Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 29, 2017	2017_591623_0004	007138-17	Resident Quality Inspection

Licensee/Titulaire de permis

Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

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

Chartwell Wynfield Long Term Care Residence
451 Woodmount Drive OSHAWA ON L1G 8E3

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

SARAH GILLIS (623), JENNIFER BATTEN (672), LYNDA BROWN (111), SUSAN DONNAN (531)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 10, 11, 12, 13, 18, 19, 20, 21, 24, 25, 26, 27, 28, 2017

The following logs were inspected concurrently during this Resident Quality Inspection:
007079-17 and 020241-16 - related to alleged staff to resident verbal abuse

021722-16 and 024944-16 - related to controlled substance missing /unaccounted for
032435-16 and 005546-17 - related to alleged resident to resident sexual abuse
027509-16 - related to an incident that caused injury requiring transfer to hospital and resulted in change in status
022742-16 - related to suspected improper care

During the course of the inspection, the inspector(s) spoke with residents, family members, Substitute Decision Makers (SDM), Representative of the Residents' Council and Family Council, the Administrator, Director of Care (DOC), Associate Director of Care (ADOC), Registered Dietitian (RD), RAI Coordinator (RAI), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Care Providers (PCP), Restorative Care Aide, Behavioural Support Staff (BSO), Environmental Services Manager (ESM), Maintenance Manager and Housekeeping Staff.

In addition, during the course of this inspection, the inspectors toured the home, observed staff to resident and resident to resident interactions, resident social programs, resident meal service, medication administration and infection control practices. The inspectors reviewed clinical health records, staff education records, external service education records, program evaluations, medication management meeting minutes, resident council meeting minutes, family council meeting minutes, the licensee's investigation documentation and the homes related policies;
Resident Safety and Risk Management - PASD, Physical Restraint, Resident Falls.
Clinical Procedures and Care Services - Continence Care, Skin Care Program Overview, Wound Care Treatment.
Abuse Free Communities - Prevention, Education and Analysis, Abuse Allegations and Follow-up.
Resident meals, Meal service and Quality Control - Trays to resident rooms.
Pharmacy and Therapeutics - Dermal Patches, Narcotics, Medication Administration, Medication Incidents.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

- **11 WN(s)**
- **6 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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 has failed to ensure that the plan of care provides clear directions to staff and others who provide direct care to the resident related to continence care.

Related to resident #020.

Review of the current plan of care in point click care (PCC) identified the following;

BLADDER FUNCTION: frequently incontinent.
Goal - will improve current level of bladder continence & have no UTI's.
Interventions - prone to UTI's-see infection/nutritional status focus for specific interventions.
- Observe/report increased voiding d/t diuretics, changes in odour, colour, frequency to Registered Staff.
- Provide assessed continence care products per Tena list. Resident wears a brief during the night only.
- Provide extensive assistance x1-2 staff depending on symptoms.

- Observe & report to Registered Staff any skin breakdown.

Requires assistance with TOILETING.
Goals - will maintain toileting function.
Interventions - requires toilet bars.
- wears pull-ups which family supply: refer to TENA list.
- Provide extensive assistance x1-2 staff depending on symptoms.

April 13, 2017, during an interview PCP #105 indicated that resident #020 uses a pull-up (family supplied) on the day shift and a brief on the evening and night shift. PCP #105 was able to show the TENA list (Last update January 2017) to inspector #623 which indicated the incontinent product that is required for each resident. For resident #020 the list indicates the following; the day shift is blank with no product identified, evening and night shift indicate SB (small brief). PCP #105 stated that resident #020 is on a toileting program requiring reminders and resident #020 is able to toilet independently.

April 19, 2017 during an interview resident #020 confirmed that he/she uses incontinent products. The resident indicated that he/she has "pull-ups" that are supplied by the family and they are kept in the closet. Inspector #623 observed seven bags of TENA pull-ups in the closet in plastic bags labelled "Shoppers Drug Mart" and receipts in the bag that identify the TENA pull-up was purchased from an outside source. Resident #020 stated that family has always supplied the pull-up ever since admission to the home. Resident #020 indicated that he/she sometimes uses the pull-up during the day shift and every night the PCP's will bring a brief and help the resident to put it on for overnight. Resident #020 confirmed that the brief is supplied by the home.

Resident #020 indicated that he/she toilets themselves and can manage the pull-up without any assistance. However resident confirmed that he/she requires assistance to apply the brief for night use as it is difficult to put on. Resident does not recall being offered an incontinence product for day use that was supplied by the home.

The plan of care fails to provide clear direction to staff for resident #020 related to level of continence, continence management and assistance that is required for toileting. [s. 6. (1) (c)]

2. The licensee has failed to ensure the plan of care set out clear directions to staff and others who provide direct care to the resident related to continence and toileting.

Related to log # 022742-16:

A critical incident report (CIR) was submitted to the Director on on a specific date for allegations of staff to resident neglect. The CIR indicated a reported complaint of neglect towards resident #027 on a specific date as it was discovered that resident #027 was wearing a pull-up that was dated for two days prior.

Review of the home's complaint log indicated two verbal complaints regarding resident #027. On a specific date it was reported that resident #027's pull-up had not been changed for approximately one week. The action taken was for staff to check and change the pull-up every am, when soiled and after bath day and staff to date and time each pull-up when changed. On a specific date it was reported a second complaint indicating the resident's pull-up had not been changed for two days.

Review of the current written plan of care for resident #027 indicated:
- under toileting: requires assistance of 2 staff. Interventions included: staff to bring resident into the bathroom, resident to pull themself up at grab bar for transfer -place call bell in hand, staff can wait in resident room, wears briefs/pads (wears pull-up); refer to TENA list. Pull up to be changed daily in the am or when soiled & on bath days. Resident #027 wears a pull up. Change pull-up on daily basis in the a.m. or when soiled -and after shower- staff to date and time pullup when change.

- under continence: incontinent of bladder. Resident #027 is able to self toilet.

Review of the RAI-MDS for resident #027 indicated the resident was frequently incontinent of bladder, wears pull-ups at all times, and requires one staff assistance for toileting. Rap summary indicated: is frequently incontinent of bladder, can sense the need to go to the bathroom and is able to tell the staff. Resident #027 wears incontinent product to maintain dry and comfortable.

Interview with PCP #116 by Inspector #111 indicated resident #027 wears pull ups supplied by the home, is frequently incontinent of bladder and the resident is also toileted every two hours.

Interview with PCP #122 by Inspector #111 indicated resident #027 wears pull-ups on days and evenings and wears medium purple briefs during the night. The PCP indicated the resident is occasionally incontinent of bladder but not daily. The PCP indicated the resident is also toileted every two hours (or as needed/requested by the resident) with 2

staff assistance and staff must remain with the resident during toileting. The PCP indicated the pull-ups were supplied by the home for the last 3-4 months and prior to that were supplied by the family. The PCP indicated the staff were to date the pull-up whenever a new pull-up or brief is applied due to concerns reported. The PCP indicated the resident was currently wearing a purple brief.

Review of the TENA list indicated resident #027 wears pull-ups on all three shifts. There was no indication the resident wore purple briefs at night. The TENA list was updated on April 18, 2017.

Interview with ADOC #112 by Inspector #111 indicated he/she was the person responsible for the continence care program in the home. The ADOC indicated the residents continence re-assessment is completed using the RAI-MDS and a bladder/continence assessment on PCC is only completed when there is a change. The ADOC indicated no other continence assessments for resident #027 (except the initial one from admission) were completed. The ADOC indicated a continence assessment would only have been completed if there was a change in continence level according to RAI-MDS. The ADOC indicated the TENA form would be completed once the resident was determined to be incontinent to determine which incontinence product the resident was to receive. The ADOC indicated he/she was unable to locate any Tena assessments for resident #027. The ADOC indicated the resident was to receive pull-ups supplied by the home but could not recall when the home began supplying the pull-ups.

There was no clear direction on the written plan of care related to toileting needs as one area identified the resident as requiring two staff assistance and staff to remain with resident and other areas indicated resident may toilet self or only required one staff assistance (MDS). It was unclear whether the resident was supposed to be wearing pull-ups or purple briefs. The action provided to address the complaints of pull-ups not being changed was already in place according to the written plan of care but staff were still unclear as to the direction related to changing of products, which products to be used and toileting. [s. 6. (1) (c)]

3. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent and complement each other related to behaviours for resident #020.

Resident #020 was admitted to the home with specific diagnosis.

Review of the most recent MDS assessment which identifies the frequency of the following behaviour has increased since the last assessment;

Socially Inappropriate / Disruptive Behavioural Symptoms (made disruptive sounds, noisiness, screaming, self-abusive acts, sexual behaviour or disrobing in public, smeared/threw food/feces, hoarding, rummaging through others' belongings) - occurs daily, not easily altered.

Review of the Point of Care (POC) documentation for the 30 day look back period that is reflected in the RAI/MDS assessment indicates that on the following dates resident #020 exhibited sexually inappropriate behaviours;
On 15 days in the 30 day look back period, this documentation was completed by PCP's#129, #130 and #131.

Review of the progress notes for a specific time period was completed by inspector #623, there is no documentation in the progress notes in PCC to support that sexually inappropriate responsive behaviours occurred for resident #020.

Review of the current plan of care for resident #020 by Inspector #623 indicates that Sexually Inappropriate Responsive Behaviours are not identified for resident #020.

April 20, 2017 during an interview PCP #105 indicated that resident #020 will on occasion resist or refuse care. Resident #020 has "preferred care givers" and does not like change. Resident #020 will also ring the call bell repetitively at times demanding attention. PCP#105 has never known resident #020 to be physically or verbally abusive towards staff or residents, and is unaware of resident #020 ever exhibiting sexually inappropriate responsive behaviours.

April 20, 2017 during an interview RAI #102 confirmed that PCP's document resident behaviours in POC. RAI #102 indicated that PCP staff have received training instructing them to document socially inappropriate behaviours such as "repetitive ringing of the call bell" under the category "sexually inappropriate behaviours". RAI #102 confirmed that for resident #020 during the 30 day look back period for mood and behaviour in the RAI/MDS assessment that was completed on a specific date, PSW's#129, #130 and #131 documented on 15 days that resident #020 exhibited sexually inappropriate behaviours. RAI#102 confirms that the definition in RAI/MDS is as follows; Socially Inappropriate / Disruptive Behavioural Symptoms (made disruptive sounds, noisiness,

screaming, self-abusive acts, sexual behaviour or disrobing in public, smeared/threw food/feces, hoarding, rummaging through others' belongings). RAI#102 confirms that resident #020 does not exhibit any of these behaviours. RAI#102 was not able to confirm that the information coded in POC by the PCP's related to behavoiurs was verified before entering it in RAI/MDS.

April 20, 2016 during an interview the DOC confirmed that resident #020 does not display sexually inappropriate responsive behaviours. The DOC verified that there were 15 days during the 30 day look back period when PCP's documented in POC that resident #020 was displaying sexually inappropriate responsive behaviours. DOC confirmed that there have been no incidents of sexually inappropriate responsive behaviours involving resident #020 and there is no documentation in PCC to support the documentation in POC. The DOC indicated that PCP's are likely choosing sexually inappropriate behaviours when resident #020 is socially inappropriate by excessive ringing of the call bell and repetitive anxious questions. The DOC confirmed that this behaviour should have been captured as "repetitive anxious complaints/concerns" under mood. [s. 6. (4) (a)]

4. The licensee has failed to ensure the care set out in the plan of care provided to the resident as specified in the plan related to continence care.

Related to log # 022742-16:

A critical incident report (CIR) was submitted to the Director on a specified date for allegations of staff to resident neglect. The CIR indicated a complaint was received indicating resident #027 was discovered to be wearing a pull-up that was dated two days prior.

Review of the home's complaint log indicated that there were two verbal complaints reported regarding resident #027's pull-up not being changed for approximately one week. The action taken was for staff to check and change the pull-up every am, when soiled and after bath day and staff to date and time each pull-up when changed. On a specific date there was a second reported complaint indicating the resident's pull-up had not been changed for two days.

Interview with the Administrator by Inspector #111, indicated a verbal complaint was received about resident #027 regarding an allegation of neglect. The Administrator indicated the investigation was completed by ADOC #112.

Interview with ADOC #112 indicated he/she became aware of the verbal complaint for resident #027 from the Administrator. The ADOC indicated he/she then spoke to staff regarding the complaint but did not document which staff were spoken to and could not recall which staff were involved in the alleged staff to resident neglect. The ADOC could not provide an explanation why the investigation was not initiated immediately. The Administrator indicated the Director was probably not informed of the verbal compliant of staff to resident neglect.

Interview with RPN #135 by Inspector #111, indicated he/she received the verbal complaint on a specific date regarding the resident's pull-up not being changed for two days. The RPN confirmed the pull-up for resident #027 on a specific date was dated two days prior and was uncertain if the staff change the pull-up. The RPN indicated he/she notified RN # 139 the same night and left a voice message for ADOC #112 regarding the complaint. RPN #135 was working on a specified date and indicated he/she recalled the incident related to pull-ups back but could not recall details of events and confirmed he/she did not document the verbal complaint.

Review of the current written care plan for resident #027 indicated under toileting/continence: requires assistance of 2 staff for toileting, is frequently incontinent of bladder, wears pull-up, refer to TENA list and pull-up to be changed daily in the am or when soiled & on bath days- staff to date and time pull-up when change.

The plan of care was not provided to resident #027 on specified dates as the resident's pull-up had not been changed as indicated in the plan. [s. 6. (7)]

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 ensuring that the plan of care provides clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: 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 failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was in compliance with and is implemented in accordance with all applicable requirements under the Act.

Under O. Reg 79/10, s.114(1) Every licensee of a long-term care home shall develop and interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents.

Under O. Reg. 79/10, s. 135(1) The licensee is to 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
(b) reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

Review of the licensee's policy "Medication Incidents" (LTC-CA-WQ-200-06-11) revised January 2017 indicated:
-on page 1 of 3, if the error involves a resident, full documentation must be completed in progress notes in the resident chart. The attending physician/nurse practitioner is to be contacted when a medication error occurs involving a resident for further actions. Medication errors that are pharmacy based are to be reported to the contracted pharmacy.
-on page 2 of 3, under procedures:
5. Report the medication error to the DOC or designate, Physician/Nurse Practitioner and when appropriate to the pharmacist.

This policy does not meet legislative requirements as the policy indicates the pharmacy is only notified when the medication error is pharmacy based. This policy also does not indicate that all medication errors are to be reported to the resident, the resident's SDM, if any, and the Medical Director. [s. 8. (1) (a)]

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 ensuring that any plan, policy, protocol, procedure, strategy or system instituted of otherwise put into place was in compliance with and is implemented in accordance with all applicable requirements under the Act., to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Related to Log # 022742-16 :

Review of the licensee's policy Risk Management-"Investigations"(LTC-CA-WQ-100-05-01) revised November 2014, indicated under procedures on page 2 of 8:
-all managers and supervisors will be aware of policies and procedures related to issues requiring investigation. These include: resident abuse
-supervisor/manager receiving the information will obtain as much information from the person reporting the issue.
-a comprehensive investigation will be undertaken using the attached form. The following provide further directions to ensure a comprehensive investigation is undertaken:
-immediately ensure that the resident is safe and receives the care required, start the investigation as soon as possible,
-information collected: gather from all sources including but not limited to: the persons

involved: interview those involved in the event directly and all witnesses of the event, take notes, obtain written statements from all involved and from witnesses.

A critical incident report (CIR) was submitted to the Director on a specified date for an allegation of staff to resident neglect. The CIR indicated on a specified date a verbal complaint was received by RPN #135 indicating an allegation that resident #027 pull-up had not been changed for two days. The CIR indicated the allegation was founded, PCP #113 was involved in the allegation and received disciplinary action as a result.

A verbal complaint was received on a specific date indicating alleged staff to resident neglect. The complainant alleged resident #027 had not had their pull-up changed for approximately one week and RPN #135 was notified at the time and changed the resident's pull-up.

Review of licensee's investigation into both verbal complaints and interview of staff indicated:
- staff interviews completed by Inspector #111 regarding both allegations of staff to resident neglect related to continence care not provided to resident #027 were confirmed.
- the investigations were initiated immediately however were not completed comprehensively as per the licensee's policy as all staff who were involved or who were aware of the allegations were not interviewed, any interviews completed were not documented and no written statements were obtained by the person completing the investigations. The form identified on the policy was used for both allegations of neglect but completed two days later and these forms were incomplete. The forms had no indication of whether the investigation was founded and actions taken to prevent a recurrence. [s. 20. (1)] (111) [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 ensuring that the licensee's written policy that promotes zero tolerance of abuse and neglect of residents is complied with,, to be implemented voluntarily.

WN #4: 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. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

Related to Log # 022742-16:

Review of the home's complaint log indicated a second verbal complaint was received regarding resident #027 on on a specific date. This verbal complaint was received by the Administrator. The complainant alleged resident #027 had not had the pull-up changed for approximately one week. This complaint was reported to RPN #135 on a specific date. The RPN #135 reported the complaint of neglect immediately to the Administrator, but the Administrator did not investigate the complaint when he/she became aware. The Administrator notified the DOC of the complaint two days later which is when the investigation was started. The DOC confirmed that no investigation was initiated until two days after the initial notification.

Review of the licensee's investigation indicated the investigation was initiated two days later by ADOC #112. The complaint recorded by the Administrator indicated RPN #135 was notified that the resident had not had the pull-up changed for one week. The RPN then changed the residents pull-up.

Interview with Administrator and ADOC #112 indicated the complaint was provided to the ADOC on May 5, 2016 by the Administrator and that was when the investigation was started. The Administrator could not recall why the investigation was not immediately initiated. [s. 23. (1) (a)]

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 ensuring that every alleged, suspected or witnessed incident of abuse/neglect that the licensee knows of, or that is reported is immediately investigated, to be implemented voluntarily.

WN #5: 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 has failed to ensure the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was 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.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

Related to Log # 022742-16:

A critical incident report (CIR) was submitted to the Director on a specific date for an allegation of staff to resident neglect. The CIR indicated on a specific date the Substitute Decision Maker (SDM) of resident #027 provided a verbal complaint to RPN #135 alleging the resident's pull-up had not been changed for two days. The CIR indicated the allegation was founded, PCP #113 was involved in the allegation and received disciplinary action as a result.

Review of the home's complaint log indicated a second verbal complaint was received by the SDM of resident #027 on a specific date (two months earlier). The verbal complaint was received by the Administrator and alleged resident #027 had not had their pull-up changed for approximately one week and was reported to RPN #135.

Review of the licensee's investigations and interview of the Administrator, DOC, and ADOC #112 confirmed the complaint by SDM of resident #027 received on a specific date alleging staff to resident neglect was not reported to the Director. They also confirmed the Administrator became aware of the second complaint from the SDM, for suspected neglect of resident #027 on a specific date and it was not reported to the Director until two days later. [s. 24. (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 ensuring that any alleged, suspected or witnessed abuse is immediately reported to the Director,, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident 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
(b) reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

Review of the home's medication incident reports from January to April 2017 indicated the following:

1) Resident #005: on a specified date, RPN #100 found a 100 mg tab of a specific

medication in the medication pouch. The order had been changed four days earlier to 75 mg every am. The report indicated that pharmacy was called regarding the error. There was no documented evidence that an assessment of the resident was completed, or the physician and SDM was notified when the received the wrong dose of a specific medication for four days. Interview with RPN #100 by Inspector #111 indicated they probably called the pharmacy and the DOC but no one else. The RPN did not recall assessing the resident or documenting the assessment.

2) Resident #052: on a specific date and time, RPN #143 indicated they forgot to administer the resident's pain medication at 1700 & 2000 hours the previous evening. The report indicated no one was notified of the medication incident.

Review of the progress notes indicated on a specific date and time by RPN #143, Resident #052's pain medication not administered last evening.

Interview with RPN #143 indicated he/she discovered the medication incident on a specific date but did not document in progress notes until the following date. The RPN confirmed he/she did not notify anyone regarding the incident but just completed the incident report. The RPN confirmed he/she did not complete a pain assessment of the resident to determine if the resident had adequate pain control. [s. 135. (1)]

2. The licensee has failed to ensure that following every medication incident involving a resident and every adverse drug reaction is reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

Related to Log # 021722-16:

On a specific date, a Critical Incident (CIR) was submitted to the Director related to Controlled Substance missing/unaccounted for. The Critical Incident was related to a missing controlled substance patch for resident #054.

Resident #054 was admitted to the home with specific medical diagnosis. On specific date and time, it was discovered that resident #054's specific controlled substance patch was missing. Review of the CIR submitted to the Director, indicated that the SDM and Pharmacy provider were not notified of the incident of a controlled substance being missing/unaccounted for. During interview with the DOC by Inspector #672, the DOC

confirmed that the home does not always notify SDMs of missing/unaccounted for controlled substances, and that the Pharmacy provider was not notified after each incident of a missing/unaccounted for controlled substance, as it was discussed during the quarterly Professional Advisory Committee (PAC) meetings.

The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction is reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. [s. 135. (1)]

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

Interview with the DOC by Inspector #111 indicated he/she reviews all medication incidents monthly when entering them into the risk management report. The DOC indicated all the medication incidents are analyzed for trends and actions taken at the quarterly Professional Advisory Committee (PAC) meetings with the Medical Director, physician, and pharmacy which is for the previous three months medication incidents. The DOC indicated the PAC meeting for the first quarter of 2017 was cancelled due to the home being in outbreak.

A review of the PAC meeting minutes was completed for the most recent PAC meeting and indicated at the January 2017 meeting: all medication errors were reviewed but no actions taken or trends were noted. [s. 135. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring 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
(b) reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider,, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent related to the specific PASD for resident #016.

On April 11,18 and 19, 2017 observations of resident #016 by inspector #623 identified that when out of bed resident #016 was seated in a wheelchair with PASD.

Review of the current plan of care in Point Click Care (PCC) indicates the following:

PASD - Tilt wheelchair
Goal - resident #016 will utilize PASD in wheelchair for proper positioning

Interventions - OT: Resident should use a PASD to support proper positioning when necessary throughout the day

Mobility - total assistance
Goal - Resident #016 will be portered as required by staff.
Interventions - Resident #016 is wheelchair bound with (PASD) and requires total assistance for all portering and locomotion.

Review of the clinical records including Physician Orders, Occupational Therapy Referral and progress notes for a six month specified time period, was completed by Inspector #623 and the following was identified;

A physicians order on a specific date indicates - OT referral for tilted wheelchair.

Progress Notes:
Occupational Therapy Note
Resident #016 was referred to Occupational Therapy for assessment. The Occupational Therapist saw and assessed the resident on a specific date. A summary of the assessment is resident seen in current device, which is not appropriate. Resident had a fall last week, should be using a specific device to ensure that he/she is safely able to sit. OT provided loaner device from residence however OT to contact family to obtain consent to trial the device with PASD, access ADP for same as resident has had change of function and body size. Further details of the assessment can be found in the OT Assessment under the Assessment Tab.
Occupational Therapist#125

Occupational Therapy Note
Note Text: Resident should use a specific feature of the assistive device as a PASD to support proper positioning when necessary throughout the day.
Occupational Therapist#126

Occupational Therapy Note (five months later)
Note Text: OT spoke with the DOC regarding policy for loaner assistive devices - resident has been using a loaner type 5 for past 6 months. DOC reports loaners are to be used for short-term while residents are waiting for their own equipment, not for long-term use. OT called to resident's SDM to discuss resident's w/c needs. No answer and writer left voice message requesting SDM contact OT to review process to purchase a new type 5 device for resident. Resident continues to benefit from loaner device, however requires

narrower 18" width to provide postural support for safe daily mobility needs. OT #126

Occupational Therapy Note
OT rec'd t/c from resident's family yesterday while OT was not at Wynfield. OT discussed resident's needs and recommendation for type 5 seating for daily mobility needs. Family reports they will speak with resident's SDM and will have SDM contact OT. OT rec'd message stating that they will leave resident #016 as is, do not want to purchase a new device. OT unable to proceed with new device as recommended as residents SDM does not wish to proceed.
Occupational Therapist #126

Review of policy #: LTC-CA-ON-200-07-18
07- Resident Safety and Risk Management - PASD (revised July 2014) (4 pages)
Form: LTC-CA-WQ-200-09-43 - Consent for use of a Personal Assistance Service Device (PASD)

Procedures:
1. Each resident that would benefit from a PASD (with the exception of bed side rails) must be assessed for the device by one of the following:
a. Physiotherapist
b. Occupational Therapist

2. The prescribing therapist is to review the use of the device with the Registered Staff, Care Staff and the resident/family/POA. Consent must be obtained by the prescriber of the PASD and documented in the resident chart (written for all with the exception of the bed side rails).

7. mandatory Documentation required in Progress Notes:
a. Concern regarding positioning of resident.
b. PASD alternative trialed and evaluation of trial.
c. Activity of Living with which the PASD will assist the resident.
d. PASD assessment request and prescription by whom, OT of PT, date and rational.
e. Resident / SDM discussion regarding the rational of PASD.
f. Resident / SDM verbal consent obtained.

During an interview RPN #111 confirmed that resident #016 uses an assistive device when up and this is considered a PASD. RPN indicated that when a resident requires a

change in seating, a restraint or a PASD, a referral is made to OT and they complete an assessment to determine what is appropriate for the resident. RPN #111 indicated that it is the OT that will then contact the SDM to update them with the recommendations related to seating, restraint or PASD and the OT is supposed to document this in the progress notes in PCC. RPN #111 verified that the PCP's document in the POC when the PASD is in use for resident #016 and reposition every two hours.

During an interview PSW #124 confirmed that when resident #016 is out of bed then he/she is placed into a wheelchair with the PASD. PSW indicated that the assistive device is considered a PASD and is documented in the POC. PCP#124 indicated that resident #016 requires the PASD.

During an interview the DOC confirmed that resident #016 uses a PASD. DOC confirmed that after reviewing the clinical records for resident #016 it could not be verified that verbal consent was obtained from the SDM for the use of the PASD. The DOC confirmed that the PASD has been in use for over a year for resident #016. [s. 33. (4) 4.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(h) residents are provided with a range of continence care products that,
(i) are based on their individual assessed needs,
(ii) properly fit the residents,
(iii) promote resident comfort, ease of use, dignity and good skin integrity,
(iv) promote continued independence wherever possible, and
(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are provided with a range of continence care products based on their individual assessed needs.

Related to log # 022742-16:

Review of the home's complaint log for 2016 indicated two verbal complaints were reported regarding resident #027. On a specified date it was reported the resident's pull-up had not been changed for approximately one week. On a specified date a second complaint was reported indicating resident #027's pull-up had not been changed for two days.

Review of the current written plan of care for resident #027 indicated under toileting/continence: is frequently incontinent of bladder, wears pull-up, refer to TENA list and pull up to be changed daily in the am or when soiled & on bath days- staff to date and time pull-up when change.

Interview with ADOC #112 by Inspector #111 indicated he/she was the person responsible for the continence care program in the home. The ADOC indicated the residents continence re-assessment is completed using the RAI-MDS and a bladder/continence assessment on PCC is only completed when there is a change. The ADOC indicated no other continence assessments for resident #027 (except the one dated 2 years prior) were completed. The ADOC indicated a continence assessment would only have been completed if there was a change in continence level according to RAI-MDS. The ADOC indicated the TENA form would be completed once the resident was determined to be incontinent to determine which incontinence product the resident was to receive. The ADOC indicated he/she was unable to locate any Tena assessments for resident #027. The ADOC indicated the resident was to receive pull-ups supplied by the home but could not recall when the home began supplying the pull-ups.

Review of the RAI-MDS for resident #027 on April 5, 2016 indicated the resident was frequently incontinent of bladder, wears pull-ups at all times, and requires one staff assistance for toileting. There had been no change in the last five quarters to the level of continence. Rap summary indicated under Urinary Incontinence and Indwelling Catheter: is frequently incontinent of bladder, can sense when the need to go to the bathroom and is able to tell the staff. Resident #027 wears incontinent product to keep dry and comfortable.

Review of the progress notes for resident #027 indicated the following;
On a specific date and time - During care conference -family requesting the use of pullup, resident has been previously assessed and noted day liner would meet the needs of the resident continence status, family displeased and requested the use of pullups, pull ups ordered and provided to resident (placed in bathroom).

Review of the TENA list indicated resident #027 wears pull-ups on all three shifts but did not indicate who supplied the pull-up. There was no indication the resident wore purple briefs at night. The TENA list was updated on April 18, 2017.

Interview with PCP#116 by Inspector #111 indicated resident #027 wears pull ups supplied by the home, is frequently incontinent of bladder and the resident is also toileted every two hours.

Interview with PCP #122 by Inspector #111 indicated resident #027 wears pull-ups on days and evenings and wears medium purple briefs during the night. The PCP indicated the resident is occasionally incontinent of bladder but not daily. The PCP indicated the resident is also toileted every two hours (or as needed/requested by the resident) with 2 staff assistance and staff must remain with the resident during toileting. The PCP indicated the pull-ups were supplied by the home for the last 3-4 months and prior to that were supplied by the family. The PCP indicated the staff were to date the pull-up whenever a new pull-up or brief is applied due to concerns from the family. The PCP indicated the resident was currently wearing a purple brief at all times.

Interview with two SDM's of resident #027 indicated they recalled the reporting of concerns with the resident pull-ups not being changed. Both SDM's indicated the family was supplying the pull-ups until recently (approximately four months ago) when the SDM discovered the home should have been supplying the pull-ups.

There was no current assessment for resident #027 to indicate what the residents assessed needs were and no assessment completed to determine which incontinence product was to be used. [s. 51. (2) (h) (i)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 122. Purchasing and handling of drugs

Specifically failed to comply with the following:

s. 122. (1) Every licensee of a long-term care home shall ensure that no drug is acquired, received or stored by or in the home or kept by a resident under subsection 131 (7) unless the drug,
(a) has been prescribed for a resident or obtained for the purposes of the emergency drug supply referred to in section 123; and O. Reg. 79/10, s. 122 (1).
(b) has been provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario. O. Reg. 79/10, s. 122 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug is acquired, received or stored by or in the home or kept by a resident unless the drug:
(a) has been prescribed for a resident or obtained for the purposes of the emergency drug supply, and
(b) has been provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario

An observation of the noon medication pass was completed on a specific date by Inspector #111 for resident #047 and identified the following:
-the administration of the medication was completed by RPN #100.
-observation of the medication cart indicated a specific medication was stored in the resident's medication container along with the resident's other current medications.

Review of resident #027 physician orders and medication administration records (MAR) indicated the specific medication was discontinued four months prior during the quarterly medication review and was discontinued on the eMAR but the drug was not removed from the medication cart. [s. 122. (1)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 133. Drug record (ordering and receiving)
Every licensee of a long-term care home shall ensure that a drug record is established, maintained and kept in the home for at least two years, in which is recorded the following information, in respect of every drug that is ordered and received in the home:

1. The date the drug is ordered.
2. The signature of the person placing the order.
3. The name, strength and quantity of the drug.
4. The name of the place from which the drug is ordered.
5. The name of the resident for whom the drug is prescribed, where applicable.
6. The prescription number, where applicable.
7. The date the drug is received in the home.
8. The signature of the person acknowledging receipt of the drug on behalf of the home.
9. Where applicable, the information required under subsection 136 (4). O. Reg. 79/10, s. 133.

Findings/Faits saillants :

1. The licensee has failed to ensure that a drug record is established, maintained and kept in the home for at least two years, in which the following information is recorded in respect of every drug that is ordered and received in the home:
7. The date the drug is received in the home
8. The signature of the person acknowledging receipt of the drug on behalf of the home.

An observation of the noon medication pass was completed on a specific date by Inspector #111 for resident #047 and identified the following:
-the administration of the medication was completed by RPN #100.
-the resident was to receive a specific medication at bedtime.
-the RPN and the Inspector were unable to locate this medication in the medication cart.
-review of the medication reorder sheet indicated on a specific date the medication was recorded and by whom. There was no indication the medication was received. The reorder sheet also identified that a controlled substance injectable was also reordered on the same date for the emergency drug box but had no indication the drug was received.
-a telephone call was placed by the inspector to the pharmacy who confirmed that both medications were sent to the home on the same date when they were reordered.

RPN #100 later found the medications and indicated the staff who received the medications must have forgotten to sign them in. [s. 133.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Review of the home's medication incident reports from January to April 2017 indicated the following:
Resident #001: on a specific date, RPN #152 reported popping out the wrong dose of narcotic medication, disposed of the narcotic medication in the garbage, and then administered the correct narcotic medication with the correct dose to the resident. Review of the physician order indicated the resident was to receive a specific medication at 0800, and a different dose of the same medication at 1200, 1600 & 2000 hours. The RPN had removed the wrong dose of the specific medication but did not administer the incorrect dose.

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

The RPN was counselled by the charge nurse on correct disposal of narcotics.

The licensee failed to ensure the proper disposal of a controlled substance. [s. 136. (3) (a)]

Issued on this 31st day of May, 2017

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

Original report signed by the inspector.