Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 1, 2019	2019_790730_0019	002270-18, 002273-18, 004860-18, 005008-18, 006459-18, 006865-18, 008494-18, 010718-18, 014731-18, 016559-18, 016963-18, 017558-18, 019168-18, 021010-18, 022150-18, 025411-18, 025508-18, 026611-18, 027009-18, 027590-18, 028826-18, 032427-18, 032685-18, 006646-19, 010036-19, 012720-19	Critical Incident System

Licensee/Titulaire de permis

Shepherd Village Inc.
3758/3760 Sheppard Avenue East TORONTO ON M1T 3K9

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

Shepherd Lodge
3760 Sheppard Avenue East TORONTO ON M1T 3K9

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

CHRISTINA LEGOUFFE (730), AMBERLY COWPERTHWAITE (435), CASSANDRA ALEKSIC (689), CHERYL MCFADDEN (745)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 8, 9, 10, 11, 12, 15, 16, 17, and 18, 2019.

The following Critical Incident intakes were completed within this inspection:

Related to the prevention of resident to resident abuse and responsive behaviours:

Critical Incident Log #021010-18/ CI #2782-000051-18
Critical Incident Log #025508-18/ CI #2782-000058-18

Related to falls prevention:

Critical Incident Log #016963-18/ CI #2782-000037-18
Critical Incident Log #017558-18/ CI #2782-000043-18
Critical Incident Log #010718-18/ CI #2782-000034-18
Critical Incident Log #014731-18/ CI #2782-000036-18
Critical Incident Log #005008-18/ CI #2782-000013-18
Critical Incident Log #002270-18/ CI #2782-000005-18
Critical Incident Log #010036-19/ CI #2782-000016-19
Critical Incident Log #016559-18/ CI #2782-000042-18
Critical Incident Log #019168-18/ CI #2782-000048-18
Critical Incident Log #025411-18/ CI #2782-000057-18
Critical Incident Log #006459-18/ CI #2782-000015-18
Critical Incident Log #022150-18/ CI #2782-000055-18
Critical Incident Log #012720-19/ CI #2782-000073-18

Related to an unexpected death:

Critical Incident Log #004860-18/ CI #2782-000012-18

Related to missing narcotics:

Critical Incident Log #032427-18/ CI #2782-000082-18
Critical Incident Log #028826-18/ CI #2782-000075-18
Critical Incident Log #027590-18/ CI #2782-000070-18

Related to the prevention of abuse and neglect:

Critical Incident Log #027009-18/ CI #2782-000064-18
Critical Incident Log #032685-18/ CI #2782-000084-18

Related to hospitalization and change in condition:

Critical Incident Log #006865-18/ CI #2782-000017-18
Critical Incident Log #008494-18/ CI #2782-000026-18
Critical Incident Log #002273-18/ CI #2782-000006-18
Critical Incident Log #026611-18/ CI #2782-000063-18
Critical Incident Log #006646-19/ CI #2782-000011-19

PLEASE NOTE: A Written Notification and Voluntary Plan of Correction related to LTCHA, 2007, c.8, s. 20(1), identified in a concurrent inspection #2019_684604_0016 (Complaint Log #007442-18) was issued in this report.

During the course of the inspection, the inspector(s) spoke with a Compliance and Quality Manager, Nurse Managers (NM), a Director of Client Care Services, a Director of Nursing (DON), a RAI- Coordinator, a Physiotherapist (PT), an Administrative Assistant, a Registered Nurse (RN), Registered Practical Nurses (RPNs), and Personal Support Workers (PSWs).

The inspectors also observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, reviewed policies and procedures of the home, reviewed meeting minutes, and observed medication

administration and drug storage areas.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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,
(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; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

The licensee has failed to ensure that residents at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff upon any return of the resident from hospital.

1. A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC), which documented an incident that caused an injury to resident #007, for which the resident was taken to hospital and resulted in a significant change in the resident's health status.

The CIS report documented that resident #007 rang their call bell to ask for pain medication to relieve a headache and the resident was received in bed with an injury. The report stated that the resident agreed to be sent to hospital for further assessment. The report documented that the resident returned from hospital with an injury and a significant change in condition.

The Care Plan Focus report for resident #007 was reviewed from Momentum Care Management and showed a focus of "skin integrity" and description stating no deficits, at risk for skin breakdown due to staying in bed all day post hospitalization.

During an interview, Nurse Manager (NM) #106 stated that when a resident returned from hospital, the assessments completed would be the same as the readmission process. NM #106 stated that the process in the home was that the resident was looked at and documented on every shift, and a full head to toe assessment and a skin and wound assessment was completed to ensure that the resident was not returning to the home with skin breakdown. The NM stated that these assessments were documented in the progress notes. When asked what information was provided by the assessments, the

NM stated that the staff would document how the resident was doing, their status, physiotherapy involvement in terms of transfer status, bed mobility and limitations. The Registered Dietitian followed up, as well.

NM #106 stated that they were familiar with resident #007. The NM reviewed resident #007's clinical record and stated that they did not see that a skin and wound assessment, though a head to toe assessment, was documented when the resident returned to the home from hospital. The NM stated that the staff did not document properly if the resident had an assessment done and stated the only thing they saw documented was that there were bruises, but no mention of a head to toe assessment completed.

The clinical records of resident #007 were reviewed and there was no documentation of a head to toe or skin and wound assessment completed on a specified date. [s. 50. (2) (a) (ii)]

2. A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC), which documented an incident that caused an injury to resident #008 for which the resident was taken to hospital and resulted in a significant change in the resident's health status.

The CIS report documented that a Registered Practical Nurse (RPN) contacted the attending doctor after assessing resident #008 due to observed pain/grimacing. The report stated that the doctor requested to send the resident to hospital for an x-ray, which showed an injury.

Progress notes were reviewed in Point Click Care (PCC) and showed a note, which stated that the resident had an injury and pain was noted upon movement, through grimacing. The note stated that an order was received to send the resident to hospital. A progress note stated that the resident returned from hospital.

During an interview, RPN #104 stated that a head to toe assessment, which included a skin assessment should be completed for a resident upon return from hospital. The RPN stated assessments were documented in the progress notes under "health condition/wellness". The RPN stated that they were familiar with resident #008, who was sent to hospital and returned with fracture. The RPN stated that there was supposed to be a head to toe and skin assessment, but that they did not see a head to toe assessment in the residents' progress notes, or a skin assessment completed under "health condition/wellness".

The Care Plan for resident #008 was reviewed in PCC and showed the focus "potential for impaired skin integrity related to incontinence", and interventions to "document/report if skin is intact, red, or open area(s)".

During an interview, NM #106 stated that they were familiar with resident #008. The NM reviewed resident #008's clinical record and stated that the resident had returned to the home from hospital on a specified date. They stated that an assessment was done to the injured area and staff documented that they looked at the circulation and sensory to the injured area. When asked if the resident was at risk for altered skin integrity, the NM stated that if they were in bed, then yes because it would have been difficult to move the resident around and they would have needed repositioning. The NM stated that a head to toe assessment should have been documented under Assessments in PCC and was not completed. The NM stated that they would expect that the head to toe assessment should have been completed when the resident had returned from hospital.

The clinical records of resident #008 were reviewed and there was no documentation of a head to toe or skin and wound assessment completed on the day the resident returned from hospital. [s. 50. (2) (a) (ii)]

3. A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC), which documented an incident that caused an injury to resident #007 for which the resident was taken to hospital and resulted in a significant change in the resident's health status.

The CIS report documented that a Personal Support Worker (PSW) reported to the Registered Practical Nurse (RPN) that the resident had a specified injury. The report stated that the medical doctor assessed the resident and ordered that the resident be transferred to hospital. The report documented that the resident returned from hospital with a diagnosis of a fracture.

The Care Plan Focus Report for resident #009 was reviewed from Momentum Care Management and documented "Focus: Skin Integrity" with "outcome: skin integrity will be maintained".

During an interview, NM #106 stated that they were familiar with resident #009. The NM reviewed resident #009's clinical record and stated that the Personal Support Worker (PSW) was providing a bath to the resident but noticed an injury and informed the unit

float nurse. The NM stated that morning, the doctor saw the resident and transferred them to hospital. The NM stated that the resident returned to the home on the same day. When asked if the resident had any assessments completed upon their return from hospital, the NM stated that there was no documentation in the progress notes that a Head to Toe Assessment was completed upon their return from hospital. The NM stated that they would expect that the head to toe assessment should have been completed when the resident had returned from hospital.

The clinical records of resident #009 were reviewed and there was no documentation of a head to toe or skin and wound assessment completed the day the resident returned from hospital.

The home's policy titled Re-Admission from Hospital, NURS V-93, with effective date January 2019 was reviewed and stated the following:
"The Unit Nurse must complete a head to toe assessment on readmission. Registered staff to take note of any altered skin condition such as bruising, pressure ulcers/open areas. If a skin alteration was found the Unit Nurse will complete a Dietary Referral and a stage specific wound assessment in the electronic skin and wound management system."

The home's policy titled Skin and Wound, NURS V-94, with effective date April 2019 was reviewed and stated the following:
"Registered staff will perform Head to Toe Assessment for all resident within 24 hours of admission, after return from hospital, or return from an absence of greater than 24 hours and quarterly."

The licensee has failed to ensure that residents #007, #008 and #009, who were at risk of altered skin integrity, received a skin assessment by a member of the registered nursing staff upon return of the resident from hospital. [s. 50. (2) (a) (ii)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

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

The home submitted three Critical Incident System (CIS) reports to the Ministry of Health and Long-Term Care (MOHLTC), over a three month span, identifying four separate incidents of missing fentanyl patches for resident #005.

Review of resident #005's progress notes, in Momentum Care Management stated that resident #005's fentanyl patch was identified missing from resident #005's body. Another progress note documented that staff were unable to locate resident #005's fentanyl patch. A progress note stated that resident #005's fentanyl patch was missing and staff were unable to locate the patch after searching. A progress note stated that resident #005 had refused to let staff check the fentanyl patch placement at shift change and upon re-checking the fentanyl patch was not in place and was determined to be missing.

During an interview with Registered Practical Nurse (RPN) #109 when asked how missing or unaccounted for fentanyl patches were identified, RPN #109 stated that they would complete an incident report. When asked when a medication incident report would be completed, RPN #109 stated right away when they suspected an incident had occurred. During an interview with RPN #114, when asked where medication incident reports were kept, RPN #114 stated that they were kept by the nurse manager.

Inspector #435 reviewed the "Medication Incident/Near Miss Reports" for resident #005's missing fentanyl patches on three dates. No "Medication Incident/Near Miss Report" for resident #005's missing fentanyl patch on one specified date, was provided to the inspector.

Inspector #435 reviewed a document titled "Medication Incident/Near Miss Summary Report" dated September to December 2018, with a review date of February 20, 2019, which was signed by the Director of Care, the Medical Director and prepared by the Clinical Pharmacist. During the review, it was documented that there were incidents on two dates, of missing fentanyl patches on a resident. There was no documentation on the report identifying missing fentanyl patches for resident #005 on two other dates.

During an interview with Nurse Manager (NM) #110, the medication management lead in the home, they said that they would expect that a medication incident report would be completed for a missing fentanyl patch. NM #110 stated that they would complete the quarterly medication incident review with the pharmacy representative. NM#110 stated that in each quarterly medication incident review they would document and record the type of medication incidents for each month and then for the quarter. They stated that after that, they would discuss the incidents that had occurred in the last quarter with front line staff. NM#110 stated that the quarterly medication incident review was documented in the meeting minutes. NM #110 stated that they did not document interventions to prevent future incidents.

Inspector presented NM #110 with the document titled "Medication Incident/Near Miss Summary Report" dated September to December 2018. When asked if this document was the homes quarterly medication incident review, NM #110 stated yes. When asked if they would expect that all medication incidents from September 2018 to December 2018 be identified in the document, NM #110 stated yes. When asked if NM #110 could show inspector where resident #005's fentanyl patches that were missing on two specified dates were identified on the review, NM #110 stated they did not see them identified. When asked if they would expect these incidents to be identified on the Medication Incident/Near Miss Summary Report, NM #110 stated yes.

The licensee has failed to ensure that a quarterly review of medication incidents included resident #005's missing fentanyl patches on two specified dates. [s. 135. (3)]

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. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (2) The drug destruction and disposal policy must also provide for the following:
2. That any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs. O. Reg. 79/10, s. 136 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the drug destruction and disposal policy in the home provided that any controlled substance that was to be destroyed and disposed of was stored in a double-locked storage area within the home, separate from any controlled substance that was available for administration to a resident, until the destruction and disposal occurred.

The home submitted three Critical Incident System (CIS) reports to the Ministry of Health and Long-Term Care (MOHLTC) over a three month span related to missing fentanyl patches for resident #005.

During an interview with Registered Practical Nurse (RPN) #109, when asked where removed fentanyl patches were stored, RPN #109 stated, in part, that removed patches were applied to a piece of paper which held four to six removed patches. When asked where these pieces of paper with the removed patches were stored, RPN #109 stated that they were stored in the narcotic bin. When asked where fentanyl patches to be administered were stored, RPN #109 stated that they were stored in the narcotic drawer inside the medication cart and in a zip lock bag. When asked if this drawer was the same drawer that the removed patches were stored in, RPN #109 stated yes.

Inspector #435 requested that RPN #109 show inspector where the removed fentanyl

patches were kept once they were removed. Inspector #435 observed RPN #109 unlock the medication cart and unlock a drawer within the medication cart and showed inspector a sheet of paper with removed fentanyl patch attached. Inspector #435 also observed a blue piece of tape across the patch, which was folded and located in a clear zip locked bag, which also contained a box of unused patches.

During another observation, on another floor of the home, inspector #435 requested that RPN #109 show them resident #012's removed fentanyl patches. Inspector #435 observed RPN #109 unlock the medication cart and unlock a drawer within the medication cart. Inspector observed RPN #109 remove a zip lock bag of resident #012's removed fentanyl patches, which were observed to be on two separate pages in two separate zip lock bags within the narcotic box, and one of the zip lock bags contained a box of unused fentanyl patches. RPN #109 stated that once the sheet was full of patches, they were directed to take it to the fourth floor where medications for destruction were kept.

Inspector reviewed the home's policy titled "Narcotic Control/Storage and Destruction" policy number "NURS VII-145" with an effective date of March 2019, identified to be currently in place. The policy did not state to store controlled substances that were to be destroyed and disposed of separately from controlled substances that were available for administration to a resident until the destruction and disposal occurred.

During an interview with Nurse Manager (NM) #106 they stated that fentanyl patches to be administered were kept in the narcotic box in the medication cart. NM #106 stated, in part, that nursing staff have two plastic bags, one for the removed patches and one with a sign out sheet and box with new patches, so that the removed and the new patches were not stored together. When inspector asked NM #106 to review the "Narcotic Control/Storage and Destruction" policy number "NURS VII-145" and where it stated that drugs for administration were to be stored separately from drugs to be destroyed and disposed of, NM#106 stated that they did not see it in the policy.

During an interview with NM #110, when asked where fentanyl patches that were removed from residents were stored prior to destruction, NM #110 stated in part that they were stored in the medication cart's narcotic bin on a piece of paper that had five spaces. NM #110 stated that this sheet was kept with the stock of medication and when the sheet was full, it was then taken down to the double locked storage box prior to destruction.

The licensee has failed to ensure that the drug destruction and disposal policy in the

home had identified that any controlled substance that was to be destroyed and disposed of was stored in a double-locked storage area within the home, separate from any controlled substance that was available for administration to a resident, until the destruction and disposal occurred. (435) [s. 136. (2) 2.]

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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Ontario Regulation 79/10 s. 114 (2) stated, "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."

Specifically, staff did not comply with the home's policy "Medication Administration Record, NURS VII-133" effective date March 2019, which was part of the licensee's medication management program.

The home's policy titled Medication Administration Record, NURS VII-133, effective date

March 2019, stated the following:
- "The eMAR program is utilized to electronically document medications that have been administered."
- "Any PRN medications administered are to be documented in the auto-populated electronic progress notes noting the date, time, medication given and the effect. If the PRN medication is not effective, supporting documentation is required in the electronic progress note."

1. A Critical Incident System (CIS) report, submitted to the Ministry of Health and Long-Term Care (MOHLTC), documented an incident that caused an injury to resident #009, to which the resident was taken to hospital and resulted in a significant change in the resident's health status.

The CIS report documented that a Personal Support Worker (PSW) reported to the Registered Practical Nurse (RPN) that the resident appeared to have a specified injury. The report documented that when the resident was asked if they were in pain, they did not answer, and instead cried out when a specified body part was touched. The report stated that the medical doctor assessed the resident and ordered that the resident be transferred to hospital. The report documented that the resident returned from hospital with a fracture.

The clinical records for resident #009 were reviewed in Point Click Care (PCC) and showed a PRN (as needed) medication physicians order for pain medication.

The Progress Note Summary and electronic Medication Administration Records (eMAR) for resident #009 were reviewed and showed five instances where pain medication was administered. There was no record of medication administration for the five instances in the residents eMAR.

During an interview, Registered Practical Nurse (RPN) #116 stated the administration of a PRN (as needed) pain medication was documented on the eMAR and staff chose the medication that they were administering and documented the reason why it was administered, and then followed up to see whether it was effective. RPN #116 reviewed the progress notes and eMAR for resident #009. When asked if they would have expected the medication administration to be documented on the eMAR and in the progress notes, the RPN stated yes.

The licensee has failed to ensure that resident #009's PRN pain medication

administration was documented on the eMAR program as per the home's policy.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's policy related to medication administration records is complied with, to be implemented voluntarily.

WN #5: 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 :

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

1. The home submitted a Critical Incident System report to the Ministry of Health and Long- Term Care (MOHLTC) regarding alleged physical abuse of resident #011, related to a specified injury to the resident.

The home's policy NURS VI- 116 with subject "Zero Tolerance of Abuse and Neglect of Residents" stated under procedures:
"7.04 The Manager/Director of Nursing will investigate the report and document the findings (Interview resident, employee, witnesses). The Director of Nursing or delegate will notify the Director of Client Care Services and Human Resources. Human Resources must be a member of the investigating committee and be kept fully informed and regularly consulted throughout the process. Documentation must include…Name and signature of person interviewed, union member (if applicable) and interviewer (s). Date

and Time of person interviewed should also be included."

A review of resident #011's progress notes in Momentum Care Management from a specified date showed a note written by Registered Practical Nurse (RPN) #112, which stated that, at a specified time a Personal Support Worker (PSW) asked the writer to look at resident #011. The note stated that the resident had a specified injury. The resident was noted to be unusually calm and quiet during care and was not resistive. The resident was noted to be awake, but was unresponsive to verbal communication. The resident was transferred to hospital for assessment shortly after.

A review of resident #011's progress notes in Momentum Care Management showed a note written by Registered Nurse (RN) #115, which stated that a receptionist had called and stated that two police officers came to the home. The police officers stated that the doctor at the hospital was concerned with what had happened regarding the resident's injuries. The writer noted that they called the Director of Care regarding the concerns and accompanied the police to the floor and showed them the resident's room.

The home's investigation notes related to this incident were reviewed by inspector #730 and included a copy of the CIS report, printed progress notes for resident #011 from Momentum Care Management from two dates and a Quarterly Review Assessment for resident #011. The investigation notes did not include documentation of staff interviews.

In an interview with RPN #112, they stated that resident #011 was often resistive to care.

In an interview with Nurse Manager #110, they stated that the RPN and PSW who had worked on resident #011's home area the night prior to the incident had been interviewed, but stated that they were unsure if notes were taken during those interviews.

During an interview with Compliance and Quality Manager #100, they stated that part of the procedure in the home for investigating allegations of abuse was that the nurse managers took hand written notes. They stated that all investigation notes were attached to the CIS report in the CIS binder. Compliance and Quality Manager #100 stated that they expected that staff interviews were part of the investigation for alleged abuse and that there should have been notes from any meetings that were held with staff. They also stated that they would expect that the notes were attached to the CIS report and kept in the CIS report binder.

2. The MOHLTC received a complaint though the ACTIONline, The complaint indicated that on a specified date, resident #013 was allegedly physically abused by another resident in the home. The complainant stated they were not called until later in the day and was informed by a nurse that the police were called.

The home submitted a Critical Incident System (CIS) report at a noted date and time to the MOHLTC Director. The CIS report indicated the Nurse Manager (NM) was informed by a PSW that resident #013 confirmed an allegation that another resident had abused them. The CIS report stated that the Power of Attorney (POA) and police were informed.

The home's policy "Management of Aggressive and Resistive Behaviours", policy #NURS VI-116, with an effective date of May 2019, under procedures 7.07 stated that where there is allegation of abuse/assault, the following people/agencies would be notified immediately: b) Resident's Power of Attorney (POA) or Substitute Decision Maker (SDM) and c) Police.

An interview was conducted with the complainant who indicated on a specified date, RN #120 called them and informed them about the alleged abuse towards resident #013. The complainant indicated they could not recall the time the RN had called them, but they were contacted 12-24hrs, after the incident had occurred. The complainant stated that the home indicated they had called the police shortly before calling the complainant. The complainant stated the RN was unable to give them accurate information as to what time of day the incident took place.

Inspector reviewed resident #013's progress notes in Momentum Care Management for a variety of dates. Momentum notes with a specified date, indicated that resident #013's POA and the police were not called immediately upon a suspicion of abuse.

Interviews were conducted with the home's Compliance and Quality Manager #100 and NM #106, who stated it was the home's policy to contact the residents POA and police immediately for any allegations of abuse. The Compliance and Quality Manager and NM reviewed the CIS and Momentum notes and acknowledged that the POA and police were not called immediately and home's policy to contact the POA and police immediately was not complied with. (604)

The licensee has failed to ensure that when allegations of abuse were made for residents #011 and #013, that the home's policy to promote zero tolerance of abuse and neglect of residents, was complied with.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #6: 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 a 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 Critical Incident System (CIS) report, submitted to the Ministry of Health and Long-Term Care (MOHLTC), documented an incident that caused an injury to resident #009, to which the resident was taken to hospital and resulted in a significant change in the resident's health status.

The CIS report documented that a Personal Support Worker (PSW) reported to the Registered Practical Nurse (RPN) that the resident appeared to have a specified injury. The report documented that when the resident was asked if they were in pain, they did not answer, and instead cried out when a specified body part was touched. The report stated that the medical doctor assessed the resident and ordered that the resident be transferred to hospital. The report documented that the resident returned from hospital with a fracture.

Care Plan Focus Report for resident #009 was reviewed from Momentum Care Management and documented "Focus: Pain."

Physicians orders for specified dates for resident #009 showed orders for specified pain medication as needed (PRN).

Progress Notes Summary for resident #009 was reviewed from Momentum Care Management which documented the following:
-On a specified date documented observed pain when touching affected site, pain score was taken, and PRN pain medication was given as per medical directive.
-A later progress note, documented the resident was unable to respond when asked about presence of pain and pain medication was given as per medical directive.
-A further progress note documented that the resident verbalized pain and was given pain medication.
-Another progress note made no mention of pain or discomfort, but documentation showed pain medication given as per medical directive.

The Electronic Medication Administration Records (eMAR) for resident #009 were reviewed and showed that pain medications were administered and documented as "ineffective" or "unknown" on four noted dates.

The home's policy titled Pain Assessment and Management, NURS V-102, with effective date, January 2017 was reviewed and stated the following under "Procedures":
- "Registered Nurse (RN) / Registered Practical Nurse (RPN):
-initiates an appropriate tool considering factors such as age and level of cognition using the following assessment tools: Pain Assessment Tool (RNAO, 2002), and Pain Management Flow Record (RNAO, 2002), Abbey Pain Scale.
-Initiate a pain management flow record when a scheduled pain medication does not relieve the pain or when pain remains regardless of interventions.
-It is recommended that on a daily basis, the resident's response to pain medication be monitored."

The clinical records of resident #009 were reviewed and there was no documentation of a Pain Assessment Tool, Pain Management Flow Record, or Abbey Pain Scale completed from specified dates.

During an interview, Registered Practical Nurse (RPN) #112 stated that the home had a

pain management program. The RPN stated that when a resident exhibited pain or discomfort, they documented an assessment within the progress notes, administered as needed (PRN) analgesics, and monitored the resident for medication effectiveness. When asked how a resident was monitored for pain, the RPN stated that they checked on the resident and followed up and if there was no change and the medication was ineffective and not helping with pain, then they would refer to the float Registered Nurse (RN) in the building. The RPN stated that the process for pain monitoring, after providing an as needed (PRN) pain medication, was to complete an assessment, check their vitals, provide intervention, and then follow up. The inspector asked when staff would use the Abbey Pain Scales or pain assessments, and the RPN stated that the Abbey Pain Scale was used for palliative residents or residents who had ongoing pain. When asked how staff assessed the effectiveness of PRN pain medications, the RPN stated that they followed up with the resident and observed if there was facial grimacing, moaning or if they had verbally stated that they did not have pain. The RPN stated that the information was then documented in the resident's progress notes and in the electronic Medication Administration Record (eMAR) if the pain medication was effective or not. When asked if a resident's pain was not relieved by initial interventions, how the resident was assessed, the RPN stated that the assessment was completed and documented in the progress notes. The RPN stated that the Abbey Pain Scale would be the only assessment that would be used to assess pain. Inspector #689 asked if the staff were using a clinically appropriate assessment to assess pain if PRN medications were not effective, and the RPN stated that they were not using a specific tool or assessment if initial interventions were not effective but went back to the resident and checked on them.

RPN #112 and Inspector #689 reviewed the clinical records for resident #009 which showed documentation of administration of PRN analgesics on various dates as "unknown" or "ineffective". The RPN stated that if there was no documentation, then staff were not following up with medication administration effectiveness for the resident. When asked when the administration of PRN medications was documented in eMAR as "ineffective" or "unknown" what assessments were completed for resident #009 to assess their pain, the RPN could not identify any pain assessments completed. The RPN stated that no assessments or monitoring tools were used for resident #009 to assess their pain and that they would have expected that pain assessments should have been completed.

The licensee has failed to ensure that when resident #009's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

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 when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument, to be implemented voluntarily.

WN #7: 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 :

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

1. The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC), related to a complaint made by resident#004's personal sitter, to the home. The complaint was that the personal sitter believed that resident #004 was being sedated by the registered nursing staff, which they felt caused the resident to have an unsteady gait during the evenings.

During a review of resident #004's medication orders, inspector #435 identified a specified medication prescribed to resident #004.

Review of resident #004's electronic medication administration record (eMAR) documented that resident #004's ordered specified medication on two consecutive dates was coded as "Hold/See Nurse Notes".

Review of a progress note, in Momentum Care Management, stated in part that resident

#004's personal sitter had questioned why resident #004 was being administered the specified medication. The note continued to state in part, that resident #004's sitter stated that they did not want resident #004 to be administered the medication and the note indicated that the medication was held by the nurse.

Review of progress notes, stated in part that resident #004's personal sitter had requested that resident #004 not receive a specified medication and documented that the medication was held by the nurse.

Review of a progress note stated in part that nursing staff had discussed resident #004's medication order with resident #004's physician. The note documented that the physician had stated that resident #004 was to continue with their medication as ordered and that directives for medications were to come from resident #004's Power of Attorney (POA), not the sitter.

During an interview with Nurse Manager (NM) #106, when asked who was able to determine if a resident was to receive an ordered medication, NM #106 stated the resident themselves, or if they were incapable, their Substitute Decision Maker (SDM). When asked if a personal sitter, who was not a resident's POA, could make decisions on behalf of a resident, NM #106 stated no. When asked if they expected that a medication would be held for a resident upon request from a personal sitter, NM #106 stated no.

2. A Critical Incident System (CIS) report submitted to the Ministry of Health and Long-Term Care (MOHLTC) documented an incident that caused an injury to resident#009, for which the resident was taken to hospital and resulted in a significant change in the resident's health status.

The CIS report documented that a Personal Support Worker (PSW) reported to the Registered Practical Nurse (RPN) that the resident had an injury. The report documented that the resident was asked if they were in pain, but they did not answer and instead cried out when the injured area was touched. The report stated that the medical doctor assessed the resident and ordered that the resident be transferred to hospital. The report documented that the resident returned from hospital with a fracture.

The clinical records for resident #009 were reviewed in Point Click Care (PCC) and showed a PRN (as needed) medication order for pain medication PRN.

The Progress Note Summary for resident #009 was reviewed and showed that the pain

medication was administered to resident #009 on a variety of dates when the resident was not exhibiting or expressing pain or fever.

During an interview, Registered Practical Nurse (RPN) #112 stated that they were familiar with resident #009 and that the resident was able to express pain. When asked if they would administer PRN pain medications if pain was not presented or exhibited by the resident, the RPN stated no, they would not provide PRN pain medications to a resident if they were not exhibiting pain. When asked if a resident had a PRN pain medication order stating to be administered if pain or fever, what would that mean, the RPN stated that the medication would only be administered if the resident had pain or fever, and if no pain or fever, then the medication should not be administered. Inspector #689 and RPN #112 reviewed the residents progress notes as documented above from their clinical record, and the RPN stated that medication administration was not provided to the resident as per the physician's order, because the order stated for pain or fever, but the staff were providing PRN analgesics for other reasons.

The licensee has failed to ensure that drugs were administered to residents #004 and #009 in accordance with the directions for use specified by the prescriber.

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 #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of an investigation related to an allegation of abuse of a resident were reported to the Director.

The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) regarding alleged physical abuse of resident#011, resulting in an injury to the resident. Review of CIS report showed that the home had been requested by the Central Intake Assessment and Triage Team (CIATT), to submit an amendment to the report including the results of the home's internal investigation. The CIS report was reviewed and failed to include the results of the investigation by the home.

During an interview with Nurse Manager #110, they stated that when resident #011 was sent to hospital related to their injuries, that the hospital had alleged that abuse of the resident may have occurred. Nurse Manager #110 stated that there had been no findings of abuse in the home's internal investigation related to this incident.

During an interview with Compliance and Quality Manager #100, they stated that they would expect that the home would have provided the MOHLTC with the results of the home's internal investigation. Compliance and Quality Manager #100 stated that the home had not amended the CIS report to include the outcome of the home's internal investigation related to the alleged abuse of resident #011.

The licensee has failed to ensure that when an allegation of abuse was made for resident #011, that the home reported the results of the investigation to the Director.

WN #9: 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 a missing or unaccounted for controlled substance no later than one business day after the occurrence of the incident.

The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) on related to missing controlled substances for resident #005 on two specified dates. Review of the CIS reporting website identified that the home had been requested by the Central Intake Assessment and Triage Team (CIATT) to submit separate CIS reports for each incident. During a review of the CIS reporting system, inspector #435 could not find a separate CIS report for the incident of the missing controlled substances on the first date.

Review of resident #005's medication identified an order for the controlled substance.

Review of resident #005's electronic medication administration record (eMAR) for a specified month, showed documentation that resident #005 had received their ordered controlled substance, which was documented as applied at a specified time. The controlled substance was documented for removal on a specified date with a code of "Other/ See Nurse Notes" and documented as applied to resident on the same date.

Review of the progress notes in Momentum Care Management for resident #005 stated that resident #005's controlled substance was identified missing and that the nurse manager (NM) was informed.

During an interview with NM #106, when asked how many medication incidents were reported in the CIS report, NM #106 confirmed there were two medication incidents reported within the report. When asked if NM #106 would expect that there would have been separate CIS reports completed for each incident, NM #106 stated yes.

The licensee has failed to ensure that the Director was informed within one business day when resident #005's missing controlled substance was identified as missing on a specified date.

Issued on this 1st day of August, 2019

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

Ministère de la Santé et des Soins de longue durée

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

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) :	CHRISTINA LEGOUFFE (730), AMBERLY COWPERTHWAITE (435), CASSANDRA ALEKSIC (689), CHERYL MCFADDEN (745)
Inspection No. / No de l'inspection :	2019_790730_0019
Log No. / No de registre :	002270-18, 002273-18, 004860-18, 005008-18, 006459-18, 006865-18, 008494-18, 010718-18, 014731-18, 016559-18, 016963-18, 017558-18, 019168-18, 021010-18, 022150-18, 025411-18, 025508-18, 026611-18, 027009-18, 027590-18, 028826-18, 032427-18, 032685-18, 006646-19, 010036-19, 012720-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Aug 1, 2019
Licensee / Titulaire de permis :	Shepherd Village Inc. 3758/3760 Sheppard Avenue East, TORONTO, ON, M1T-3K9
LTC Home / Foyer de SLD :	Shepherd Lodge 3760 Sheppard Avenue East, TORONTO, ON, M1T-3K9

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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 Administrator / Nom de l'administratrice ou de l'administrateur : Cathy Fiore

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To Shepherd Village 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 :

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 must be compliant with O. Reg. 79/10, s. 50 (2).

Specifically the licensee must:

a) Ensure that for residents #007, #008, and #009 and all residents at risk of altered skin integrity receive a skin assessment by a member of the registered nursing staff upon any return of the resident from hospital.

Grounds / Motifs :

1. The licensee has failed to ensure that residents at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff upon any return of the resident from hospital.

A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC), which documented an incident that caused an injury to resident #007, for which the resident was taken to hospital and resulted in a significant change in the resident's health status.

The CIS report documented that resident #007 rang their call bell to ask for pain medication to relieve a headache and the resident was received in bed with an injury. The report stated that the resident agreed to be sent to hospital for further assessment. The report documented that the resident returned from hospital with an injury and a significant change in condition.

The Care Plan Focus report for resident #007 was reviewed from Momentum Care Management and showed a focus of "skin integrity" and description stating no deficits, at risk for skin breakdown due to staying in bed all day post hospitalization.

During an interview, Nurse Manager (NM) #106 stated that when a resident returned from hospital, the assessments completed would be the same as the readmission process. NM #106 stated that the process in the home was that the resident was looked at and documented on every shift, and a full head to toe assessment and a skin and wound assessment was completed to ensure that the resident was not returning to the home with skin breakdown. The NM stated that these assessments were documented in the progress notes. When asked what information was provided by the assessments, the NM stated that the staff

would document how the resident was doing, their status, physiotherapy involvement in terms of transfer status, bed mobility and limitations. The Registered Dietitian followed up, as well.

NM #106 stated that they were familiar with resident #007. The NM reviewed resident #007's clinical record and stated that they did not see that a skin and wound assessment, though a head to toe assessment, was documented when the resident returned to the home from hospital. The NM stated that the staff did not document properly if the resident had an assessment done and stated the only thing they saw documented was that there were bruises, but no mention of a head to toe assessment completed.

The clinical records of resident #007 were reviewed and there was no documentation of a head to toe or skin and wound assessment completed on a specified date. [s. 50. (2) (a) (ii)]

2. A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC), which documented an incident that caused an injury to resident #008 for which the resident was taken to hospital and resulted in a significant change in the resident's health status.

The CIS report documented that a Registered Practical Nurse (RPN) contacted the attending doctor after assessing resident #008 due to observed pain/grimacing. The report stated that the doctor requested to send the resident to hospital for an x-ray, which showed an injury.

Progress notes were reviewed in Point Click Care (PCC) and showed a note, which stated that the resident had an injury and pain was noted upon movement, through grimacing. The note stated that an order was received to send the resident to hospital. A progress note stated that the resident returned from hospital.

During an interview, RPN #104 stated that a head to toe assessment, which included a skin assessment should be completed for a resident upon return from hospital. The RPN stated assessments were documented in the progress notes under "health condition/wellness". The RPN stated that they were familiar with resident #008, who was sent to hospital and returned with fracture. The RPN

stated that there was supposed to be a head to toe and skin assessment, but that they did not see a head to toe assessment in the residents' progress notes, or a skin assessment completed under "health condition/wellness".

The Care Plan for resident #008 was reviewed in PCC and showed the focus "potential for impaired skin integrity related to incontinence", and interventions to "document/report if skin is intact, red, or open area(s)".

During an interview, NM #106 stated that they were familiar with resident #008. The NM reviewed resident #008's clinical record and stated that the resident had returned to the home from hospital on a specified date. They stated that an assessment was done to the injured area and staff documented that they looked at the circulation and sensory to the injured area. When asked if the resident was at risk for altered skin integrity, the NM stated that if they were in bed, then yes because it would have been difficult to move the resident around and they would have needed repositioning. The NM stated that a head to toe assessment should have been documented under Assessments in PCC and was not completed. The NM stated that they would expect that the head to toe assessment should have been completed when the resident had returned from hospital.

The clinical records of resident #008 were reviewed and there was no documentation of a head to toe or skin and wound assessment completed on the day the resident returned from hospital. [s. 50. (2) (a) (ii)]

3. A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC), which documented an incident that caused an injury to resident #007 for which the resident was taken to hospital and resulted in a significant change in the resident's health status.

The CIS report documented that a Personal Support Worker (PSW) reported to the Registered Practical Nurse (RPN) that the resident had a specified injury. The report stated that the medical doctor assessed the resident and ordered that the resident be transferred to hospital. The report documented that the resident returned from hospital with a diagnosis of a fracture.

The Care Plan Focus Report for resident #009 was reviewed from Momentum

Care Management and documented "Focus: Skin Integrity" with "outcome: skin integrity will be maintained".

During an interview, NM #106 stated that they were familiar with resident #009. The NM reviewed resident #009's clinical record and stated that the Personal Support Worker (PSW) was providing a bath to the resident but noticed an injury and informed the unit float nurse. The NM stated that morning, the doctor saw the resident and transferred them to hospital. The NM stated that the resident returned to the home on the same day. When asked if the resident had any assessments completed upon their return from hospital, the NM stated that there was no documentation in the progress notes that a Head to Toe Assessment was completed upon their return from hospital. The NM stated that they would expect that the head to toe assessment should have been completed when the resident had returned from hospital.

The clinical records of resident #009 were reviewed and there was no documentation of a head to toe or skin and wound assessment completed the day the resident returned from hospital.

The home's policy titled Re-Admission from Hospital, NURS V-93, with effective date January 2019 was reviewed and stated the following:
"The Unit Nurse must complete a head to toe assessment on readmission. Registered staff to take note of any altered skin condition such as bruising, pressure ulcers/open areas. If a skin alteration was found the Unit Nurse will complete a Dietary Referral and a stage specific wound assessment in the electronic skin and wound management system."

The home's policy titled Skin and Wound, NURS V-94, with effective date April 2019 was reviewed and stated the following:
"Registered staff will perform Head to Toe Assessment for all resident within 24 hours of admission, after return from hospital, or return from an absence of greater than 24 hours and quarterly."

The licensee has failed to ensure that residents #007, #008 and #009, who were at risk of altered skin integrity, received a skin assessment by a member of the registered nursing staff upon return of the resident from hospital. [s. 50. (2) (a) (ii)]

The severity of this issue was determined to be a level 1 as there was no harm to the residents. The scope of the issue was a level 3 as it was related to 3 out of 3 residents reviewed. The home had a level 3 history as they had previous noncompliance to the same subsection of the LTCHA that included:
- Written Notification (WN) and Voluntary Plan of Correction (VPC) issued June 29, 2018 (2018_630589_0003).
(689)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 23, 2019

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions;
(b) any changes and improvements identified in the review are implemented; and

(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 135 (3).

Specifically the licensee must:

a) Ensure that a quarterly review is undertaken of all medication incidents and adverse drug reactions that occurred in the home since the time of the last review.

Grounds / Motifs :

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

The home submitted three Critical Incident System (CIS) reports to the Ministry of Health and Long-Term Care (MOHLTC), over a three month span, identifying four separate incidents of missing fentanyl patches for resident #005.

Review of resident #005's progress notes, in Momentum Care Management stated that resident #005's fentanyl patch was identified missing from resident #005's body. Another progress note documented that staff were unable to locate

resident #005's fentanyl patch. A progress note stated that resident #005's fentanyl patch was missing and staff were unable to locate the patch after searching. A progress note stated that resident #005 had refused to let staff check the fentanyl patch placement at shift change and upon re-checking the fentanyl patch was not in place and was determined to be missing.

During an interview with Registered Practical Nurse (RPN) #109 when asked how missing or unaccounted for fentanyl patches were identified, RPN #109 stated that they would complete an incident report. When asked when a medication incident report would be completed, RPN #109 stated right away when they suspected an incident had occurred. During an interview with RPN #114, when asked where medication incident reports were kept, RPN #114 stated that they were kept by the nurse manager.

Inspector #435 reviewed the "Medication Incident/Near Miss Reports" for resident #005's missing fentanyl patches on three dates. No "Medication Incident/Near Miss Report" for resident #005's missing fentanyl patch on one specified date, was provided to the inspector.

Inspector #435 reviewed a document titled "Medication Incident/Near Miss Summary Report" dated September to December 2018, with a review date of February 20, 2019, which was signed by the Director of Care, the Medical Director and prepared by the Clinical Pharmacist. During the review, it was documented that there were incidents on two dates, of missing fentanyl patches on a resident. There was no documentation on the report identifying missing fentanyl patches for resident #005 on two other dates.

During an interview with Nurse Manager (NM) #110, the medication management lead in the home, they said that they would expect that a medication incident report would be completed for a missing fentanyl patch. NM #110 stated that they would complete the quarterly medication incident review with the pharmacy representative. NM#110 stated that in each quarterly medication incident review they would document and record the type of medication incidents for each month and then for the quarter. They stated that after that, they would discuss the incidents that had occurred in the last quarter with front line staff. NM#110 stated that the quarterly medication incident review was documented in the meeting minutes. NM #110 stated that they did not

document interventions to prevent future incidents.

Inspector presented NM #110 with the document titled "Medication Incident/Near Miss Summary Report" dated September to December 2018. When asked if this document was the homes quarterly medication incident review, NM #110 stated yes. When asked if they would expect that all medication incidents from September 2018 to December 2018 be identified in the document, NM #110 stated yes. When asked if NM #110 could show inspector where resident #005's fentanyl patches that were missing on two specified dates were identified on the review, NM #110 stated they did not see them identified. When asked if they would expect these incidents to be identified on the Medication Incident/Near Miss Summary Report, NM #110 stated yes.

The licensee has failed to ensure that a quarterly review of medication incidents included resident #005's missing fentanyl patches on two specified dates. [s. 135. (3)]

The severity of this issue was determined to be a level 2 as there was minimal risk of harm to residents. The scope of the issue was a level 2 as it was related to 2 out of 4 medication incidents reviewed. The home had a level 2 history as they had previous noncompliance to different subsections of the LTCHA.

(435)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 11, 2019

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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 : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 136. (2) The drug destruction and disposal policy must also provide for the following:
1. That drugs that are to be destroyed and disposed of shall be stored safely and securely within the home, separate from drugs that are available for administration to a resident, until the destruction and disposal occurs.
2. That any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs.
3. That drugs are destroyed and disposed of in a safe and environmentally appropriate manner in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
4. That drugs that are to be destroyed are destroyed in accordance with subsection (3). O. Reg. 79/10, s. 136 (2).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 136 (2).

Specifically the licensee must:

a) Ensure that the home's drug destruction and disposal policy provides for the following: That any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs, and that the policy is complied with.

b) Educate all registered staff on the updated drug destruction and disposal policy and ensure a record is kept of the education and staff attendance.

Grounds / Motifs :

1. The licensee has failed to ensure that the drug destruction and disposal policy in the home provided that any controlled substance that was to be destroyed

and disposed of was stored in a double-locked storage area within the home, separate from any controlled substance that was available for administration to a resident, until the destruction and disposal occurred.

The home submitted three Critical Incident System (CIS) reports to the Ministry of Health and Long-Term Care (MOHLTC) over a three month span related to missing fentanyl patches for resident #005.

During an interview with Registered Practical Nurse (RPN) #109, when asked where removed fentanyl patches were stored, RPN #109 stated, in part, that removed patches were applied to a piece of paper which held four to six removed patches. When asked where these pieces of paper with the removed patches were stored, RPN #109 stated that they were stored in the narcotic bin. When asked where fentanyl patches to be administered were stored, RPN #109 stated that they were stored in the narcotic drawer inside the medication cart and in a zip lock bag. When asked if this drawer was the same drawer that the removed patches were stored in, RPN #109 stated yes.

Inspector #435 requested that RPN #109 show inspector where the removed fentanyl patches were kept once they were removed. Inspector #435 observed RPN #109 unlock the medication cart and unlock a drawer within the medication cart and showed inspector a sheet of paper with removed fentanyl patch attached. Inspector #435 also observed a blue piece of tape across the patch, which was folded and located in a clear zip locked bag, which also contained a box of unused patches.

During another observation, on another floor of the home, inspector #435 requested that RPN #109 show them resident #012's removed fentanyl patches. Inspector #435 observed RPN #109 unlock the medication cart and unlock a drawer within the medication cart. Inspector observed RPN #109 remove a zip lock bag of resident #012's removed fentanyl patches, which were observed to be on two separate pages in two separate zip lock bags within the narcotic box, and one of the zip lock bags contained a box of unused fentanyl patches. RPN #109 stated that once the sheet was full of patches, they were directed to take it to the fourth floor where medications for destruction were kept.

Inspector reviewed the home's policy titled "Narcotic Control/Storage and

Destruction" policy number "NURS VII-145" with an effective date of March 2019, identified to be currently in place. The policy did not state to store controlled substances that were to be destroyed and disposed of separately from controlled substances that were available for administration to a resident until the destruction and disposal occurred.

During an interview with Nurse Manager (NM) #106 they stated that fentanyl patches to be administered were kept in the narcotic box in the medication cart. NM #106 stated, in part, that nursing staff have two plastic bags, one for the removed patches and one with a sign out sheet and box with new patches, so that the removed and the new patches were not stored together. When inspector asked NM #106 to review the "Narcotic Control/Storage and Destruction" policy number "NURS VII-145" and where it stated that drugs for administration were to be stored separately from drugs to be destroyed and disposed of, NM#106 stated that they did not see it in the policy.

During an interview with NM #110, when asked where fentanyl patches that were removed from residents were stored prior to destruction, NM #110 stated in part that they were stored in the medication cart's narcotic bin on a piece of paper that had five spaces. NM #110 stated that this sheet was kept with the stock of medication and when the sheet was full, it was then taken down to the double locked storage box prior to destruction.

The licensee has failed to ensure that the drug destruction and disposal policy in the home had identified that any controlled substance that was to be destroyed and disposed of was stored in a double-locked storage area within the home, separate from any controlled substance that was available for administration to a resident, until the destruction and disposal occurred. (435) [s. 136. (2) 2.]

The severity of this issue was determined to be a level 2 as there was minimal risk of harm to residents. The scope of the issue was a level 3 as this policy applies to the whole home. The home had a level 2 history as they had previous noncompliance to different subsections of the LTCHA.
(730)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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 : Oct 28, 2019

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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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 1st day of August, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Christina Legouffe

Service Area Office /
Bureau régional de services : Central East Service Area Office