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
Jul 17, 2017	2017_263524_0009	003289-17	Resident Quality Inspection

Licensee/Titulaire de permis

Schlegel Villages Inc
325 Max Becker Drive Suite 201 KITCHENER ON N2E 4H5

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

THE VILLAGE OF RIVERSIDE GLEN
60 WOODLAWN ROAD EAST GUELPH ON N1H 8M8

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

INA REYNOLDS (524), ALI NASSER (523), AMIE GIBBS-WARD (630), DONNA TIERNEY (569), DOROTHY GINTHER (568), TRACY RICHARDSON (680)

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): March 21, 22, 23, 24, 28, 29, 30, 31, April 3, 4, 5, 6, 2017.

The following intakes were completed within the RQI:
Follow-up:
Log # 027439-16 / Director Referral #001 related to dining observations, compliance order #003 related to continence care and #005 related to nutrition and hydration
Log # 027444-16 / Director Referral #002 related to sufficient staffing and

compliance order #004 related to infection prevention & control
Log # 028701-16 / Compliance order #001related to responsive behaviours
Log # 028715-16 / Compliance order #001 related to snack observations, #002 related to bedrails and #004 related to plan of care
Log # 028716-16 / Compliance order #003 related to policies and #005 related to duty to protect.
Complaints:
Log # 009078-16 / IL-43410-LO related to allegations of neglect
Log # 009503-16 / IL-43877-LO related to medications and responsive behaviours
Log # 023464-16 / IL-45653-LO related to allegations of abuse
Log # 026980-16 / IL-46551-LO related to falls prevention
Log # 030333-16 / IL-47387-LO related to the falls prevention
Log # 002074-17 / IL-49005-LO related to allegations of abuse
Log # 003254-17 / IL-49280-LO related to falls prevention.
Critical Incidents:
Log # 018655-16 / CIR 2915-000040-16 related to allegations of abuse
Log # 019925-16 / CIR 2915-000044-16 related to allegations of abuse
Log # 020508-16 / CIR 2915-000038-16 related to allegations of abuse
Log # 022256-16 / CIR 2915-000051-16 related to falls prevention
Log # 024443-16 / CIR 2915-000053-16 related to allegations of abuse
Log # 026759-16 / CIR 2915-000055-16 related to falls prevention
Log # 028996-16 / CIR 2915-000060-16 related to allegations of abuse
Log # 029376-16 / CIR 2915-000061-16 related to allegations of abuse
Log # 029611-16 / CIR 2915-000064-16 related to allegations of abuse
Log # 031854-16 / CIR 2915-000062-16 related to falls prevention
Log # 032308-16 / CIR 2915-000068-16 related to allegations of abuse
Log # 033305-16 / CIR 2915-000071-16 related to falls prevention
Log # 001476-17 / CIR 2915-000003-17 related to falls prevention
Log # 006425-17 / CIR 2915-000020-17 related to falls prevention
Log # 006425-17 / CIR 2915-000020-17 related to falls prevention.

During the course of the inspection, the inspector(s) spoke with the General Manager, Assistant General Manager, Director of Nursing, three Assistant Director of Nursing Care, Director of Environmental Services, Director of Food Service, Assistant Director of Food Service, Corporate Registered Dietitian, two Registered Dietitians, one Physiotherapist, one Pharmacist, one Kinesiologist, Registered Nurse Consultant, one Registered Nurse, two Resident Assessment Instrument/Quality Initiative (RAI/QI) Registered Practical Nurses, eighteen

Registered Practical Nurses, three Neighbourhood Coordinators, 35 Personal Care Aides, two Food Service Aides, one Housekeeping Aide, one Recreation Aide, Resident Council representative, Family Council representative, residents and families.

The inspector(s) also conducted a tour of the home, observed care and activities provided to residents, medication administration, a medication storage area, dining and snack service, resident/staff interactions, infection prevention and control practices, reviewed clinical records and plans of care for identified residents, postings of required information, minutes of meetings related to the inspection, internal investigation notes, relevant policies and procedures of the home, and observed the general maintenance, cleanliness and condition of the home.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
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
Snack Observation
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **19 WN(s)**
- **9 VPC(s)**
- **7 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 #002	2016_325568_0016	568
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #005	2016_325568_0016	568
O.Reg 79/10 s. 229. (5)	CO #004	2016_448155_0008	630
O.Reg 79/10 s. 30. (1)	CO #001	2016_448155_0008	630
O.Reg 79/10 s. 31. (3)	CO #002	2016_448155_0008	568
O.Reg 79/10 s. 55.	CO #001	2016_325568_0017	630
O.Reg 79/10 s. 68. (2)	CO #005	2016_448155_0008	630
O.Reg 79/10 s. 73. (1)	CO #003	2016_448155_0008	630

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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident was properly cared for in a manner consistent with his or her needs.

On a specific date and time, during an interview with an identified resident's Substitute Decision Maker (SDM) they shared with the inspector that they had just spoken with a Personal Care Aide (PCA) and told them that the resident needed to be changed. The SDM told the inspector that the PCA said they would come after they were finished with

what they were currently doing. The PCA was then observed to finish with care being provided in one room and go into the room next door to assist another staff member. When the PCA exited this room they were observed to go down the opposite hallway. The PCA was not observed speaking with another PCA before they went to the opposite hall.

On a specific date and time, the resident's SDM spoke with the PCA near the nursing station and advised them that the resident needed to be changed. The PCA acknowledged the SDM's request and then went into the lounge area. When they exited the lounge they were seen picking up the snack cart to commence delivery of nourishment to residents.

At a specific time, the resident was observed by the inspector lying on their bed and there was an obvious odour of stool in the room. The resident stated that they were waiting for someone to come and help them.

On a specific date and time, the resident's SDM returned to their family members room and saw that the resident had not yet been provided with care. The SDM told the inspector that the resident was becoming agitated now and they were upset they had not yet been provided with their personal care needs. The SDM said they needed to leave but were concerned that their family would not receive the care they needed. The inspector asked the SDM if the resident had used the call bell to alert staff and they said "no". The SDM said that they did not think the resident knew what it was for and would not want to bother anyone. The SDM then pushed the call bell.

On a specific date and time, an identified PCA was observed going into the resident's room and closing the door. When the PCA exited the room they told the inspector that they had answered the call bell, and when they went to see the resident they found they needed to be changed.

During an interview with a PCA at a specific date and time, they told the inspector they had just finished doing a bath. When asked, the PCA acknowledged that earlier the resident's SDM had told them that the resident needed to be changed. The PCA stated that they had been pulled away to do something else and had forgotten to attend to the resident. The PCA said they should have either provided the care for the resident or at least notified another staff member of the resident's care needs.

The licensee failed to ensure that the resident was properly cared for in a manner

consistent with their care needs. [s. 3. (1) 4.]

2. The licensee has failed to ensure that the resident's right to be told who was responsible for and who was providing the resident's direct care was fully respected and promoted.

The Substitute Decision Maker (SDM) for an identified resident reported in a complaint letter and to the inspector that the resident or the family were not informed of the role of the Neighbourhood Coordinator (NC) and the Quality Assurance Nurse. The SDM said that they were aware that the resident had the right to know who was taking care of them and that the home had not provided the resident with that right.

In interviews the Assistant General Manager (AGM) and Assistant Director of Nursing (ADON) said that it was the home's expectation that the NC and QA Nurse would meet with the resident and family members, inform them of their roles and duties, and those meetings would be documented in the clinical records. A clinical record review with the AGM and the ADON showed no documented evidence that the NC and QA Nurse informed the resident and SDM about their roles. [s. 3. (1) 7.]

3. The licensee has failed to ensure that every resident had the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with the Act.

Observation on a specific date, during medication administration a medication package with a resident name, date, time and medications that were in the package was reviewed. At the bottom of the packet was the resident's room number and a bar scanner. The package was ripped down the side and the information on the package remained intact. A Registered Practical Nurse (RPN) threw this package in the garbage as described above. During an observation on another date, the inspector found a medication package in the garbage bin on the medication cart on an identified neighbourhood, which had the resident's name, location and medications clearly visible on top of the garbage bin. On observation of the destruction pails for discarded medications there were numerous packages with residents name and drug names clearly visible on the packaging and not destroyed.

A Registered Practical Nurse (RPN) stated that the name was not completely erased from the medication strip packages and although ripped the RPN acknowledged the resident was still identifiable. The RPN was unsure of the policy regarding disposal of

medication packages. The ADNC stated medication packages with the name would be destroyed and not placed in the garbage. The ADNC acknowledged that by placing it in the garbage they were not following their policy.

The licensee had failed to ensure that every resident had the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with the Act.

The scope of this area of non-compliance was a pattern and the severity was determined to be minimal harm/risk or potential for actual harm/risk. The home had a history of noncompliance in this sub-section of the legislation as it was previously issued as a WN on April 14, 2014 and a VPC on May 11, 2015. [s. 3. (1) 11.]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with 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. (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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

a) Review of a Critical Incident report submitted by the home to the Ministry of Health and Long Term Care , stated that an identified resident sustained an unwitnessed fall resulting in an injury.

Record review of the resident's fall history on Gold Care documented numerous falls between an identified period of time.

The hard copy of the care plan, located in the team binder in the unit nursing station, was reviewed on March 29, 2017, and it was noted that the care plan indicated that the resident was at risk of falls and was to wear an identified device when up to add protection if a fall should occur. Review of the plan of care and progress notes on Gold Care indicated that this intervention was discontinued, as the resident no longer attempted to ambulate independently.

Upon interview with a Personal Care Aide (PCA), it was stated that they would reference the care plan in the neighbourhood binder for care interventions. Upon interview with a Registered Practical Nurse it was stated that the care plan in the team binder for this resident had not reflected current practice and should have given clear direction to staff related to falls interventions. The Neighbourhood Coordinator acknowledged that the plan of care on Goldcare and in the team binder were not consistent and should have been.

b) Clinical record review for an identified resident showed that the care plan goals that were active on a certain date, stated the following:
"Weight maintenance within goal weight range through review. Gradual weight loss through nutritionally adequate diet through review".

Clinical record review indicated that the resident's weight had increased during a specific period of time.

In an interview the ADON said that the plan of care was confusing and did not set out clear direction to staff as it had the goals of maintaining the weight which was achieved and continuation with the gradual weight loss at the same time.

In an interview the AGM reviewed the plan of care and said that it had two opposing goals and acknowledged that the plan of care did not set out clear direction to staff and others who provided direct care to the resident. The AGM said that it was the home's expectation that the plan of care would set out a clear directions to staff and others who provided direct care to the resident. [s. 6. (1) (c)]

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

a) On August 26, 2016, related to inspection number 2016_325568_0016, as part of Compliance Order (CO) #004 the home was ordered to ensure that where a resident was identified in the plan of care as requiring a supplement, the supplement was provided to the resident as set out in the plan of care, and the intake of the supplement was documented. The due date for this CO was September 23, 2016.

On a specific date, the inspector observed that an identified resident consumed a coffee during the nourishment service which was provided by a PCA. There was a labelled bottle of a supplement on the snack cart for the resident and this was not observed to be

offered to the resident. Review of the "Nutrition and Hydration Flow Sheet" for the resident documented that fluids were consumed but it did not identify that the supplement was not consumed.

The PCA said that their usual practice when giving a supplement from the snack cart was to go by the labelled snacks and the list and then record as part of the intake of fluids as there was not a separate place to record that information. The PCA said that the resident did not receive the supplement labelled on the cart.

On a specific date, another PCA told the inspector that the resident usually refused the labelled supplement on the snack cart as they preferred to drink coffee. The PCA said that the usual practice was to record the supplement intake with the other fluids on the intake sheets. On a specific date, the resident told the inspector that they preferred to have coffee to drink between meals and did not like the supplement drink that was being offered as it was too sweet and they did not usually drink this item.

The plan of care for the resident stated that they were at nutritional risk related to altered skin integrity. This plan of care did not include that a labelled commercial supplement was to be provided at snacks. Review of the "Snack Delivery Report" showed that the resident was to receive a supplement at specific snack times.

A nutritional assessment note by the Registered Dietitian (RD) identified that they had received a referral for weight change. This assessment showed that the resident weight had significantly changed. This assessment stated that the resident was consuming snacks but did not include any reference to the supplement the kitchen was providing at snacks.

On March 24, 2017, Assistant Food Services Manager (AFSM) told the Inspector that the PCAs in the home used the diet list and the labelled snacks on the beverage cart to know what residents were to be served including supplements that were offered at snack times. The AFSM said that the fluid intake recorded on the "Nutrition and Hydration Flow Sheet" did not distinguish between the intake of the supplement or the intake of a different fluid and acknowledged that based on this documentation it was not possible to identify if the supplement had been consumed. AFSM said they were working on a system in the home at the time of the inspection to improve the documentation of the intake of supplements. The home's policy titled "Nutritional Care Nourishments" identified that the "Snack Delivery Report" would list "diet and special requirements/nourishments". This policy also stated that "labelled supplements" would be included on the

nourishment cart.

On March 28, 2017, the Registered Dietitian (RD) and Nutrition Manager (NM) told the Inspector that it was the expectation in the home that staff were offering the commercial supplements to residents based on the plan of care which included the items listed on the "Snack Delivery Report" on the nourishment carts. They said that staff were documenting the supplements provided on the nourishment carts within the overall fluid intake on the "Nutrition and Hydration Flow Sheet" and acknowledged that it was difficult to distinguish between the documentation of supplement intake and intake of other fluids based on this record.

b) On August 26, 2016, related to inspection number 2016_325568_0016, as part of Compliance Order (CO) #004 the home was ordered to ensure that where a resident was identified in the plan of care as requiring a supplement, the supplement was provided to the resident as set out in the plan of care, and the intake of the supplement was documented. The due date for this CO was September 23, 2016.

On March 23, 2017, the Inspector observed that an identified resident was offered a specific supplement poured into a glass which was a labelled item on the nourishment cart. The resident refused the offer of the supplement. The Inspector observed that the resident was not re-approached with the supplement.

The "Snack Delivery Report" identified that the resident was to receive an identified supplement at a specific snack. The "Nutrition and Hydration Flow Sheet" for the resident marked the fluid for the snack on a specific date, as "refused" but did not identify if this was the supplement that was refused. This record showed that the resident had no fluid intake at the snack on numerous days but this form did not identify whether the supplement was offered or consumed at those snacks.

The plan of care for the resident indicated they were at "Nutritional Risk" related to significant weight change and "refuses protein sources on meal entrees, impaired skin". This plan of care stated that the resident was to receive two specific supplements numerous times per day. This plan of care did not address what to do with the supplement if the resident was sleeping.

The Medication Administration Record (MAR) for a specific month, showed that the resident was marked as "sleeping" numerous times and that a specific supplement was to be provided. This MAR also showed no documentation for whether the supplement

was provided on numerous times.

On a specific date, two RPNs said that the resident was to receive a supplement from the registered nursing staff but often disliked it and refused the item. They reviewed the MAR for a specific month and they acknowledged that it was incomplete regarding the supplement. They said if a resident was regularly refusing a supplement they could tell from the documentation and then would notify the RD.

On March 24, 2017, the Assistant Food Services Manager (AFSM) told the inspector that the PCAs in the home used the diet list and the labelled snacks on the beverage cart to know what residents were to be served including supplements that were offered at snack times. AFSM said that the fluid intake recorded on the "Nutrition and Hydration Flow Sheet" did not distinguish between the intake of the supplement or the intake of a different fluid and acknowledged that based on this documentation it was not possible to identify if the supplement had been consumed. AFSM said they were working on a system in the home at the time of the inspection to improve the documentation of the intake of supplements.

On March 28, 2017, the Registered Dietitian (RD) and Nutrition Manager (NM) told the inspector that it was the expectation in the home that staff were offering the commercial supplements to residents based on the plan of care which included the items listed on the "Snack Delivery Report" on the nourishment carts. They said that staff were documenting the supplements provided on the nourishment carts within the overall fluid intake on the "Nutrition and Hydration Flow Sheet" and acknowledged that it was difficult to distinguish between the documentation of supplement intake and intake of other fluids based on this record.

On March 29, 2017, the DNC said it was the expectation in the home that the provision and consumption of nutritional supplements would be included in the MAR. The DNC said it was their understanding based on discussion with the home's Corporate Registered Dietitian that supplements provided on the snack carts were not considered supplements and therefore did not need to be documented by staff in the same way. The DNC acknowledged that the MAR for the resident had incomplete documentation regarding the specific supplement.

On March 31, 2017, Corporate RD said that they viewed the two commercial supplement drinks provided on the nourishment carts as food and therefore these were not required to be documented by staff in the home in the same way as other identified supplements.

On March 31, 2017, the inspector reviewed the home's policy titled "Nutritional Care Nourishments" with the AFSM. This policy identified that "labelled supplements" were being provided on the nourishment carts to residents and AFSM said it was their understanding that the two commercial supplements were considered to be nutritional supplements for residents in the home.

Based on the observations, clinical record review and interviews the nutritional plan of care for the identified resident was not provided to the resident as specified in the plan.

c) On a specific date, the RPN told the inspector that an identified resident had altered sleep patterns and numerous personal expressions. The RPN said that they thought that pain was contributing to the behaviours and the resident was not able to express pain verbally. RPN said that they had worked with the physician to adjust the pain medications for the resident and they thought this had been effective. The RPN said they had recently changed to a pain assessment in Point Click Care (PCC) and that the resident had difficulties answering the pain scale in that assessment so they would help assign a number on the pain scale when doing the assessment.

The "personal expressions" plan of care for the resident stated "address their pain concerns as per their pain care plan." The "pain" plan of care stated "use a validated pain assessment tool as per Village policy when required by using the Abbey Pain Scale as the resident is not always able to voice when in pain". This plan of care also stated "administer routine analgesia as per physician's order and indicated on the Medication Administration Record (MAR)".

Review of the MAR for the resident for a specific month, showed that two identified medications were to be given at specific times and dates, and there was no documented evidence that this had been given. This MAR also showed that a pain assessment was to be completed on each shift for a specific time period, and this was not documented as having been completed on three identified shifts.

On March 29, 2017, the DNC was asked to provide any pain assessments that had been completed in the home for the resident between a specific time period. There were only three documented Abbey Pain Scale assessments that were provided. The DNC said there were no other paper pain assessments that could be located for this resident. The DNC said that starting in March the staff were documenting pain assessment in Point

Click Care (PCC) and it was the expectation that staff would be completing these based on the policy and plan of care for a resident.

Review of the pain assessments completed for the resident between specific time periods, found that staff had completed the numeric pain assessment six times and the PAINAD one time.

On March 29, 2017, Resident Assessment Instrument Quality Improvement (RAI QI) Coordinator told the Inspector that the staff were no longer using the Abbey Pain Scale to assess residents in the home and instead were using a pain assessment form in PCC. The RAI QI said that the staff were to use the “PAINAD” scale version of the assessment not the numeric scale for residents with cognitive impairments.

Based on the interviews and clinical record review the home did not provide the resident with the assessments and care regarding pain that was specified in the plan of care.

d) An observation was completed of an identified resident on a specific date. The resident was noted to be seated in a Personal Assistive Services Device (PASD) and not repositioned during a specific time frame.

The resident's plan of care stated “Reposition every 2 hours".

The Assistance Director of Nursing Care stated that the resident was to be repositioned when seated in a PASD and that the expectation was that the resident was to be repositioned every two hours.

Upon interview with a Personal Care Aide (PCA), it was stated that “the PCA’s are supposed to reposition every three hours, we do not wake the resident up if they were sleeping. We do not disturb them unless they wake up". The PCA acknowledged that they did not reposition the resident. Interview with three other PCAs, it was acknowledged they did not reposition this resident as directed every two hours and that this was not the normal procedure for this resident.

A review of the plan of care stated that the resident was to be "repositioned every two hours to prevent skin breakdown" and that the resident was to be positioned comfortably at all times and turned every two hours when in bed or in a seated position.

During observations on another date and time, the resident was observed to not be

repositioned as directed in the care plan.

Interviews with four Personal Care Aides (PCAs) acknowledged that they did not reposition the resident during that time, PCA’s stated they checked on the resident after a meal but they did not reposition the resident.

The Director Nursing Care (DNC) and Assistant Director Nursing Care (ADNC) stated that the expectation was that the Personal Assistive Services Device (PASD) be released and the resident physically repositioned every two hours.

Review of the plan of care, specifically the PASD monitoring form on the specified date of the inspectors observation it was recorded that the resident had been repositioned and toileted during that time frame. The DNC and Neighbourhood coordinator identified that all documentation was to be accurate and that the observations made did not support the documentation that had been completed. Both the DNC and the ADNC as well as a Neighbourhood Coordinator stated that the expectation was that the monitoring form be accurate as to the care provided.

The licensee had failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan. [s. 6. (7)]

3. The licensee has failed to ensure that the resident's plan of care was revised when a goal in the plan was met and the care set out in the plan was no longer necessary.

Clinical record review showed that an identified resident's weight had increased during a specific period of time.

Clinical record review for the resident showed that the care plan goals active on two specific dates, stated the following:
Weight maintenance within an identified goal weight range. Gradual weight loss through nutritionally adequate diet through review.

In an interview the ADON said that the Registered Dietitian (RD) reassessed the resident on two specific dates, the resident weight was maintained within the goal weight range but the intervention to gradually lose weight continued. In an interview the AGM reviewed the plan of care and progress notes by the RD, the RD assessed the resident on a specific date, due to weight loss in one month. The RD continued with the same interventions.

The AGM said that the weight loss interventions continued despite the fact that the resident was now below the goal weight range. AGM said that the plan of care was not revised when the goal was achieved. AGM said that it was the home's expectation that the plan of care would have been revised when a goal in the plan was met and the care set out in the plan was no longer necessary. [s. 6. (10) (a)]

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

a) Record review of the current plan of care in Gold Care and hard copy in the Team binder in the unit nursing station for an identified resident under the falls prevention and management focus directed staff to complete periodic checks initiated on a specific date. Staff interview with a Personal Care Aide on an identified date, indicated the resident no longer required the periodic checks.

A Neighbourhood Coordinator (NC) stated, that the interval checks were initiated for a certain time period, and said the checks were no longer required for the resident. The NC further acknowledged that the care plan intervention had not been revised when the residents care needs changed and the care set out in the plan was no longer necessary.

b) Review of an identified resident's clinical record identified that they received medical care on a specific date, for further assessment of potential injuries sustained as a result of multiple falls. A progress note stated that the resident had sustained an injury. A Kinesiologist documented that they had completed an assessment of the resident's walking ability post-fall. The resident walked in the hall with the Kinesiologist and another team member while the resident's SDM brought a Personal Assistive Services Device (PASD) behind. The Kinesiologist used a transfer device while they assisted the resident. The resident walked from their room to the lounge and then back to their bedroom.

On a specific date and time, this inspector observed a Personal Care Aide (PCA) enter the resident's room and tell them they were there to help the resident walk to the dining room for a meal. The PCA assisted the resident to stand from their easy chair and then walk out of their room and down the hall. The resident's SDM asked the PCA to use a transfer device that they held in their hand but the PCA said it was not needed. Instead, the PCA was observed to place one hand at the small of the resident's back to guide the

resident. The resident was observed to show signs of fatigue and their legs started to buckle mid way down the hall to the dining room, but the PCA continued to encourage the resident to keep walking. The SDM suggested that they should have the PASD behind as they had that morning when the Kinesiologist had walked with the resident, but the PCA told the SDM it was not necessary. The resident made it to the door of the dining room at which point the PCA called for assistance so they could get the resident into a chair as the resident's legs were collapsing.

During a review of the plan of care, it stated that the resident required extensive assistance of two team members using a PASD for transfers. In terms of locomotion, the resident required limited assistance of one staff with a PASD.

During an interview with the PCA on an identified date, they told the inspector that they do not normally work on the identified neighbourhood. They said that when they were not familiar with a resident they checked their care plan to determine specific resident care needs. The care plan was easily accessible in their flow sheet binders. In terms of this resident, the PCA stated that they used a PASD with one person assistance for ambulation. The staff member was not aware that they were to use a specific transfer device. The PCA said they would not normally bring the PASD behind unless the resident requested it. They rely on the resident to let them know. The PCA acknowledged that the resident seemed to be getting tired when walking to the dining room and they may have benefited from more assistance or a rest part way.

During an interview with the Kinesiologist they told this inspector that they had walked with the resident on the morning of an identified date, using a transfer device and with another staff while the SDM brought the PASD behind. The resident had done very well and did not take a rest despite their urging. The Kinesiologist said that the resident was still in the early post-fall with injury stages and may fatigue easily which was why they had the PASD behind. The Kinesiologist acknowledged that they had not updated the resident's plan of care with respect to ambulation after a significant change in status.

The licensee failed to ensure that the resident was reassessed and the plan of care related to locomotion was reviewed and revised when the resident's care needs changed.

The scope of this area of non-compliance was a pattern and the severity was determined to be minimal harm/risk or potential for actual harm/risk. The home had a history of non-compliance in this section of the legislation as it was previously issued as Compliance

Order #001 on March 17, 2016 and Compliance Order #004 on August 26, 2016. [s. 6. (10) (b)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was in compliance with and was implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).

Long-Term Care Homes Act S.O. 2007 c.8 s. 21 requires the home to ensure that there are written procedures that comply with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints.

In an interview a Substitute Decision Maker (SDM) said that they had shared concerns related to an identified resident's care with the resident's physician and other staff members and did not hear back from them.

Long-Term Care Homes Act S.O. 2007 c.8 s. 21 requires the home to ensure that there are written procedures that comply with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints.

O. Reg. 79/10, s. 101. (1). 1 stated that every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows: the complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.

In an interview with the resident's Substitute Decision Maker (SDM) they told the inspector that they had several complaints with the home and were not happy with how the home addressed their concerns.

A review of the home's policy subject "Resident/Family Concerns" Tab 11-21 not dated, under procedure number four said that the Neighbourhood Coordinator will contact the family member or resident directly within five working days of the commencement of the investigation, unless the complaint alleges harm, to discuss the results of the investigation and remedial action if any. Procedure number 13 said that if the family member or resident was still not satisfied they would be encouraged to refer the matter to the General Manager (either in meeting or in written format), which would be responded to in writing within 10 days.

In an interview the AGM acknowledged that the O. Reg. 79/10, s. 101. (1). 1 specified a response within 10 business days of the receipt of the complaint and not from the beginning of the investigation. They said that according to their policy it was at least 15 days to respond in writing to the family and/or resident. The AGM said that the policy was not in compliance with O. Reg. 79/10, s. 101. (1). 1 and told the Inspector that they would be working with the corporate office to update the policy. [s. 8. (1) (a)]

2. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

On August 26, 2016, related to inspection number 2016_325568_0016, as part of Compliance Order (CO) #003 the home was ordered to ensure that their Nutrition and Hydration policy in regards to documentation of the food and fluid intake of residents, including appropriate supplements, on flow sheets at the time of meal and snack service was complied with. The due date for this CO was September 30, 2016.

The home's policy titled "Nutrition and Hydration – Riverside Glen" Tab 07-24 not dated,

stated "commercial supplements or alcoholic beverages will be documented on the Medication Administration Record (MAR) by registered team members." The policy stated that "PCAs will take note of the meal each resident is served, as well as the total amount of fluids served to each resident to ensure accurate documentation. This policy also stated "the Nutrition and Hydration binders will be placed on the teacart at the time of each nourishment service" and "food and fluid intake will be documented at the time of the service."

On a specific date, the Assistant Food Services Manager (AFSM) told the inspector that the PCAs in the home used the diet list and the labelled snacks on the beverage cart to know what residents were to be served including commercial supplements that were offered at snack times. The AFSM said that the fluid intake recorded on the "Nutrition and Hydration Flow Sheet" did not distinguish between the intake of the commercial supplement or the intake of a different fluid and acknowledged that based on this documentation it was not possible to identify if the supplement had been consumed. The AFSM said a resident's intake of the other types of supplements were to be documented by the registered staff on the MAR. AFSM said they were working on a system in the home at the time of the inspection to improve the documentation of the intake of supplements.

On a specific date, the Registered Dietitian (RD) and Nutrition Manager (NM) told the inspector that it was the expectation in the home that staff were following the home's Nutrition and Hydration Policy regarding the documentation of resident's food, fluid and supplement intake. They said that staff were documenting the supplements provided on the nourishment carts and were to include them with the overall fluid intake on the "Nutrition and Hydration Flow Sheet" instead of in the MAR and acknowledged that it was difficult to distinguish between supplement intake and intake of other fluids based on this documentation. The NM said it was the expectation that staff would be documenting the intake of food and fluids at the time that snacks were offered. The RD said it was the expectation that supplements provided by the registered staff would consistently be documented on the MAR.

a) On a specific date, the inspector observed that an identified resident consumed a full commercial supplement during the nourishment service which was provided by a PCA from the labelled items on the snack cart. Review of the "Nutrition and Hydration Flow Sheet" for this resident documented on a specific date, that the fluids were consumed but it did not identify that this was a commercial supplement.

On a specific date, the inspector observed that the resident was offered a commercial supplement during the snack which was provided by a PCA from the labelled items on the snack cart. Review of the "Nutrition and Hydration Flow Sheet" for this resident documented for the snack, that fluids were refused but it did not identify that this was a commercial supplement that had been refused. The Nutrition and Hydration Binder was not observed on the cart at the time of the nourishment service and the PCA was not documenting the fluid intake at the time of the service.

On a specific date, the PCA said that their usual practice when documenting the residents' intake of the labelled commercial supplements provided on the snack carts was to record them under the fluid section. The PCA said that there was no place on the intake record to record that a supplement was provided or refused. The PCA said they had not recorded the fluid intake of residents during the identified nourishment service.

Nutritional assessment by the RD on a specific date, identified that this resident had a significant weight change and was below their goal weight. The assessment stated that the resident's "intake is poor". The interventions listed in the assessment included that the resident was to receive a specific supplement multiple times per day. The plan of care identified that the resident was at nutritional risk. This plan of care identified that the resident was to receive a supplement multiple times per day.

Review of the resident's intake documented on the "Nutrition and Hydration Flow Sheet" for a specific date range, showed no fluid intake on numerous occasions and did not identify whether it was the supplement that was not consumed at these times or other fluids. Review of the Medication Administration Record (MAR) for a specific month, showed that the intake of the supplement was not documented by the registered staff multiple times for this resident.

On a specific date, two RPN's told the inspector that the resident received a supplement on the snack carts as well as one provided during medication pass by the registered staff. The RPN's reviewed the specific MAR and they acknowledged that the intake of the supplement had not been documented each time it was ordered to be provided.

b) A nutritional assessment documented on a specific date, for an identified resident showed that the resident had experienced a weight change. This assessment identified fluctuating intake and frequent refusal of protein items and changed the plan of care to a supplement multiple times per day with the medication pass.

On a specific date, the RPN told the inspector that the resident received a specific supplement from the registered staff during medication pass and this was recently ordered. The RPN said that the resident's intake of this item was to be documented on the Medication Administration Record (MAR). Reviewed resident's MAR with the RPN and it was acknowledged that the intake was not documented each time it was ordered to be offered (multiple times) between a specific date range. The RPN said that they thought that sometimes staff had forgotten to document the intake of the supplement on the MAR.

c) On a specific date, the inspector was observing care provided in an identified Neighbourhood for a specific period of time. The inspector observed that an identified resident was sleeping during this time and did not have food or fluid for the meal. The inspector reviewed the "Nutrition and Hydration Flow Sheet" for the specific date, and it showed that this resident had consumed all food and fluid at the meal.

The inspector reviewed the intake record for the resident with a Neighbourhood Coordinator (NC) and the Director of Nursing Care (DNC) and they said it was the expectation in the home for staff to document the intake of residents accurately as per the home's policy.

On a specific date, the AGM told the inspector that they were conducting an investigation and submitted a Critical Incident System (CIS) report to the Ministry of Health and Long Term Care (MOHLTC) regarding the documentation and the offering of meals to this resident on the observed date.

On a specific date, the AGM provided the inspector with the home's documentation regarding the investigation. This documentation showed that a staff member of the home had been given a one day suspension regarding not following the home's Nutrition and Hydration Policy and falsifying the documentation regarding a resident's consumption.

d) On a specific date, during a meal in a unit Neighbourhood the inspector observed that an identified resident was not in the dining room during the meal. The PCA told the inspector that this resident was usually offered food later. The inspector observed that the resident was offered a meal by tray service later during the nourishment cart but this resident did not consume any food that had been offered. The inspector observed a PCA remove the meal at a specific time and no food had been eaten by the resident. The inspector observed that the PCA staff did not have the "Nutrition and Hydration Flow Sheet" binder with them during the specific nourishment service and were not recording

the intake of residents at the time of the service.

On a specific date and time, the inspector observed that nothing had been recorded on the "Nutrition and Hydration Flow Sheets" for any resident in this Neighbourhood or for the snack or the meal for the identified resident.

On a specific date, the PCA told the inspector that the process they followed for recording intake depended on the time and the resident. The PCA acknowledged that they had not recorded the intake of the residents at the time of the snack service. The inspector reviewed the "Nutrition and Hydration Flow Sheet" for the identified resident for a meal on a specific date, and found that staff had documented that the resident had consumed a full meal. This documentation did not correspond with the observations made by the inspector during that meal.

On a specific date, the Director of Nursing Care (DNC) said they had revised the Nutrition and Hydration – Riverside Glen after they received the Compliance Order and they provided re-education for staff. The DNC said it was the expectation in the home that all staff would comply with the revised Nutrition and Hydration policy.

Based on multiple observations, record reviews and interviews the home failed to ensure that all aspects of the Nutrition and Hydration policy were complied with. [s. 8. (1) (a),s. 8. (1) (b)]

2. On August 26, 2016, related to inspection number 2016_325568_0016, as part of Compliance Order (CO) #003 the home was ordered to ensure that their Pain Management policy in regards to completion and documentation of pain assessments was complied with. The due date for this CO was September 30, 2016.

On a specific date, a PCA said that an identified resident at times had behaviours in a certain area of the home and provided examples of the behaviours. The PCA said that pain was also a potential trigger for behaviours for the resident but they were not always able to say they were in pain.

On a specific date, a RPN told the inspector that the resident had altered sleep patterns and numerous personal expressions. The RPN said that they thought that pain was contributing to the behaviours and the resident was not able to express pain verbally. The RPN said that they had worked with the physician to adjust the pain medications for this resident and they thought this had been effective. The RPN said they had recently

changed to a pain assessment in Point Click Care (PCC) and that the resident had difficulties answering the pain scale in that assessment so they would help assign a number on the pain scale when doing the assessment.

The "personal expressions" plan of care for the resident stated "address their pain concerns as per their pain care plan." The "pain" plan of care stated "use a validated pain assessment tool as per Village policy when required by using the Abbey Pain Scale as the resident is not always able to voice when in pain".

A progress note on a specific date, identified that the resident was having responsive behaviours and that the behaviours could be related to pain. This progress note stated that pain assessments would be started each shift for a specific time frame to help assess the pain medication changes that were being implemented and to "reflect any changes in personal expressions with the new pain control."

Review of the MAR for the resident for a specific month, showed that a pain assessment was to be completed on each shift for a specific date range and this was not documented as having been completed on multiple shifts.

On a specific date, the DNC was asked to provide any pain assessments that had been completed in the home for this resident between a certain date range. There were only a few documented Abbey Pain Scale assessments that were provided. The DNC said there were no other paper pain assessments that could be located for the resident.

A progress note for a specific date, identified that the pain level based on the numeric pain scale for the resident was zero. This note stated "resident is suspected as having discomfort when they become expressive. They were unable to focus on writer or any questions."

Review of the pain assessments completed in PCC for the resident between a specific time frame, found that staff had completed the numeric pain assessment multiple times and the PAINAD one time.

The home's policy titled "Pain Management Program" Tab 04-48 stated "Schlegel Villages will use clinically-appropriate pain assessment tools to meet the resident's needs and preferences for pain management." This policy directed that staff would complete and document pain assessments "when there are personal expressions exhibited by resident that may be an indicator for the onset of pain." The policy stated that staff were

to use the Abbey Pain Scale "for measurement of pain in residents living with a cognitive concern." This policy did not include direction for staff regarding the PCC pain assessments.

On a specific date, the RAI QI told the inspector that the staff were no longer using the Abbey Pain Scale to assess residents in the home and instead were using a pain assessment form in PCC. The RAI QI said that the staff were to use the "PAINAD" scale version of the assessment not the numeric scale for residents with cognitive impairments.

The DNC said that starting in March the staff were documenting pain assessment in Point Click Care (PCC). The DNC said that the home's pain policy was being updated to reflect the change to the assessment process and forms in PCC but the new policy had not been implemented in the home. The DNC said it was the expectation in the home that staff were following the pain policy. [s. 8. (1) (a),s. 8. (1) (b)]

3. a) The home's policy titled "Pain Management Program" Tab 04-48 not dated, stated that the registered team would:
i) Complete and document a pain assessment when a resident returns from hospital, when there is a change in condition with pain onset, when there are personal expressions exhibited by a resident that may be an indicator for the onset of pain and when there is a diagnosis of a painful disease.
ii) Determine if able the type of pain i.e. chronic, acute, nociceptive and or neuropathic.
iii) Include support strategies related to the assessed pain and symptom management in the plan of care.

Review of an identified resident's clinical record identified that the resident had a fall on a specific date, and was found laying on the floor. The resident sustained injuries on multiple areas and there looked to be some potential injury deeper than skin. The resident required medical attention for further assessment and treatment of their injuries.

During a review of progress notes for the resident there were a number of entries between a specific date range, that stated the resident exhibited signs of pain during treatment care. There was no evidence that a pain assessment was conducted for the resident during the identified period. The plan of care did not include the locations of pain, type of pain or specific strategies to manage the identified symptoms.

On a specific date, the RAI / Quality RPN acknowledged that the home had not followed their Pain Management Program policy for the resident with respect to conducting a pain assessment when the resident returned from hospital having sustained injuries in a fall, as well as when the resident demonstrated signs of pain during treatment care. In addition, the plan of care related to pain was not updated to reflect the assessment of pain and support strategies related to symptom management.

b) The home's policy titled "Pain Management Program" Tab 04-48 not dated, stated under the "Procedure" that the registered team would complete and document a pain assessment when the resident or family volunteered that pain was present and with a change in condition with pain onset. As part of the assessment they would determine if able the type of pain and possible source. The policy provided for the "Abbey Pain Scale" assessment to be used for residents living with a cognitive concern and "The Pain Assessment Tool" for residents with no cognitive concern.

Review of an identified resident's clinical record identified that the resident had multiple falls on a specific date. The first fall was unwitnessed and the resident was found in their room. The resident was assessed as having no injuries. The second fall took place at a later time and was witnessed by several staff. The resident was ambulating and lost their balance. During the fall the resident was noted to have struck their head. Again, a post fall assessment was conducted by registered staff and no injuries were identified. No pain assessments were conducted following either fall.

On a certain date and time, this inspector was approached by the resident's Substitute Decision Maker (SDM). The SDM said that they were concerned about the resident as they had multiple falls on a specific date and now they were not walking. The SDM said that up until the specific date the resident was walking on their own with a PASD and today they were not able to walk. They were concerned that the resident was in pain but because of their diagnosis they were not able to express them self.

Review of health care record for the resident identified a PAINAD assessment dated a specific date and time. According to the assessment the SDM communicated with the resident and the resident reported that they had pain. The registered staff documented that there was no facial grimacing but when asked if they were in pain, the resident had said "yes". The assessment did not identify the area of the resident's pain nor did it clarify the type of pain or potential source of the pain. A progress note on a specific date and time, stated that the resident's SDM approached the Director of Nursing regarding their concern that the resident could not walk. It was agreed that the resident would

benefit from further assessment and medical attention. A progress note on a specific date and time, identified that the resident had a significant change in status.

During an interview with a Registered Practical Nurse (RPN), they told the inspector that they had conducted a pain assessment on a specific date, because the resident's SDM insisted that the resident was in pain and that was why they were not walking. When asked what type of assessment they had used for the resident they said the numerical scale in the PAINAD on Point Click Care (PCC). They used to use the Abbey Pain Scale, a paper assessment, but that was before they transitioned to PCC. When the RPN was asked if they determined the location and source of the pain they said they had not identified this in their assessment. The RPN said that Point Click Care was new to them and they were not aware that there were two types of assessments, one for residents with impaired cognition and one for cognizant residents. They acknowledged that they should have completed the assessment for non-cognizant residents and included the location and type of pain, to further determine a possible source.

c) The home's policy titled "Pain Management Program" tab 04-48 not dated, stated that the registered team will complete and document a pain assessment:
i) on initiation of pain medication or PRN,
ii) when a resident reports any pain or symptoms especially those of greater than 4 out of 10 on a severity scale for 24-48 hours,
iii) when there was a change in condition with pain onset. The registered team would determine the type of pain (chronic, acute nociceptive or neuropathic).

On a specific date, an identified resident shared with the inspector that they had been experiencing pain in a certain part of their body. The resident did not know what happened and stated that it just started hurting. According to the resident the doctor was supposed to come to see them but had not come. When asked if the resident had been provided anything for pain relief, the resident said that they had been given medication but it was not taking the pain away. On a specific day, the resident told another inspector that they had a very bad bout of pain the last two weeks. It had just finally settled down this week. The resident said that although they were given extra medication it had not always helped.

During an interview with the Director of Nursing (DON), they shared that the home had just undergone a transition from one electronic documentation system to another. Prior to March of 2017, staff were expected to complete an Abbey Pain Assessment which was paper based for those residents experiencing pain. Since early March 2017, the staff

were now expected to complete a PAINAD on Point Click Care (PCC) when assessing residents for pain. The PAINAD had two versions depending on the resident's cognitive abilities. The DON said they were working on revising their policy to reflect changes in their practices since the transition to PCC.

Record review identified progress notes on multiple dates, where the resident complained of body pain. Pain levels were documented in the progress notes as greater than four out of ten. Medication was given as per the physician's orders for as needed (PRN) pain control.There was no documentation of a Pain Assessment using the PAINAD on the electronic clinical record nor was there any paper based Pain Assessment found in the resident's chart.

On specific date, the Assistant Director of Care acknowledged that staff had not followed their pain policy with respect to completing a pain assessment when a resident reports pain symptoms of greater than four out of ten and when PRN pain medication was given.

The licensee failed to ensure that the home policy titled "Pain Management Program" was complied with. [s. 8. (1) (a),s. 8. (1) (b)]

4. On August 26, 2016, related to inspection number 2016_325568_0016, as part of Compliance Order (CO) #003 the home was ordered to ensure that their Spa (Shower, tub Bath, Sponge Bath) policy in regards to the documentation of the type of spa provided, level of assistance provided on the PSW flow sheet, including skin assessment and if concerns identified was complied with. If the resident declined their spa it was to be documented as per policy. The due date for this CO was September 30, 2016.

Review of the home's policy titled "Spa (Shower, Tub Bath, Sponge Bath)" not dated, identified under the procedure that staff were to document the type of spa provided and the level of assistance provided on the PSW flow sheet, including nail and skin care.

On a specific date, a Personal Care Aide (PCA) told the inspector that information related to a particular resident's bathing needs would be found on their care plan. A copy of the care plan could be found in the flow sheet binder so that staff could reference it when providing care. Staff were expected to document on the flow sheets under the "Spa" section what type of bathing was provided, the level of care and level of staff assistance needed as well as their nail and skin care. When a resident refused a bath or shower this must also be documented on the flow sheets.

Review of the plan of care for an identified resident in terms of bathing stated that the resident was dependent on staff for their bathing needs. The resident was to receive a bath/shower twice a week as per the spa schedule. Hair was to be washed and dried during each bath.

Record review of the resident's Personal Care Observation and Monitoring Forms for a four week period, identified that the resident received either a bath or shower twice during the first two weeks. During one week, it was documented that the resident had one shower. During another week, it was documented that the resident had one shower.

During an interview with a Neighbourhood Coordinator (NC), they said they had spoken with the staff providing care for this resident during the identified time period. Based on the staff accounts and a review of the bathing schedule the NC said that the resident received their bath on both days, but staff had forgotten to document on the Personal Care Observation and Monitoring Forms. The NC acknowledged that staff had not followed the Spa policy with respect to documentation of bathing including level and number of staff providing assistance as well as the provision of nail and skin care. [s. 8. (1) (a),s. 8. (1) (b)]

5. a) The home's policy titled "Skin and Wound Care Program" Tab 04-78 not dated, stated that a registered team member would complete a skin assessment when there was a change in skin integrity and when a resident returned from hospital. Registered staff would also complete weekly wound assessments and document these assessments in the clinical record.

Review of a resident's clinical record and a Critical Incident (CI) report identified that a resident sustained multiple wounds during a fall on a specific date. The resident was assessed, provided first aid treatment of their wounds, and transferred to hospital for further assessment and treatment. A progress note, stated that the resident returned from hospital later the same day. On a specific date, there was an entry in the progress notes that described the location of the injuries and wounds.

During a review of the resident's clinical record there was no documentation that the resident's wounds, sustained during a fall on a specific date, were assessed by a registered team member and that weekly wound assessments were conducted until the areas had healed.

On a specific date, the Skin / Wound Lead RPN acknowledged that an initial Skin / Wound assessment and weekly wound assessments had not been conducted for the resident's identified wounds.

b) The home's policy titled "Skin and Wound Care Program" Tab 04-78 not dated, stated that the Nursing staff (RN and RPN) would complete a Skin Assessment when there was a change in skin integrity. The staff member would assess altered skin integrity including skin breakdown, pressure injuries, skin tears and wounds weekly and document within the assessment for pressure and stasis injuries. They would also make a referral to inter-professional team members as required.

The home's policy titled "Nutritional Care - Skin & Wound Care" Tab 07-89 stated under "Procedure" that residents with all stages of skin breakdown, including skin tears, would be referred to the food services department via the nutrition consultation. The registered dietitian (RD) would then conduct a nutritional assessment and make recommendations for the nutritional treatment plan for that particular resident.

An identified resident's admission assessment on a specific date, identified an area of altered skin integrity on the resident. There was no evidence that a Skin / Wound assessment was completed for this area of altered skin integrity and no documentation of a weekly Skin / Wound assessment. There was no mention in the nutritional notes that the Registered Dietitian had assessed the resident related to the area of altered skin integrity.

During an interview with a Registered Dietitian (RD) on a specific date, they told the inspector that it was the home's expectation that the RD provide a nutritional consultation for all residents with altered skin integrity. The Skin / Wound Lead acknowledged that the resident did not have a Skin assessment when the area of altered skin integrity was first identified, or did not have weekly wound assessments as outlined by the home's policy for Skin and Wound Care management.

The licensee failed to ensure that the Skin and Wound Care Management and Nutritional Care - Skin & Wound Care policies were complied with. [s. 8. (1) (a),s. 8. (1) (b)]

6. a) Long-Term Care Homes Act S.O. 2007 c.8 s. 11. (1) (a) requires the licensee of a long-term care home shall ensure that there is an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents.

The home's policy titled "Nutrition and Hydration", Tab 04-46 dated April 2014, indicated that each evening, the Nutrition and Hydration Flow Sheets would be tallied by the night Personal Care Aide (PCA) team, which would include the Daily Additional Fluids Chart. The night Registered Practical Nurse/Registered Nurse (RPN/RN) would review and initial the total daily fluid intake. Any resident who had a fluid intake, less than their estimated fluid requirements, would be reported to the oncoming RPN/RN so that interventions could be initiated. The RPN/RN would assess for signs and symptoms of dehydration (Dehydration Risk Assessment Tool). If a resident exhibited signs and symptoms of dehydration (as documented in the Dehydration Risk Assessment Tool), ensure the request for Nutrition consultation (Tab 07-41) had been initiated for the Registered Dietitian to assess. The Request for Nutrition Consultation would be completed when a resident had a fluid intake of less than 1000 millilitres per individual fluid requirement, as per the plan of care, for three consecutive days and there was at least one sign or symptom of dehydration present.

A review of an identified resident's Nutrition and Hydration Flow Sheet for a specific period of time, showed that there were no total daily fluid intakes done for multiple days and there were no RPN/RN initials for all days.

The resident 's nutritional plan of care stated what their minimum daily fluid requirement was per day; the resident did not meet the required amount for multiple consecutive days on numerous occasions during an identified period of time. Record review also revealed that there were no Dehydration Risk Assessments completed for the resident.

The ADON and AGM reviewed and acknowledged that there was to be a Dehydration Risk Assessment completed if a resident had a fluid consumption of less than their individual requirement for three consecutive days. They also said that the resident had not had a Dehydration Risk Assessment completed at the specific period of time and that there was no request for nutrition consultation made to the registered dietitian due to the low fluid intake.

The home failed to ensure that the Nutrition and Hydration policy was complied with.

b) Long-Term Care Homes Act S.O. 2007 c.8 s. 21 requires the home to ensure that there are written procedures that comply with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints.

In an interview a Substitute Decision Maker (SDM) said that they had shared concerns

related to an identified resident 's care with the resident’s physician and other staff members and did not hear back from them.

The home’s policy titled "Subject Resident/Family Concerns" Tab 11-21 not dated, stated that if a family member or resident expressed a concern to a team member, the team member was to notify the Neighbourhood Coordinator (NC) or designate in writing by way of an Incident Report Form, providing as much detail about the nature of the complaint as possible.

A review of an email from the SDM to the physician on a specific date, showed that the SDM shared concerns about the resident's health status, specific diagnostic tests and treatments consideration. No reply was noted for this email.

In an interview the AGM said that the process was for every staff member who was made aware of a family concern to inform the NC of this concern and the NC would follow the home’s process in responding to the specific concern. AGM said that the physicians were expected to follow the home’s process in responding to the residents or families concerns. If the family informed the physician directly of any concerns then the physician was expected to communicate the concerns to the home so they could address and follow up accordingly.

The AGM reviewed documentation provided by the SDM related to concerns about the health status of the resident on a specific date, with no response to these concerns. The AGM said that there was no concerns/complaint forms completed for this resident or family in their records. The AGM said that the expectation was for the physician to comply with the home’s policy.

The scope of this area of non-compliance was a pattern and the severity was determined to be minimal harm/risk or potential for actual harm/risk. The home had a history of non-compliance in this sub-section of the legislation as it was previously issued as Compliance Order #001 on January 19, 2016 and Compliance Order #003 on August 26, 2016. [s. 8. (1) (b)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

a) Review of a Critical Incident (CI) report identified that a resident had a fall on a specific date. The CI reported that the resident was at risk to fall. As a result of the fall, the resident sustained multiple injuries. On a specific date, a progress note stated that the resident was quite uncomfortable while receiving care and the resident was given medication to help with discomfort.

On a specific date, during a review of the resident's plan of care it was identified that the resident had multiple areas of altered skin integrity. Interventions included ensuring adequate pain control and following treatments as outlined on the Treatment Administration Record (TAR). The plan of care related to pain last updated on a specific date, identified a pain score. It stated that team members were to assess for pain when providing care. For nonverbal or non-cognizant residents an Abbey Pain Scale assessment would be conducted.

Progress notes identified on multiple occasions over an identified period of time that the resident was in pain or discomfort during care.

On a specific date, during a review of the clinical record there was no evidence that the resident had been assessed for their pain, either using the paper based Abbey Pain Scale or the electronic PAINAD on Point Click Care. The Medication Administration Record (MAR) identified that the resident was being given medication for pain control.

During an interview with the RAI / Quality RPN on a specific date, they said that residents that returned from hospital, expressed a new area of pain, or when there was a change in condition with onset of pain, should have a pain assessment conducted by a member of the registered staff. The RAI / Quality RPN told this inspector that because the home had just transitioned to a new electronic documentation system they had changed from using the paper based Abbey Pain Scale assessment to the PAINAD. The PAINAD had two different forms, one for those residents with a cognitive impairment and another for those that have minimal impairment. Given the recent fall resulting in injuries with reports of ongoing pain, RAI / Quality RPN said that they would have expected that a pain assessment be conducted. The RAI / Quality RPN acknowledged that there were no pain assessments completed using a clinically appropriate assessment for this resident when they reported pain during the identified period of time.

b) On a specific date, during stage one of the Resident Quality Inspection, an identified resident told the inspector that they had been experiencing pain for approximately one week. The resident said that the doctor was supposed to come on a certain day but they did not. They had been given medication but it did not take away the pain. On another date, the resident told the inspector that they recently had a very bad bout of pain. The resident said that they had been given medication for the pain, but it didn't always help and there were times when it was unbearable. When asked if they had been provided with treatment other than medication to help relieve the pain, the resident could not recall anything. The resident said that over the last several days they were happy that the pain had gradually eased and they were feeling much better.

The resident's Medication Administration Record (MAR) for an identified month, noted that the resident had been given multiple medications for pain control and also had an order for an identified medication on an as needed basis for pain. Documentation on the MAR and Medication Treatment Notes identified that the resident was given medication on multiple occasions during a period of time for complaints of pain. Review of the progress notes identified the resident presented with pain on multiple occasions.

On an identified date, a PCA told this inspector that the resident frequently reported pain related to their diagnosis. The staff member recalled a recent flare up of pain. They recalled that the resident was visibly upset by the pain and they had reported it to the registered staff.

During an interview with the Assistant Director of Care (ADOC) on a specific date, they said that it was the home's expectation that when there was a change in condition with

pain onset; when a resident started taking a new pain medication; or when an "as needed" analgesic was given then a pain assessment should be completed. The current pain assessment being used in the home would be the PAINAD. The ADOC said that because they had just transitioned to a new electronic documentation system some staff were not sure where to document their assessment and may just have put it in a progress note. The ADOC acknowledged that when the resident's pain was not relieved by initial interventions staff did not conduct an assessment using a clinically appropriate assessment instrument.

The scope of this area of non-compliance was a pattern and the severity was determined to be minimal harm/risk or potential for actual harm/risk. The home had a history of non-compliance in this sub-section of the legislation as it was previously issued as a WN VPC on May 11, 2015. [s. 52. (2)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(a) three meals daily; O. Reg. 79/10, s. 71 (3).
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).
(c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident was offered a minimum of a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner and a snack in the afternoon and evening.

a) On August 26, 2016, related to inspection number 2016_325568_0016, as part of Compliance Order (CO) #001 the home was ordered to ensure that all residents were offered a between-meal beverage in the morning, afternoon and evening and a snack in the afternoon and evening. This order also stated that when a resident was not available i.e. sleeping during the meal/snack, the resident is offered something to eat/drink when they wake up unless otherwise documented in the plan of care. The due date for this CO was September 23, 2016.

On an identified date and time, the inspector observed the nourishment service provided in a specific neighbourhood. The inspector observed that the residents who were sleeping during the snack were not offered a drink or a snack.

On an identified date, a PCA told inspector that there were residents in the area who had not been offered snacks as they were sleeping.

On an identified date and time, the inspector observed a nourishment service provided by a PCA in another Neighbourhood. An identified resident was observed to be sleeping in the lounge over the course of the observations. Staff attempted to wake up the resident with a verbal cue but the resident did not respond. The resident was observed not to be re-approached or offered the labelled commercial supplement or snack item from the cart.

On an identified date, a PCA said that their usual practice when providing snacks was to not wake up residents who were sleeping and then re-approach at a later time. The PCA said that they did not re-approach the residents who were sleeping during the nourishment pass as they had to go and provide a shower to another resident. The PCA said that the resident did not receive a snack or the supplement on the cart as the resident was sleeping.

A Nutritional assessment by the RD on an identified date, stated that this resident received a supplement at multiple snacks. This assessment also stated that the resident "remains at Nutritional Risk due to varied intake". The current printed version of the plan of care for the resident identified that the resident was at "Nutritional Risk" related to "potential for dehydration" and history of weight change. This plan of care had not provided direction regarding not offering the food, beverages or commercial supplements at snacks due to their sleeping pattern.

Review of the resident's intake documented on the "Nutrition and Hydration Flow Sheet"

for an identified period of time, showed that there were multiple days when they had no fluid intake at the morning snack; and, multiple days when they had no fluid or food intake at the afternoon and evening snack.

On a specific date, the Registered Dietitian (RD) and Nutrition Manager (NM) told the inspector that it was the expectation in the home that staff provided beverages at morning snack and beverages and a snack at the afternoon and evening pass unless it was specified in their plan of care that based on an assessment the resident did not need to be woken up or re-approached by staff. The RD and NM acknowledged that there were residents who slept regularly at snacks who were not offered the items but did not have this included in the plan of care.

b) On a specific date and time, the inspector observed the nourishment service provided by a PCA to the residents in a specific Neighbourhood. An identified resident was observed to be sleeping in the lounge over the course of the observations. The resident was not woken or offered a beverage by the PCA or any other staff during this time period.

The PCA said that their usual practice when providing snacks was if a resident was sleeping they would leave them sleep and then re-approach at a later time. The PCA said that they did not wake up the resident or provide this resident with a beverage during the nourishment service.

On a specific date, the Neighbourhood Coordinator provided the current printed version of the plan of care to the inspector and said that was where the staff would look to know the care needs of the resident. This plan of care identified that the resident was at "Nutritional Risk" related to "potential for inadequate intake of protein and energy due to history of erratic intake". This plan of care did not identify anything regarding sleeping in the mornings or afternoons or direction for staff regarding re-approaching with fluid or food if sleeping at the meals or snacks.

On a specific date, the Registered Dietitian (RD) and Food Service Manager (FSM) said it was the expectation in the home that staff would provide between meal beverages to all residents three times per day unless otherwise specified in the plan of care based on a nutritional assessment. The FSM and RD acknowledged that the plan of care for the resident did not reflect that the resident had been assessed as not needing a beverage between identified meals and therefore it was the expectation that staff would offer a beverage between the meals.

The scope of this area of non-compliance was a pattern and the severity was determined to be minimal harm/risk or potential for actual harm/risk. The home had a history of non-compliance in this sub-section of the legislation as it was previously issued as Compliance Order #001 on August 26, 2016. [s. 71. (3) (b)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

a) Review of an identified resident's Admission Head to Toe Assessment on a specific date, identified an area of altered skin integrity. Upon review of the clinical record there

was no evidence of a Skin and Wound Assessment specific to altered skin integrity.

During a review of the home's policy titled "Skin and Wound Care Program" Tab 04-78, it stated that the registered team member would complete a Skin Assessment when there was a change in skin integrity.

On a specific date, the Skin / Wound Lead told the inspector that in a particular month, when the resident was identified as having altered skin integrity, it was the home's expectation that a Skin Assessment Concerns form would be completed. This form included a checklist to ensure that the appropriate assessments and referrals were then conducted. If it was a particular type of wound then the staff would also need to complete the Wound Assessment Tool. The Skin / Wound Lead acknowledged that the resident's altered skin integrity was not assessed by a member of the registered nursing staff using a clinically appropriate assessment instrument.

b) Review of an identified resident's clinical record and a Critical Incident (CI) report identified that on a specific date, the resident was found laying on the floor. The resident had sustained multiple identified injuries.

Review of the resident's progress notes identified an entry on a specific date, which stated that registered staff noted the areas of altered skin integrity and described the specific treatment provided for their injuries. During a review of the clinical record, there was no evidence that a Skin / Wound assessment had been completed for the specific areas identified on the resident.

On a specific date, the resident was observed in the lounge area of their neighbourhood and the resident's injuries were visible.

On a specific date, the Skin / Wound Lead Registered Practical Nurse (RPN) told the inspector that staff had not completed a head to toe assessment because the resident had not been admitted to hospital. The Skin / Wound Lead RPN stated that it was the home's expectation that all areas of altered skin integrity would be assessed by a registered staff using their assessment tool. The Skin / Wound Lead RPN said that they were not able to find a Skin Concern Assessment form for the resident's identified areas and there was no assessment completed for these areas.

The licensee failed to ensure that the resident's altered skin integrity were assessed by registered staff using a clinically appropriate assessment instrument that was specifically

designed for skin and wound assessment. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds had been assessed by a registered dietitian who was a member of the staff of the home, and any changes made to the plan of care related to nutrition and hydration were implemented.

Review of the Admission assessment for and identified resident on a specific date, identified an area of altered skin integrity. There was no documentation found in the clinical record that the resident had been seen by the registered dietitian (RD) with regards to altered skin integrity.

During an interview with the RD, they shared that it was the home's expectation that a Dietary referral be sent for an RD consult for all resident's exhibiting altered skin integrity. When shown the documentation for the resident with respect to their altered skin integrity, the RD reviewed the clinical record and acknowledged that there was no documentation on the admission nutritional assessment with respect to the skin condition and nothing in the dietary progress notes to indicate that the RD had assessed the resident related to their altered skin integrity.

The licensee failed to ensure the resident exhibiting altered skin integrity had been assessed by a registered dietitian who was a member of the staff of the home. [s. 50. (2) (b) (iii)]

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

a) Review of the Admission assessment for an identified resident on a specific date, identified an area of altered skin integrity. There was no documentation in the Treatment Administration Record (TAR) related to the monitoring and treatment of the skin condition until a later identified date. There was no documentation found with respect to weekly skin assessments related to the identified altered skin integrity on the identified area.

The home's policy titled "Skin and Wound Care Program" tab 04-78 stated that the registered team member would complete assessments of the areas of altered skin integrity and weekly thereafter.

During an interview with the Skin / Wound Lead on a specific date, they acknowledged that there had been no weekly assessments conducted for the altered skin integrity for the resident.

b) Review of an identified resident's clinical record and a Critical Incident (CI) report identified that on a specific date, the resident was found laying on the floor. The resident had sustained multiple areas of altered skin integrity.

On a specific date, the resident was observed in the lounge area of their neighbourhood and the resident's multiple injuries were visible.

Review of the Treatment Administration Record (TAR) for a specific period of time for the resident identified an entry for an area of altered skin integrity and the specific treatment required. There was no documentation on this TAR that the treatment had been provided to the resident and no documentation that a weekly assessment of the altered skin integrity had been conducted. Review of the TAR for another month identified an entry for a weekly assessment of another identified area. It was signed that the assessment was conducted on a specific date, but not on multiple subsequent weeks. There was no evidence of completed weekly altered skin integrity assessments for the areas of altered skin integrity on the resident's third identified area during the specific period of time.

During an interview with the Skin / Wound Lead RPN on a specific date, they told the inspector that it was the home's expectation that registered staff complete a weekly assessment on all areas of altered skin integrity. The assessment would be conducted on the home's assessment tool form and filed in the resident's clinical record. The Skin / Wound Lead RPN acknowledged that according to documentation, registered staff had not completed all weekly altered skin integrity assessments for the resident.

c) In the progress notes on a specific date, the registered staff noted that the doctor had assessed an area of altered skin integrity for an identified resident and that a specific medical procedure would be placed in the Treatment Administration Record (TAR). Review of the TAR did not show the documentation of the medical procedure for the altered skin condition. The Assistant Director of Nursing Care (ADNC) stated that there were no TAR's for the skin condition found for the specific date.

On another specific date, progress notes stated that the resident was found to have altered skin integrity. Further review of the progress notes and assessments indicated that weekly skin assessment were not always completed or were not signed as

completed.

The RAI/QI Coordinator acknowledged that assessments were to be completed by the registered practical nurses on the home area weekly for altered skin integrity. Assistant Director Nursing Care acknowledged that the treatment and assessments for the resident were not completed consistently as ordered.

The licensee failed to ensure that the resident exhibited 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.

The scope of this area of non-compliance was a pattern and the severity was determined to be minimal harm/risk or potential for actual harm/risk. The home had a history of non-compliance in this sub-section of the legislation as it was previously issued as a WN VPC on April 22, 2014 and June 12, 2015. [s. 50. (2) (b) (iv)]

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (3) The drugs must be destroyed by a team acting together and composed of,
(a) in the case of a controlled substance, subject to any applicable requirements under the Controlled Drugs and Substances Act (Canada) or the Food and Drugs Act (Canada),
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) a physician or a pharmacist; and O. Reg. 79/10, s. 136 (3).

s. 136. (3) The drugs must be destroyed by a team acting together and composed of,
(b) in every other case,
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) one other staff member appointed by the Director of Nursing and Personal Care. O. Reg. 79/10, s. 136 (3).

s. 136. (6) For the purposes of this section a drug is considered to be destroyed when it is altered or denatured to such an extent that its consumption is rendered impossible or improbable. O. Reg. 79/10, s. 136 (6).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a drug was destroyed and was a controlled substance, it was done by a team acting together and composed of, (i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and (ii) a physician or a pharmacist.

A review of the policy "Disposal of Discontinued/expired drugs, narcotics and controlled substances" stated: "The Narcotic and Controlled substances Surplus Drug Form is also completed (or as per facility policy) when placing medication awaiting disposal in the double locked centralized storage area". This form included documentation of:
a) Date of removal of the drug from the unit
b) Resident name
c) Prescription number
d) Drug name drug strength, quantity

e) Reason for removal.
In addition, the policy stated that "Narcotics and controlled substances are to be destroyed by a member of the registered staff appointed by Director of Nursing/Care or Resident Service Manager and the pharmacist (or physician) on site according to legislated requirements".

Review of Policy "Stericycle Disposal System" How to destroy and dispose of discontinued/expired medications (non-Narcotics) dated January 2017 stated: "to be completed by the Pharmacist and one member of the registered nursing staff appointed by the Director of Nursing and Personal Care…destruction will include:
- oral medications, creating a slurry and adding to medication container for disposal
- for injectable, opening package and wasting in medication container".

A Registered Practical Nurse (RPN) stated that when a narcotic or controlled substance was taken out of the packaging and ready to administer but the resident refused and it was not administered, the medication was to be destroyed with a witness present. If the medication was crushed the medication went in the sharp container, if not the nurses then made it unusable and placed it in the sharps container. The RPN stated they had observed wasted narcotics/controlled substances being placed in the sink. The RPN stated there was no form to sign as to how and where it was destroyed.

Interview with a second RPN stated that for a narcotic or controlled substance that had been refused they would get another nurse to witness the waste. The RPN stated that there was no documentation as to where the nurse put the medication or how it was destroyed. The RPN stated that they have observed nurses crush the medication and put the narcotic/controlled substance in the garbage and sometimes in the sharp container and that they do not always put fluid with the medication to destroy it.

A third RPN stated narcotic/controlled substance that were refused were to be wasted and a second nurse was to witness the wastage; the two nurses would put water on the medication and put the discarded medication in the sharps container.

Assistant Director of Nursing Care (ADNC) stated that narcotic and controlled substances should never be put in the garbage or the sink and the expectation was that it was always slurred and put in the disposal bins or sharps container. The ADNC acknowledged that the policy was not being followed and that two nurses were to destroy the narcotics/controlled substances. The ADNC also acknowledged that recording how or where the drug was destructed was not being recorded.

The licensee failed to ensure that when a drug was destroyed and was a controlled substance, it was done by a team acting together and composed of, (i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and (ii) a physician or a pharmacist. [s. 136. (3) (a)]

2. The licensee has failed to ensure that where a drug was to be destroyed and was not a controlled substance, it was to be done by a team acting together and composed of, (i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and (ii) one other staff member appointed by the Director of Nursing.

Review of policy "Stericycle Disposal System' How to destroy and dispose of discontinued/expired medications (non-Narcotics)" dated January 2017 stated:
-To be completed by: a registered nurse and one other staff member appointed by the Director of Nursing
1. Place the expired or discontinued medication into the small opening of the sealed Stericycle container at the end of each shift or at the time of disposal…
2. Once the container is almost full, 2 of the staff designated above, can create a slurry by pouring water or some other form of liquid into the container
3. The Non-Narcotic and Non-Controlled Drugs Medication Destruction record should be also completed at this time by 2 designated staff members….

During observations of the medication room on an identified date, the inspector found that there were pails with lids that were not fully engaged on the pail and had medication packages in them. Observations of the medication rooms showed that these pails were in each of the medication rooms.

A Registered Practical Nurse (RPN) stated the pails were for discontinued medications and that staff were to place the entire medication package in the pail when discarding the medication. The RPN stated they had not been directed to remove the packaging before discarding. The RPN was not aware of the slurring technique to be performed.

Interview with a second RPN stated the discontinued medication was put in the pail until it was sealed and taken to the medication room for removal. This pail sits open in the medication room until it was full then it was sealed. When the pail was ready to be sealed, water or lactulose was poured in the pail. The RPN stated the pills were not taken out of the packages, but that some pills were not in the packages when put into the container. The RPN stated that no one watched the nurses pour fluid over the

medication and that the RPN was unaware of a policy regarding this procedure.

A third RPN stated they had a pail to put all discontinued drugs in. The RPN stated that when the pail was full RPNs put water in the pail and then seal the pail by putting the lid on. The RPN stated that the medications were thrown into the pail in their packaging unless they were already out of the packaging. RPN stated staff would not remove the packaging before pouring water into the pail.

Record of Secure storage of Non-narcotic and non-controlled drugs for destruction record was last signed April 22, 2016. This form stated "Drugs must be destroyed by a team acting and composed of one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and one other staff member appointed by the Director of Nursing and Personal Care. Upon completion, the container was sealed and stored securely in the designated area for pick up by medical waste company for disposal".

In an interview with the Assistant Director of Nursing Care (ADNC) they stated that all non-narcotic medication for destruction were put into pails in the medication rooms, and when full brought to an identified unit, where they were put into boxes to be picked up by pharmacy to be destroyed. ADNC stated that the nurse on the home areas destroyed the medication before putting them in the pails, and that the destruction should have a witness. ADNC also stated that it was an expectation that staff were to remove the pills from the packaging when they place them in the buckets. ADNC acknowledged that the Record of Secure storage of Non-narcotic and non-controlled drugs for destruction record was last signed April 2016, and that the expectation was that it be signed each time the destruction waste company removed the pails.

Interview with the Operations Manager Medi-system Pharmacy stated that all non-narcotic destruction must be done on site at the home. The medication to be destroyed were put into pails, and before the pail was sealed the pail was covered with fluid usually lactulose and slurred so that the medication was not usable, then the lid was sealed on the pail and a company removed them from the building for destruction.

The licensee failed to ensure that where a drug was to be destroyed and was not a controlled substance, it was be done by a team acting together and composed of, (i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and (ii) one other staff member appointed by the Director of Nursing. [s. 136. (3) (b)]

3. The licensee has failed to ensure that when a drug was destroyed, the drug was altered or denatured to such an extent that its consumption was rendered impossible or improbable.

A Registered Practical Nurse (RPN) stated the pails were for discontinued medications and that staff were to place the entire medication package in the pail when discarding the medication. The RPN stated they had not been directed to remove the packaging before discarding and the RPN was not aware of the slurring technique to be performed.

A second RPN stated they have a pail to put all discontinued drugs in. The RPN stated that when the pail was full RPNs put water in the pail and then seal the pail by putting the lid on. The RPN stated that the medications were thrown into the pail in their packaging unless they were already out of the packaging. The RPN stated staff did not remove the packaging before pouring water into the pail.

The inspector found that the pails were full and that the medications in the pail were not out of the packaging and the pails were open in the medication rooms. One pail that was brought to the identified area was not sealed and medication was still in the packaging there was no fluid in the pail. The inspector and the ADNC toured the medication rooms and the ADNC acknowledged that the medication had been placed in the pail with their packaging and not rendered unusable.

In an interview with the Assistant Director of Nursing Care (ADNC), they stated that all non-narcotic medication for destruction were put into pails in the medication rooms. The ADNC stated that the nurse on the home area destroyed the medication before putting them in the pails and that the destruction should have a witness.

Review of the policy "Disposal of Discontinued/Expired Drugs, Narcotics and Controlled Substances" under point number six stated that "For non-narcotic medication waste (including unused ampoules, vials, IV products, syringes, liquids, topical products) one member of the registered nursing staff appointed by the Director of Nursing/Care and one other staff member will act as a team to destroy the medications. They will render the discarded medications unusable and seal the medication in the destruction containers provided by the bio hazardous waste company selected by pharmacy".

The licensee failed to ensure that when a drug was destroyed, the drug was altered or denatured to such an extent that its consumption was rendered impossible or

improbable.

The scope of this area of non-compliance was widespread and the severity was determined to be minimal harm/risk or potential for actual harm/risk. The home had unrelated non-compliance in the last three years. [s. 136. (6)]

Additional Required Actions:

CO # - 007 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

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

A Critical Incident (CI) report was submitted on a specific date and time for an incident that took place in the home on the same day. The CI indicated that a staff member had witnessed an incident of staff to resident abuse.

A review of the resident's clinical chart showed a follow-up note to the abuse incident on a specific date and time. It stated a head to toe assessment of the resident was completed by a Registered Practical Nurse (RPN) accompanied by the Assistant Director of Care (ADOC). It stated "Head to toe to be completed on all 3 shifts x 3 days to monitor skin for bruising. Head injury routine started." Record review indicated that the resident was dependent on staff for all their care needs.

During an interview with one of the PCAs on a specific date and time, they shared that they had witnessed an incident of staff to resident abuse

The Assistant General Manager was interviewed on a specific date. They shared that the PCA reported the witnessed abuse to home management at a specific time and date. The home then started an immediate investigation into the incident, placed the identified PCA on a leave from work until further notice, and reported the incident to the police. The investigation concluded on a specific date, and the identified PCA's employment with the home was terminated. Review of the Termination of Employment letter addressed to the PCA stated "The Employer has determined that you have violated the Resident Bill of Rights, engaged in resident abuse".

The licensee failed to ensure that the resident was protected from physical abuse by an identified PCA.

The scope of this area of non-compliance was isolated and the severity was determined to be minimal harm or potential for actual harm/risk. The home had related non-compliance in the last three years. [s. 19. (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 residents are protected from abuse by anyone, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

A review of the homes policy titled "Prevention of Abuse and Neglect" Tab 04-06 not dated, stated that "any person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and information upon which it is based to their immediate supervisor or any member of the leadership team: 2. Abuse of a resident by anyone or neglect of a resident by the village or team member that resulted in harm or risk of harm to the resident."

a) A Critical Incident (CI) report was submitted by the home on a specific date and time, for a witnessed incident of staff to resident abuse. The CI stated that the team was notified of an incident that happened earlier in the day.

During an interview with the PCA who witnessed the incident, they shared that they and another PCA were providing care to the resident at a specific date and time, when they witnessed the incident of abuse. The PCA said that they were shocked when this occurred. Both PCAs then continued on with their care tasks for the resident and other

residents. At break the same day, the PCA confided in a fellow colleague, about the abuse by the co-worker that was witnessed earlier that day and expressed to them that they "didn't know what to do". The colleague strongly urged the PCA to immediately report the witnessed incident to the home leadership. The PCA said that they finished their shift and then went to the AGM to report what was witnessed. When asked why the PCA waited until the end of their shift to report, it was said "I'm nervous of this PCA" and "I didn't want them to find out".

In an interview with the AGM, they said it was the expectation that staff were to report witnessed abuse immediately to the home and in this case it was not.

b) A complaint was reported to the Ministry of Health and Long Term Care Infoline regarding allegations of staff to resident abuse. Record review of progress notes in Gold Care indicated that an identified resident presented with an injury that required medical attention. A registered nurse recorded that the resident was unable to state how the injury occurred other than stating they "did it" referring to a personal care aide. The register nurse interviewed two staff who were present for care with the resident and documented that an internal incident report was completed.

In an interview with the Assistant General Manager on a specific date, it was stated that the home was unable to find an internal incident report form related to the resident's incident. In an interview with the Assistant Director of Nursing, it was acknowledged that the registered staff member had failed to report the suspected abuse to their immediate supervisor or to the leadership team and they should have followed the process in place.

The licensee failed to ensure that the Prevention of Abuse and Neglect policy was complied with.

The scope of this area of non-compliance was isolated and the severity was determined to be potential for risk. The home had a history of non-compliance in this sub-section of the legislation as it was previously issued on June 12, 2015 as a WN, VPC. [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 the written policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #10: 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:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care related to pain was based on an interdisciplinary assessment with respect to the resident's health conditions including pain and other special needs.

Review of an identified resident's clinical record identified that they had a fall on a specific date. As a result of the fall the resident sustained multiple injuries that required further assessment and treatment. Records also identified that the resident had areas of altered skin integrity and was being treated for the altered skin integrity.

During a specific period of time, progress notes stated that the resident was experiencing pain related to the injuries sustained as a result of the fall that occurred on a specific date, in addition to their altered skin integrity and during treatments. Review of the resident's plan of care identified a pain score. Interventions included reporting to registered team members when the resident was experiencing pain; team members to assess for pain when providing care, staff to use the Abbey Pain Scale; and allow resident time to accomplish activities. There were no pain assessments found in the resident's clinical record for the identified period.

During an interview with a Registered Nurse (RN) / Nurse Consultant, they told the inspector that it was the home's expectation that as part of a resident's assessment related to pain they would identify the location of pain, severity, description, contributing factors, and possible etiology. This would all be used when developing the care plan for the resident. When shown the resident's care plan related to pain the RN / Nurse Consultant stated that it should have included specifics as to the areas of pain, severity, contributing factors and potential source in order to develop specific interventions directed at the pain. The RN / Nurse Consultant acknowledged that resident's plan of care was not based on an interdisciplinary assessment of the resident's pain.

The scope of this area of non-compliance was isolated and the severity was determined to be minimal harm/risk or potential for actual harm/risk. The home had related non-compliance in the last three years. [s. 26. (3) 10.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care related to pain is based on an interdisciplinary assessment with respect to the resident's health conditions including pain and other special needs, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that for each resident demonstrating responsive behaviours that triggers were identified and there were actions taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

Multiple observations by the inspector on two specific dates, found an identified resident demonstrating responsive behaviours.

On an identified date, a PCA said that they thought that the resident had some personal expressions. The PCA said they usually did not provide care to the resident but would look in the plan of care if they needed to know the potential triggers or interventions for behaviours.

Another PCA said that the resident had behaviours in a certain location of the home. The PCA said that resident's sleep pattern could affect them. The PCA also said that the resident would have increased expressions during a specific personal care. The PCA said that pain was also a potential trigger for behaviours for the resident. The PCA said that the resident refused care at times but had not hurt any staff. The PCA said they would look in the plan of care to identify triggers and interventions as well as the sheets provided by the Personal Expressions Resource Team (PERT) in their binders.

On a identified date, the RPN said that the resident had multiple personal expressions related to their diagnosis, sleep patterns and discomfort.

Review of the clinical record for the resident found that the resident had been referred to the home's PERT for assessment. The progress notes between an identified date range, showed that the resident was having multiple ongoing responsive behaviours. The documented actions taken to respond to the responsive behaviours related to assessments, reassessments, interventions and the effectiveness of interventions in relation to responsive behaviours in the record included the following:
- An incomplete "Personal Expressions Discussion Notes" assessment form which was documented by a PERT PCA but not dated.
- Dementia Observation Screening (DOS) charting was done intermittently between an identified period of time. The DOS forms were found to have incomplete documentation.
- The "Personal Expressions" plan of care identified potential triggers and a specific interventions. During the observations on the identified neighbourhood by the inspector, this was not observed to be implemented. The documentation in the progress notes also did not show this was implemented consistently.

On an identified date, the PERT Lead/ADNC said the resident was being followed by the PERT due to ongoing responsive behaviours. The PERT Lead/ADNC said there were some risks related to the behaviours but that there had been no recent altercations with other residents which resulted in injury. The PERT Lead/ADNC said that the resident had been referred to the program prior to them taking on the position of PERT Lead in the home and the initial assessments and discussions were completed by the PERT PCAs and the neighbourhood team. The PERT Lead/ADNC acknowledged that the PERT assessment form was not dated and that the DOS charting for the resident was part of their assessment and was incomplete. PERT Lead/ADNC said they were working on improvements to the PERT program for responsive behaviours. They said that these improvements included more structured assessments, reassessments and the

documentation of interventions including the effectiveness of interventions and they were planning to complete a comprehensive assessment of the resident's responsive behaviours in the near future.

The scope of this area of non-compliance was a pattern and the severity was determined to be minimal harm/risk or potential for actual harm/risk. The home had a history of non-compliance in this sub-section of the legislation as it was previously issued as a WN VPC on May 11, 2015. [s. 53. (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 for each resident demonstrating responsive behaviours that triggers are identified and there are actions taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's response to interventions are documented, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. 1. The licensee has failed to ensure that a documented record was kept in the home that included, (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant.

In an interview a Neighbourhood Coordinator (NC) said that a Substitute Decision Maker had emailed them on several occasions with different concerns related to an identified resident's care and shared with the inspector those emails.

The NC was not able to provide a documented record that included the nature of each verbal or written complaint, the date the complaint was received, the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required, the final resolution, if any, every date on which any response was provided to the complainant and a description of the response and any response made in turn by the complainant.

The Assistant General Manager said in an interview that there was no documented record of any concerns or complaints raised from this resident or family members and no documentation on the complaint log forms of receiving any complaint or concern from this resident or the family. The AGM said in an interview that it was the home's expectation that a resident/concern form would be completed and kept in the home for each concern/complaint raised by a resident or a family member that would include all information required under the Long-Term Care Homes Act and Regulations.

The scope of this area of non-compliance was isolated and the severity was determined to be minimal harm/risk or potential for actual harm/risk. The home had related non-compliance in the last three years. [s. 101. (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 a documented record is kept in the home that includes, (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The licensee policy titled Medication Reconciliation updated June 23, 2014 showed:
The nurse obtains an accurate and complete medication history by checking as many of the
following that are available
• The MAR sheet from another LTC facility
• Discharge list of medications from hospital or specialist
• Speaking with resident/family member directly

• Checking medication vials and containers brought in by the resident/family member
• CCAC notes
• Community pharmacy medication record summary
• Bottles of over-the-counter medications.

An identified resident was admitted to the home on a specific date. Documentation that accompanied the resident to the home included the Medication Administration Record (MAR) and Minimum Data Set Home Care (MDS-HC) assessment provided by the Community Care Access Centre (CCAC).

A review of the clinical record showed that the resident was to receive a specific dose of an identified medication. During the medication reconciliation process, the order was not correctly transcribed and the resident received a higher dose of the medication for an identified period of time. Record review of the New Admission order form for the resident showed the Source of Medication Information section of the form was not completed.

A Registered Practical Nurse (RPN) stated that they only reviewed the Medication Administration Record to initiate the New Admission Order Form and completed the Medication Order and Directions section of the form only, it was the end of the shift and they left the oncoming nurse to complete the form.

A second RPN stated that they did not complete the form in its entirety, stated that the doctor was called and obtained a verbal order to approve the medications as listed, and could not recall what sources of information were used to verify the prescribed medication that the resident was taking prior to admission. The nurse stated that they only remembered signing the form and getting the doctors order.

Both RPN's stated that they were not aware of any medication incidents involving their practice and the medication incident had not been brought to their attention by management. One RPN stated that they heard about it from other staff. They had heard that the dose was different from the previous facility, but that management had not spoken to them about this incident.

In an interview the Director of Nursing Care (DNC) shared that one RPN received education on medication reconciliation a couple of days later but that there was no documentation to support this. The DNC stated that the last mandatory education on Medication Reconciliation was on an identified date, in which both RPN's attended. There was another education booked for May 10, 2017, where medication reconciliation

would be discussed.

The licensee policy titled Medication Incidents updated October 1, 2012, showed "in the case of an inadvertent overdose or the administration by a wrong route, the nearest poison control centre must be consulted immediately regarding possible treatment." The policy also stated "A medication Incident Report must be completed promptly and sent to the Director of Nursing/Care. All pertinent information should be included especially reasons or contributing factors, so that proper measures may be taken to prevent recurrence of similar incidents".

There was no documentation to support that the poison control centre had been notified of this incident as per the policy. The DNC stated that the poison control centre was not called and that the resident received a higher than intended dose of medication.

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

The scope of this area of non-compliance was isolated and the severity was determined to be minimal harm/risk or potential for actual harm/risk. The home had unrelated non-compliance in the last three years. [s. 114. (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 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, to be implemented voluntarily.

WN #14: 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 has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

a) Review of the home's policy titled "Administration of Medications", not dated, stated that “Medication can only be given when ordered by a physician, nurse practitioner or physician assistant.”

Two medications with specific doses were ordered by the physician for an identified resident on two specific dates. On multiple identified dates, the resident's medication was not administered in accordance with directions for use by the physician.

The Assistant Director of Nursing Care (ADNC) stated that it was an expectation that the physicians’ orders were followed as directed and if registered staff had concerns to follow up with the physician immediately. The ADNC acknowledged that the medications were not administered to the resident in accordance with the directions for use specified by the prescriber.

b) A review of the medication administration record (MAR) for a specific month, showed a specific medication ordered for an identified resident. A review of the progress note on a specific date and time, showed that the RPN did not administer the medication as per the transcription on the MAR.

In an interview the RPN acknowledged that it was reported to them that another RPN did not administer the medication as per the transcription on the MAR. In interviews the ADON and AGM acknowledged that the medication was not administered as transcribed on the MAR and they said the expectation would be for drugs to be administered to residents in accordance with the directions for use specified by the prescriber.

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

The scope of this area of non-compliance was isolated and the severity was determined to be minimal harm/risk or potential for actual harm/risk. The home had related non-compliance in the last three years. [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 #15: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident was, (a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and (b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical

Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

During record review it was noted that an identified resident received multiple wrong medications. These incidents were not recorded on a Medication Incident Report form and only recorded in the clinical notes.

Review of the Medication Incident Report form for a specific date, showed that a second identified resident had not received multiple medications that were prescribed to be given at set times. On a clinical record review, there was no documentation for monitoring or assessment of this resident following this omission of medications.

A review of the Medication Incident Report on a specific date, stated that a third identified resident was not supplied enough medication for all doses of multiple medications for a specific period of time. The resident was also missing a controlled substance on identified dates.

In an interview Registered Practical Nurse (RPN) stated that “many doses were not given” due to the pharmacy not sending the supply. The RPN stated that some of the medications were sent but not all the medications.

The Assistant Director of nursing Care (ADNC) stated it would be an expectation that a medication incident report be recorded and submitted to the Director of Nursing Care (DNC)/ADNC for the identified resident when they received the wrong medications. It was acknowledged that they would have expected a complete assessment for the resident's cognitive status following receiving the wrong medications as this resident was a fall risk.

The ADNC stated that specific identified doses that were missed were vital for this resident to receive and the expectation was that pharmacy would have been notified immediately. The ADNC stated that the nurse should have done vitals and recorded them and acknowledged there was no note indicating vital signs were done.

In an interview with the Operations Manager Medisystem Pharmacy stated they were not aware of any missing medications for the identified period.

The licensee had failed to ensure that every medication incident involving a resident was; (a) documented, together with a record of the immediate actions taken to assess and

maintain the resident's health, and; (b) reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. [s. 135. (1)]

2. The licensee has failed to ensure that, (a) all medication incidents and adverse drug reactions were documented, reviewed and analyzed; (b) corrective action was taken as necessary; and (c) a written record was kept of everything required under clauses (a) and (b).

A review of the Medication Incident Reports showed that 37 forms had been completed for the time frame January 1, 2017 until March 31, 2017.

Review of the Medication Errors Q1 2017 form showed 33 incident reports were recorded and in the Professional Advisory Committee Meeting Minutes dated March 27, 2017, 10 incidents were reviewed in the meeting and that further incidents were reviewed following the meeting between the Director of Nursing (DNC) and the pharmacist.

During record review it was noted that an identified resident received the wrong medications. These incidents were not recorded on a Medication Incident Report form and only recorded in the clinical notes.

In review of the Medication Incident Report form showed that Section III-to be completed by pharmacy manager, Section IV-to be completed by pharmacy, Section V-facility evaluation were not completed on the forms.

In an interview with the Director of Nursing (DNC) they stated that some follow up occurred in email communications with pharmacy. The DNC stated that the pharmacy did not always give a response to the incident reports that involved nursing errors, that pharmacy would prioritize the incident reports and that the errors involving nursing errors were not always responded to.

The Operations Manager Medisystem Pharmacy stated that pharmacy responded to pharmacy concerns on the web portal for the home and that medication incidents regarding errors were to be addressed by the pharmacist when they were at the home.

The Assistant Director of nursing Care (ADNC) stated it would be an expectation that a medication incident report be recorded for every medication error and submitted to the

Director of Nursing Care (DNC)/ADNC.

The licensee failed to ensure that; (a) all medication incidents and adverse drug reactions were documented, reviewed and analyzed; (b) corrective action was taken as necessary, and; (c) a written record was kept of everything required under clauses (a) and (b).

The scope of this area of non-compliance was isolated and the severity was determined to be minimal harm/risk or potential for actual harm/risk. The home had unrelated non-compliance in the last three years. [s. 135. (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 every medication incident involving a resident is, (a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and (b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider and to ensure that, (a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; (b) corrective action is taken as necessary; and (c) a written record is kept of everything required under clauses (a) and (b), to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee has failed to ensure that a written record was maintained for each resident of the home and the resident's written record was kept up to date at all times.

a) A clinical record review for an identified resident showed that the flow sheets for two identified weeks, were not found. In addition, a clinical record review for the resident showed flow sheets for the week started on a specific date, and another flow sheet for the same week started on the next day.

In an interview ADON acknowledged that the specified flow sheets were not found and ADON said that the expectation was for the clinical record to be maintained for each resident and all parts of those records be available and not lost. The ADON and AGM reviewed the flow sheets and acknowledged that two flow sheets had overlapped; the two sheets were completed by different staff members and reflected different and opposing information. The ADON said that the expectation was to have one flow sheet per week per resident, and information be accurate and up to date.

b) A clinical record review for a resident for a specific time frame showed that the medication ordered by the physician was transcribed inaccurately.

The ADON and AGM reviewed the clinical record and said in interviews that this was inaccurate documentation, the expectation was for the medication to be transcribed as ordered and for the records to be kept up to date.

c) A clinical record review showed the following on two occasions: Pain assessment tool completed on a specific date, showed pain score was 1/10. The pain assessment progress note for the same day, stated pain score was 0/10. The pain assessment tool was not signed by the registered staff.

The ADON said the expectation was for the staff to sign the assessment once it was completed and that the progress notes and the assessment should be reflective of each other.

d) In an interview a Neighbourhood Coordinator said that the home completed and annual conference with an identified resident and Substitute Decision Maker and that this conference was documented in the progress notes. A review of the clinical record showed that there was no documentation of the annual conference completed during the

identified year.

The ADON reviewed the clinical record and acknowledged that there was no record of the annual conference for the identified year. The ADON and AGM said that the expectation was for the annual conference to be documented in the progress notes and for the clinical record to be kept up to date.

e) Clinical record review for an identified resident’s progress notes showed a progress note completed on a specific date and time, where a registered staff member documented that the physician assessed the resident at 1100 hours of the same day. Clinical record review showed no documentation about that specific assessment.

The ADON and AGM acknowledged that there was no documentation about the physician’s assessment. They said that it was the home's expectation that staff complete documentation as they complete their tasks and the expectation was that the physicians complete the documentation on their assessments and tasks.

f) Clinical record review for an identified resident's progress notes showed a progress note completed on a specific date and time, where a registered staff member documented that the resident refused a meal and continued to have a cough off and on. Clinical record review of the Nutrition and hydration flow sheet for the specific date and meal, showed that resident had a quarter of their meal and 100 millilitres of fluids.

In interviews ADON and AGM said that the expectation was that staff would collaborate and ensure that documentation in the flow sheets and progress notes would be accurate and complement each other ensuring that the records were accurate and up to date.

g) Clinical record review for an identified resident’s progress note showed that "transfer reason: POA insists" and did not have enough information about the events that led to the resident's transfer.

The AGM reviewed the clinical record and acknowledged that there was no documentation about the events that led to the decision that the resident had to be transferred. The AGM said that the expectation was to document any event with the resident in the clinical record to ensure records were kept up to date.

The scope of this area of non-compliance was isolated and the severity was determined to be minimal harm/risk or potential for actual harm/risk. The home had unrelated non-

compliance in the last three years. [s. 231.]

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 record is maintained for each resident of the home and the resident's written record is kept up to date at all times, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Record review of an identified resident's plan of care indicated the resident was at risk for falls and interventions under the fall focus directed staff to complete identified incremental time checks for safety for a specific period time.

Review of the incremental time check documentation for an identified period of time, indicated that staff did not always document the time checks and/or the absence of documentation on numerous occasions.

Upon interview with a Neighbourhood Coordinator (NC) on a specific date, it was acknowledged that staff did not always document the interval safety checks and the absence of documentation related to falls for the resident. The NC agreed that it was the expectation that staff should have completed the documentation related to the safety checks.

The scope of this area of non-compliance was isolated and the severity was determined to be minimum risk. The home had related non-compliance in the last three years. [s. 30. (2)]

WN #18: 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. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of the following incident in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): 3. A missing or unaccounted for controlled substance.

A controlled substance was reported missing on two separate identified dates, on a medication incident report form for two identified residents.

The Director of Nursing Care (DNC) stated that there were no critical incidents reported regarding the missing controlled substance and no police notification for either of the missing controlled substances. The Acting General Manager (AGM) acknowledged that there were no reports made through the critical incident reporting system for missing controlled substances on the two identified dates.

The licensee failed to ensure that the Director was informed of the following incident in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): 3. A missing or unaccounted for controlled substance.

The scope of this area of non-compliance was isolated and the severity was determined to be minimum risk. The home had similar related non-compliance in the last three years. [s. 107. (3) 3.]

WN #19: 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 :

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

Observation on a specific date and time, at an identified nursing station showed an unlocked medication box on a treatment cart in the nurse's room with multiple identified medications.

In an interview a Registered Practical Nurse (RPN) said that these boxes needed to be locked, they all had locks with combination codes and staff would access them when needed, but "I don't know" where the locks for these boxes were. The RPN said that it was the expectation that those medication boxes be locked and drugs stored securely.

The scope of this area of non-compliance was isolated and the severity was determined to be minimum risk. The home had related non-compliance in the last three years. [s. 129. (1) (a) (ii)]

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

Issued on this 12th day of October, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	INA REYNOLDS (524), ALI NASSER (523), AMIE GIBBS-WARD (630), DONNA TIERNEY (569), DOROTHY GINTHER (568), TRACY RICHARDSON (680)
Inspection No. / No de l'inspection :	2017_263524_0009
Log No. / No de registre :	003289-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jul 17, 2017
Licensee / Titulaire de permis :	Schlegel Villages Inc 325 Max Becker Drive, Suite 201, KITCHENER, ON, N2E-4H5
LTC Home / Foyer de SLD :	THE VILLAGE OF RIVERSIDE GLEN 60 WOODLAWN ROAD EAST, GUELPH, ON, N1H-8M8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Bryce McBain

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,

i. participate fully in the development, implementation, review and revision of his or her plan of care,

ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,

iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal

Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and

other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.

24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.

25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.

26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.

27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

The licensee shall ensure that an identified resident and all residents are properly cared for in a manner consistent with his or her needs; that all residents are told who is responsible for and who is providing the resident's direct care; and, that every resident has his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with the Act.

Grounds / Motifs :

1. The licensee has failed to ensure that every resident was properly cared for in a manner consistent with his or her needs.

On a specific date and time, during an interview with an identified resident's Substitute Decision Maker (SDM) they shared with the inspector that they had just spoken with a Personal Care Aide (PCA) and told them that the resident needed to be changed. The SDM told the inspector that the PCA said they would come after they were finished with what they were currently doing. The PCA was then observed to finish with care being provided in one room and go into the room next door to assist another staff member. When the PCA exited this room they were observed to go down the opposite hallway. The PCA was not observed speaking with another PCA before they went to the opposite hall.

On a specific date and time, the resident's SDM spoke with the PCA near the nursing station and advised them that the resident needed to be changed. The PCA acknowledged the SDM's request and then went into the lounge area.

When they exited the lounge they were seen picking up the snack cart to commence delivery of nourishment to residents.

At a specific time, the resident was observed by the inspector lying on their bed and there was an obvious odour of stool in the room. The resident stated that they were waiting for someone to come and help them.

On a specific date and time, the resident's SDM returned to their family members room and saw that the resident had not yet been provided with care. The SDM told the inspector that the resident was becoming agitated now and they were upset they had not yet been provided with their personal care needs. The SDM said they needed to leave but were concerned that their family would not receive the care they needed. The inspector asked the SDM if the resident had used the call bell to alert staff and they said "no". The SDM said that they did not think the resident knew what it was for and would not want to bother anyone. The SDM then pushed the call bell.

On a specific date and time, an identified PCA was observed going into the resident's room and closing the door. When the PCA exited the room they told the inspector that they had answered the call bell, and when they went to see the resident they found they needed to be changed.

During an interview with a PCA at a specific date and time, they told the inspector they had just finished doing a bath. When asked, the PCA acknowledged that earlier the resident's SDM had told them that the resident needed to be changed. The PCA stated that they had been pulled away to do something else and had forgotten to attend to the resident. The PCA said they should have either provided the care for the resident or at least notified another staff member of the resident's care needs.

The licensee failed to ensure that the resident was properly cared for in a manner consistent with their care needs. [s. 3. (1) 4.] (568)

2. The licensee has failed to ensure that the resident's right to be told who was responsible for and who was providing the resident's direct care was fully respected and promoted.

The Substitute Decision Maker (SDM) for an identified resident reported in a complaint letter and to the inspector that the resident or the family were not

informed of the role of the Neighbourhood Coordinator (NC) and the Quality Assurance Nurse. The SDM said that they were aware that the resident had the right to know who was taking care of them and that the home had not provided the resident with that right.

In interviews the Assistant General Manager (AGM) and Assistant Director of Nursing (ADON) said that it was the home's expectation that the NC and QA Nurse would meet with the resident and family members, inform them of their roles and duties, and those meetings would be documented in the clinical records. A clinical record review with the AGM and the ADON showed no documented evidence that the NC and QA Nurse informed the resident and SDM about their roles. [s. 3. (1) 7.] (523)

3. The licensee has failed to ensure that every resident had the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with the Act.

Observation on a specific date, during medication administration a medication package with a resident name, date, time and medications that were in the package was reviewed. At the bottom of the packet was the resident's room number and a bar scanner. The package was ripped down the side and the information on the package remained intact. A Registered Practical Nurse (RPN) threw this package in the garbage as described above. During an observation on another date, the inspector found a medication package in the garbage bin on the medication cart on an identified neighbourhood, which had the resident's name, location and medications clearly visible on top of the garbage bin. On observation of the destruction pails for discarded medications there were numerous packages with residents name and drug names clearly visible on the packaging and not destroyed.

A Registered Practical Nurse (RPN) stated that the name was not completely erased from the medication strip packages and although ripped the RPN acknowledged the resident was still identifiable. The RPN was unsure of the policy regarding disposal of medication packages. The ADNC stated medication packages with the name would be destroyed and not placed in the garbage. The ADNC acknowledged that by placing it in the garbage they were not following their policy.

The licensee had failed to ensure that every resident had the right to have his or

her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with the Act.

The scope of this area of non-compliance was a pattern and the severity was determined to be minimal harm/risk or potential for actual harm/risk. The home had a history of noncompliance in this sub-section of the legislation as it was previously issued as a WN on April 14, 2014 and a VPC on May 11, 2015. (680)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2017

Order # / Ordre no : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2016_325568_0016, CO #004;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that the care set out in the plan of care is provided to identified residents and all other residents as specified in the plan.

Grounds / Motifs :

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

On a specific date, the RPN told the inspector that an identified resident had altered sleep patterns and numerous personal expressions. The RPN said that they thought that pain was contributing to the behaviours and the resident was not able to express pain verbally. RPN said that they had worked with the physician to adjust the pain medications for the resident and they thought this had been effective. The RPN said they had recently changed to a pain assessment in Point Click Care (PCC) and that the resident had difficulties answering the pain scale in that assessment so they would help assign a number on the pain scale when doing the assessment.

The "personal expressions" plan of care for the resident stated "address their pain concerns as per their pain care plan." The "pain" plan of care stated "use a validated pain assessment tool as per Village policy when required by using the Abbey Pain Scale as the resident is not always able to voice when in pain". This plan of care also stated "administer routine analgesia as per physician's order and indicated on the Medication Administration Record (MAR)".

Review of the MAR for the resident for a specific month, showed that two

identified medications were to be given at specific times and dates, and there was no documented evidence that this had been given. This MAR also showed that a pain assessment was to be completed on each shift for a specific time period, and this was not documented as having been completed on three identified shifts.

On March 29, 2017, the DNC was asked to provide any pain assessments that had been completed in the home for the resident between a specific time period. There were only three documented Abbey Pain Scale assessments that were provided. The DNC said there were no other paper pain assessments that could be located for this resident. The DNC said that starting in March the staff were documenting pain assessment in Point Click Care (PCC) and it was the expectation that staff would be completing these based on the policy and plan of care for a resident.

Review of the pain assessments completed for the resident between specific time periods, found that staff had completed the numeric pain assessment six times and the PAINAD one time.

On March 29, 2017, Resident Assessment Instrument Quality Improvement (RAI QI) Coordinator told the Inspector that the staff were no longer using the Abbey Pain Scale to assess residents in the home and instead were using a pain assessment form in PCC. The RAI QI said that the staff were to use the "PAINAD" scale version of the assessment not the numeric scale for residents with cognitive impairments.

Based on the interviews and clinical record review the home did not provide the resident with the assessments and care regarding pain that was specified in the plan of care.
(630)

2. On August 26, 2016, related to inspection number 2016_325568_0016, as part of Compliance Order (CO) #004 the home was ordered to ensure that where a resident was identified in the plan of care as requiring a supplement, the supplement was provided to the resident as set out in the plan of care, and the intake of the supplement was documented. The due date for this CO was September 23, 2016.

On March 23, 2017, the Inspector observed that an identified resident was

offered a specific supplement poured into a glass which was a labelled item on the nourishment cart. The resident refused the offer of the supplement. The Inspector observed that the resident was not re-approached with the supplement.

The "Snack Delivery Report" identified that the resident was to receive an identified supplement at a specific snack. The "Nutrition and Hydration Flow Sheet" for the resident marked the fluid for the snack on a specific date, as "refused" but did not identify if this was the supplement that was refused. This record showed that the resident had no fluid intake at the snack on numerous days but this form did not identify whether the supplement was offered or consumed at those snacks.

The plan of care for the resident indicated they were at "Nutritional Risk" related to significant weight change and "refuses protein sources on meal entrees, impaired skin". This plan of care stated that the resident was to receive two specific supplements numerous times per day. This plan of care did not address what to do with the supplement if the resident was sleeping.

The Medication Administration Record (MAR) for a specific month, showed that the resident was marked as "sleeping" numerous times and that a specific supplement was to be provided. This MAR also showed no documentation for whether the supplement was provided on numerous times.

On a specific date, two RPNs said that the resident was to receive a supplement from the registered nursing staff but often disliked it and refused the item. They reviewed the MAR for a specific month and they acknowledged that it was incomplete regarding the supplement. They said if a resident was regularly refusing a supplement they could tell from the documentation and then would notify the RD.

On March 24, 2017, the Assistant Food Services Manager (AFSM) told the inspector that the PCAs in the home used the diet list and the labelled snacks on the beverage cart to know what residents were to be served including supplements that were offered at snack times. AFSM said that the fluid intake recorded on the "Nutrition and Hydration Flow Sheet" did not distinguish between the intake of the supplement or the intake of a different fluid and acknowledged that based on this documentation it was not possible to identify if the supplement had been consumed. AFSM said they were working on a

system in the home at the time of the inspection to improve the documentation of the intake of supplements.

On March 28, 2017, the Registered Dietitian (RD) and Nutrition Manager (NM) told the inspector that it was the expectation in the home that staff were offering the commercial supplements to residents based on the plan of care which included the items listed on the "Snack Delivery Report" on the nourishment carts. They said that staff were documenting the supplements provided on the nourishment carts within the overall fluid intake on the "Nutrition and Hydration Flow Sheet" and acknowledged that it was difficult to distinguish between the documentation of supplement intake and intake of other fluids based on this record.

On March 29, 2017, the DNC said it was the expectation in the home that the provision and consumption of nutritional supplements would be included in the MAR. The DNC said it was their understanding based on discussion with the home's Corporate Registered Dietitian that supplements provided on the snack carts were not considered supplements and therefore did not need to be documented by staff in the same way. The DNC acknowledged that the MAR for the resident had incomplete documentation regarding the specific supplement.

On March 31, 2017, Corporate RD said that they viewed the two commercial supplement drinks provided on the nourishment carts as food and therefore these were not required to be documented by staff in the home in the same way as other identified supplements.

On March 31, 2017, the inspector reviewed the home's policy titled "Nutritional Care Nourishments" with the AFSM. This policy identified that "labelled supplements" were being provided on the nourishment carts to residents and AFSM said it was their understanding that the two commercial supplements were considered to be nutritional supplements for residents in the home.

Based on the observations, clinical record review and interviews the nutritional plan of care for the identified resident was not provided to the resident as specified in the plan. (630)

3. On August 26, 2016, related to inspection number 2016_325568_0016, as part of Compliance Order (CO) #004 the home was ordered to ensure that

where a resident was identified in the plan of care as requiring a supplement, the supplement was provided to the resident as set out in the plan of care, and the intake of the supplement was documented. The due date for this CO was September 23, 2016.

On a specific date, the inspector observed that an identified resident consumed a coffee during the nourishment service which was provided by a PCA. There was a labelled bottle of a supplement on the snack cart for the resident and this was not observed to be offered to the resident. Review of the "Nutrition and Hydration Flow Sheet" for the resident documented that fluids were consumed but it did not identify that the supplement was not consumed.

The PCA said that their usual practice when giving a supplement from the snack cart was to go by the labelled snacks and the list and then record as part of the intake of fluids as there was not a separate place to record that information. The PCA said that the resident did not receive the supplement labelled on the cart.

On a specific date, another PCA told the inspector that the resident usually refused the labelled supplement on the snack cart as they preferred to drink coffee. The PCA said that the usual practice was to record the supplement intake with the other fluids on the intake sheets. On a specific date, the resident told the inspector that they preferred to have coffee to drink between meals and did not like the supplement drink that was being offered as it was too sweet and they did not usually drink this item.

The plan of care for the resident stated that they were at nutritional risk related to altered skin integrity. This plan of care did not include that a labelled commercial supplement was to be provided at snacks. Review of the "Snack Delivery Report" showed that the resident was to receive a supplement at specific snack times.

A nutritional assessment note by the Registered Dietitian (RD) identified that they had received a referral for weight change. This assessment showed that the resident weight had significantly changed. This assessment stated that the resident was consuming snacks but did not include any reference to the supplement the kitchen was providing at snacks.

On March 24, 2017, Assistant Food Services Manager (AFSM) told the Inspector that the PCAs in the home used the diet list and the labelled snacks on

the beverage cart to know what residents were to be served including supplements that were offered at snack times. The AFSM said that the fluid intake recorded on the "Nutrition and Hydration Flow Sheet" did not distinguish between the intake of the supplement or the intake of a different fluid and acknowledged that based on this documentation it was not possible to identify if the supplement had been consumed. AFSM said they were working on a system in the home at the time of the inspection to improve the documentation of the intake of supplements. The home's policy titled "Nutritional Care Nourishments" identified that the "Snack Delivery Report" would list "diet and special requirements/nourishments". This policy also stated that "labelled supplements" would be included on the nourishment cart.

On March 28, 2017, the Registered Dietitian (RD) and Nutrition Manager (NM) told the Inspector that it was the expectation in the home that staff were offering the commercial supplements to residents based on the plan of care which included the items listed on the "Snack Delivery Report" on the nourishment carts. They said that staff were documenting the supplements provided on the nourishment carts within the overall fluid intake on the "Nutrition and Hydration Flow Sheet" and acknowledged that it was difficult to distinguish between the documentation of supplement intake and intake of other fluids based on this record. (630)

4. An observation was completed of an identified resident on a specific date. The resident was noted to be seated in a Personal Assistive Services Device (PASD) and not repositioned during a specific time frame.

The resident's plan of care stated "Reposition every 2 hours".

The Assistance Director of Nursing Care stated that the resident was to be repositioned when seated in a PASD and that the expectation was that the resident was to be repositioned every two hours.

Upon interview with a Personal Care Aide (PCA), it was stated that "the PCA's are supposed to reposition every three hours, we do not wake the resident up if they were sleeping. We do not disturb them unless they wake up". The PCA acknowledged that they did not reposition the resident. Interview with three other PCAs, it was acknowledged they did not reposition this resident as directed every two hours and that this was not the normal procedure for this resident.

A review of the plan of care stated that the resident was to be "repositioned every two hours to prevent skin breakdown" and that the resident was to be positioned comfortably at all times and turned every two hours when in bed or in a seated position.

During observations on another date and time, the resident was observed to not be repositioned as directed in the care plan.

Interviews with four Personal Care Aides (PCAs) acknowledged that they did not reposition the resident during that time, PCA's stated they checked on the resident after a meal but they did not reposition the resident.

The Director Nursing Care (DNC) and Assistant Director Nursing Care (ADNC) stated that the expectation was that the Personal Assistive Services Device (PASD) be released and the resident physically repositioned every two hours.

Review of the plan of care, specifically the PASD monitoring form on the specified date of the inspectors observation it was recorded that the resident had been repositioned and toileted during that time frame. The DNC and Neighbourhood coordinator identified that all documentation was to be accurate and that the observations made did not support the documentation that had been completed. Both the DNC and the ADNC as well as a Neighbourhood Coordinator stated that the expectation was that the monitoring form be accurate as to the care provided.

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

The scope of this area of non-compliance was a pattern and the severity was determined to be minimal harm/risk or potential for actual harm/risk. The home had a history of non-compliance in this section of the legislation as it was previously issued as Compliance Order #001 on March 17, 2016 and Compliance Order #004 on August 26, 2016. (680)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2017

Order # / Ordre no : 003 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2016_325568_0016, CO #003;

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee shall ensure the following plans, policies, protocols, procedures, strategies or systems instituted or otherwise put in place are complied with specifically related to:
a) Skin and Wound Care Program
b) Pain Management Program
c) Nutrition and Hydration policy
d) Spa (Shower, tub Bath, Sponge Bath) policy
e) Resident/Family Concerns policy.

Grounds / Motifs :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

a) The home's policy titled "Skin and Wound Care Program" Tab 04-78 not dated, stated that a registered team member would complete a skin assessment when there was a change in skin integrity and when a resident returned from hospital. Registered staff would also complete weekly wound assessments and document these assessments in the clinical record.

Review of a resident's clinical record and a Critical Incident (CI) report identified that a resident sustained multiple wounds during a fall on a specific date. The

resident was assessed, provided first aid treatment of their wounds, and transferred to hospital for further assessment and treatment. A progress note, stated that the resident returned from hospital later the same day. On a specific date, there was an entry in the progress notes that described the location of the injuries and wounds.

During a review of the resident's clinical record there was no documentation that the resident's wounds, sustained during a fall on a specific date, were assessed by a registered team member and that weekly wound assessments were conducted until the areas had healed.

On a specific date, the Skin / Wound Lead RPN acknowledged that an initial Skin / Wound assessment and weekly wound assessments had not been conducted for the resident's identified wounds.

b) The home's policy titled "Skin and Wound Care Program" Tab 04-78 not dated, stated that the Nursing staff (RN and RPN) would complete a Skin Assessment when there was a change in skin integrity. The staff member would assess altered skin integrity including skin breakdown, pressure injuries, skin tears and wounds weekly and document within the assessment for pressure and stasis injuries. They would also make a referral to inter-professional team members as required.

The home's policy titled "Nutritional Care - Skin & Wound Care" Tab 07-89 stated under "Procedure" that residents with all stages of skin breakdown, including skin tears, would be referred to the food services department via the nutrition consultation. The registered dietitian (RD) would then conduct a nutritional assessment and make recommendations for the nutritional treatment plan for that particular resident.

An identified resident's admission assessment on a specific date, identified an area of altered skin integrity on the resident. There was no evidence that a Skin / Wound assessment was completed for this area of altered skin integrity and no documentation of a weekly Skin / Wound assessment. There was no mention in the nutritional notes that the Registered Dietitian had assessed the resident related to the area of altered skin integrity.

During an interview with a Registered Dietitian (RD) on a specific date, they told the inspector that it was the home's expectation that the RD provide a nutritional

consultation for all residents with altered skin integrity. The Skin / Wound Lead acknowledged that the resident did not have a Skin assessment when the area of altered skin integrity was first identified, or did not have weekly wound assessments as outlined by the home's policy for Skin and Wound Care management.

The licensee failed to ensure that the Skin and Wound Care Management and Nutritional Care - Skin & Wound Care policies were complied with. (568)

2. a) The home's policy titled "Pain Management Program" Tab 04-48 not dated, stated that the registered team would:
i) Complete and document a pain assessment when a resident returns from hospital, when there is a change in condition with pain onset, when there are personal expressions exhibited by a resident that may be an indicator for the onset of pain and when there is a diagnosis of a painful disease.
ii) Determine if able the type of pain i.e. chronic, acute, nociceptive and or neuropathic.
iii) Include support strategies related to the assessed pain and symptom management in the plan of care.

Review of an identified resident's clinical record identified that the resident had a fall on a specific date, and was found laying on the floor. The resident sustained injuries on multiple areas and there looked to be some potential injury deeper than skin. The resident required medical attention for further assessment and treatment of their injuries.

During a review of progress notes for the resident there were a number of entries between a specific date range, that stated the resident exhibited signs of pain during treatment care. There was no evidence that a pain assessment was conducted for the resident during the identified period. The plan of care did not include the locations of pain, type of pain or specific strategies to manage the identified symptoms.

On a specific date, the RAI / Quality RPN acknowledged that the home had not followed their Pain Management Program policy for the resident with respect to conducting a pain assessment when the resident returned from hospital having sustained injuries in a fall, as well as when the resident demonstrated signs of pain during treatment care. In addition, the plan of care related to pain was not updated to reflect the assessment of pain and support strategies related to

symptom management.

b) The home's policy titled "Pain Management Program" Tab 04-48 not dated, stated under the "Procedure" that the registered team would complete and document a pain assessment when the resident or family volunteered that pain was present and with a change in condition with pain onset. As part of the assessment they would determine if able the type of pain and possible source. The policy provided for the "Abbey Pain Scale" assessment to be used for residents living with a cognitive concern and "The Pain Assessment Tool" for residents with no cognitive concern.

Review of an identified resident's clinical record identified that the resident had multiple falls on a specific date. The first fall was unwitnessed and the resident was found in their room. The resident was assessed as having no injuries. The second fall took place at a later time and was witnessed by several staff. The resident was ambulating and lost their balance. During the fall the resident was noted to have struck their head. Again, a post fall assessment was conducted by registered staff and no injuries were identified. No pain assessments were conducted following either fall.

On a certain date and time, this inspector was approached by the resident's Substitute Decision Maker (SDM). The SDM said that they were concerned about the resident as they had multiple falls on a specific date and now they were not walking. The SDM said that up until the specific date the resident was walking on their own with a PASD and today they were not able to walk. They were concerned that the resident was in pain but because of their diagnosis they were not able to express them self.

Review of health care record for the resident identified a PAINAD assessment dated a specific date and time. According to the assessment the SDM communicated with the resident and the resident reported that they had pain. The registered staff documented that there was no facial grimacing but when asked if they were in pain, the resident had said "yes". The assessment did not identify the area of the resident's pain nor did it clarify the type of pain or potential source of the pain. A progress note on a specific date and time, stated that the resident's SDM approached the Director of Nursing regarding their concern that the resident could not walk. It was agreed that the resident would benefit from further assessment and medical attention. A progress note on a specific date and time, identified that the resident had a significant change in

status.

During an interview with a Registered Practical Nurse (RPN), they told the inspector that they had conducted a pain assessment on a specific date, because the resident's SDM insisted that the resident was in pain and that was why they were not walking. When asked what type of assessment they had used for the resident they said the numerical scale in the PAINAD on Point Click Care (PCC). They used to use the Abbey Pain Scale, a paper assessment, but that was before they transitioned to PCC. When the RPN was asked if they determined the location and source of the pain they said they had not identified this in their assessment. The RPN said that Point Click Care was new to them and they were not aware that there were two types of assessments, one for residents with impaired cognition and one for cognizant residents. They acknowledged that they should have completed the assessment for non-cognizant residents and included the location and type of pain, to further determine a possible source.

c) The home's policy titled "Pain Management Program" tab 04-48 not dated, stated that the registered team will complete and document a pain assessment:
i) on initiation of pain medication or PRN,
ii) when a resident reports any pain or symptoms especially those of greater than 4 out of 10 on a severity scale for 24-48 hours,
iii) when there was a change in condition with pain onset. The registered team would determine the type of pain (chronic, acute nociceptive or neuropathic).

On a specific date, an identified resident shared with the inspector that they had been experiencing pain in a certain part of their body. The resident did not know what happened and stated that it just started hurting. According to the resident the doctor was supposed to come to see them but had not come. When asked if the resident had been provided anything for pain relief, the resident said that they had been given medication but it was not taking the pain away. On a specific day, the resident told another inspector that they had a very bad bout of pain the last two weeks. It had just finally settled down this week. The resident said that although they were given extra medication it had not always helped.

During an interview with the Director of Nursing (DON), they shared that the home had just undergone a transition from one electronic documentation system to another. Prior to March of 2017, staff were expected to complete an Abbey Pain Assessment which was paper based for those residents experiencing pain.

Since early March 2017, the staff were now expected to complete a PAINAD on Point Click Care (PCC) when assessing residents for pain. The PAINAD had two versions depending on the resident's cognitive abilities. The DON said they were working on revising their policy to reflect changes in their practices since the transition to PCC.

Record review identified progress notes on multiple dates, where the resident complained of body pain. Pain levels were documented in the progress notes as greater than four out of ten. Medication was given as per the physician's orders for as needed (PRN) pain control.There was no documentation of a Pain Assessment using the PAINAD on the electronic clinical record nor was there any paper based Pain Assessment found in the resident's chart.

On specific date, the Assistant Director of Care acknowledged that staff had not followed their pain policy with respect to completing a pain assessment when a resident reports pain symptoms of greater than four out of ten and when PRN pain medication was given.

The licensee failed to ensure that the home policy titled "Pain Management Program" was complied with. (568)

3. On August 26, 2016, related to inspection number 2016_325568_0016, as part of Compliance Order (CO) #003 the home was ordered to ensure that their Pain Management policy in regards to completion and documentation of pain assessments was complied with. The due date for this CO was September 30, 2016.

On a specific date, a PCA said that an identified resident at times had behaviours in a certain area of the home and provided examples of the behaviours. The PCA said that pain was also a potential trigger for behaviours for the resident but they were not always able to say they were in pain.

On a specific date, a RPN told the inspector that the resident had altered sleep patterns and numerous personal expressions. The RPN said that they thought that pain was contributing to the behaviours and the resident was not able to express pain verbally. The RPN said that they had worked with the physician to adjust the pain medications for this resident and they thought this had been effective. The RPN said they had recently changed to a pain assessment in Point Click Care (PCC) and that the resident had difficulties answering the pain

scale in that assessment so they would help assign a number on the pain scale when doing the assessment.

The "personal expressions" plan of care for the resident stated "address their pain concerns as per their pain care plan." The "pain" plan of care stated "use a validated pain assessment tool as per Village policy when required by using the Abbey Pain Scale as the resident is not always able to voice when in pain".

A progress note on a specific date, identified that the resident was having responsive behaviours and that the behaviours could be related to pain. This progress note stated that pain assessments would be started each shift for a specific time frame to help assess the pain medication changes that were being implemented and to "reflect any changes in personal expressions with the new pain control."

Review of the MAR for the resident for a specific month, showed that a pain assessment was to be completed on each shift for a specific date range and this was not documented as having been completed on multiple shifts.

On a specific date, the DNC was asked to provide any pain assessments that had been completed in the home for this resident between a certain date range. There were only a few documented Abbey Pain Scale assessments that were provided. The DNC said there were no other paper pain assessments that could be located for the resident.

A progress note for a specific date, identified that the pain level based on the numeric pain scale for the resident was zero. This note stated "resident is suspected as having discomfort when they become expressive. They were unable to focus on writer or any questions."

Review of the pain assessments completed in PCC for the resident between a specific time frame, found that staff had completed the numeric pain assessment multiple times and the PAINAD one time.

The home's policy titled "Pain Management Program" Tab 04-48 stated "Schlegel Villages will use clinically-appropriate pain assessment tools to meet the resident's needs and preferences for pain management." This policy directed that staff would complete and document pain assessments "when there are personal expressions exhibited by resident that may be an indicator for the

onset of pain." The policy stated that staff were to use the Abbey Pain Scale "for measurement of pain in residents living with a cognitive concern." This policy did not include direction for staff regarding the PCC pain assessments.

On a specific date, the RAI QI told the inspector that the staff were no longer using the Abbey Pain Scale to assess residents in the home and instead were using a pain assessment form in PCC. The RAI QI said that the staff were to use the "PAINAD" scale version of the assessment not the numeric scale for residents with cognitive impairments.

The DNC said that starting in March the staff were documenting pain assessment in Point Click Care (PCC). The DNC said that the home's pain policy was being updated to reflect the change to the assessment process and forms in PCC but the new policy had not been implemented in the home. The DNC said it was the expectation in the home that staff were following the pain policy. (630)

4. On August 26, 2016, related to inspection number 2016_325568_0016, as part of Compliance Order (CO) #003 the home was ordered to ensure that their Nutrition and Hydration policy in regards to documentation of the food and fluid intake of residents, including appropriate supplements, on flow sheets at the time of meal and snack service was complied with. The due date for this CO was September 30, 2016.

The home's policy titled "Nutrition and Hydration – Riverside Glen" Tab 07-24 not dated, stated "commercial supplements or alcoholic beverages will be documented on the Medication Administration Record (MAR) by registered team members." The policy stated that "PCAs will take note of the meal each resident is served, as well as the total amount of fluids served to each resident to ensure accurate documentation. This policy also stated "the Nutrition and Hydration binders will be placed on the teacart at the time of each nourishment service" and "food and fluid intake will be documented at the time of the service."

On a specific date, the Assistant Food Services Manager (AFSM) told told the inspector that the PCAs in the home used the diet list and the labelled snacks on the beverage cart to know what residents were to be served including commercial supplements that were offered at snack times. The AFSM said that the fluid intake recorded on the "Nutrition and Hydration Flow Sheet" did not distinguish between the intake of the commercial supplement or the intake of a

different fluid and acknowledged that based on this documentation it was not possible to identify if the supplement had been consumed. The AFSM said a resident's intake of the other types of supplements were to be documented by the registered staff on the MAR. The AFSM said they were working on a system in the home at the time of the inspection to improve the documentation of the intake of supplements.

On a specific date, the Registered Dietitian (RD) and Nutrition Manager (NM) told the inspector that it was the expectation in the home that staff were following the home's Nutrition and Hydration Policy regarding the documentation of resident's food, fluid and supplement intake. They said that staff were documenting the supplements provided on the nourishment carts and were to include them with the overall fluid intake on the "Nutrition and Hydration Flow Sheet" instead of in the MAR and acknowledged that it was difficult to distinguish between supplement intake and intake of other fluids based on this documentation. The NM said it was the expectation that staff would be documenting the intake of food and fluids at the time that snacks were offered. The RD said it was the expectation that supplements provided by the registered staff would consistently be documented on the MAR.

a) On a specific date, the inspector observed that an identified resident consumed a full commercial supplement during the nourishment service which was provided by a PCA from the labelled items on the snack cart. Review of the "Nutrition and Hydration Flow Sheet" for this resident documented on a specific date, that the fluids were consumed but it did not identify that this was a commercial supplement.

On a specific date, the inspector observed that the resident was offered a commercial supplement during the snack which was provided by a PCA from the labelled items on the snack cart. Review of the "Nutrition and Hydration Flow Sheet" for this resident documented for the snack, that fluids were refused but it did not identify that this was a commercial supplement that had been refused. The Nutrition and Hydration Binder was not observed on the cart at the time of the nourishment service and the PCA was not documenting the fluid intake at the time of the service.

On a specific date, the PCA said that their usual practice when documenting the residents' intake of the labelled commercial supplements provided on the snack carts was to record them under the fluid section. The PCA said that there was

no place on the intake record to record that a supplement was provided or refused. The PCA said they had not recorded the fluid intake of residents during the identified nourishment service.

Nutritional assessment by the RD on a specific date, identified that this resident had a significant weight change and was below their goal weight. The assessment stated that the resident's "intake is poor". The interventions listed in the assessment included that the resident was to receive a specific supplement multiple times per day. The plan of care identified that the resident was at nutritional risk. This plan of care identified that the resident was to receive a supplement multiple times per day.

Review of the resident's intake documented on the "Nutrition and Hydration Flow Sheet" for a specific date range, showed no fluid intake on numerous occasions and did not identify whether it was the supplement that was not consumed at these times or other fluids. Review of the Medication Administration Record (MAR) for a specific month, showed that the intake of the supplement was not documented by the registered staff multiple times for this resident.

On a specific date, two RPN's told the inspector that the resident received a supplement on the snack carts as well as one provided during medication pass by the registered staff. The RPN's reviewed the specific MAR and they acknowledged that the intake of the supplement had not been documented each time it was ordered to be provided.

b) A nutritional assessment documented on a specific date, for an identified resident showed that the resident had experienced a weight change. This assessment identified fluctuating intake and frequent refusal of protein items and changed the plan of care to a supplement multiple times per day with the medication pass.

On a specific date, the RPN told the inspector that the resident received a specific supplement from the registered staff during medication pass and this was recently ordered. The RPN said that the resident's intake of this item was to be documented on the Medication Administration Record (MAR). Reviewed resident's MAR with the RPN and it was acknowledged that the intake was not documented each time it was ordered to be offered (multiple times) between a specific date range. The RPN said that they thought that sometimes staff had forgotten to document the intake of the supplement on the MAR.

c) On a specific date, the inspector was observing care provided in an identified Neighbourhood for a specific period of time. The inspector observed that an identified resident was sleeping during this time and did not have food or fluid for the meal. The inspector reviewed the "Nutrition and Hydration Flow Sheet" for the specific date, and it showed that this resident had consumed all food and fluid at the meal.

The inspector reviewed the intake record for the resident with a Neighbourhood Coordinator (NC) and the Director of Nursing Care (DNC) and they said it was the expectation in the home for staff to document the intake of residents accurately as per the home's policy.

On a specific date, the AGM told the inspector that they were conducting an investigation and submitted a Critical Incident System (CIS) report to the Ministry of Health and Long Term Care (MOHLTC) regarding the documentation and the offering of meals to this resident on the observed date.

On a specific date, the AGM provided the inspector with the home's documentation regarding the investigation. This documentation showed that a staff member of the home had been given a one day suspension regarding not following the home's Nutrition and Hydration Policy and falsifying the documentation regarding a resident's consumption.

d) On a specific date, during a meal in a unit Neighbourhood the inspector observed that an identified resident was not in the dining room during the meal. The PCA told the inspector that this resident was usually offered food later. The inspector observed that the resident was offered a meal by tray service later during the nourishment cart but this resident did not consume any food that had been offered. The inspector observed a PCA remove the meal at a specific time and no food had been eaten by the resident. The inspector observed that the PCA staff did not have the "Nutrition and Hydration Flow Sheet" binder with them during the specific nourishment service and were not recording the intake of residents at the time of the service.

On a specific date and time, the inspector observed that nothing had been recorded on the "Nutrition and Hydration Flow Sheets" for any resident in this Neighbourhood or for the snack or the meal for the identified resident.

On a specific date, the PCA told the inspector that the process they followed for recording intake depended on the time and the resident. The PCA acknowledged that they had not recorded the intake of the residents at the time of the snack service. The inspector reviewed the "Nutrition and Hydration Flow Sheet" for the identified resident for a meal on a specific date, and found that staff had documented that the resident had consumed a full meal. This documentation did not correspond with the observations made by the inspector during that meal.

On a specific date, the Director of Nursing Care (DNC) said they had revised the Nutrition and Hydration – Riverside Glen after they received the Compliance Order and they provided re-education for staff. The DNC said it was the expectation in the home that all staff would comply with the revised Nutrition and Hydration policy.

Based on multiple observations, record reviews and interviews the home failed to ensure that all aspects of the Nutrition and Hydration policy were complied with. (630)

5. On August 26, 2016, related to inspection number 2016_325568_0016, as part of Compliance Order (CO) #003 the home was ordered to ensure that their Spa (Shower, tub Bath, Sponge Bath) policy in regards to the documentation of the type of spa provided, level of assistance provided on the PSW flow sheet, including skin assessment and if concerns identified was complied with. If the resident declined their spa it was to be documented as per policy. The due date for this CO was September 30, 2016.

Review of the home's policy titled "Spa (Shower, Tub Bath, Sponge Bath)" not dated, identified under the procedure that staff were to document the type of spa provided and the level of assistance provided on the PSW flow sheet, including nail and skin care.

On a specific date, a Personal Care Aide (PCA) told the inspector that information related to a particular resident's bathing needs would be found on their care plan. A copy of the care plan could be found in the flow sheet binder so that staff could reference it when providing care. Staff were expected to document on the flow sheets under the "Spa" section what type of bathing was provided, the level of care and level of staff assistance needed as well as their nail and skin care. When a resident refused a bath or shower this must also be

documented on the flow sheets.

Review of the plan of care for an identified resident in terms of bathing stated that the resident was dependent on staff for their bathing needs. The resident was to receive a bath/shower twice a week as per the spa schedule. Hair was to be washed and dried during each bath.

Record review of the resident's Personal Care Observation and Monitoring Forms for a four week period, identified that the resident received either a bath or shower twice during the first two weeks. During one week, it was documented that the resident had one shower. During another week, it was documented that the resident had one shower.

During an interview with a Neighbourhood Coordinator (NC), they said they had spoken with the staff providing care for this resident during the identified time period. Based on the staff accounts and a review of the bathing schedule the NC said that the resident received their bath on both days, but staff had forgotten to document on the Personal Care Observation and Monitoring Forms. The NC acknowledged that staff had not followed the Spa policy with respect to documentation of bathing including level and number of staff providing assistance as well as the provision of nail and skin care. (568)

6. a) Long-Term Care Homes Act S.O. 2007 c.8 s. 11. (1) (a) requires the licensee of a long-term care home shall ensure that there is an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents.

The home's policy titled "Nutrition and Hydration", Tab 04-46 dated April 2014, indicated that each evening, the Nutrition and Hydration Flow Sheets would be tallied by the night Personal Care Aide (PCA) team, which would include the Daily Additional Fluids Chart. The night Registered Practical Nurse/Registered Nurse (RPN/RN) would review and initial the total daily fluid intake. Any resident who had a fluid intake, less than their estimated fluid requirements, would be reported to the oncoming RPN/RN so that interventions could be initiated. The RPN/RN would assess for signs and symptoms of dehydration (Dehydration Risk Assessment Tool). If a resident exhibited signs and symptoms of dehydration (as documented in the Dehydration Risk Assessment Tool), ensure the request for Nutrition consultation (Tab 07-41) had been initiated for the Registered Dietitian to assess. The Request for Nutrition Consultation would be

completed when a resident had a fluid intake of less than 1000 millilitres per individual fluid requirement, as per the plan of care, for three consecutive days and there was at least one sign or symptom of dehydration present.

A review of an identified resident's Nutrition and Hydration Flow Sheet for a specific period of time, showed that there were no total daily fluid intakes done for multiple days and there were no RPN/RN initials for all days.

The resident 's nutritional plan of care stated what their minimum daily fluid requirement was per day; the resident did not meet the required amount for multiple consecutive days on numerous occasions during an identified period of time. Record review also revealed that there were no Dehydration Risk Assessments completed for the resident.

The ADON and AGM reviewed and acknowledged that there was to be a Dehydration Risk Assessment completed if a resident had a fluid consumption of less than their individual requirement for three consecutive days. They also said that the resident had not had a Dehydration Risk Assessment completed at the specific period of time and that there was no request for nutrition consultation made to the registered dietitian due to the low fluid intake.

The home failed to ensure that the Nutrition and Hydration policy was complied with.

b) Long-Term Care Homes Act S.O. 2007 c.8 s. 21 requires the home to ensure that there are written procedures that comply with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints.

In an interview a Substitute Decision Maker (SDM) said that they had shared concerns related to an identified resident 's care with the resident's physician and other staff members and did not hear back from them.

The home's policy titled "Subject Resident/Family Concerns" Tab 11-21 not dated, stated that if a family member or resident expressed a concern to a team member, the team member was to notify the Neighbourhood Coordinator (NC) or designate in writing by way of an Incident Report Form, providing as much detail about the nature of the complaint as possible.

A review of an email from the SDM to the physician on a specific date, showed

that the SDM shared concerns about the resident's health status, specific diagnostic tests and treatments consideration. No reply was noted for this email.

In an interview the AGM said that the process was for every staff member who was made aware of a family concern to inform the NC of this concern and the NC would follow the home's process in responding to the specific concern. AGM said that the physicians were expected to follow the home's process in responding to the residents or families concerns. If the family informed the physician directly of any concerns then the physician was expected to communicate the concerns to the home so they could address and follow up accordingly.

The AGM reviewed documentation provided by the SDM related to concerns about the health status of the resident on a specific date, with no response to these concerns. The AGM said that there was no concerns/complaint forms completed for this resident or family in their records. The AGM said that the expectation was for the physician to comply with the home's policy.

The scope of this area of non-compliance was a pattern and the severity was determined to be minimal harm/risk or potential for actual harm/risk. The home had a history of non-compliance in this sub-section of the legislation as it was previously issued as Compliance Order #001 on January 19, 2016 and Compliance Order #003 on August 26, 2016. (523)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2017

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Order / Ordre :

The licensee shall ensure that when identified residents and any other resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Grounds / Motifs :

1. The licensee has failed to ensure that when the resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

a) Review of a Critical Incident (CI) report identified that a resident had a fall on a specific date. The CI reported that the resident was at risk to fall. As a result of the fall, the resident sustained multiple injuries. On a specific date, a progress note stated that the resident was quite uncomfortable while receiving care and the resident was given medication to help with discomfort.

On a specific date, during a review of the resident's plan of care it was identified that the resident had multiple areas of altered skin integrity. Interventions included ensuring adequate pain control and following treatments as outlined on the Treatment Administration Record (TAR). The plan of care related to pain last updated on a specific date, identified a pain score. It stated that team members were to assess for pain when providing care. For nonverbal or non-cognizant residents an Abbey Pain Scale assessment would be conducted.

Progress notes identified on multiple occasions over an identified period of time that the resident was in pain or discomfort during care.

On a specific date, during a review of the clinical record there was no evidence that the resident had been assessed for their pain, either using the paper based Abbey Pain Scale or the electronic PAINAD on Point Click Care. The Medication Administration Record (MAR) identified that the resident was being given medication for pain control.

During an interview with the RAI / Quality RPN on a specific date, they said that residents that returned from hospital, expressed a new area of pain, or when there was a change in condition with onset of pain, should have a pain assessment conducted by a member of the registered staff. The RAI / Quality RPN told this inspector that because the home had just transitioned to a new electronic documentation system they had changed from using the paper based Abbey Pain Scale assessment to the PAINAD. The PAINAD had two different forms, one for those residents with a cognitive impairment and another for those that have minimal impairment. Given the recent fall resulting in injuries with reports of ongoing pain, RAI / Quality RPN said that they would have expected that a pain assessment be conducted. The RAI / Quality RPN acknowledged that there were no pain assessments completed using a clinically appropriate assessment for this resident when they reported pain during the identified period of time.

b) On a specific date, during stage one of the Resident Quality Inspection, an identified resident told the inspector that they had been experiencing pain for approximately one week. The resident said that the doctor was supposed to come on a certain day but they did not. They had been given medication but it did not take away the pain. On another date, the resident told the inspector that they recently had a very bad bout of pain. The resident said that they had been given medication for the pain, but it didn't always help and there were times when it was unbearable. When asked if they had been provided with treatment other than medication to help relieve the pain, the resident could not recall anything. The resident said that over the last several days they were happy that the pain had gradually eased and they were feeling much better.

The resident's Medication Administration Record (MAR) for an identified month, noted that the resident had been given multiple medications for pain control and also had an order for an identified medication on an as needed basis for pain. Documentation on the MAR and Medication Treatment Notes identified that the resident was given medication on multiple occasions during a period of time for

complaints of pain. Review of the progress notes identified the resident presented with pain on multiple occasions.

On an identified date, a PCA told this inspector that the resident frequently reported pain related to their diagnosis. The staff member recalled a recent flare up of pain. They recalled that the resident was visibly upset by the pain and they had reported it to the registered staff.

During an interview with the Assistant Director of Care (ADOC) on a specific date, they said that it was the home's expectation that when there was a change in condition with pain onset; when a resident started taking a new pain medication; or when an "as needed" analgesic was given then a pain assessment should be completed. The current pain assessment being used in the home would be the PAINAD. The ADOC said that because they had just transitioned to a new electronic documentation system some staff were not sure where to document their assessment and may just have put it in a progress note. The ADOC acknowledged that when the resident's pain was not relieved by initial interventions staff did not conduct an assessment using a clinically appropriate assessment instrument.

The scope of this area of non-compliance was a pattern and the severity was determined to be minimal harm/risk or potential for actual harm/risk. The home had a history of non-compliance in this sub-section of the legislation as it was previously issued as a WN VPC on May 11, 2015. (568)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2017

Order # / Ordre no : 005

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

Linked to Existing Order / Lien vers ordre existant: 2016_325568_0016, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(a) three meals daily;
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and
(c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

Order / Ordre :

The licensee shall ensure that each resident including identified residents are offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and (c) a snack in the afternoon and evening.

Grounds / Motifs :

1. The licensee has failed to ensure that each resident was offered a minimum of a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner and a snack in the afternoon and evening.

a) On August 26, 2016, related to inspection number 2016_325568_0016, as part of Compliance Order (CO) #001 the home was ordered to ensure that all residents were offered a between-meal beverage in the morning, afternoon and evening and a snack in the afternoon and evening. This order also stated that when a resident was not available i.e. sleeping during the meal/snack, the resident is offered something to eat/drink when they wake up unless otherwise documented in the plan of care. The due date for this CO was September 23, 2016.

On an identified date and time, the inspector observed the nourishment service provided in a specific neighbourhood. The inspector observed that the residents who were sleeping during the snack were not offered a drink or a snack.

On an identified date, a PCA told inspector that there were residents in the area who had not been offered snacks as they were sleeping.

On an identified date and time, the inspector observed a nourishment service provided by a PCA in another Neighbourhood. An identified resident was observed to be sleeping in the lounge over the course of the observations. Staff attempted to wake up the resident with a verbal cue but the resident did not respond. The resident was observed not to be re-approached or offered the labelled commercial supplement or snack item from the cart.

On an identified date, a PCA said that their usual practice when providing snacks was to not wake up residents who were sleeping and then re-approach at a later time. The PCA said that they did not re-approach the residents who were sleeping during the nourishment pass as they had to go and provide a shower to another resident. The PCA said that the resident did not receive a snack or the supplement on the cart as the resident was sleeping.

A Nutritional assessment by the RD on an identified date, stated that this resident received a supplement at multiple snacks. This assessment also stated that the resident "remains at Nutritional Risk due to varied intake". The current printed version of the plan of care for the resident identified that the resident was at "Nutritional Risk" related to "potential for dehydration" and history of weight change. This plan of care had not provided direction regarding not offering the food, beverages or commercial supplements at snacks due to their sleeping pattern.

Review of the resident's intake documented on the "Nutrition and Hydration Flow Sheet" for an identified period of time, showed that there were multiple days when they had no fluid intake at the morning snack; and, multiple days when they had no fluid or food intake at the afternoon and evening snack.

On a specific date, the Registered Dietitian (RD) and Nutrition Manager (NM) told the inspector that it was the expectation in the home that staff provided beverages at morning snack and beverages and a snack at the afternoon and evening pass unless it was specified in their plan of care that based on an assessment the resident did not need to be woken up or re-approached by staff. The RD and NM acknowledged that there were residents who slept regularly at snacks who were not offered the items but did not have this included in the plan

of care.

b) On a specific date and time, the inspector observed the nourishment service provided by a PCA to the residents in a specific Neighbourhood. An identified resident was observed to be sleeping in the lounge over the course of the observations. The resident was not woken or offered a beverage by the PCA or any other staff during this time period.

The PCA said that their usual practice when providing snacks was if a resident was sleeping they would leave them sleep and then re-approach at a later time. The PCA said that they did not wake up the resident or provide this resident with a beverage during the nourishment service.

On a specific date, the Neighbourhood Coordinator provided the current printed version of the plan of care to the inspector and said that was where the staff would look to know the care needs of the resident. This plan of care identified that the resident was at "Nutritional Risk" related to "potential for inadequate intake of protein and energy due to history of erratic intake". This plan of care did not identify anything regarding sleeping in the mornings or afternoons or direction for staff regarding re-approaching with fluid or food if sleeping at the meals or snacks.

On a specific date, the Registered Dietitian (RD) and Food Service Manager (FSM) said it was the expectation in the home that staff would provide between meal beverages to all residents three times per day unless otherwise specified in the plan of care based on a nutritional assessment. The FSM and RD acknowledged that the plan of care for the resident did not reflect that the resident had been assessed as not needing a beverage between identified meals and therefore it was the expectation that staff would offer a beverage between the meals.

The scope of this area of non-compliance was a pattern and the severity was determined to be minimal harm/risk or potential for actual harm/risk. The home had a history of non-compliance in this sub-section of the legislation as it was previously issued as Compliance Order #001 on August 26, 2016. (630)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2017

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 006

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(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;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(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).

Order / Ordre :

The licensee shall ensure that identified residents and any other resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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; that an identified resident and any other residents are assessed by a registered dietitian who is a member of the staff of the home; and, that identified residents and any other residents are reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Grounds / Motifs :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

a) Review of an identified resident's Admission Head to Toe Assessment on a specific date, identified an area of altered skin integrity. Upon review of the clinical record there was no evidence of a Skin and Wound Assessment specific to altered skin integrity.

During a review of the home's policy titled "Skin and Wound Care Program" Tab 04-78, it stated that the registered team member would complete a Skin Assessment when there was a change in skin integrity.

On a specific date, the Skin / Wound Lead told the inspector that in a particular month, when the resident was identified as having altered skin integrity, it was the home's expectation that a Skin Assessment Concerns form would be completed. This form included a checklist to ensure that the appropriate assessments and referrals were then conducted. If it was a particular type of wound then the staff would also need to complete the Wound Assessment Tool. The Skin / Wound Lead acknowledged that the resident's altered skin integrity was not assessed by a member of the registered nursing staff using a clinically appropriate assessment instrument.

b) Review of an identified resident's clinical record and a Critical Incident (CI) report identified that on a specific date, the resident was found laying on the floor. The resident had sustained multiple identified injuries.

Review of the resident's progress notes identified an entry on a specific date, which stated that registered staff noted the areas of altered skin integrity and described the specific treatment provided for their injuries. During a review of the clinical record, there was no evidence that a Skin / Wound assessment had been completed for the specific areas identified on the resident.

On a specific date, the resident was observed in the lounge area of their neighbourhood and the resident's injuries were visible.

On a specific date, the Skin / Wound Lead Registered Practical Nurse (RPN) told the inspector that staff had not completed a head to toe assessment because the resident had not been admitted to hospital. The Skin / Wound Lead RPN stated that it was the home's expectation that all areas of altered skin integrity would be assessed by a registered staff using their assessment tool. The Skin / Wound Lead RPN said that they were not able to find a Skin Concern Assessment form for the resident's identified areas and there was no assessment completed for these areas.

The licensee failed to ensure that the resident's altered skin integrity were assessed by registered staff using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. (568)

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds had been assessed by a registered dietitian who was a member of the staff of the home, and any changes made to the plan of care related to nutrition and hydration were implemented.

Review of the Admission assessment for and identified resident on a specific date, identified an area of altered skin integrity. There was no documentation found in the clinical record that the resident had been seen by the registered dietitian (RD) with regards to altered skin integrity.

During an interview with the RD, they shared that it was the home's expectation that a Dietary referral be sent for an RD consult for all resident's exhibiting altered skin integrity. When shown the documentation for the resident with respect to their altered skin integrity, the RD reviewed the clinical record and acknowledged that there was no documentation on the admission nutritional

assessment with respect to the skin condition and nothing in the dietary progress notes to indicate that the RD had assessed the resident related to their altered skin integrity.

The licensee failed to ensure the resident exhibiting altered skin integrity had been assessed by a registered dietitian who was a member of the staff of the home. (568)

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

a) Review of the Admission assessment for an identified resident on a specific date, identified an area of altered skin integrity. There was no documentation in the Treatment Administration Record (TAR) related to the monitoring and treatment of the skin condition until a later identified date. There was no documentation found with respect to weekly skin assessments related to the identified altered skin integrity on the identified area.

The home's policy titled "Skin and Wound Care Program" tab 04-78 stated that the registered team member would complete assessments of the areas of altered skin integrity and weekly thereafter.

During an interview with the Skin / Wound Lead on a specific date, they acknowledged that there had been no weekly assessments conducted for the altered skin integrity for the resident.

b) Review of an identified resident's clinical record and a Critical Incident (CI) report identified that on a specific date, the resident was found laying on the floor. The resident had sustained multiple areas of altered skin integrity.

On a specific date, the resident was observed in the lounge area of their neighbourhood and the resident's multiple injuries were visible.

Review of the Treatment Administration Record (TAR) for a specific period of time for the resident identified an entry for an area of altered skin integrity and the specific treatment required. There was no documentation on this TAR that the treatment had been provided to the resident and no documentation that a

weekly assessment of the altered skin integrity had been conducted. Review of the TAR for another month identified an entry for a weekly assessment of another identified area. It was signed that the assessment was conducted on a specific date, but not on multiple subsequent weeks. There was no evidence of completed weekly altered skin integrity assessments for the areas of altered skin integrity on the resident's third identified area during the specific period of time.

During an interview with the Skin / Wound Lead RPN on a specific date, they told the inspector that it was the home's expectation that registered staff complete a weekly assessment on all areas of altered skin integrity. The assessment would be conducted on the home's assessment tool form and filed in the resident's clinical record. The Skin / Wound Lead RPN acknowledged that according to documentation, registered staff had not completed all weekly altered skin integrity assessments for the resident.

c) In the progress notes on a specific date, the registered staff noted that the doctor had assessed an area of altered skin integrity for an identified resident and that a specific medical procedure would be placed in the Treatment Administration Record (TAR). Review of the TAR did not show the documentation of the medical procedure for the altered skin condition. The Assistant Director of Nursing Care (ADNC) stated that there were no TAR's for the skin condition found for the specific date.

On another specific date, progress notes stated that the resident was found to have altered skin integrity. Further review of the progress notes and assessments indicated that weekly skin assessment were not always completed or were not signed as completed.

The RAI/QI Coordinator acknowledged that assessments were to be completed by the registered practical nurses on the home area weekly for altered skin integrity. Assistant Director Nursing Care acknowledged that the treatment and assessments for the resident were not completed consistently as ordered.

The licensee failed to ensure that the resident exhibited 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.

The scope of this area of non-compliance was a pattern and the severity was determined to be minimal harm/risk or potential for actual harm/risk. The home

had a history of non-compliance in this sub-section of the legislation as it was previously issued as a WN VPC on April 22, 2014 and June 12, 2015. (568)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2017

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 007

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 136. (3) The drugs must be destroyed by a team acting together and composed of,
(a) in the case of a controlled substance, subject to any applicable requirements under the Controlled Drugs and Substances Act (Canada) or the Food and Drugs Act (Canada),
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) a physician or a pharmacist; and
(b) in every other case,
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) one other staff member appointed by the Director of Nursing and Personal Care. O. Reg. 79/10, s. 136 (3).

Order / Ordre :

The drugs must be destroyed by a team acting together and composed of, (a) in the case of a controlled substance, (i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and (ii) a physician or a pharmacist; and, (b) in every other case, (i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and (ii) one other staff member appointed by the Director of Nursing.

Grounds / Motifs :

1. The licensee has failed to ensure that when a drug was destroyed and was a controlled substance, it was done by a team acting together and composed of, (i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and (ii) a physician or a pharmacist.

A review of the policy "Disposal of Discontinued/expired drugs, narcotics and controlled substances" stated: "The Narcotic and Controlled substances Surplus Drug Form is also completed (or as per facility policy) when placing medication awaiting disposal in the double locked centralized storage area". This form

included documentation of:
a) Date of removal of the drug from the unit
b) Resident name
c) Prescription number
d) Drug name drug strength, quantity
e) Reason for removal.
In addition, the policy stated that "Narcotics and controlled substances are to be destroyed by a member of the registered staff appointed by Director of Nursing/Care or Resident Service Manager and the pharmacist (or physician) on site according to legislated requirements".

Review of Policy "Stericycle Disposal System" How to destroy and dispose of discontinued/expired medications (non-Narcotics) dated January 2017 stated: "to be completed by the Pharmacist and one member of the registered nursing staff appointed by the Director of Nursing and Personal Care…destruction will include:
- oral medications, creating a slurry and adding to medication container for disposal
- for injectable, opening package and wasting in medication container".

A Registered Practical Nurse (RPN) stated that when a narcotic or controlled substance was taken out of the packaging and ready to administer but the resident refused and it was not administered, the medication was to be destroyed with a witness present. If the medication was crushed the medication went in the sharp container, if not the nurses then made it unusable and placed it in the sharps container. The RPN stated they had observed wasted narcotics/controlled substances being placed in the sink. The RPN stated there was no form to sign as to how and where it was destroyed.

Interview with a second RPN stated that for a narcotic or controlled substance that had been refused they would get another nurse to witness the waste. The RPN stated that there was no documentation as to where the nurse put the medication or how it was destroyed. The RPN stated that they have observed nurses crush the medication and put the narcotic/controlled substance in the garbage and sometimes in the sharp container and that they do not always put fluid with the medication to destroy it.

A third RPN stated narcotic/controlled substance that were refused were to be wasted and a second nurse was to witness the wastage; the two nurses would

put water on the medication and put the discarded medication in the sharps container.

Assistant Director of Nursing Care (ADNC) stated that narcotic and controlled substances should never be put in the garbage or the sink and the expectation was that it was always slurred and put in the disposal bins or sharps container. The ADNC acknowledged that the policy was not being followed and that two nurses were to destroy the narcotics/controlled substances. The ADNC also acknowledged that recording how or where the drug was destructed was not being recorded.

The licensee failed to ensure that when a drug was destroyed and was a controlled substance, it was done by a team acting together and composed of, (i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and (ii) a physician or a pharmacist. (680)

2. The licensee has failed to ensure that where a drug was to be destroyed and was not a controlled substance, it was to be done by a team acting together and composed of, (i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and (ii) one other staff member appointed by the Director of Nursing.

Review of policy "Stericycle Disposal System' How to destroy and dispose of discontinued/expired medications (non-Narcotics)" dated January 2017 stated:
-To be completed by: a registered nurse and one other staff member appointed by the Director of Nursing
1. Place the expired or discontinued medication into the small opening of the sealed Stericycle container at the end of each shift or at the time of disposal…
2. Once the container is almost full, 2 of the staff designated above, can create a slurry by pouring water or some other form of liquid into the container
3. The Non-Narcotic and Non-Controlled Drugs Medication Destruction record should be also completed at this time by 2 designated staff members….

During observations of the medication room on an identified date, the inspector found that there were pails with lids that were not fully engaged on the pail and had medication packages in them. Observations of the medication rooms showed that these pails were in each of the medication rooms.

A Registered Practical Nurse (RPN) stated the pails were for discontinued

medications and that staff were to place the entire medication package in the pail when discarding the medication. The RPN stated they had not been directed to remove the packaging before discarding. The RPN was not aware of the slurring technique to be performed.

Interview with a second RPN stated the discontinued medication was put in the pail until it was sealed and taken to the medication room for removal. This pail sits open in the medication room until it was full then it was sealed. When the pail was ready to be sealed, water or lactulose was poured in the pail. The RPN stated the pills were not taken out of the packages, but that some pills were not in the packages when put into the container. The RPN stated that no one watched the nurses pour fluid over the medication and that the RPN was unaware of a policy regarding this procedure.

A third RPN stated they had a pail to put all discontinued drugs in. The RPN stated that when the pail was full RPNs put water in the pail and then seal the pail by putting the lid on. The RPN stated that the medications were thrown into the pail in their packaging unless they were already out of the packaging. RPN stated staff would not remove the packaging before pouring water into the pail.

Record of Secure storage of Non-narcotic and non-controlled drugs for destruction record was last signed April 22, 2016. This form stated "Drugs must be destroyed by a team acting and composed of one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and one other staff member appointed by the Director of Nursing and Personal Care. Upon completion, the container was sealed and stored securely in the designated area for pick up by medical waste company for disposal".

In an interview with the Assistant Director of Nursing Care (ADNC) they stated that all non-narcotic medication for destruction were put into pails in the medication rooms, and when full brought to an identified unit, where they were put into boxes to be picked up by pharmacy to be destroyed. ADNC stated that the nurse on the home areas destroyed the medication before putting them in the pails, and that the destruction should have a witness. ADNC also stated that it was an expectation that staff were to remove the pills from the packaging when they place them in the buckets. ADNC acknowledged that the Record of Secure storage of Non-narcotic and non-controlled drugs for destruction record was last signed April 2016, and that the expectation was that it be signed each time the destruction waste company removed the pails.

Interview with the Operations Manager Medi-system Pharmacy stated that all non-narcotic destruction must be done on site at the home. The medication to be destroyed were put into pails, and before the pail was sealed the pail was covered with fluid usually lactulose and slurred so that the medication was not usable, then the lid was sealed on the pail and a company removed them from the building for destruction.

The licensee failed to ensure that where a drug was to be destroyed and was not a controlled substance, it was be done by a team acting together and composed of, (i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and (ii) one other staff member appointed by the Director of Nursing.

The scope of this area of non-compliance was widespread and the severity was determined to be minimal harm/risk or potential for actual harm/risk. The home had unrelated non-compliance in the last three years. (680)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e) 151, rue Bloor Ouest, 9e étage Toronto ON M5S 2T5	Directeur a/s du coordonnateur/de la coordonnatrice en matière d'appels Direction de l'inspection des foyers de soins de longue durée Ministère de la Santé et des Soins de longue durée 1075, rue Bay, 11e étage Toronto ON M5S 2B1 Télécopieur : 416 327-7603

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

Issued on this 17th day of July, 2017

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector /
Nom de l'inspecteur : Ina Reynolds

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