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

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

Central East Service Area Office
419 King Street West Suite #303
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Telephone: (905) 433-3013
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Bureau régional de services du Centre-Est
419 rue King Ouest bureau 303
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Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Feb 07, 2019	2018_749722_0012 (A1)	019030-18	Follow up

Licensee/Titulaire de permis

Trilogy LTC Inc.
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

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

Chartwell Trilogy Long Term Care Residence
340 McCowan Road SCARBOROUGH ON M1J 3P4

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

Amended by COREY GREEN (722) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The compliance due date was revised in the text description of compliance order #001 within inspection #2018_749722_0014 from March 29, 2019, to May 30, 2019. May 30, 2019 is the accurate compliance due date for this order that was determined in consultation with the licensee.

Issued on this 7 th day of February, 2019 (A1)

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

Original report signed by the inspector.

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

Long-Term Care Homes Division
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Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

Amended by COREY GREEN (722) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): December 10, 11, 12, 13 and 14, 2018

During this inspection, Follow-up intake log #019030-18, was inspected to determine compliance with compliance order #001, issued on July 23, 2018, within inspection report #2018_486653_0012 under LTCHA, 2007. c. 8. s. 6 (7) plan of care.

PLEASE NOTE: A Written Notification and Compliance Order related to LTCHA, 2007, c.8, s. 6(7), identified in a concurrent inspection #2018_749722_0014 (Log #026358-17, Log #026358-17, and Log #010789-17), was issued in this report.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Wound Care Coordinator, and Registered Practical Nurses (RPNs).

The inspector observed resident care; and reviewed the compliance order, the licensee's compliance plan, administrative records, and resident clinical records.

The following Inspection Protocols were used during this inspection:
Medication
Skin and Wound Care

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

2 WN(s)
1 VPC(s)
1 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On July 23, 2018, compliance order (CO) #001 was issued to the licensee during inspection #2018_749722_0012, under LTCHA, 2007, c.8 s. 6 (7) with a compliance date of September 06, 2018. The licensee was ordered to do the following:

The licensee must be compliant with s. 6 (7) of the Long-Term Care Homes Act (LTCHA).

Upon receipt of this order the licensee shall: prepare, submit, and implement a plan to ensure the following:
1. Resident #009 and #032's health records, including but not limited to the electronic Treatment Administration Record (eTAR) and written plan of care, consistently reflect the prescribed treatments for areas of altered skin integrity.
2. Prescribed treatments for resident #009 and #032's areas of altered skin integrity are provided to them as specified in their plan of care.
3. The above mentioned documentation shall be available to the inspector upon request.

The plan is to be submitted by e-mail to CentralEastSAO.MOH@ontario.ca referencing report #2018_486653_0012 to Romela Villaspir, LTC Homes Inspector, MOHLTC, by August 6, 2018, and implemented by September 6, 2018.

The licensee completed a plan and submitted the plan to Inspector #653 by August 6, 2018, and completed item 3. The licensee failed to complete items 1 and 2, when the eTAR did not reflect prescribed treatments for altered skin integrity for resident #009 and #032, and the prescribed treatments were not provided as specified in their plan of care.

NOTE: Resident #001 in this report corresponds to resident #009, and resident #002 in this report corresponds to resident #032, as referenced in CO #001 within inspection #2018_486653_0012.

Related to resident #001

Inspector #722 reviewed resident #001's current written care plan on a specified

date, which indicated the following intervention for resident #001's specified area of altered skin integrity: Complete skin treatments to area of altered skin integrity as per MD's order in TAR (treatment administration record). This intervention was added to resident #001's written care plan on a specified date.

On a specified date, Inspector #722 reviewed the physician's orders for resident #001's area of altered skin integrity, including the most recent three-month medication review (TMMR). The TMMR for resident #001 for a specified period, was signed and approved by the licensee's physician on a specified date, and indicated "Discontinue All Previous Orders". A box was checked on the TMMR that indicated 'Continue' beside a specified treatment order for resident #001's specified area of altered skin integrity.

On a specified date, Inspector #722 reviewed the electronic treatment administration record (eTAR) for resident #001, which specified a treatment regime for the resident's area of altered skin integrity that was different than the treatment regime specified above in the TMMR. Registered staff initials and check marks on the eTAR indicated that this treatment was initiated on a specified date prior to the order specified above in the TMMR, and was ongoing at the time of this inspection.

On a specified date and time, Inspector #722 interviewed RPN #103, the home's wound care coordinator, who confirmed that resident #001 did not receive the treatment that was ordered and approved by the licensee's physician on the TMMR on the specified date. The RPN indicated that the resident continued to receive the previous treatment that was ordered by the physician on an earlier specified date. RPN #103 indicated that resident #001 received the appropriate treatments based on the ET nurse recommendations, and that the treatments in the TMMR approved by the physician were previously discontinued treatment orders that were continued in error.

Related to resident #002

Inspector #722 reviewed resident #002's current written care plan on a specified date, which indicated the following interventions for specified areas of altered skin integrity: Complete skin treatments to areas of altered skin integrity as per MD's order in TAR. This intervention was initially added to resident #002's written care plan on a specified date.

On a specified date, Inspector #722 reviewed the physician's orders for resident #002's areas of altered skin integrity, including the three-month medication review (TMMR). The TMMR for resident #002 for the specified period, was signed and approved by the licensee's physician on a specified date, and indicated "Discontinue All Previous Orders". A box was checked that indicated 'Continue' beside specified treatment orders for resident #002's areas of altered skin integrity.

On a specified date, Inspector #722 reviewed the eTAR for resident #002, which indicated specified treatments for the specified areas of altered skin integrity that were different than the treatment regimes specified in the TMMR identified above, and continued for a specified period of time after the new treatment order was signed and approved by the licensee's physician on the TMMR.

On a specified date and time, Inspector #722 interviewed RPN #103, the home's wound care coordinator, who confirmed that resident #002 did not receive the treatment for their specified areas of altered skin integrity as approved and ordered by the licensee's physician in the TMMR on a specified date. RPN #103 confirmed that resident #002 continued to receive the treatments ordered by the licensee's physician on an earlier specified date for specified areas of altered skin integrity. RPN #103 indicated that resident #002 received the appropriate treatments based on the ET nurse recommendations, and that the treatments in the TMMR approved by the physician were previously discontinued treatment orders that were continued in error.

The licensee's policy related to the three month medication review (Policy #LTC-CA-WQ-200-06-21), revised December 2017, was reviewed by Inspector #722 on December 12, 2018, and indicated the following:
- Definitions: "Three Month Medication Review" means a comprehensive review of all physician orders; this includes treatments, diet, medications, diagnostic testing, etc.
- Policy: Physician's/Nurse Practitioners are responsible to complete the three month medication reviews in a timely manner and prior to the start of the three month time period. Once the 3MMR [3-Month Medication Review] is completed and signed all previous orders are no longer valid.

Inspector #722 interviewed the Director of Care (DOC) on a specified date and time, who confirmed that resident #001 did not receive treatments for the specified area of altered skin integrity as ordered by the physician on a specified

date; and resident #002 did not receive treatments for their specified areas of altered skin integrity as ordered by the physician on another specified date. The DOC indicated that those orders were previously printed on the TMMR, and that the registered staff reviewing the pre-printed TMMR orders should have identified and reconciled the orders with the appropriate orders and ET recommendations. The DOC indicated that all medications and treatments on the TMMR were considered formal orders on the date signed and approved by the licensee's physician, and that the expectation is that residents #001 and #002 should receive care based on the physician's treatment orders.

The licensee failed to ensure that care set out in the plan of care was provided to the resident as specified in the plan, when residents #001 and #002 did not receive treatments for specified areas of altered skin integrity as ordered by the physician on specified dates. [s. 6. (7)]

2. The following evidence related to resident #004 was found under inspection report #2018_749723_0014.

Related to log #024670-17

A complaint was received by resident #004's substitute decision maker (SDM) through the Ministry of Health and Long-Term Care (MOHLTC) Action Line on a specified date, related to the resident not receiving adequate assistance with meals and hydration.

Inspector #722 reviewed the current written care plan for resident #004, which indicated that the resident required assistance with eating, and the following interventions related to eating were specified in the written care plan:
- Provide total assistance with eating by one person; speak to the resident about meal time or drink time and encourage to eat and drink
- Resident is able to participate in a specified way to consume beverages, but needs to be supervised

On a specified date and time, Inspector #722 observed the breakfast meal service for resident #004. Resident #004 was observed sitting at their assigned table in the dining room, and no staff were at the table with the resident.

At a later specified time, RPN #120 was observed providing resident #004 with some specified assistance with the meal service, and left the resident alone for

specified periods of time with food items from the breakfast menu. During an interview with Inspector #120 on the same specified date, RPN #120 confirmed that they had left the resident alone at the table, with a breakfast menu item, and that the resident was feeding themselves.

Approximately one minute later, RPN #120 returned to the table to assist and encourage resident #004 to consume their meal, and then left the resident alone at the table again. RPN #120 was observed for the next several minutes going from table-to-table assisting other residents during the meal. RPN #120 returned to resident #004's table at a later specified time, and assisted and encouraged the resident to consume their lunch meal.

At a later specified time, RPN #120 was observed feeding resident #004 the contents from a plate containing other meal items from the breakfast menu. Inspector #722 observed that RPN #120 left resident #004's table, leaving the plate of partially eaten food on the table, and left the dining room to administer medications to another resident in the dining room. RPN #120 returned to resident #004's table at a later specified time and continued assisting the resident to eat their breakfast.

RPN #120 was interviewed by Inspector #722 on a specified date, during the breakfast meal service, who indicated that they help all the residents in the dining room. RPN #120 indicated that they were aware that resident #004 is a full assist with eating, and confirmed that this meant that someone needs to sit with the resident for the full meal, help the resident, and feed them everything. RPN #120 confirmed that they did not provide resident #004 with full assistance during the breakfast meal service on this occasion.

On a specified date and time, Inspector #722 interviewed PSW #128, who indicated that resident #004 required total staff assistance at meals, and that they feed the resident their meal as per their diet order and as tolerated. The PSW indicated that the resident will sometimes participate in feeding themselves, and indicated that they must always supervise the resident.

Inspector #722 interviewed the DOC on a specified date, who confirmed that resident #004 required a one-person assist with eating as per the current written care plan, and that the resident must be supervised when participating as specified in feeding themselves. The DOC indicated that when a resident's written care plan indicated that they required one-person assistance at meal times, that

the staff will take the plate to the resident only when they are available to offer assistance to the resident, the staff will sit with the resident during the meal and give them their undivided attention while providing assistance, and that food should not be left on the table with the resident unattended. The DOC also indicated for resident #004, that the expectation was that a staff person must be present with the resident at all times, including when they were participating as specified in feeding themselves. The DOC confirmed that resident #004 did not receive care as per the resident's plan of care with respect to assistance with eating.

The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, when resident #004 was not provided one-person assistance during the breakfast meal service on a specified date. [s. 6. (7)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended: CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts. 2007, c. 8, s. 195 (12); 2017, c. 25, Sched. 5, s. 23.

Findings/Faits saillants :

1. The licensee has failed to comply with the following requirement of the LTCHA, 20017: it is a condition of every licence that the licensee shall comply with every order made under this Act.

The licensee failed to comply with the following compliance order (CO #001) from inspection #2018_749722_0012, issued on July 23, 2018, with a compliance date of September 6, 2018:

The licensee must be compliant with s. 6 (7) of the Long-Term Care Homes Act (LTCHA).

Upon receipt of this order the licensee shall: prepare, submit, and implement a plan to ensure the following:
1. Resident #009 and #032's health records, including but not limited to the electronic Treatment Administration Record (eTAR) and written plan of care, consistently reflect the prescribed treatments for areas of altered skin integrity.
2. Prescribed treatments for resident #009 and #032's areas of altered skin integrity are provided to them as specified in their plan of care.
3. The above mentioned documentation shall be available to the inspector upon request.

The plan is to be submitted by e-mail to CentralEastSAO.MOH@ontario.ca referencing report #2018_486653_0012 to Romela Villaspir, LTC Homes Inspector, MOHLTC, by August 6, 2018, and implemented by September 6, 2018.

The licensee completed a plan and submitted the plan to Inspector #653 by August 6, 2018, and completed item 3. The licensee failed to complete items 1 and 2, when the eTAR did not reflect prescribed treatments for residents #009 and #032 related to altered skin integrity, and prescribed treatments were not

provided as specified in the resident's plan of care.

NOTE: Resident #001 in this report corresponds to resident #009, and resident #002 in this report corresponds to resident #032, as referenced in CO #001 within inspection #2018_486653_0012.

On specified dates, Inspector #722 reviewed the physician orders, three-month medication review (TMMR), and eTAR related to treatments for resident #001's specified area of altered skin integrity, which indicated that resident #001 did not receive treatment as ordered by the physician in the TMMR on a specified date. The DOC and wound care nurse (RPN #103) confirmed this finding in separate interviews on a specified date.

On specified dates, Inspector #722 reviewed the physician orders, TMMR, and eTAR related to treatments for resident #002's specified areas of altered skin integrity, which indicated that resident #002 did not receive treatments as ordered by the physician in the TMMR on a specified date. The DOC and wound care nurse (RPN #103) confirmed this finding in separate interviews on December 12, 2018.

Refer to the Grounds in CO #001 of this report for additional information to support this area of non-compliance related to residents #001 and #002.

The licensee has failed to comply with the following requirement of the LTCHA, 2017: it is a condition of every licence that the licensee shall comply with every order made under this Act, when the licensee failed to comply with compliance order (CO #001) from inspection #2018_749722_0012, issued on July 23, 2018, with a compliance date of September 6, 2018. [s. 101. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with the following requirement of the LTCHA, 20017: it is a condition of every licence that the licensee shall comply with every order made under this Act, to be implemented voluntarily.

Issued on this 7 th day of February, 2019 (A1)

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

Original report signed by the inspector.

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

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

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	Amended by COREY GREEN (722) - (A1)
Inspection No. / No de l’inspection :	2018_749722_0012 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	019030-18 (A1)
Type of Inspection / Genre d’inspection :	Follow up
Report Date(s) / Date(s) du Rapport :	Feb 07, 2019(A1)
Licensee / Titulaire de permis :	Trilogy LTC Inc. 100 Milverton Drive, Suite 700, MISSISSAUGA, ON, L5R-4H1
LTC Home / Foyer de SLD :	Chartwell Trilogy Long Term Care Residence 340 McCowan Road, SCARBOROUGH, ON, M1J-3P4
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Christine Maragh

To Trilogy LTC 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)

Linked to Existing Order / Lien vers ordre existant: 2018_486653_0012, CO #001;

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 :

(A1)
The licensee must be compliant with s. 6 (7) of the Long-Term Care Homes Act (LTCHA).

Upon receipt of this order the licensee shall: prepare, submit, and implement a plan to ensure the following:

1. Prescribed treatments for areas of altered skin integrity, and required level of assistance for eating, are provided to residents as specified in their plan of care.
2. The written plan of care for residents accurately reflects the prescribed treatments for areas of altered skin integrity, and required level of assistance for eating.
3. Audits are completed to ensure compliance with directives 1 and 2 above.
4. Documentation shall be maintained of audits and made available upon inspector request.

The plan is to be submitted by e-mail to CentralEastSAO.MOH@ontario.ca referencing report #2018_749722_0012 to Corey Green, LTC Homes Inspector, MOHLTC, by February 13, 2019, and implemented by May 30, 2019.

Grounds / Motifs :

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

On July 23, 2018, compliance order (CO) #001 was issued to the licensee during inspection #2018_749722_0012, under LTCHA, 2007, c.8 s. 6 (7) with a compliance date of September 06, 2018. The licensee was ordered to do the following:

The licensee must be compliant with s. 6 (7) of the Long-Term Care Homes Act (LTCHA).

Upon receipt of this order the licensee shall: prepare, submit, and implement a plan to ensure the following:
1. Resident #009 and #032's health records, including but not limited to the electronic Treatment Administration Record (eTAR) and written plan of care, consistently reflect the prescribed treatments for areas of altered skin integrity.
2. Prescribed treatments for resident #009 and #032's areas of altered skin integrity are provided to them as specified in their plan of care.
3. The above mentioned documentation shall be available to the inspector upon request.

The plan is to be submitted by e-mail to CentralEastSAO.MOH@ontario.ca referencing report #2018_486653_0012 to Romela Villaspir, LTC Homes Inspector, MOHLTC, by August 6, 2018, and implemented by September 6, 2018.

The licensee completed a plan and submitted the plan to Inspector #653 by August 6, 2018, and completed item 3. The licensee failed to complete items 1 and 2, when the eTAR did not reflect prescribed treatments for altered skin integrity for resident #009 and #032, and the prescribed treatments were not provided as specified in their plan of care.

NOTE: Resident #001 in this report corresponds to resident #009, and resident #002 in this report corresponds to resident #032, as referenced in CO #001 within inspection #2018_486653_0012.

Related to resident #001

Inspector #722 reviewed resident #001's current written care plan on a specified

date, which indicated the following intervention for resident #001's specified area of altered skin integrity: Complete skin treatments to area of altered skin integrity as per MD's order in TAR (treatment administration record). This intervention was added to resident #001's written care plan on a specified date.

On a specified date, Inspector #722 reviewed the physician's orders for resident #001's area of altered skin integrity, including the most recent three-month medication review (TMMR). The TMMR for resident #001 for a specified period, was signed and approved by the licensee's physician on a specified date, and indicated "Discontinue All Previous Orders". A box was checked on the TMMR that indicated 'Continue' beside a specified treatment order for resident #001's specified area of altered skin integrity.

On a specified date, Inspector #722 reviewed the electronic treatment administration record (eTAR) for resident #001, which specified a treatment regime for the resident's area of altered skin integrity that was different than the treatment regime specified above in the TMMR. Registered staff initials and check marks on the eTAR indicated that this treatment was initiated on a specified date prior to the order specified above in the TMMR, and was ongoing at the time of this inspection.

On a specified date and time, Inspector #722 interviewed RPN #103, the home's wound care coordinator, who confirmed that resident #001 did not receive the treatment that was ordered and approved by the licensee's physician on the TMMR on the specified date. The RPN indicated that the resident continued to receive the previous treatment that was ordered by the physician on an earlier specified date. RPN #103 indicated that resident #001 received the appropriate treatments based on the ET nurse recommendations, and that the treatments in the TMMR approved by the physician were previously discontinued treatment orders that were continued in error.

Related to resident #002

Inspector #722 reviewed resident #002's current written care plan on a specified date, which indicated the following interventions for specified areas of altered skin integrity: Complete skin treatments to areas of altered skin integrity as per MD's order in TAR. This intervention was initially added to resident #002's written care plan on a specified date.

On a specified date, Inspector #722 reviewed the physician's orders for resident #002's areas of altered skin integrity, including the three-month medication review (TMMR). The TMMR for resident #002 for the specified period, was signed and approved by the licensee's physician on a specified date, and indicated "Discontinue All Previous Orders". A box was checked that indicated ‘Continue’ beside specified treatment orders for resident #002’s areas of altered skin integrity.

On a specified date, Inspector #722 reviewed the eTAR for resident #002, which indicated specified treatments for the specified areas of altered skin integrity that were different than the treatment regimes specified in the TMMR identified above, and continued for a specified period of time after the new treatment order was signed and approved by the licensee's physician on the TMMR.

On a specified date and time, Inspector #722 interviewed RPN #103, the home's wound care coordinator, who confirmed that resident #002 did not receive the treatment for their specified areas of altered skin integrity as approved and ordered by the licensee’s physician in the TMMR on a specified date. RPN #103 confirmed that resident #002 continued to receive the treatments ordered by the licensee’s physician on an earlier specified date for specified areas of altered skin integrity. RPN #103 indicated that resident #002 received the appropriate treatments based on the ET nurse recommendations, and that the treatments in the TMMR approved by the physician were previously discontinued treatment orders that were continued in error.

The licensee's policy related to the three month medication review (Policy #LTC-CA-WQ-200-06-21), revised December 2017, was reviewed by Inspector #722 on December 12, 2018, and indicated the following:
- Definitions: "Three Month Medication Review" means a comprehensive review of all physician orders; this includes treatments, diet, medications, diagnostic testing, etc.
- Policy: Physician's/Nurse Practitioners are responsible to complete the three month medication reviews in a timely manner and prior to the start of the three month time period. Once the 3MMR [3-Month Medication Review] is completed and signed all previous orders are no longer valid.

Inspector #722 interviewed the Director of Care (DOC) on a specified date and time, who confirmed that resident #001 did not receive treatments for the specified area of

altered skin integrity as ordered by the physician on a specified date; and resident #002 did not receive treatments for their specified areas of altered skin integrity as ordered by the physician on another specified date. The DOC indicated that those orders were previously printed on the TMMR, and that the registered staff reviewing the pre-printed TMMR orders should have identified and reconciled the orders with the appropriate orders and ET recommendations. The DOC indicated that all medications and treatments on the TMMR were considered formal orders on the date signed and approved by the licensee's physician, and that the expectation is that residents #001 and #002 should receive care based on the physician's treatment orders.

The licensee failed to ensure that care set out in the plan of care was provided to the resident as specified in the plan, when residents #001 and #002 did not receive treatments for specified areas of altered skin integrity as ordered by the physician on specified dates. [s. 6. (7)] (722)

2. The following evidence related to resident #004 was found under inspection report #2018_749723_0014.

Related to log #024670-17

A complaint was received by resident #004's substitute decision maker (SDM) through the Ministry of Health and Long-Term Care (MOHLTC) Action Line on a specified date, related to the resident not receiving adequate assistance with meals and hydration.

Inspector #722 reviewed the current written care plan for resident #004, which indicated that the resident required assistance with eating, and the following interventions related to eating were specified in the written care plan:
- Provide total assistance with eating by one person; speak to the resident about meal time or drink time and encourage to eat and drink
- Resident is able to participate in a specified way to consume beverages, but needs to be supervised

On a specified date and time, Inspector #722 observed the breakfast meal service for resident #004. Resident #004 was observed sitting at their assigned table in the dining room, and no staff were at the table with the resident.

At a later specified time, RPN #120 was observed providing resident #004 with some specified assistance with the meal service, and left the resident alone for specified periods of time with food items from the breakfast menu. During an interview with Inspector #120 on the same specified date, RPN #120 confirmed that they had left the resident alone at the table, with a breakfast menu item, and that the resident was feeding themselves.

Approximately one minute later, RPN #120 returned to the table to assist and encourage resident #004 to consume their meal, and then left the resident alone at the table again. RPN #120 was observed for the next several minutes going from table-to-table assisting other residents during the meal. RPN #120 returned to resident #004's table at a later specified time, and assisted and encouraged the resident to consume their lunch meal.

At a later specified time, RPN #120 was observed feeding resident #004 the contents from a plate containing other meal items from the breakfast menu. Inspector #722 observed that RPN #120 left resident #004's table, leaving the plate of partially eaten food on the table, and left the dining room to administer medications to another resident in the dining room. RPN #120 returned to resident #004's table at a later specified time and continued assisting the resident to eat their breakfast.

RPN #120 was interviewed by Inspector #722 on a specified date, during the breakfast meal service, who indicated that they help all the residents in the dining room. RPN #120 indicated that they were aware that resident #004 is a full assist with eating, and confirmed that this meant that someone needs to sit with the resident for the full meal, help the resident, and feed them everything. RPN #120 confirmed that they did not provide resident #004 with full assistance during the breakfast meal service on this occasion.

On a specified date and time, Inspector #722 interviewed PSW #128, who indicated that resident #004 required total staff assistance at meals, and that they feed the resident their meal as per their diet order and as tolerated. The PSW indicated that the resident will sometimes participate in feeding themselves, and indicated that they must always supervise the resident.

Inspector #722 interviewed the DOC on a specified date, who confirmed that resident #004 required a one-person assist with eating as per the current written care plan,

and that the resident must be supervised when participating as specified in feeding themselves. The DOC indicated that when a resident's written care plan indicated that they required one-person assistance at meal times, that the staff will take the plate to the resident only when they are available to offer assistance to the resident, the staff will sit with the resident during the meal and give them their undivided attention while providing assistance, and that food should not be left on the table with the resident unattended. The DOC also indicated for resident #004, that the expectation was that a staff person must be present with the resident at all times, including when they were participating as specified in feeding themselves. The DOC confirmed that resident #004 did not receive care as per the resident's plan of care with respect to assistance with eating.

The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, when resident #004 was not provided one-person assistance during the breakfast meal service on a specified date. [s. 6. (7)]

The severity of this issue was determined to be a level 2 as there was potential for actual harm to the residents. The scope of the issue was a level 3 (widespread) as it related to three of three residents observed. The home had a level 4 history of on-going non-compliance with this section of the Act that included:
- Voluntary plan of correction (VPC) issued March 15, 2016 (2016_382596_0003)
- VPC issued November 3, 2016 (2016_235507_0014)
- VPC issued November 3, 2016 (2016_235507_0015)
- VPC issued November 21, 2017 (2017_493652_0013)
- Written notification issued July 23, 2018 (2018_486653_0012)
- Compliance Order (CO) issued July 23, 2018 (2018_486653_0012), with a compliance due date of September 6, 2018 (722) (722)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : May 30, 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 7 th day of February, 2019 (A1)

Signature of Inspector / Signature de l’inspecteur :

Name of Inspector / Nom de l’inspecteur : Amended by COREY GREEN (722) - (A1)

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