Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 24, 2017	2017_525596_0015	021624-17	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 Westbury Long Term Care Residence
495 The West Mall ETOBICOKE ON M9C 5S3

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

THERESA BERDOE-YOUNG (596), JANET GROUX (606), JOY IERACI (665)

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): September 8, 12, 13, 14, 15, 18, 19, 20, 21, 22, 25, 26, 2017.

The following critical incident (CI) reports were inspected concurrently with the Resident Quality Inspection (RQI):
log #017811-16, #021109-16 related to alleged resident abuse, #011582-17, #006003-17, #028315-16 related to falls prevention, #027222-15 related to injury with cause unknown, and #034721-16 related to responsive behaviours.

During the course of the inspection, the inspector(s) spoke with the Administrator, Co-Directors of Care (co-DOC), Physician, family and community coordinator, registered dietitian (RD), educator, behavioural support ontario (BSO) staff, registered nurse (RN), registered practical nurse (RPN), personal care provider (PCP), dietary aide (DA), recreation aide (RA), infection control and skin and wound coordinator (IC/SWC), residents and family members.

During the course of this inspection, the inspectors toured the home, observed resident care, observed staff to resident interaction, reviewed resident health records, meeting minutes, schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

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

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

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that sets out the planned care for the resident.

The home submitted a critical incident (CI) report to the ministry of health and long term care (MOHLTC) related to resident to resident abuse. The CI indicated that resident #028 exhibited identified responsive behaviours towards other residents and staff. Resident #028 interacted with resident #029 causing an injury.

Review of resident #028's progress notes revealed he/she had a history of responsive behaviours towards other residents and staff as follows:

In December 2016, resident #028's behavior worsened when he/she exhibited an identified behaviour towards co-residents and staff. Staff had difficulty in distracting or redirecting the resident and the registered staff left a note for the physician to assess. Subsequently resident #028 had another altercation with resident #035.

During a five day period prior to the date of the above mentioned critical incident, there were numerous incidents of identified behaviours toward other residents.

Resident #028 did not have a plan of care in place for the responsive behaviours toward co-residents. Further to this, the plan of care for the identified behaviours was not developed or implemented until six days after the altercation with resident #035 and two days after the altercation with resident #029.

Interview with personal care provider (PCP) #146 indicated he/she witnessed the altercation between resident #028 and resident #029. The PCP indicated that on the day of the incident, he/she received report from the registered staff that resident #028 had heightened responsive behaviours and would enter into other residents' rooms. The PCP indicated he/she observed resident #028's behaviour escalating during this the shift. The PCP indicated he/she was not aware of specific triggers of resident #028 and did not review the plan of care at the start of his/her shift but received a report from the registered staff of residents with responsive behaviour, including resident #028.

Interviews with registered practical nurses (RPN) #119 and #142 indicated resident #028 had responsive behaviours towards staff and residents. The RPNs indicated it is the home's expectation for the written plan of care to be updated with interventions to mitigate the safety risk of resident #028's responsive behaviours towards other residents. The RPNs reviewed the written plan of care for resident #028 and acknowledged the plan of care was not updated with interventions to manage resident's responsive behaviours towards co-residents until six days after the initial incident with resident #035 and two days after the second incident with injury to resident #029.

Interview with the Co-DOC #138 indicated resident #028 was known to have identified responsive behaviours towards residents and staff. The Co-DOC indicated it is the home's process for the home's behavioural support ontario (BSO) team to assess the resident with responsive behaviour, develop interventions, meet with staff regarding the interventions and the plan of care is to be updated. The Co-DOC reviewed the written plan of care and stated the plan of care for resident #028 was not updated as per the

home's expectation. [s. 6. (1) (a)]

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

The nutrition and hydration inspection protocol (IP) triggered from stage one of the resident quality inspection (RQI) related to no plan, low basal metabollic rate (BMI) for resident #006.

Record review of resident #006's progress notes dated July 2017, revealed documentation by the registered dietitian (RD) recommending to continue with the provision of special snacks to promote weight gain. Progress notes indicated a care conference was held in August 2017, with the resident's substitute decision maker (SDM) and interventions were agreed upon, included peanut butter sandwich at lunch and supper, and bread at each meal. It indicated that diet books and care plan will be updated.
Record review of the resident's care plan and kardex reflected the same interventions mentioned above and that the resident was at high nutritional risk.

Interview with RPN revealed he/she observed the resident and supervised lunch service on September 15, 2017, and the resident ate 100% of the meal. He/she stated the resident was not offered bread or sandwich as the care plan directed staff to do.

Interview with PCP #121 assigned to the resident revealed that he/she ate 50-75% of the meal at lunch time and bread was not offered as per the care plan. PCP #121 stated that the resident should have been offered bread as the care plan indicated. [s. 6. (7)]

3. The skin and wound care IP triggered from stage one of the RQI related to altered skin integrity for resident #007.

Resident #007 was observed to have altered skin integrity.

Record review of the resident's clinical record revealed a progress note and physician order dated February 2017, indicating physician #141 ordered a dermatology consult for the altered skin integrity. Resident #007 was seen by a dermatologist four and a half months later, and a treatment was ordered. A progress note by RPN #112 indicated that two samples of the recommended treatment was provided by the dermatology clinic.

Review of resident #007's electronic medication administration record (EMAR) and electronic treatment administration record (ETAR) for the period of June to September 2017, did not include the recommended treatment.

On September 15, 2017, the inspector observed the medication room with RPN #111 and found two small boxes of the above mentioned treatment on top of the treatment cart, with an information pamphlet about the product, and the resident's name and room number.

Interviews with RPNs #103 and #111 indicated the order for resident #007's treatment were considered treatment for the resident's altered skin integrity, and it was to be entered into the resident's ETAR. The RPNs stated that when processing physician orders, there are two checks by registered staff and the second check must confirm that the order is entered into the ETAR for administration. The RPNs reviewed resident #007's EMARs and ETARs for the period of June to September 2017, and indicated that the order for the treatment was not entered into the ETAR as per the home's expectation. RPN #103 indicated since the treatment was not in the ETAR, it meant that it was not administered to resident #007 and he/she was unaware if the resident received the treatment. The above mentioned RPNs acknowledged that the care set out in resident #007's plan of care was not provided as specified in the plan.

Interview with the home's Infection Control and Skin and Wound Coordinator (IC/SWC) #114 indicated when a resident returns from a medical appointment with physician orders, it is the expectation of the home for the registered staff to call the resident's physician or the on-call physician to confirm the order. The order is processed by having two registered staff check and sign off on the order. The IC/SWC indicated that the second check must confirm that the order is in the resident's EMAR or ETAR. The IC/SWC reviewed resident #007's EMARs and ETARs for the period of June to September 2017 and indicated that he/she did not find the order for the treatment. The IC/SWC acknowledged that the plan of care for resident #007 was not provided as specified in the plan. [s. 6. (7)]

4. The licensee has failed to ensure that staff and others who provide direct care to a resident were kept aware of the contents of the plan of care and given convenient and immediate access to it.

The nutrition and hydration inspection protocol (IP) triggered from stage one of the RQI related to no plan, low BMI for resident #006.

Record review of resident #006's progress notes in July 2017, revealed documentation by RD recommending to continue with the provision of special snacks to promote weight gain. Progress notes indicated a care conference was held the following month, with the resident's SDM and interventions were agreed upon, included peanut butter sandwich at lunch and supper, and bread at each meal. It indicated that diet books and care plan will be updated.

Record review of the resident's care plan and kardex reflected the same interventions mentioned above, and that the resident was at high nutritional risk.

Interview with PCP #121 assigned to the resident on September 15, 2017, during the RQI revealed that the resident ate 50-75% of the meal at lunch time and bread was not offered as per the care plan. PCP #121 stated that he/she was not aware that offering bread to the resident at each meal was listed as a dietary intervention to promote weight gain, however he/she was easily able to access the resident's kardex in point of care (POC) and the care plan at the nursing station. [s. 6. (8)]

5. Record review of a critical incident (CI) report submitted to the MOHLTC reported that resident #009 was found by a staff member laying on the livingroom floor on a specified date in March 2017. The resident was transferred to hospital for further assessment and diagnosed with a medical condition.

Record review of the resident's morse falls risk assessment upon admission to the home in January 2017, and subsequent one dated February 27, 2017, deemed the resident high risk for falls.

Record review of the resident's kardex and written plan of care identified interventions that included: visual checks every 15 minutes (mins).

Interview with PCP #128 revealed that he/she was a primary caregiver for the resident and had access to the point of care (POC) to read the resident's kardex, but was not aware that the kardex directed staff to check the resident every 15 minutes. PCP #128 stated that he/she thought the resident was to be monitored every two hours.

Interview with Co-DOC #138 revealed that the home's expectations was that all PCP staff access resident's kardexes in the POC and be aware of their care needs at all times. [s. 6. (8)]

6. The licensee has failed to ensure that the plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs changed.

Record review of a CI report submitted to the MOHLTC reported an incident of resident to resident abuse.

Review of resident #021's progress notes on a specified date in 2016, indicated that as the resident walked by the elevator, he/she stopped and interacted with resident #022 and pulled his/her jacket; resident #022 had been waiting to get on the elevator. The progress notes indicated staff separated the two residents and both residents were assessed and did not sustain any injuries.

Further review of resident #022's progress notes indicated resident #021 was admitted to the home in March 2016. The resident's clinical record did not indicate any history of responsive behaviours.

Review of the progress notes for an eleven week period indicated that resident #021 had displayed responsive behaviours with a total of 28 entries. The progress notes revealed that resident #021 began displaying identified responsive behaviors towards residents and staff in April 2016.

Review of resident #021's responsive behaviour debrief documentation in May 2016, revealed the resident was referred to the BSO team and the careplan was updated. Review of resident #021's written care plan did not include any responsive behaviour interventions.

Interviews with PSWs #155 and #105 reported resident #021 had identified responsive behaviours towards staff and co-residents. Resident #021 was usually re-approached when exhibiting identified responsive behaviours.They stated that the information should be reflected in the care plan.

Interview with RPN #114 revealed that the resident did not display responsive behaviours when he/she was admitted and was fairly quiet and calm, but started displaying responsive behaviours shortly afterward. He/she stated it may be due to the resident realizing he/she was in a long term care home. RPN #144 confirmed resident #021's written care plan did not have a focus and interventions to manage his/her responsive behaviours. [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 that there is a written plan of care for each resident that sets out the planned care for the resident, that the care set out in the plan of care is provided to the resident as specified in the plan, that staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it, and 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, 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 has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

The skin and wound care IP triggered from stage one of the RQI related to altered skin integrity for resident #001.

According to O.Reg. 79/10, s. 48(1)2, the licensee is required to ensure that a skin and wound care program to promote skin integrity, prevent the development of wounds and

pressure ulcers, and provide effective skin and wound care interventions is implemented in the home.

The home's policy #LTC-CA-WQ-200-08-03, titled wound care treatment, with revision date November 2015, stated that a physician or RN (EC) order is required for wound care involving a stage three or greater pressure ulcer. Enterostomal Therapists can be consulted for wound care recommendations however, before the order can be implemented it must be reviewed and approved by a physician.

Record review revealed resident #001 had an identified number of areas of altered skin integrity. Review of the resident's weekly pressure ulcer assessment on a specified date in January 2017, revealed altered area of skin to an identified area of the body, with a description of an identified injury. The weekly pressure ulcer assessment on a specified date in September 2017, indicated the altered area of skin to the above mentioned identified area of the body.

Inspector observed wound care in September 2017, with IC/SWC #114 and noted the identified area of altered skin integrity to the resident's above mentioned identified body area was treated with a particular dressing.

Review of resident #001's physician orders did not include a treatment order for the identified area of altered skin integrity to the resident's above mentioned identified area of the body for the period of January to September 2017. Review of the resident's ETARs and EMARs for the same period revealed only one treatment order which started on a specified date in September 2017 for the altered area of skin. Review of the resident's physician orders on a specified date six days after the above mentioned specified date in September 2017 did not include a corresponding physician order for the first specified date in September 2017, treatment order in the ETAR.

Interview with IC/SWC #114 revealed it is the home's expectation for identified levels of altered skin integrity to have a treatment order from the physician. He/she acknowledged resident #001 did not have a treatment order for the identified area of altered skin integrity to an identified body area since discovery of the altered area of skin integrity in January 2017, and the identified area of altered skin integrity was being treated with the same treatment as another identified area of multiple altered skin integrity.

Interview with Co-DOC #125 revealed it was the home's policy for a physician's order to be obtained to treat identified levels of skin integrity. The Co-DOC stated each area of

identified altered skin should be identified and requires a separate order from the physician, and acknowledged there was no treatment order for the resident's area of altered skin integrity since January 2017. The Co-DOC further acknowledged the home did not follow process in ensuring a physician's order was obtained for treatment to resident #001's area of altered skin integrity . [s. 8. (1) (a),s. 8. (1) (b)]

2. The home uses Classic Care Pharmacy policies and procedures. Classic Care Pharmacy's policy #5.8, titled Medication Disposal with a revision date of July 2014, directed the home to routinely inspect all medication storage areas, perhaps monthly, for the ongoing identification, destruction and disposal of expired drugs.

According to O.Reg 79/10, s136. (1) Every licensee of a long-term care home shall ensure, as part of the medication management system, that a written policy is developed in the home that provides for the ongoing identification, destruction and disposal of (a) all expired drugs.

The home has a schedule for weekly check and cleaning of medication rooms, carts, oxygen concentrators and suction equipment which is posted in the unit's medication room. The schedule directs the nurse to remove all expired medications once their check is completed.

During the medication administration observation for storage of narcotics and controlled substances on September 14, 2017, on an identified resident home area, a sleeve of an expired controlled substance medication containing 15 pills for resident #031 was observed to be in the narcotic bin in the medication cart. The sleeve of medication had an expiry date of January 2017.
Review of resident #031's quarterly physician medication review for the period of August 1 to October 31, 2017, had a physician order for the above mentioned medication, one tablet by mouth every six hours as needed. Review of the resident's narcotic and controlled drug administration and shift count records from January to September 14, 2017, revealed the resident received the expired medication on 12 occasions in a seven month period in 2017.

Interviews with RN #104 and #132, RPNs #140 and #147 reported that it was the home's expectation for expired medication to be removed from the medication cart and the home had a weekly cleaning schedule every Friday evening when the medication room and medication carts were cleaned by registered staff, and all medications checked for expiry dates. It is the responsibility of registered staff to check the supply of medications and

remove any expired medications including controlled substances from the medication cart, then re-order the medication if required. The above mentioned staff stated that the nurse must sign off on the schedule that the check was completed. RN #104 acknowledged that staff did not follow the home's expectation as the sleeve of expired controlled substance medication for resident #031 was not removed and re-ordered from the narcotic bin as per the home's policy.

Review of the weekly check and cleaning schedules on an identified unit for the months of January to September 2017, with the exception of August 2017, revealed 21 dates without a registered staff signature.

Interview with Co-DOC #125 indicated it was the home's expectation for registered staff to check that all medications are not expired before administering it. The Co-DOC indicated the home did weekly checks of the medication cart on Friday evenings on each unit and it was the home's expectation that expired medications are removed for disposal as per policy. The Co-DOC reviewed the weekly check and cleaning schedules for the above mentioned identified unit from January to September 2017, except August 2017, and stated that the 21 dates that were not signed indicated the check was not completed by the registered staff. The Co-DOC reviewed resident #031's sleeve of expired controlled substance medication and the narcotic and controlled drug administration and shift count records from January to September 14, 2017, and acknowledged the home did not follow their policy regarding weekly checks of expired medications for resident #031. [s. 8. (1) (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 that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The home submitted a CI report to the MOHLTC related to resident to resident abuse. The CI indicated that resident #028 exhibited identified responsive behaviours towards other residents and staff. Resident #028 interacted with resident #029 causing an injury.

Review of resident #028's progress notes revealed he/she had a history of responsive behaviours towards other residents and staff as follows:

In December 2016, resident #028's behavior worsened when he/she exhibited an identified behaviour towards co-residents and staff. Staff had difficulty in distracting or redirecting the resident and the registered staff left a note for the physician to assess. Subsequently, resident #028 had another altercation with resident #035.

During a five day period prior to the date of the above mentioned critical incident, there were numerous incidents of an identified behaviour towards other residents.

A progress note revealed residents and family were concerned about the safety of the environment on the resident home area due to the identified responsive behaviour of resident #028.

Review of the written plan of care for resident #028 at the time of the altercations mentioned above revealed that there was no plan of care in place for the identified responsive behaviours toward co-residents. Further to this, the plan of care for the identified responsive behaviours was not developed or implemented until after the two altercations with residents #029 and #035.

Review of resident #028's EMAR during a seven day period in December 2016, revealed the resident received a particular prescribed medication on two specified dates, which was noted to be ineffective in managing his/her behaviours. The resident received the

same medication twice on another specified date in December 2016, and it was noted to be effective. There were no further interventions to include informing the physician that the medications were not effective. The resident was not seen until three days after the above mentioned particular medication was prescribed, when the Nurse Practitioner assessed the resident and prescribed a particular treatment for a medical condition.

Interviews with the home's BSO PCP #145, and Recreation Aide (RA) #143 indicated resident #028 had identified responsive behaviours towards staff and residents. The PCP and RA reported resident #028's responsive behaviours occurred with and without provocation and considered the altercation between resident #028 and #029 to be abuse towards resident #029.

Interview with PCP #146 indicated he/she witnessed the above mentioned interaction between resident #028 towards resident #029. The PCP indicated that on the day of the incident, he/she received report from the registered staff that resident #028 was exhibiting responsive behaviours. The PCP indicated he/she observed resident #028's behaviour escalating during the shift. The PCP stated that he/she observed resident #028 in the hallway, when resident #028 started exhibiting responsive behaviours towards resident #029; resident #029 sustained an inury. The PCP indicated he/she was not aware of specific triggers of resident #028 and did not review the plan of care at the start of his/her shift but received a report from the registered staff of residents with responsive behaviour including resident #028. The PCP acknowledged the incident to be abuse by resident #028 to resident #029.

Interviews with RPNs #119 and #142 indicated resident #028 had identified responsive behaviours towards staff and residents. The RPNs indicated it is the home's expectation for the written plan of care to be updated with interventions to mitigate the safety risk of resident #028's responsive behaviours towards other residents. The RPNs reviewed the written plan of care for resident #028 and acknowledged the plan of care was not updated with interventions to manage resident's identified responsive behaviours towards co-residents until after the altercations with residents #029 and #035.

Interview with the Co-DOC #138 indicated it is the home's expectation for residents to be protected from abuse by anyone. He/she indicated resident #028 was known to have identified responsive behaviours towards residents and staff. The Co-DOC indicated it is the home's process for the home's BSO team to assess the resident with responsive behaviour, develop interventions, meet with staff regarding the interventions and the plan of care is to be updated. The Co-DOC reviewed resident #028's responsive behaviour

debrief assessments for the two above mentioned incidents, and indicated the identified responsive behaviour towards co-residents was new for resident #028 at the time of the first incident with resident #035. The Co-DOC reviewed the written plan of care and stated the plan of care for resident #028 was not updated after the two above mentioned incidents with resident #035 and #029 occurred. He/she acknowledged the incident between resident #028 and resident #029 was considered to be abuse and the home did not put interventions in place to protect resident #029 as per home's expectation. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance residents are protected from abuse by anyone and are not neglected by licensee or staff, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying interventions.

The home submitted a CI report to the MOHLTC related to resident to resident abuse. The CI indicated that resident #028 exhibited identified responsive behaviours towards

other residents and staff. Resident #028 interacted with resident #029 causing an injury.

Review of resident #028's progress notes revealed he/she had a history of responsive behaviours towards other residents and staff as follows:

In December 2016, resident #028's behaviors worsened when he/she exhibited an identified behaviour towards co-residents and staff. Staff had difficulty in distracting or redirecting the resident and the registered staff left a note for the physician to assess. Subsequently resident #028 had another altercation with resident #035.

During a five day period prior to the date of the above mentioned critical incident, there were numerous incidents of identified behaviours towards other residents.

After the interaction with resident #035, a progress note dated the same day indicated the home contacted the psychogeriatric physician regarding resident #028's recent changes in behaviour. An order was received from the psychogeriatrician for an increase of two particular prescribed medications; it was initiated on a specified date in December 2016.

Two days after the above mentioned medications were prescribed resident #028's progress note indicated the resident's identified responsive behaviours continued towards staff and other residents.

Three days after the above mentioned medications were prescribed resident #028's progress note revealed the resident exhibited identified responsive behaviours throughout the day as follows:

- At 1230 hours, resident #028 was observed in an altercation with an identified resident, and at 1312 hours, resident #028 was observed in an altercation with another identified resident.

- At 1530 hours, resident #028 was observed in an altercation with resident #029. The progress notes indicated resident #028 exhibited identified responsive behaviours towards resident #029, causing resident #029 to sustain an injury.

Review of the written plan of care for resident #028 at the time of the altercations between resident #028 and #029 as well as with resident #035, included specified interventions. There was no plan of care in place for the identified responsive behaviours

toward co-residents. Further to this, the plan of care for the identfied responsive behaviours was not developed or implemented until after the above mentioned altercations occurred.

Review of resident #028's EMAR during a seven day period in December 2016, revealed the resident received a particular prescribed medication on two specified dates, which was noted to be ineffective in managing his/her behaviours. The resident received the same medication twice on another specified date in December 2016, and it was noted to be effective. There were no further interventions to include informing the physician that the medications were not effective. The resident was not seen until three days after the above mentioned particular medications was prescribed, when the Nurse Practitioner assessed the resident and prescribed a particular treatment for a medical condition.

Interviews with the home's BSO PCP #145, and RA #143 indicated resident #028 had identified responsive behaviours towards staff and residents. The PCP and RA reported resident #028's responsive behaviours occurred with and without provocation and considered the altercation between resident #028 and #029 to be abuse towards resident #029.

Interview with PCP #146 indicated he/she witnessed the above mentioned interaction between resident #028 towards resident #029. The PCP indicated that on the day of the incident, he/she received report from the registered staff that resident #028 was exhibiting responsive behaviours. The PCP indicated he/she observed resident #028's behaviour escalating during the shift. The PCP stated that he/she observed resident #028 in the hallway, when resident #028 started exhibiting responsive behaviours towards resident #029; resident #029 sustained an injury. The PCP indicated he/she was not aware of specific triggers of resident #028 and did not review the plan of care at the start of his/her shift but received a report from the registered staff of residents with responsive behaviour including resident #028. The PCP acknowledged the incident to be abuse by resident #028 to resident #029.

Interviews with RPNs #119 and #142 indicated resident #028 had identified responsive behaviours towards staff and residents. The RPNs indicated it is the home's expectation for the written plan of care to be updated with interventions to mitigate the safety risk of resident #028's responsive behaviours towards other residents. The RPNs reviewed the written plan of care for resident #028 and acknowledged the plan of care was not updated with interventions to manage resident's identified responsive behaviours towards co-residents until after the two above mentioned altercations with residents #029

and #035.

Interview with the Co-DOC #138 indicated resident #028 was known to have identified responsive behaviours towards residents and staff. He/she indicated it is the home's process for the home's BSO team to assess the resident with responsive behaviour, develop interventions, meet with staff regarding the interventions and the plan of care is to be updated. The Co-DOC reviewed resident #028's responsive behaviour debrief assessments for the altercations involving resident #029 and #035 and indicated the identified responsive behaviour towards co-residents was new for resident #028. The Co-DOC reviewed the written plan of care and stated the plan of care for resident #028 was not updated after the two above mentioned altercations with residents #029 and #035. He/she acknowledged the home did not identify interventions for resident #028 to minimize the risk of altercations and potentially harmful interactions with other residents, as per home's expectation. [s. 54. (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 that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying interventions, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.

On September 14, 2017, at 1450 hours on an identified resident home area, the inspector observed PCPs #128 and #139, providing care to resident #034 in the resident's room with the door open. The PCPs were observed repositioning the resident in bed exposing the resident's legs and brief.

Interviews with PCPs #128 and #139 revealed it is the home's expectation for residents' room doors to be closed when care is provided to ensure privacy. The PCPs acknowledged they did not provide resident #034 privacy when care was provided with the room door open according to the Residents' Bill of Rights.

Interview with Co-DOC #125 indicated it was the home's expectation for room doors to be closed when care is provided to residents to ensure privacy. The Co-DOC acknowledged that PCPs #128 and #139 did not provide resident #034 privacy in caring for his/her personal needs. [s. 3. (1) 8.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The skin and wound IP triggered from stage one of the RQI related to altered skin integrity for resident #007.

Record review of resident #007's clinical records revealed a progress note and physician order dated February 14, 2017, indicating physician #141 ordered a dermatology consult for resident #007's altered skin integrity.

Interviews with RPNs #103 and #111, revealed they were aware of resident #007's the altered skin integrity. The RPNs stated it was the home's expectation for an initial skin and wound assessment be completed upon discovery of altered skin integrity, followed by weekly skin and wound assessments. The RPNs reviewed resident #007's progress notes and skin and wound care assessments from the period of March 2016 to September 2017, and did not find any skin and wound assessments completed regarding resident #007's altered skin integrity. Both RPNs acknowledged resident #007 did not receive a skin and wound assessment and should have.

Interview with the home's IC/SWC #114 revealed when a resident develop areas of altered skin integrity registered staff are expected to complete an initial skin and wound assessment upon discovery, followed by the weekly skin and wound assessments. He/she reviewed the skin and wound assessments for resident #007 and confirmed a skin and wound assessment addressing the resident's altered skin integrity was not completed as per the home's expectation. [s. 50. (2) (b) (i)]

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

Review of a CI dated September 24, 2015, reported resident #020 sustained an injury of unknown cause.

Review of the home's policy titled Skin Care Program Overview, policy #LTC-CA-

WQ-200-08, revised on November 2014 indicated that residents with altered skin integrity will have their skin assessed with weekly wound care assessment. The appropriate assessment in Point Click Care (PCC) will be initiated when there is an alteration in a resident's skin integrity. The record is to be completed weekly by registered staff and is used to document specific information regarding areas of alteration as well as the treatment and healing of the affected area.

Review of resident #020's progress notes indicated around midnight on September 24, 2015, staff reported that the resident was observed with an area of altered skin integrity of unknown cause. Resident #020 was assessed by RN # 135, and the resident did not verbalize any pain during range of motion (ROM) and no swelling to the area. The resident was monitored and not transferred to the hospital.

Further review of resident #020's progress notes dated September 2015, indicated the resident had been transferred to the hospital related to another medical condition, and during the time at the hospital a diagnostic test was done and confirmed that the resident had sustained an injury. Further review indicated resident #020 returned from hospital five days later and on assessment it was noted that the areas of altered skin integrity on the resident were very apparent.

Review of a skin assessment dated October 1, 2015, indicated resident #020 was assessed for new skin alterations and indicated multiple areas of skin alterations. Further review of resident #020's assessment records showed no evidence of any further skin assessments for the above mentioned skin alterations.

Interviews with PCPs #151 and #155 revealed they observed resident #020 to have an area of skin alteration on an identified area of the body and was not aware of how the resident sustained the skin alteration.
Interviews with RN #135, Co-DOCs #125 and #138 revealed resident #020 returned from hospital with a confirmed injury as per the diagnostic test results, and had a skin alteration due to the injury; the resident's initial area of altered skin integrity should have been assessed and monitored on a weekly basis until resolved. [s. 50. (2) (b) (iv)]

WN #7: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident was 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.

A review of the home's 2017 medication incidents revealed two medication incidents involving residents #001 and #032 were not reported to the resident or the residents' substitute decision makers (SDM).

Review of a medication incident report for resident #001 revealed on a specified date in March 2017, there was an omission of a particular prescribed medication at a specified time.
Review of a medication incident report for resident #032 revealed on a specified date in March 2017, there was an omission of three particular prescribed medications at a specified time.The medication incident reports did not indicate if the residents or their family/SDM were notified about the incidents.

Review of residents #001 and #032's progress notes did not include documentation that the residents' or their family/SDM were notified about the medication incidents.

Interviews with RPN #147 and RN #104 revealed it is the home's process when a medication incident occurs, the resident or resident's SDM is notified and documentation completed on the incident report.

During interview with Co-DOC #125 he/she revealed that the registered staff are to inform the resident or their respective SDMs when a medication incident occurs. The Co-DOC reviewed the incident reports and progress notes of residents #001 and #032 and acknowledged that the staff did not notify the above mentioned residents or their respective SDMs regarding the medication incidents. [s. 135. (1)]

Issued on this 22nd day of November, 2017

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

Original report signed by the inspector.