidity values of approximately 44% (Humidex 27).

No hygrometers were found in the Westdale, Gage, Mountain Brow, Jamesville (hygrometer not working) dining rooms and no hygrometers were found in any of the other common spaces. Most of the nurse's stations were equipped with thermometers which did not include humidity values.

The licensee's written hot weather related illness prevention and management plan was not developed to include interior air temperature and humidity monitoring to ensure that designated cooling areas could be established and monitored when required to address the adverse effects on residents related to heat. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a written hot weather related illness prevention and management plan for the home that meets the needs of the residents is developed in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices and is implemented when required to address the adverse effects on residents related to heat, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that all staff used safe transferring techniques when assisting residents.

A review of CI log #015845-18, 2853-000010-18, indicated that on an identified date, resident #070 was being transferred using an identified lift, as per their plan of care, by PSW #136 and RPN #135. During the transfer, according to review of the CI, review of internal investigation notes, and interviews with PSW #136 and RPN #135, the resident sustained a fall. The resident was sent to hospital for an assessment where no further injuries were identified.

A review of the written plan of care for resident #070 identified that they required two staff for all transfers using an identified lift.

The home's internal investigation notes indicated that on an identified date, a re-enactment of the incident was done to determine possible causes of the fall. An identified number of possible situations were trialed and as per the home's internal investigation notes, they concluded that it was possible that the resident was not properly positioned during the transfer.

In an interview with the Resident Care and Services Nursing Consultant on an identified date, they acknowledged that the only way resident #070 could have sustained the identified fall was if a specific part of the transfer was done incorrectly.

The home did not ensure that PSW #136 and RPN #135 used safe transferring techniques when assisting resident #070 on an identified date.

Please note: This non-compliance was issued as a result of CI inspection: 015845-18 related to 20454 / 2853-000010-18, which was conducted concurrently with the RQI [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Resident #008 was admitted to the home on an identified date, and since that time had identified diagnoses. According to the written plan of care, the resident was identified as high risk for skin breakdown and had recurring impaired skin to various areas of an identified body part. A review of the plan of care, specifically the weekly skin and wound assessments for just over one year, identified that the resident had at least an identified number of areas of impaired skin integrity to the identified body part during that time period, which required treatment and routine monitoring. A review of the skin and wound assessments completed for the areas of impaired skin integrity to the identified body part revealed that the affected areas were not consistently reassessed weekly when it was clinically indicated.

The identified area of impaired skin integrity was assessed on an identified date and was not reassessed until 14 days later, on an identified date. The area was not reassessed until 19 days later, on an identified date, until 22 days later, on an identified date, until 15 days later, on an identified date, until 15 days later, on an identified date, and until 13 days later, on an identified date, at which time it had resolved.

A different area of impaired skin integrity to the same body part was assessed on an identified date and was not reassessed until 14 days later. The area was not reassessed until 19 days later, until 22 days later, until 15 days later, until 15 days later, until 13 days later, until 67 days later, and until 22 days later. The area was reassessed on an identified date, and was not reassessed until 13 days later. The area was reassessed on an identified date, and was not reassessed until 28 days later.

Different areas of impaired skin integrity to the same body part were identified as a new area of altered skin integrity on an identified date, and were not reassessed until 15 days later. The area was not reassessed until 103 days later, on an identified date. The area was reassessed on an identified date, and was not reassessed until 13 days later.

A different area of impaired skin integrity on the same body part was assessed on an identified date, and was not reassessed until 14 days later.

The resident also had an area of impaired skin integrity to a different area on the identified body part during the identified time period, which was assessed weekly by registered staff.

A review of the skin and wound assessments during this time and interview with the DOC

on an identified date confirmed that not all of the affected areas were assessed weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

2. The licensee failed to ensure that any resident who was unable to reposition themselves was repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated.

Resident #064 was unable to reposition themselves while sitting in an identified mobility device and during observations made on an identified date, it was noted that the resident was not assisted to reposition themselves for a period of time in excess of two hours.

Resident #064's plan of care directed that the resident required an identified level of assistance for all activities of daily living including bed mobility, transfers and was to be assisted to reposition themselves every two hours while in bed and assisted to reposition while sitting in their identified mobility device.

Resident #064 was observed at an identified time on an identified date, to be sitting in an identified mobility device in the dining room awaiting meal service. The resident was observed at an identified time on the identified date to be sitting in the same position in their identified mobility device and again at an identified time on the identified date the resident was observed to be sitting in the same position in the identified mobility device.

During an interview with PSW #115 at an identified time on an identified date, they confirmed that they had provided care to resident #064 during their shift and assisted the resident into their identified mobility device at an identified time. At this time PSW #115 confirmed that they had not repositioned the resident since assisting the resident into the identified mobility device at the identified time.

Resident #064's plan of care and RPN #117 identified that the resident was being treated for an identified area of altered skin integrity.

During interviews with PSW #114, PSW #115 and RPN #117 it was confirmed that staff who provided care to resident #064 were aware the resident was unable to position themselves.

Based on observations made of resident #064's position and care information provided by PSW #115, resident #064 was not repositioned while sitting in their identified mobility

device over a three hour period of time on an identified date. [s. 50. (2) (d)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated and any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated, to be implemented voluntarily.

WN #6: 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 failed to ensure that steps were 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.

A review of CI log #017745-17, 2853-000032-17, indicated that on an identified date, there was an altercation between resident #034 and #035 which resulted in injuries to resident #034. Resident #034 had a history of identified responsive behaviours. Resident #035 also exhibited some behaviours.

On an identified date, resident #034 engaged in an altercation with resident #035 which resulted in resident #034 sustaining identified injuries.

Resident #034's plan of care at the time of the incident indicated there was a care focus related to an identified behaviour and there were interventions in place for the identified behaviour. In an interview with the DOC on an identified date, they confirmed that at the time of the incident one of resident #034's identified interventions was not in place and they identified resident #035's preferences around their personal space.

Resident #035's plan of care at the time of the incident indicated that there was a care focus related to identified behaviours and a goal about their safety. Their care plan identified that they may demonstrate behaviours if their personal space was compromised. A specific intervention was in place to respond to the identified behaviours.

In an interview with the DOC on an identified date, and review of clinical documentation confirmed that no interventions were identified or implemented when staff were aware resident #035 demonstrated identified behaviours when other residents entered their personal space.

Staff in the home failed to take steps to minimize the risk of an altercation between resident #034 who had identified behaviours and resident #035 who had identified behaviours when others entered their personal space.

Please note: This non-compliance was issued as a result of CI inspection: 017745-17 related to 2853-000032-17, which was conducted concurrently with the RQI. [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 and among residents, including 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, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee failed to ensure that steps were taken to ensure that all areas where drugs are stored were kept locked at all times, when not in use.

A medication cart was noted to be positioned in the hallway outside the dining room on an identified home area during the initial tour of the home on an identified date. The medication cart was observed to be unlocked, there were no registered staff in the area of the medication cart and residents were observed to pass by the medication cart on the way into the dining room. RPN #101 was observed to walk down the hall while escorting a resident in a wheelchair to the dining room. RPN #101, who was responsible for medication administration for this home area on the date identified above, acknowledged that the medication cart had been left unlocked and unattended.

The identified medication cart where drugs were stored was not kept locked at all times when not in use. [s. 130. 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that steps are taken to ensure the security of the drug supply, including all areas where drugs are stored shall be kept locked at all times, when not in use, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Staff in the home failed to ensure that drugs were administered to resident #043 and resident #046 in accordance with the directions specified by the physicians who ordered the identified medications.

A) Resident #043 was not administered an identified drug in accordance with the directions specified by their physician.
On an identified date, the resident's physician ordered the resident to receive an identified medication to be applied to an identified area of the body. The physician's order also directed that staff could repeat the treatment in an identified number of days if the identified condition was not better.

A review of the Medication Administration Record (MAR) from an identified month confirmed that staff had administered the medication on an identified date at an identified time. RPN #101 documented an occurrence note in resident #043's clinical record on an identified date, which confirmed they had administered the above noted drug a second time on an identified date, which was not in accordance with the physician's order to administer the drug one time and administer the drug again in an identified number of days if the clinical condition had not improved.

RPN #101 reported this incident to the DOC who created a Medication Incident Form (MIF) on the same day, in response to RPN #101's acknowledgement that they had administered the drug in error.

During an interview the DOC confirmed they created a MIF on the same day RPN #101 reported the incident which indicated that the resident had received too many doses of the medication as a result of misunderstanding the physician's order and incorrect input on the MAR by the Pharmacy provider.

During an interview on an identified date, the DOC confirmed they had contacted the resident's physician, contacted the Pharmacy provider who immediately removed the order from the computerized record, contacted resident #043's SDM and provided counselling to RPN #101.

The DOC, RPN #101, the MAR from the identified month, the MIR created by the DOC and resident #043's clinical record confirmed that resident #043 had not received the identified drug in accordance with the directions specified by the physician who wrote the order for this medication.

A review of the written plan of care confirmed that there was no documentation to indicate that resident #043 had experienced a negative outcome as a result of this medication incident.

B) Resident #046 was not administered an identified drug in accordance with the directions specified by their physician and the pharmacist when RPN #112 administered the identified drug in a specific location.

Resident #046's plan of care indicated the resident had experienced identified changes in an identified body part due to an ongoing medical issue and as a result experienced an increase in pain and issues related to mobility and ambulation. A review of resident #046's clinical record indicated on an identified date, the resident's physician wrote an order for the resident to receive an identified drug. The resident's physician documented in a progress note on an identified date that they would administer the medication once the supplies arrived. The Pharmacy provider processed the above noted order and created a MAR that directed the identified medication one time only administration for seven days to be administered by Medical Doctor (MD).

A review of resident #046's plan of care indicated that on an identified date, the resident reported that they had received the identified medication to a specific body part the previous day. At the time of this inspection resident #046 was not available to be interviewed. During an interview the DOC confirmed that at the time of the incident resident #046 was aware and a reliable witness to the care they received.

Following the above noted disclosure from resident #046, the home initiated an investigation into the incident and reported the incident to the Director through a CI report log #033130-16, 2853-000044-16.

Investigative notes provided by the DOC at the time of this inspection indicated that the resident reported to registered staff on an identified date, that they had the medication administered to a specific body part the previous day and was now having difficulty ambulating and was noted to be using an identified ambulation device.

Resident #046's physician was notified of the incident and nursing measures were implemented to monitor the resident's level of pain every shift for 7 days, document on the condition of the identified body part, as well as to monitor for signs of possible infection.

The DOC, the home's investigative notes and the MAR indicated that the above noted medication had been signed on the electronic MAR as administered on an identified date at an identified time by RPN #112. During the investigation conducted by the DOC it was identified that the vial in which the identified medicaiton was contained was found empty.

The DOC contacted the resident's physician who assessed the resident and ordered a specific medical test to examine the identified body part of resident #046 as well as an assessment by the Physiotherapist. The identified medical test verified ongoing structural changes in the resident's identified body part related to the identified medical condition.

The DOC confirmed that RPN #112 was contacted by the home as part of their investigation, would not make contact with the DOC in order to further investigate the above noted incident and the home was unable to provide current contact information for RPN #112.

Please Note: This non-compliance was issued as a result of CI inspection: 033130-16 related to 2853-000044-16, which was conducted concurrently with the RQI. [s. 131. (2)]

Additional Required Actions:

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

WN #9: 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 failed to ensure that all staff participated in the implementation of the Infection Prevention and Control Program.

Staff did not participate in the implementation of the licensee's Infection Prevention and Control Program when there was no notification that infection control precautions were in place and equipment/supplies required were not available for the use of staff when it was identified that resident #064 had an identified infection.

The licensee's Infection Prevention and Control Program included policy "Antibiotic Resistant Organisms-Prevention and Management," identified as LTC-CA-WQ-205-03-01, with an identified revise date. This policy was provided by the DOC and reviewed at the time of this inspection. Directions contained in this policy related to an identified infection were; "if the culture returns positive for colonization of [an identified infection] the resident will be placed on Contact Precautions for direct care. A contact precaution sign should be posted on the door or at the bedside of the resident."

The above noted policy included a reference to another Infection Prevention and Control Program policy "Routine Practices and Additional Precautions," identified as LTC-CA-WQ-205-03--07 with an identified revision date. This policy provided directions that contact precautions would be used when a resident had been colonized with an identified infection and Personal Protective Equipment (PPE) which included gloves and gowns were required for activities that involved direct care. The activities related to direct care identified in the policy included bathing, washing, turning residents, changing clothes, continence care, wound care and toileting.

A review of resident #064's plan of care identified that the resident had an identified infection and the care interventions directed that staff were to use contact precautions for direct care, hand sanitizer was to be available and PPE was to be available for visitors as required.

Observations made on an identified date indicated that there was no signage which identified that infection control precautions were in place, there was no hand sanitizer in or around the resident's room and there was no PPE available for staff or visitors.

During an interview on an identified date, the DOC confirmed that resident #064 continued to have the identified infection and indicated what they believed happened to

the resident's infection control signage and equipment.

Staff did not participate in the implementation of the licensee's Infection Prevention and Control Program when it was observed on an identified date that there was no indication in or around resident #064's room that infection control contact precautions were in place for anyone entering the room, there was no PPE available in or around the residents room for staff/visitors to use and there were no supplies available for cleansing hands when staff or visitors exited the resident's room. [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 #10: 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 following is further evidence to support the order issued on December 22, 2017, during RQI inspection 2017_546585_0018 (A1) to be complied February 15, 2018.

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

A) O. Reg. 79/10, s. 2(1) defines emotional abuse as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

A review of CI log #023634-17, 2853-000040-17 and a review of the home's internal investigation notes identified two occasions on two consecutive days where RPN #120 witnessed PSW #125 demonstrating inappropriate behaviours and providing inappropriate care to resident #028. On one of the identified dates, PSW #126 also observed inappropriate behaviour from PSW #125 in the presence of resident #028.

A review of the clinical record for resident #028 identified that they had an identified diagnosis, had a specific cognitive performance scale (CPS) score, and identified specifics around communication. In an interview with resident #028 and their Power of Attorney (POA) on an identified date, the resident was unable to recall the incident from the identified month.

In an interview with PSW #126 on an identified date, they confirmed that PSW #125 demonstrated inappropriate behaviour in front of resident #028.

In an interview with RPN #120 on an identified date, who witnessed the incident, they acknowledged that the summary of the incident identified in the CI was correct and confirmed that PSW #125 demonstrated inappropriate behaviour in front of resident #028 and/or that the resident would have been able understand PSW#125's inappropriate behaviour.

A review of the employee file for PSW #125 identified a specific report that was sent out as a result of the identified incidents. The identified report indicated suspected abuse and neglect on an identified date.

In an interview with the DOC on an identified date, they indicated that it was the home's process to send a referral form to the identified outside resource any time they thought there was suspected abuse and they confirmed that there was suspected abuse for this incident involving PSW #125 and resident #028. Inspector #683 read the definition of emotional abuse to the DOC and they confirmed that resident #028 was not protected from emotional abuse by PSW #125 on the identified date.

Please note: This non-compliance was issued as a result of critical incident inspection: 023634-17 related to 2853-000040-17, which was conducted concurrently with the RQI.

B) O. Reg. 79/10, s. 2(1) defines physical abuse as the use of physical force by a resident that causes physical injury to another resident.

A review of CI log #012038-17, 2853-000028-17, identified that on an identified date, there was an altercation between resident #032 and resident #033. Resident #032 sustained identified injuries and was sent to hospital for assessment and treatment. The appropriate authorizes were called and responded to the incident.

A review of the home's investigation notes from an identified date indicated that resident #032 demonstrated unpredicted responsive behaviours on an identified date. The resident previously identified responsive behaviours on one identified date and there was no negative outcome from that incident.

A review of the clinical health record identified that resident #032 had a known history of responsive behaviours. There was one documented incident of a specific responsive behaviour towards a staff member and one incident of a similar responsive behaviour towards a resident.

In an interview with RPN #129 on an identified date, they stated that the resident did have a history of specific behaviours due to an identified diagnosis but staff were able to redirect this behaviour. They stated there was no previous history of identified behaviours between the two residents.

On an identified date, PSW #127, who observed the incident between the two residents was interviewed and stated that resident #032 had a history of specific behaviours but had not demonstrated a specific type of behaviour towards other residents that they were aware of.

The DOC confirmed in an interview on an identified date, that resident #033 was not protected from abuse by resident #032.

Please note: This non-compliance was issued as a result of CI inspection: 012038-17 related to 2853-000028-17, which was conducted concurrently with the RQI. [s. 19. (1)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care was based on, at a minimum, interdisciplinary assessment of the sleep patterns and preferences with respect to the resident.

In an interview with resident #002 by Inspector #129 on an identified date, during stage one of the RQI, they identified that they did not get to choose what time they got up in the morning and what time they went to bed and they identified that they were not okay with it.

A review of the clinical record for resident #002 on an identified date, did not identify an assessment of the sleep patterns or preferences for resident #002, and review of their written plan of care on an identified date, did not identify the resident's sleep patterns and preferences.

In an interview with the DOC on an identified date, they indicated that they reviewed resident #002's clinical record and they were unable to find an assessment for their sleep patterns and preferences. They DOC confirmed that resident #002's plan of care was not based on an interdisciplinary assessment of their sleep patterns and preferences. [s. 26. (3) 21.]

Issued on this 5th day of September, 2018

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

Original report signed by the inspector.