Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

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

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 10, 2019	2019_684604_0020	000091-18, 001931-18, 002154-18, 004319-18, 004547-18, 004781-18, 004828-18, 007635-18, 009260-18, 009380-18, 009764-18, 010120-18, 010867-18, 014046-18, 014406-18, 016543-18, 021458-18, 021676-18, 024612-18, 025427-18, 026601-18, 026925-18, 027277-18, 030239-18, 032067-18, 032833-18, 001219-19, 005269-19	Critical Incident System

Licensee/Titulaire de permis

ATK Care Inc.
1386 Indian Grove MISSISSAUGA ON L5H 2S6

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

River Glen Haven Nursing Home
160 High Street P.O. Box 368 Sutton West ON L0E 1R0

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

SHIHANA RUMZI (604), AMANDEEP BHELA (746), DIANE BROWN (110), JOVAIRIA AWAN (648)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 29, 30, 31, August 1, 2, 6, 7, 8, 9, 12, 13, 14, 15, and 16, 2019.

During the course of the inspection the following Critical Incident System (CIS) intake logs where inspected:
Related to allegations of resident to resident abuse:
-Intake log #002154-18
-Intake log #001931-18
-Intake log #014406-18
-Intake log #021676-18
-Intake log #010867-18
-Intake log #010120-18
-Intake log #024612-18
-Intake log #004547-18
-Intake log #007635-18

Related to allegations of staff to resident abuse:
-Intake log #009764-18
-Intake log #004781-18

Related to medication incidents:
-Intake log #021458-18

Related to falls:
-Intake log #009380-18
-Intake log #027277-18
-Intake log #004828-18
-Intake log #032833-18

-Intake log #026925-18
-Intake log #025427-18
-Intake log #026601-18
-Intake log #014046-18
-Intake log #000009-18
-Intake log #030239-18
-Intake log #009260-18
-Intake log #014046-18
-Intake log #005269-19
-Intake log #001219-19

Related to responsive behaviors:
-Intake log #004319-18

Related to injury of unknown cause:
-Intake log #032067-18

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Previous DOC, Associate Director(s) of care (ADOC), Previous ADOC, Charge Registered Nurse (CRN), Registered Nurse (RN), Registered Practical Nurse (RPN), Gem Agency RN, Personal Support Worker (PSW), Classic Care Pharmacist (CCP), Physiotherapist (PT), and Substitute Decision Maker (SDM).

During the course of the inspection, the inspector conducted observations of staff to resident interactions, provisions of care, conducted reviews of health records, staff training records, review of the home's Critical Incident System (CIS) binder along with investigation notes, and relevant home policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

9 WN(s)
4 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with 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 :

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

In accordance with O. Reg 79/10, s. 48. (1), states every licensee of a long-term care home shall ensure a falls prevention and management program to reduce the incidence of falls and the risk of injury was developed and implemented in the home.

Under Falls prevention and Management O. Reg 79/10 s 49. (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, included the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids.

An identified policy of the home was reviewed which provided direction to the staff related to an identified care.

The home submitted a Critical Incident System (CIS) report on an identified date to the Ministry of Long-Term Care (MLTC) Director indicating resident#001 was found in an identified location of the home with identified injuries and transferred to the hospital for further assessment.

A record review of resident #001's hospital discharge summary revealed identified

diagnosis, and injures.

A review of the home's "Risk Management Report" identified the resident had a history of incidents within an identified period of time.

A record review and separate staff interviews where carried out with RPN #128 and #129, who confirmed post resident #001's incidents they did not identify risk factors leading to the incidents and the residents plan of care was not updated with interventions to prevent further incidents.

An interview with Associate Director of Care (ADOC) #107 confirmed that the home's identified policy was not followed.

2. In accordance with O.Reg 79/10, r. 123 (b) states that every licensee of a long-term care home who maintains an emergency drug supply for the home shall ensure, that a written policy was in place to address the location of the supply, procedures and timing for reordering drugs, access to the supply, use of drugs in the supply and tracking and documentation with respect to the drugs maintained in the supply.

The home follows Tri MD Pharmacy policy "Emergency Medication Box" policy 2.4 which indicates that the contents of the emergency medication box must be accounted for and match the inventory monitoring sheet.

The home submitted a CIS report on an identified date to the MLTC Director indicating a controlled substance was missing/unaccounted for in the emergency (STAT) box.

A STAT box medication storage observation was conducted on an identified location of the home. Inspector #746 informed Registered Practical Nurse (RPN) #122 of the medication observation and during the medication storage observation Inspector #604 was present overseeing the process. During the medication observation it was noted four "Narcotic Control Record" (NCR) sheets with prescription (Rx) numbers for did not match the medication stored in the STAT box.

Interviews were conducted with RPN #122 and the home's Director of Care (DOC) #106, indicated when staff remove medication from the STAT box for use for a resident, they are to ensure the NRC sheet and the medication Rx numbers match to ensure that the home can account for inventory monitoring. The RPN and the DOC acknowledged that the four NCR sheets and the medication stored in the STAT box did not match and they

are unable to account for the medication taken out of the STAT box. The RPN and DOC further acknowledged the home's policy was not followed.

3. In accordance with O.Reg 79/10, r. 114. (2), states the licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

The home follows Tri MD Pharmacy related to medication which was reviewed by Inspector #604. The policy directed staff to ensure that staff to sign the ICMR sheet each time a dose is administered, include the date, time, amount given, amount wasted, and quantity remaining and to utilize one line on the record is used per dose administered.

A medication storage area observation was conducted on an identified location of the home with RPN #116 and Inspector #746 observing the process. During the observation it was identified that an identified mediation sheet for resident #049's identified medication count was incorrect.

The sample size was expanded as areas of non-compliance was identified in an identified location of the home related to an identified home process.

The home submitted a CIS report on an identified date to the MLTC Director indicating controlled substance was missing/unaccounted for in the STAT box.

A controlled medication storage area observation was conducted on an identified location of the home with RPN #122. Inspector #746 informed RPN #122 of the observation and during the medication storage observation Inspector #604 was present overseeing the process. It was noted resident #050, #51, and #052's identified medication blister packs and ICMR sheets had discrepancies in the count.

An interview was conducted with RPN #122 who indicated they administered the controlled medication as identified to the identified residents and did not sign each ICMR sheets when they administered the medication. The RPN acknowledge the above three residents ICMR sheets did not correlate with the resident's blister packs as the quantity was different.

Interview was conducted with RPN #112, #116, and the home's DOC #106 who reviewed the above mentioned ICMR sheets for the above residents and acknowledged that the

ICMR sheets did not match the corresponding blister pack and the home did not follow its policy.

2. The MLTC ACTIONline received a complaint on an identified date and the complainant indicated concerns related to a medication error which had occurred in the home. The complainant stated resident # 011 was involved in an identified medication incident which had occurred in the home.

The sample size was expanded as non-compliance was identified for resident #011 and resident #032 related to medication incidents.

The home follows Tri MD Pharmacy policy "Medication Pass" policy 3-6 which indicates all medications are to be administered as listed on the residents Medication Administration Record (MAR) to ensure each resident receives the correct medication in the correct prescribed dosage, at the correct time and the correct route. The policy indicates to find the MAR for the resident and identify medications for the pass time.

A review of the home's "Medication Incident Binder" for an identified time was carried out and a "Medication Incident Report" (MIR) on an identified date for resident #012, was reviewed. The medication incident had occurred on an identified date, where RPN #115 who administered resident #012 an identified medication on an identified shift three hrs prior to when the medication was to be administered. The MIR further indicated the resident's identified mediation was held, the Substitute Decision Maker (SDM) was notified, and teaching was provided to the RPN.

Inspector #746 attempted to contact Agency RPN #110 who was involved in the above medication incident and was unsuccessful.

Interview's were carried out with Charge RN #101 and DOC #106, who reviewed the above progress notes and MIR. The CRN and DOC acknowledged that the above medication incident had occurred and the RPN did not follow the prescriber's directions for medication administration for resident #012.

3. The home follows Tri MD Pharmacy policy "Shift Change Controlled Medication Record" policy 6.7 which indicates controlled medications must be counted daily at each shift change. The policy outlines the procedure where the resident name, drug name, drug strength and quantity received to be recorded. Two Registered staff (incoming and outgoing together; count the quantity remaining, record the date, time and quantity of

medication and each sign in the appropriate spaces on the Shift Change Controlled Medication Record and confirm the quantity is the same as the amount recorded on the Individual Controlled Medication Record for PRN's, injectables, patches and liquids.

A narcotic and controlled substance observation was carried out on an identified shift and location and of the home. During the narcotic and controlled substance observation it was identified that the "Shift Change Controlled Medication Record" did not consist of the date of count and signature of the incoming nurse was missing on the five controlled medication record pages.

The sample size was expanded as areas of non-compliance was identified on an identified location of the home related to the "Shift Change Controlled Medication Record" sheet not being completed as per home's policy.

A second narcotic and controlled substance observation was carried out on an identified location of the home, it was identified that the signature of the incoming nurse was missing on six pages of the "Shift Change Controlled Medication Record" sheets.

A third narcotic and controlled substance observation was carried out on an identified location of the home and signature of the incoming nurse was missing on six pages of the "Shift Change Controlled Medication Record" sheets.

Interview's were carried out with Registered Practical Nurse (RPN) #116, #122, #117, who were scheduled to work on an identified date and floor of the home and DOC #106. The RPN staff and DOC reviewed the above "Shift Change Controlled Medication Record" sheets and acknowledged the narcotic shift count must be completed and signed with two staff together at shift change as per home's policy.

4. The home's policy "Narcotic/Controlled Substance", index id RCSM F-30, with a date of February 2017, under procedure number seven it states that a discrepancy is defined as the count not adding up correctly, any missing signatures, missing drugs, missing reason for destruction, the date of destruction, and or any misleading or wrong information on the narcotic count sheet. Under the procedure "Missing/Lost Narcotic" it states an in-house investigation by the Registered Nurses (RN), RPN, DOC, Associate Director of Care (ADOC) and/or Administrator must take place and to document all conversations of witnesses that have been interviewed.

The home submitted a CIS report on an identified date to the MLTC director indicating

that the STAT box had missing/unaccounted controlled substance. The CIS report stated that the Pharmacist completed a routine general systems audit which included the STAT box and noted that specific medication where unaccounted for. The CIS report further indicated the pharmacy had sent a staff to carryout and assist the home with an investigation.

An interview was carried out with the home's DOC who indicated that they where unable to find investigation notes as per the home's policy and acknowledged that the home's policy was not followed. The DOC further stated the home will restart the investigation for the above CIS report submitted and will also amend the CIS report.

5. The MLTC O.Reg 79/10, s. 114 (1), states that every licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

The home follows Tri MD Pharmacy policy "Shift Change Controlled Medication Record" policy 6.7 which indicates the procedure is for the resident name, drug name, drug strength and quantity received to be recorded.

A review of the narcotic and controlled substance shift count was conducted on an identified shift and location of the home.

The sample size was expanded as non-compliance was identified on an identified location of the home.

During a medication audit conducted by Inspector #604 it was noted the "Individual Narcotic and Controlled Drug Count" (INCDC) sheet and medication blister packages on an identified floor for resident ##051, #053, #054, #055 and #056's blister packs and INCDC sheets had a discrepancy in the count.

Interview with RPN # 117 was carried out where the above mentioned INCDS were reviewed for resident #051, #053, #054, #055 and #056, RPN #117 confirmed that they had signed out the above mentioned medications prior to administering.

Interview with DOC #106 where the above mentioned INCDC were reviewed and acknowledged that RPN#117 did not follow the home's policy.

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 this Regulation required the licensee of a long-term care home to have, any policy or system instituted or otherwise put in place was complied with, to be implemented voluntarily.

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 controlled substances where stored in a separate, double-locked stationary cupboard in the locked area.

The home submitted a CIS report on an identified date to the MTLC Director indicating a controlled substance was missing/unaccounted for in the STAT box.

Inspector #604 carried out a medication storage observation on an identified date and location of the home with RPN #116 and Inspector #746 observing the process. During the medication storage observation, the medication cart was observed to be parked outside the nursing station in the hall. The RPN unlocked the medication cart and the narcotic bin was found to be unlocked as the Inspector was able to lift the lid off the narcotic bin.

Interviews where carried out with RPN #116 and DOC #106 who indicated narcotics are to be double locked as per the home's policy and acknowledged that the narcotics where not double locked.

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 controlled substances where stored in a separate, double-locked stationary cupboard in the locked area, to be implemented voluntarily.

WN #3: 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. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

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 :

The licensee has failed to ensure that no drug was used by or administered to a resident in the home unless the drug had been prescribed to the resident.

The MLTC ACTIONline received a complaint on an identified date related to a medication incident which had occurred in the home involving resident #011.

Inspector #746 reviewed resident #011's Electronic Medication Administration Record (EMAR) and Physician Order's for an identified time and the Inspector was unable to find evidence of an identified medication being prescribed to the resident.

A record review of resident #011's Point Click Care (PCC) progress notes was carried out for an identified time period which indicated a medication incident had occurred on an identified date.

Inspector #746 reviewed the home's "Classic Care Medication Incident Report and Analysis Form" completed on an identified date related to the medication incident. The form indicated the incident was discovered on an identified date by Agency RPN #100. The form indicated due to miss communication an identified medication incident had occurred involving resident #011.

An interview was carried out with Agency RPN #100 who stated they were unfamiliar with the residents on the identified home area and sought the home's PSW staff in identifying residents in an identified location of the home and further stated they recalled the medication incident involving resident #011.

Interviews were carried out with Charge RN #101 and DOC #106, where the above PCC

progress note and "Classic Care Medication Incident Report and Analysis Form" was reviewed. The Charge RN and the DOC acknowledged resident #011 was involved in an identified medication incident.

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

The MLTC ACTIONline received a complaint on an identified date related to a medication error which had occurred in the home involving resident #011.

The sample size was expanded as non-compliance was identified for resident #011.

A review of the home's "Medication Incident Binder" for an identified period of time was carried out and a "Medication Incident Report" was found to be completed on an identified date for resident #032. The incident was discovered by RPN #115 on an identified shift when they went to provide an identified nursing care to resident #032 and found an identified medication incident had occurred. The RPN reported the medication incident to Charge RN #101 and the physician was contacted for further direction.

A review of resident #032's EMAR and physician orders were reviewed for an identified time period which provided direction related to the resident's medication administration process.

An interview was carried out with agency RPN #137, who confirmed they worked on an identified date and location of the home and stated they where able to recall a medication incident. The agency RPN acknowledged that they should have reported to the Charge RN of the medication incident involving resident #032 as they did not follow the resident's physician order related to an identified medication.

Inspector #746 attempted to contact without success Agency Charge RN #138 and RPN #115 who were worked on an identified date and location of the home.

Interview's were conducted with Charge RN #101 and DOC #106. The Charge RN and the DOC reviewed the above progress notes and "Medication Incident Form". The Charge RN and DOC acknowledged that a medication incident involving resident #032 had occurred and the prescriber's order was note followed related to an identified medication.

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:
-no drug was used by or administered to a resident in the home unless the drug had been prescribed to the resident,
-drugs were administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 133. Drug record (ordering and receiving)
Every licensee of a long-term care home shall ensure that a drug record is established, maintained and kept in the home for at least two years, in which is recorded the following information, in respect of every drug that is ordered and received in the home:
1. The date the drug is ordered.
2. The signature of the person placing the order.
3. The name, strength and quantity of the drug.
4. The name of the place from which the drug is ordered.
5. The name of the resident for whom the drug is prescribed, where applicable.
6. The prescription number, where applicable.
7. The date the drug is received in the home.
8. The signature of the person acknowledging receipt of the drug on behalf of the home.
9. Where applicable, the information required under subsection 136 (4). O. Reg. 79/10, s. 133.

Findings/Faits saillants :

1. The licensee has failed to ensure that a drug record was established, maintained and kept in the home for at least two years, in which the following information was recorded, in respect to every drug that was ordered and received in the home:
1. The date the drug is ordered
2. The signature of the person placing the order
3. The name, strength and quantity of the drug
4. The name of the place from which the drug is ordered
5. The name of the resident for whom the drug is prescribed, where applicable
6. The prescription number, where applicable
7. The date the drug is received in the home
8. The signature of the person acknowledging receipt of the drug on behalf of the home
9. Where a controlled substance is destroyed, including documentation as per section 136(4)

The home submitted a CIS report on an identified date to the MLTC director indicating that the STAT box had missing/unaccounted controlled substance. The CIS report stated that the Pharmacist completed a routine general systems audit which included the STAT box and noted specific medications were unaccounted for.

During the inspection process the Inspector requested the home's investigation notes along with the home's drug book for an identified time period which was to consist of the above information from the home's DOC #106. After four days the DOC indicated that they where unable to locate the drug record book. The DOC acknowledged that the home failed to maintain a drug record as required by the legislation.

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 drug record was established, maintained and kept in the home for at least two years, in which the following information was recorded, in respect to every drug that was ordered and received in the home:
1. The date the drug is ordered
2. The signature of the person placing the order
3. The name, strength and quantity of the drug
4. The name of the place from which the drug is ordered
5. The name of the resident for whom the drug is prescribed, where applicable
6. The prescription number, where applicable
7. The date the drug is received in the home
8. The signature of the person acknowledging receipt of the drug on behalf of the home
9. Where a controlled substance is destroyed, including documentation as per section 136(4), to be implemented voluntarily.

WN #5: 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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

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).

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

Findings/Faits saillants :

The licensee has failed to ensure that staff and others who provide direct care to the resident was kept aware of the contents of the plan of care and have convenient and immediate access to it.

The home submitted a Critical Incident System (CIS) report on an identified date to the Ministry of Long-Term Care (MLTC) Director indicating resident#001 was found in an identified location of the home with identified injuries and transferred to the hospital for further assessment.

A record review of resident #001's hospital discharge summary revealed identified diagnosis and injures.

A record review of resident #001's Minimum Data Set (MDS) identified cognitive impairment.

A review of the home's "Risk Management Report" identified the resident had a history of

incidents within an identified period.

An identified home assessment was carried out on an identified date for resident #001, and identified the resident was found in an identified location of the home and the resident had attempted to perform an identified task and had an incident.

The resident's written plan of care at the time of the incident indicated the resident required one-person extensive assist, staff to provide assistance and remain close by to assist the resident with identified care needs. The resident's written plan of care also identified residents' risk for an identified incident and interventions where to be followed.

Following resident #001's identified incident on an identified day the written plan of care was updated which directed staff to monitor the resident's whereabouts at identified intervals on an identified shift and offer to assist the resident with identified care to prevent further identified incidents.

A record review identified resident #001 had multiple identified incidents in the home during and identified time period.

On an identified date resident #001 was transferred to hospital for further assessment due to an identified incident in the home.

A record review of resident #001's TASK report in PCC, where PSW's were to identify and check when a task has been completed, referred to resident #001's identified care needs. The TASK's did not reflect the identified care needs where provided to the resident as indicated.

An interview was carried out with PSW #111 who indicated they worked on an identified date and provided care to resident #001. The PSW shared they were unaware that resident #001 was at risk for identified incidents and required monitoring within an identified time period and required extensive assistance with an identified care need.

An interview was carried out with PSW #113, stated they worked on an identified date and provide care to resident #001 when the resident had an identified injury. The PSW indicated they where unaware that the resident was at risk for an identified incident and required close monitoring and to offer to assist with identified ADL's. The staff shared that they do not have time to read each resident's plan of care at the beginning of the shift and that when registered staff update the care plan they do not always get an update to

the PSW staff.

An interview was carried out with PSW #113 who stated they where unaware of resident #001's identified incidents and that the resident required monitoring at identified intervals and also required assistance with identified ADL's.

An interview was carried out with RPN #122 who stated during shift report PSW staff are kept aware of changes to a resident's plan of care and that PSW's are to read the care plans before their shift but that it does not happen. The RPN also stated that the computers, where PSW's reference the care plans, have been known to be not working on a fairly regular basis.

An interview was carried out with RPN #129 who stated resident #001's unit PSW staff would refer to the TASK section on Point of Care (POC) for care and that resident #001's TASK for an identified care was incorrect and that the TASKS had not been updated for staff to be kept aware of the resident's revised plan of care.

An interview was carried out with ADOC #107, confirmed that the PSW had not been kept aware of the contents of resident #001's plan of care as the intervention by which staff were directed to check resident #001's whereabouts at identified intervals on an identified shift and offer to assist with an identified ADL when if required to prevent further identified incidents.

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

The home submitted a CIS report on an identified date to the MLTC Director, indicating an incident causing an injury to the resident for which the resident was taken to hospital and a significant change in the resident's health status had occurred. The CIS further stated Personal Support Worker (PSW) staff found resident #034 in an identified location of the home. The RPN was paged, upon arrival the resident was assessed, and RN was called. The resident appeared to be in discomfort, assessed, and noted to have identified injuries and was transferred to hospital for further assessment.

A review of resident #034's Point Click Care (PCC) progress notes was carried for an identified period. During the progress notes review it was noted that the resident had an

identified incident occur multiple times in an identified location of the home.

A review of resident #034's plans of care for an identified period was carried out which included focuses related to the residents identified incidents.

Interviews where carried out with RN #109, RPN #114, and PSW #108 who indicated they worked with resident #034. The staff stated that the resident had declining and utilized an identified mobility device to get around the home. The staff identified the resident to be a high risk for an identified incident. The staff reviewed the identified plans of care and acknowledged that the set plan of care was not effective as the resident kept having an identified incident.

An interview was carried out with the DOC #106 and was provided the plans of care and history of the identified incidents for resident #034. The DOC reviewed the two plans of care and the incident history and acknowledged that the set plans of care was not effective, and the plans of care was not reassessed for the resident as the resident continued to have the same identified incident.

3. The licensee has failed to ensure that when the resident was being reassessed and the plan of care was being revised because care set out in the plan has not been effective, have different approaches been considered in the revision of the plan of care.

The home submitted a Critical Incident System (CIS) report on an identified date to the Ministry of Long-Term Care (MLTC) Director indicating resident#001 was found in an identified location of the home with identified injuries and transferred to the hospital for further assessment.

A record review of resident #001's hospital discharge summary revealed identified diagnosis, and injures.

A record review of resident #001's Minimum Data Set (MDS) identified cognitive impairment.

A review of the home's "Risk Management Report" identified the resident had a history of incidents within an identified period.

An identified home assessment carried out on an identified date for resident #001, and identified the resident was found in an identified location of the home and the resident

had attempted to perform a task and had an incident.

The resident's written plan of care at the time of the incident provided identified interventions which where to be provided to resident #001.

Following resident #001's incident on an identified date, the written plan of care was updated which directed staff to monitor the resident at identified intervals on an identified shift and also directed staff to provide assistance for an identified ADL.

A record review identified resident #001 had multiple identified incidents on an identified shift.

On an identified date resident #001 was transferred to hospital for further assessment.

A record review of resident #001's TASK report in PCC, where PSW's were to identify and check when a task has been completed, referred to resident #001's identified care needs. The TASK's did not reflect the identified care needs where provided to the resident as indicated.

An interview was carried out with RPN #128, revealed that they did not feel the current interventions were effective in preventing resident #001 from further incident and shared it was the RN on shift who considers the effectiveness of the interventions related to the residents incidents and additional interventions to prevent future incidents where carried out through an interdisciplinary meeting process. A record review failed to identify documentation by an agency RN #131 on shift.

An interview was carried out with the agency RN #131, who revealed that after the residents identified incident other interventions were not considered and that they had not initiated an interdisciplinary meeting.

An interview was carried out with RPN #103, who completed an identified assessment revealed that they did not feel the current interventions were effective in preventing the resident from an identified incident. The RPN shared that they or the agency RN #140 on duty had not conducted an interdisciplinary meeting or considered other interventions to help prevent future identified incident and stated the resident check should have been considered. A record review failed to identify documentation by an agency RN #140 on that shift including the agency RN was not available for interview at the time of this inspection.

An interview was carried out with RPN #122 shared that the RPN would identify if the interventions were in place prior to an identified incident and post incident an identified committee would consider other interventions to prevent further identified incidents. The RPN further shared that they had not seen an interdisciplinary meeting being held to identify incidents and intervention strategies to prevent further resident incidents.

An interview was carried out with ADOC #107 and they identified that the residents plan of care had not been effective following the residents consecutive incidents and that different approaches had not been considered in the revision of the plan of care.

The licensee was issued a Compliance Order (CO) #002 related to s. 6, on an identified date in an identified report with an identified compliance due date. The home was identified to be in compliance on an identified date therefore, a Written Notification (WN) is being issued following this inspection.

WN #6: 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 :

The licensee had failed to protect residents from physical abuse by anyone.

The definition of abuse in subsection 2 (1) of the Act "abuse" means, subject to section (2), (c) the use of physical force by a resident that causes physical injury to another resident. O. Reg 79/10 s. 2 (c).

The home submitted four separate CIS reports on four separate dates to the MLTC Director related to resident #021's identified abuse towards resident #022, #023, #024, who sustained identified injuries.

A review of resident #021's clinical records was carried out for an identified time period which identified additional incidents of identified behaviours towards co-residents in the home had occurred.

Interviews were carried out with PSW #104, #102, #120, and RN #101, and the Behavioral Support Services (BSO) lead #139 related to resident #021. All staff identified resident #021 to present with identified behaviors since admission and was not easily redirected. Staff interviewed acknowledged resident #021 was a risk to other residents in the home due to the behaviours which could not be anticipated. Staff interviewed were unable to demonstrate steps where taken and interventions where implemented to minimize the risk of harmful interactions between resident #021 and co-residents in the home.

An interview was carried out with DOC #106 who identified awareness of resident #021's history of behaviours and incidents with co-residents in the home. The DOC stated identified care had been initiated related to occurrences of harmful interaction between resident #021 and co-residents in the home. The DOC acknowledged the residents identified in the CIS report sustained identified injury as a result of abuse from resident #021. The DOC was unable to demonstrate steps where taken and interventions where implemented to minimize the risk of harmful interactions between resident #021 and co-residents in the home.

2. The home submitted a CIS report on an identified date to the MLTC Director indicating PSW #121 observed resident #025 and #026 have identified interaction. The CIS further stated resident #026 was transferred to hospital for further assessment and was diagnosed to have an identified injury.

A review of resident #025's clinical was carried out from admission to an identified period. The progress notes identified the resident to present with identified behaviours and identified care was initiated for an identified period of time.

A review of resident #025's plan of care in place during the period of this review did not identify individualized strategies and interventions to minimize the risk of harmful interactions between resident #026 and co-residents in the home.

An interview was carried out with PSW #121, who indicated they worked on an identified date and location of the home and had responded to an incident as indicated in the CIS report. The PSW stated they were at the far end of an identified location of the home and

heard resident #025 and #026 engage in a verbal argument and observed resident #025 and resident #026 to have a physical altercation. The PSW indicated they where on the unit alone as the nurse went off the unit and the second PSW was on break. The PSW reported resident #026 presented with unpredictable behaviours towards co-residents and staff and identified resident #026 was a risk to co-residents in the home due to their identified behaviours. The PSW was unable to identify interventions had been implemented to prevent harmful interactions between residents in the home and resident #026.

An interview was conducted with PSW #118 identified they worked on an identified location of the home which consisted of residents who presented with identified behaviours. The PSW identified resident #026 to have identified behaviours towards staff and residents, and stated the resident was a risk to co-residents in the home due to unpredictable identified behaviours and was triggered by co-residents. The PSW was unable to identify interventions had been implemented to prevent harmful interactions between residents in the home and resident #026.

An interview was carried out with RPN #117 who identified resident #026 presented with identified responsive behaviours and stated the resident exhibited the identified behaviours upon admission and was a safety risk to co-residents and staff as their behaviours were unpredictable. The RPN was unable to demonstrate interventions had been implemented to prevent harmful interactions between resident #026 and co-residents in the home.

An interview was carried out with DOC #106. DOC #106 identified awareness of resident #021's history of identified behaviours and incidents with co-residents in the home. The DOC stated identified care was provided to the resident after the last incident as indicated in the CIS report. The DOC acknowledged the residents identified in the above CIS reports sustained injury as a result of abuse from resident #021. The DOC was unable to demonstrate that steps were taken, and interventions were put in place to minimize harmful interactions between resident #021 and co-residents #022, #023, and #024. The DOC acknowledged the home was unable to demonstrate interventions to prevent identified altercations resulting in injury towards residents #022, #023, and #024 by resident #021.

3. The home submitted a CIS report on an identified date to the MLTC Director indicating PSW #121 observed resident #025 and #026 have identified interaction. The CIS further stated resident #026 was transferred to hospital for further assessment and was

diagnosed to have an identified injury.

A review of resident #026's clinical was carried out from admission to an identified period. The progress notes identified the resident to present with identified behaviours and identified care was initiated for an identified period of time.

A review of resident #026's plans of care in place during the period of the above CIS reports did not identify individualized strategies and interventions to minimize the risk of harmful interactions between resident #026 and co-residents.

An interview was carried out with PSW #121, who indicated they worked on an identified date and location of the home and had responded to the above incident as indicated in the CIS report. The PSW stated they were at the far end of the unit in an identified location of the home and heard resident #025 and #026 engage in a verbal argument and observed resident #025 present with an identified behaviour towards resident #026. The PSW indicated they were on the unit alone as the nurse went off the unit and the second PSW was on break. The PSW reported resident #026 presented with identified behaviours. The PSW was unable to identify interventions had been implemented to prevent harmful interactions between residents in the home and resident #026.

An interview was conducted with PSW #118 who stated they worked on an identified location of the home which consisted of residents who presented with identified behaviours. The PSW identified resident #026 to have identified behaviours and was triggered by co-residents. The PSW was unable to identify interventions had been implemented to prevent harmful interactions between residents in the home and resident #026.

An interview was carried out with RPN #117 who identified resident #026 to present with identified responsive behaviours. The RPN stated the resident exhibited the identified behaviours upon admission and was a safety risk to co-residents and staff as their behaviours were unpredictable. The RPN was unable to demonstrate interventions had been implemented to prevent harmful interactions between resident #026 and co-residents in the home.

An interview was carried out with DOC #106 where the above CIS report, record review and staff interviews were reviewed. The DOC reported residents presenting with unpredictable behaviour would require keeping them away from other residents to minimize resident to resident altercations. The DOC stated the homes environment was

not equipped to manage resident #026's identified behaviors. The DOC was unable to demonstrate interventions had been implemented to prevent interactions between resident #026 and co-residents in the home including resident #025.

The licensee was issued a Compliance Order (CO) #001 related to s. 19 (1), an identified date and report with an identified compliance due date. The home was identified to be in compliance, therefore, a Written Notification (WN) is being issued following the identified of CIS report.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 79/10, s. 49 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids.

The home submitted a CIS report on an identified date to the MLTC Director related to resident #011. The CIS report indicated resident #011 sustained an identified incident and was transferred to the hospital. The resident returned to the home with an unconfirmed diagnosis.

A record review of the progress notes identified resident #011 sustained multiple identified incidents and subsequently transferred to the hospital.

A review of the resident's written plan of care for an identified period identified care related to an identified ADL was the be provided.

A progress note with in identified date indicated resident #011 had an identified incident in an identified location of the home which was witnessed by a PSW.

A record review and interview with ADOC # 107 confirmed that the home's identified policy had not been followed by the RN as there was no RN documentation related to the identified incident as per policy. The ADOC confirmed the care plan had not been reviewed to identify interventions were in place prior to the identified incident.

A further record review of the resident's progress notes showed multiple identified incidents had occurred during an identified period of time.

A record review and interview with ADOC #107confirmed that the home's identified program did not provide for strategies to reduce or mitigate an identified incident including the monitoring of residents, the review of residents, drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
O. Reg. 79/10, s. 107 (4).
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).
5. The name and title of the person who made the initial report to the Director under subsection (1) or (3), the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

The licensee has failed to ensure that they inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident: 1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident. 2. A description of the individuals involved in the incident, including, i. names of any residents involved in the incident, ii. names of any staff members or other persons who were present at or discovered the incident, and iii. names of staff members who responded or are responding to the incident. 3. Actions taken in response to the incident, including, i. what care was given, or action taken as a result of the incident, and by whom, ii. whether a physician or registered nurse in the extended class was contacted, iii. what other authorities were contacted about the incident, if any, iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and v. the outcome or current status of the individual or individuals who were involved in the incident. 4. Analysis and follow-up action, including, i. the immediate actions that have been taken to prevent recurrence, and ii. the long-term actions planned to correct the situation and prevent recurrence.

The home submitted a CIS report on an identified date to the MLTC director indicating the STAT box had missing/unaccounted controlled substance. The CIS report stated that the Pharmacist completed a routine general systems audit which included the STAT box and noted that specified medications were unaccounted. The CIS report further indicated the pharmacy had sent a staff to carryout and assist the home with the investigation and on an identified date one of the specified medications was destroyed and never reordered to have back in the STAT box.

Upon review of the home's amended CIS report the report did not provide the information required as per MLTC regulations as indicated above.

An interview was carried out with the home's DOC #106 who indicated that when a CIS report was submitted to the MLTC all the areas are to be completed as required in the CIS report. The DOC reviewed the above CIS report and acknowledged that the CIS did no consist of pertinent information as required by O.Reg 79/10 r. 107. (4). The DOC further stated that the home will amend the CIS report with the missing information.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 123. Emergency drug supply
Every licensee of a long-term care home who maintains an emergency drug supply for the home shall ensure,
(a) that only drugs approved for this purpose by the Medical Director in collaboration with the pharmacy service provider, the Director of Nursing and Personal Care and the Administrator are kept;
(b) that a written policy is in place to address the location of the supply, procedures and timing for reordering drugs, access to the supply, use of drugs in the supply and tracking and documentation with respect to the drugs maintained in the supply;
(c) that, at least annually, there is an evaluation done by the persons referred to in clause (a) of the utilization of drugs kept in the emergency drug supply in order to determine the need for the drugs; and
(d) that any recommended changes resulting from the evaluation are implemented. O. Reg. 79/10, s. 123.

Findings/Faits saillants :

The licensee has failed to ensure that at least annually, there was an evaluation done by the Medical Director, pharmacy service provider, Director of Nursing Patient Care (DONPC), and Administrator, of the utilization of drugs kept in the emergency drug supply in order to determine the need for the drug.

The home submitted a CIS report on an identified date to the MLTC director indicating the emergency (STAT) box had a missing/unaccounted controlled substance. The CIS report stated that the Pharmacist completed a routine general systems audit which included the STAT box and noted that specified medications where unaccounted for. The CIS report further indicated the pharmacy had sent a staff to carryout and assist the home with the investigation and on an identified date found that one of the specified medications where destroyed and never reordered to have back in the STAT box.

An interview was carried out with the home's DOC who indicated the home does utilize a STAT box. The DOC stated Classic Care Pharmacy was utilized till an identified date at which point Tri MED Pharmacy took over pharmacy service for the home. The DOC acknowledged that the home did not carryout an evaluation of the medication kept in the emergency drug supply box in order to determine the need for the drug.

Issued on this 23rd day of October, 2019

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

Original report signed by the inspector.