Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 9, 2018	2017_520622_0039	024646-17	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
5015 Spectrum Way Suite 600 MISSISSAUGA ON 000 000

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

HEARTWOOD
201-11TH STREET EAST CORNWALL ON K6H 2Y6

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

HEATH HEFFERNAN (622), AMANDA NIXON (148), MELANIE SARRAZIN (592)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): November 27 - 30, 2017 and December 1, 5, 6, 7, 8, 2017.

The following critical incident logs were also inspected:

log #017302-17 related to an incident with injury to the resident/hospital transfer/significant change in status.
log #000294-17 related to alleged staff to resident abuse.
log #006035-17 related to alleged resident to resident sexual abuse.
log #022255-17 and log #021848-17 related to alleged improper/incompetent treatment of a resident.

During the course of the inspection, the inspector(s) spoke with the Administrator, The Director of Care (DOC), the Activity Manager, the Resident Services Resource Coordinator, the Environmental Services Manager (ESM), the Human Resources/Scheduling Manager, the MDS Coordinator, the Pharmacist, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), a food services worker (FSW), a housekeeper, residents, and families.

Also during the course of the inspection the inspectors conducted a tour of the home, reviewed health records, medication incidents, the home's critical incident investigation documentation, resident council minutes, home policies and procedures related to medication incidents, head injury routine, prevention of abuse, PSW job routines and observed resident care and services.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

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

- **8 WN(s)**
- **4 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care is based on an assessment of the resident and the needs and preference of that resident.

Resident #014 required assistance with activities of daily living including transfers and bed mobility.

On three separate occasions between two specified dates, Inspector #148 observed the bed system of resident #014. On each occasion, there was a quarter rail in the up position nearest the wall and a second quarter assist rail on the opposite side of the bed in the down position. Resident #014 indicated that the bed rails are used to help him/her change position in bed and that both rails are in the up position when he/she is in bed. The most recent MDS assessment indicates the use of other side rails. During an interview with PSW #110, it was reported that the resident has two bed rails in use when the resident is in bed; a quarter rail nearest the wall and a quarter rail in the assist (vertical) position on the opposite side of the bed. In an interview with PSW #123 she indicated that the right side rail is up in the assist position when the resident is received in bed at the start of the day shift.

The plan of care for bed mobility describes an intervention created on a specified date, whereby the resident needs do not include bed rails. The plan of care was not based on

the most recent assessment of the resident and the current needs and preferences of the resident, as the plan of care does not indicate the use of bed rails. [s. 6. (2)]

2. The licensee has failed to ensure that the care set out in the plan of care is provided to resident #013 as specified in the plan.

Resident #013 was identified having altered skin integrity.

A review of the resident's health care record was done by Inspector #592 which indicated that resident #013 was admitted on a specified date with several diagnosis. The resident health care records further indicated that resident #013 was identified with altered skin integrity on a specified date and was provided with daily monitoring and treatment.

As per the current Treatment Administration Records Sheet (TARS), resident #013 is to have a daily monitoring and to provide treatment twice weekly and to complete a weekly wound assessment.

A further review of the resident #013 health care records indicated that a skin assessment was completed on a specified date which described the specified area of altered skin integrity.

On a specified date, RPN #112, indicated to Inspector #592 that resident #013 was currently exhibiting altered skin integrity to two specified areas. She further indicated that the one specified area was healing well but that the second specified area has re-opened slowly. She further indicated that she was the resource person for the skin care program and that she was responsible to instruct registered staff members of which treatment to be provided to the resident's as per the home's skin care protocol. She further indicated that she would document the instructions for the registered staff members on the TARS for the specific care to be provided to the resident including the frequency and the type of treatment. She further indicated that the registered staff will document on the TARS sheet when the treatment had been provided to the resident. RPN #112 further indicated that the treatment to the altered skin integrity was to be provided twice a week on specified days and as needed as per the home's skin program. She further indicated that the registered staff had to monitor the area on a daily basis and that they were responsible to document that the treatment was provided and that the daily monitoring was done on the TARS.
RPN #112 provided to the Inspector the TARS documentation for a specified one month period.

It was noted that during a specified nine day period during the specified month, there was no documentation found on two specified dates that the treatment had been provided to resident #013 as per the instructions on the TARS. The last documentation of the treatment being provided to the resident was found on the weekly assessment form dated on a specified date.

In a review of the progress notes of resident #013 with the presence of RPN #112, there was documentation indicating that on a specified date, resident #013's treatment was assessed by a registered staff member which documented that the resident’s treatment remained intact, therefore was not changed at that time. There was no other documentation found for the specified date on the day that the treatment was to be provided to the resident.

During the interview with RPN #112, she indicated to the Inspector that she recalled on the specified date not providing the treatment to resident #013, therefore the treatment had been delegated to the evening nurse but was unable to confirm that the treatment had been provided to the resident as there was no documentation. She further indicated that the treatment was required to be completed twice weekly as per the care set out in the plan of care.

As per the review of the resident health records, the treatment was not provided twice a week on two specified dates as per the care set out in resident #013's plan of care. [s. 6. (7)]

3. This finding of non-compliance is related to a critical incident system report (CIS).

The Licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident’s care needs change or care set out in the plan is no longer necessary.

On a specified date, a CIS report was submitted by DOC #130 to the Director of the Ministry of Health and Long Term Care. The critical incident indicated alleged staff to resident abuse which resulted in harm or risk of harm to resident #021 took place during a specified shift and specified date.

A review of the homes investigation notes indicated the written statement provided by RPN #125 dated a specified date, indicated PSW #128 had stated resident #021 had been ringing multiple times and she was not going to answer the call bell anymore.

A review of the care plan in place at the time of the incident dated a specified date included specified interventions, however, further review of the most up to date care plan indicated on a specified date, specified directives were initiated and did not include direction for any activities of daily living for resident #021. The specified directives were still in place at the time of the inspection.

A review of the Kardex dated a specified date gave specified direction.

During an observation inspector #622 observed resident #021 whose condition did not appear to match the care plans focus.

During an interview with inspector #622, RPN #125 indicated resident #021 previously had a marked change in health status and was placed on specified care directives. RPN #125 indicated staff receive direction for care from the care plan which should be updated to focus on the resident's current abilities. RPN #125 further indicated resident #021's health had improved prior to the care plan review date and the care plan should have been updated.

During an interview with inspector #622, MDS Co-ordinator #131 indicated that resident #021 had been placed on a specified care directive however their health had improved and would not be considered that specified level of care at the time of the inspection. MDS co-ordinator #131 reviewed the care plan dated a specified date which indicated resident #021 was still identified as receiving the specified level of care. MDS Co-ordinator #131 further indicated the care plan had not been updated to reflect resident #021's care requirements at the time of the inspection.

During an interview with inspector #622, DOC #130 indicated that resident #021 had been at a specified care level a couple of months earlier however he/she was not currently at that level. DOC #130 reviewed the care plan dated a specified date and indicated the care plan should have been updated as it was not current to the resident's needs at the time of the inspection.

Therefore, the licensee failed to ensure that the plan of care for resident #021 was revised when the resident's care needs changed or the care set out in the plan was no longer necessary. [s. 6. (10) (b)]

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 the care set out in the plan of care specific to altered skin integrity is provided to resident #013 as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to 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.

In accordance with O.Regulation 79/10 section 2(1), physical abuse means, the use of physical force by anyone other than a resident that causes physical injury or pain.

On a specified date, a critical incident report (CIR) was submitted to the Director indicating incompetent care that resulted in harm or risk of harm to resident #014. The CIR made reference to PSW #110 being rough with resident #014. As indicated by the CIR and interview with the home's DOC, PSW #111, reported to the DOC on a specified date, that resident #014 wanted to speak with the DOC to discuss an incident whereby PSW #110 had been rough with him/her.

On a specified date, the DOC initiated an investigation by speaking with PSW #110, who described a transfer whereby the resident bumped the bed and sustained a minor injury. The resident was interviewed by the DOC on a specified date two days later, whereby the resident indicated that PSW #110 had been a little fast with the transfer and that he/she sustained a minor injury. On the same day the DOC proceeded to examine the bed system for any cause of the injury and found there to be none.

The licensee's policy to promote zero tolerance of abuse and neglect of residents, titled Resident Non-Abuse policy # LP-C-20-ON, indicates the following under immediate interventions following allegations of resident abuse:
"The first priority is to ensure the safety and comfort of the abuse victim, first taking all reasonable steps to provide for their immediate safety and well-being, then through completion of full assessments, a determination of the resident's needs and a documented plan to meet those needs."

The licensee failed to take reasonable steps to provide for the immediate safety and well-being of resident #014, in that the lead of the investigation interviewed and assessed the resident's injury two days after the report of PSW #110 being rough and failed to assessed the safety of the bed system that was reported to have been potentially responsible for the minor injury. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance 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, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Resident #013 was identified having altered skin integrity to a specified area.

A review of the resident's health care record was done by Inspector #592 which indicated that resident #013 was admitted on a specified date with several diagnosis. The resident health care records further indicated that resident #013 was identified with altered skin integrity on a specified date and was provided with daily monitoring and treatments since.

As per the current Treatment Administration Records Sheet (TARS), resident #013 is to have a daily monitoring of the specified treatment on two specified days weekly and to complete a weekly wound assessment.

A further review of resident #013's health care records indicated that a wound assessment was completed on a specified date which described the area of altered skin integrity.

On a specified date, RPN #112, indicated to Inspector #592 that resident #013 was currently exhibiting altered skin integrity. She further indicated that the one specified area had re-opened slowly. She further indicated that a weekly skin assessment was performed for each resident exhibiting altered skin integrity including pressure ulcers using the "Ongoing Wound Assessment-Treatment Observation Record" located in the wound binder. The RPN #112 indicated that she was the resource person for the skin care program and that she was responsible to ensure that the weekly skin assessments were performed for the residents exhibiting altered skin integrity.

In a review of the resident's health care record with the presence of RPN #112, Inspector #592 was unable to find any skin assessments performed from a specified nine day period. As per the TARS, a weekly wound assessment was to be performed on a specified date but no documentation was found. RPN # 112 indicated after reviewing the resident health care records that resident # 013 should have had a weekly wound assessment completed as part of the home's wound care program. [s. 50. (2) (b) (i)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds are reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

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

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

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 every medication incident involving a resident and every adverse drug reaction is reported to the resident, the resident's Substitute Decision-Maker (SDM), if any.

Over the course of the inspection, the process for medication incident reporting was reviewed by Inspector #592 with the Director of Care (DOC).

According to the DOC, medication incidents are reported through an electronic reporting system which is called "Medication Incident Report System" (MIRS) completed for each resident by the registered nursing staff member. The DOC further indicated that the registered staff members are responsible to contact the resident's SDM, the physician and send out the form to the pharmacy once the form is completed. Once the follow-up is done by the Pharmacy, an email will be sent to the DOC to review the information and to ensure that corrective actions and preventive measures are put into place if the nursing staff member was involved in the medication incident.

Inspector #592 reviewed the medication incidents for a three month period.

Upon review of the home's medication incident reports, four incidents were completed by registered nursing staff in the home. This report identified that the incident shall be reported to Resident, Family/Power of Attorney (POA) and the Physician and to indicate the date of the reporting.
It was noted that on three out of four incidents, the resident/POA were not made aware of the medication incidents involving residents in the home.

On a specified date in an interview with the DOC, she indicated to the Inspector that she did not have any other documentation to support that the resident/POA were informed as it was the registered staff who were responsible to complete the medication incident report form as per the home's process, therefore was unsure if the resident/POA were made aware. [s. 135. (1)]

2. The licensee has failed to comply with section 135(2) of the Regulation in that the licensee has failed to ensure that all medication incidents are reviewed and analyzed.

According to the DOC, medication incidents are reported through an electronic reporting system which is called "Medication Incident Report System" (MIRS) completed by the registered nursing staff member.
The DOC further indicated that the medication incidents are sent out to the Pharmacy provider by the registered staff member once the form is completed through the electronic reporting system. She further indicated that an e-mail will be forwarded to her attention, once the pharmacy have reviewed the medication incidents and that she will review each of the medication incidents and do some follow-up actions if the medication incidents involved one of the nursing staff members. She further indicated that the pharmacy will also do some follow-up action and corrective measures with their

pharmacy staff members if the medication incident is related to a failure in their pharmacy internal process.

Inspector #592 reviewed the medication incidents for a three month period.
It was noted that the Medication Incident form contained specific questions under severity of incidents and investigation such as corrective action to prevent recurrence and summary of the corrective actions to prevent recurrence.

Three resident's medication incidents were reviewed:

The first incident dated on a specified date indicated that resident #024 had not received his/her evening dose of a specified medication which was prescribed twice a day for 10 days. The medication had been signed for as administered but was still available in the medication package.
Under the severity and investigation section, no analysis and corrective action was found on the medication form.

The second incident dated on a specified date, indicated that three medications for resident #025 had been administered as prescribed during the lunch medication pass. The same three medications were noted to be missing from the supper time medication packages, indicating resident #025 may have received a double dose of the medications during the lunch time pass.
Under severity and investigation section, no analysis and corrective action was found on the medication form.

The third incident dated on a specified date indicated that resident #026 was administered the wrong specified medication.
Under the severity and investigation section, no analysis and corrective action was found on the medication form.

On a specified date in an interview with the DOC she indicated that all the medication incidents described above were involving nursing staff members and that follow-up actions including corrective measures and analysis were done, however, she was unable to provide to the Inspector any documentation for the three medication incidents above, relating to analysis and corrective measures taken at that time.

Therefore, no record of review and analysis and corrective actions of the medication

incidents described above was found. [s. 135. (2)]

3. The licensee has failed to comply with section 135 (3) of the Regulation in that the licensee has failed to ensure that a quarterly review was 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.

According to the DOC, medication incidents are reported through an electronic reporting system which is called "Medication Incident Report System" (MIRS) completed by the registered nursing staff members.
The DOC further indicated that the medication incidents are sent out to the Pharmacy provider by the registered nursing staff member through the electronic reporting system. She further indicated that an email will be forwarded to her attention, once the pharmacy has review the medication incident. The DOC indicated that she will review each of the medication incidents and do follow-up actions if the medication incidents are involving nursing staff members.

During the interview, the DOC provided the Inspector with a Medication Incident Reporting document indicating that since a specified date, 15 medication incidents had occurred. The DOC further indicated that the quarterly review of all the medication incidents was usually done during the Professional Advisory Committee (PAC) which was held quarterly. The DOC provided the PAC minutes dated on two specified dates and it was noted by the Inspector that no documentation was found for the review of the medication incidents. Furthermore when the DOC was asked about the quarterly review of all medication incidents, she indicated that since the new pharmacy took over on a specified date, there was no quarterly review done of the medication incidents. [s. 135. (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 to ensure that that all medication incidents and adverse drug reactions are documented, reviewed and analyzed and corrective action is taken as necessary, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's Medication Administration and Disposal of Medications policies and procedures in place during this inspection were complied with.

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

Over the course of the inspection, medication observation was done by Inspector #592. On a specified date, when Inspector #592 inquired about the storage of the three month supply medications available for the residents, RPN # 100 indicated that the three month supply medications were kept in a cupboard located in the locked medication room. Inspector #592 was shown by RPN #100 the location of the medications. Inspector #592

observed that there were several medication containers with labels indicating that they were expired.

RPN #100 who was present during the observation told the inspector that the expired medications were not to be left in the cupboard as they were expired and medications had to be maintained with a current date in order to ensure their efficacy, therefore the expired medications should not be administered to the residents. She further indicated that the medications should have been discarded and RPN #100 was observed removing the expired medications from the cupboard. RPN #100 further indicated that usually the pharmacy would come and do a verification of the medications and expired dates, however told the Inspector that she had not seen them for a while.

Upon a review of the home's Policy titled "Drug and Inventory Control" last revised on January 16, 2017 indicated under the disposal of discontinued/expired Medications that:

The following medications will be identified, destroyed and disposed of including:
a) Expired medications

On a specified date in an interview with the DOC, she indicated to the Inspector that the RN scheduled on the night shift was the person responsible to ensure that all medications identified with expired dates were destroyed and disposed of. The DOC was not aware that expired medications were kept available for residents in the three month supply cupboard and indicated to the Inspector that they should have been destroyed as per the home policy. [s. 8. (1) (b)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

Resident #014 requires assistance with activities of daily living including transfers and bed mobility. The resident is identified by the plan of care as being at risk for impaired skin integrity.

On a specified date, a critical incident report (CIR) was submitted to the Director indicating incompetent care that resulted in harm or risk of harm to resident #014. The CIR made reference to PSW #110 being rough with resident #014, including a transfer whereby resident #014 potentially suffered a minor injury and that actions included the removal of a quarter bed rail. During the home's investigation, resident #014 indicated he/she had bumped against the metal bed rail.

On three separate occasions, Inspector #148 observed the bed system of resident #014. On each occasion, there was a quarter rail in the up position nearest the wall and a second quarter assist rail on the opposite side of the bed in the down position.

Inspector #148 observed that the assist rail is located near the area where a transfer to bed would occur. When in the current down position, the bed rail is at an angle with one end (nearest the head of bed) to be angled toward the floor and the other end is angled up. This end has two areas were the metal ends of the rail are present, each metal end is a hollow tube. On one of these ends there is a black cap covering the hollow portion of the metal tube. The other end is without this black cap which creates for a rough metal edge, rather than smooth.

Inspector #148 brought this to the attention of the DOC on the morning of a specified date. In the afternoon of the specified date, the Inspector approached the home's Environmental Services Manager, and made the ESM aware of the rail disrepair. One day later during the morning, Inspector #148 observed the rail to have both black caps applied whereby the edges of the rail tubes were smooth.

The licensee failed to ensure that the bed rail for resident #014 was in a state of good repair. [s. 15. (2) (c)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a person who has reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident or abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident has occurred or may occur, shall immediately report the suspicion and the information upon which it is based to the Director.

On a specified date, a critical incident was submitted through the after-hours pager, by the home's Administrator to the Director indicating incompetent care that resulted in harm or risk of harm to resident #014. As indicated by the critical incident report of a specified date and the Inspector's interview with the home's DOC, PSW #111 had reported to the DOC on a specified date that resident #014 wanted to speak with the DOC to discuss an incident whereby PSW #110 had been rough with him/her.

On a specified date, the DOC initiated an investigation by speaking with PSW #110. PSW #110 reported to the DOC that one day earlier, the resident was transferred to bed while the resident held on to his/her wheelchair. During the transfer, the resident may have bumped them self on the bed and sustained a minor injury. During an interview with

Inspector #148, PSW #110 described that the resident was transferred to bed using his/her walker to hold on to, that the resident bumped themselves. PSW #110 describes that the cause of the minor injury may have been an old scratch that reopened. The resident was interviewed by the DOC on a specified date two days later, whereby the resident indicated that PSW #110 had been a little fast with the transfer and he/she had suffered the minor injury to a specified area of the body.

In an interview, the DOC reported to Inspector #148 that she did not interpret the information provided on the specified date by PSW #111 was reasonable grounds for abuse. The DOC reported that she found the complaint of PSW #110 being rough as odd, as there had never been such a complaint about PSW #110 in the past. She indicated she had initiated an investigation as she would do for any concern or complaint. The DOC further indicated that after interviewing PSW #110 she did not conclude that there had been any fault in the transfer or care provided to resident #014 on the specified date.

In an interview, the home's Administrator reported that he had first been made aware of the report by PSW #111 and subsequent interviews with PSW #110 and resident #014 on a specified date two days after the initial report to the DOC. On the same date he reported the critical incident as incompetent care as an injury had occurred during a transfer. In discussion of the initial report related to PSW #110 being rough with the resident, he acknowledged that this information would have been reasonable to suspect abuse. [s. 24. (1)]

2. This finding of non-compliance is related to a critical incident.

The licensee failed to ensure that a person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident has occurred or may occur, shall immediately report the suspicion and the information upon which it is based to the Director

On a specified date, a critical incident was submitted by DOC #130 to the Director of the Ministry of Health and Long Term Care. The critical incident indicated alleged staff to resident abuse which resulted in harm or risk of harm to resident #021 took place during the night shift on a specified date one day earlier.

A review of the progress notes indicated on a specified date, RPN #125 had been

informed by the staff that PSW #128 had indicated resident #021 rang the call bell all night, the resident was not aware of what he/she wanted and had grabbed the front of PSW #128's uniform. PSW #128 had indicated she was not answering resident #021's call bell any longer. On a specified date and time, resident #021 had complained to PSWs #120 and #126 that he/she had been up most of the night, was upset by the way PSW # 127 had treated him/her. Furthermore, on the specified date and time, staff had requested RPN #125 report to resident #021's room as he/she was crying and upset and became more upset when he/she attempted to inform RPN #125 of his/her concerns. Resident #021 was provided reassurance by RPN #125 that necessary steps would be taken to prevent further recurrence. RPN #125 reported the incident to RN #129 who gave direction for RPN #125 to take statements and address the documents to the DOC or the Administrator.

During an interview with inspector #622 on December 1, 2017, RPN #125 indicated on the specified date, staff had reported that resident #021 was upset related to an incident which had occurred during the night. RPN #125 indicated she had a hard time getting a statement from the resident. RPN #125 indicated she asked staff to provide written statements of the incident related to resident #021 and left a note for the Director of Care or the Administrator. RPN #125 indicated she reported the incident to RN #129 as she suspected verbal abuse at the time. RPN #125 indicated since this would have been considered suspected staff to resident abuse, the Ministry of Health and Long Term Care should have been notified immediately.

During an interview, DOC #130 indicated that she became aware of the incident of alleged/suspected staff to resident abuse of resident #021 on a specified date. DOC #130 reviewed the CIS report submitted by the home which indicated the date of submission was one day later. DOC #130 indicated the Director of the Ministry of Health and Long Term Care had not been notified immediately. [s. 24. (1)]

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

Specifically failed to comply with the following:

s. 107. (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):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. This finding of non-compliance is related to a CIS report.

The Licensee has failed to ensure that the Director was informed no later than one business day after an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

A review of the Progress notes indicated on specified date and time, resident #029 had an unwitnessed fall with a suspected injury. The RN, Administrator and the physician were informed. The physician requested that resident #029 be transferred to hospital for assessment on a specified date. One day later, the hospital contacted the nursing home to inform them that the resident had suffered a specified injury with significant change in condition.

A review of the Ministry of Health and Long Term Care Critical Incident System indicated

there were no incident reports submitted by the nursing home on the specified date related to resident #029's fall with hospital transfer and significant change in condition.

During an interview with inspector #622, the Administrator indicated he asked the DOC if she had submitted a critical incident report to the Ministry of Health and Long Term Care related to resident #029's fall with hospital transfer and significant change in condition on the specified date. The Administrator indicated the DOC said for an incident related to a fall in which the resident was transferred to hospital with a significant change in condition, she would normally print a copy of the report if she did one, furthermore, they could not find a copy of a report. The Administrator also indicated the DOC said that she does not recall if she did a critical incident report to the Ministry of Health and Long Term Care or not related to this incident. The Administrator indicated that he looked on the Ministry of Health and Long Term Care website and did not see any critical incident reports for the fall incident related to resident #029 on the specified date when he/she was transferred to hospital with an injury and significant change in status.

During an interview with inspector #622, DOC #130 indicated for an incident such as a fall with a suspected injury, the home would get the order from the physician to transfer the resident to hospital, contact the Substitute Decision Maker and file a CIS report to the Ministry of Health and Long Term Care. The DOC indicated the incident related to resident #029 on the specified date when the resident fell, was injured and was transferred to the hospital should have been reported to the Ministry of Health and Long Term Care. DOC #130 further indicated that she did not know why but assumed one had not been completed.

Therefore the Licensee failed to ensure that the Director was informed no later than one business day after an incident that caused an injury to resident #029 for which the resident was taken to a hospital and resulted in a significant change in the resident's health condition. [s. 107. (3)]

Issued on this 10th day of January, 2018

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

Original report signed by the inspector.