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
Sep 13, 2017	2017_652625_0013	013086-17	Resident Quality Inspection

Licensee/Titulaire de permis

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

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

PINEWOOD COURT
2625 WALSH STREET EAST THUNDER BAY ON P7E 2E5

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

KATHERINE BARCA (625), JULIE KUORIKOSKI (621), LAUREN TENHUNEN (196)

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): July 10 to 14 and 17 to 21, 2017.

Additional intakes completed during the Resident Quality Inspection (RQI) were:
- one log related to a Critical Incident System (CIS) report submitted for an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status;
- one log related to a complaint regarding a resident's health status;
- two logs related to CIS reports submitted for two allegations of staff to resident abuse;
- one log related to a Follow-up to Compliance Order #001 issued during inspection #2017_463616_0003 regarding Ontario Regulation 79/10, s. 229. (4) staff participation in the implementation of the Infection Prevention and Control Program; and
- one log related to a CIS report submitted for an unexpected death.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Acting Director of Care (Acting DOC), the Associate Director of Care/Resident Services Coordinator (ADOC/RSC), the Environmental Services Manager (ESM), an Environmental Services employee, a Housekeeping Aide, the Program Manager, the Volunteer Coordinator/Recreation Aide, Recreation Aides, the Registered Dietitian (RD), a physiotherapy assistant (PTA), the Resident Assessment Instrument (RAI) Coordinator, the Pharmacist, the Pharmacy Manager, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and families.

The Inspectors also reviewed residents' health care records, various home's policies and procedures, council meeting minutes, the home's investigation files and incident reports. Inspectors conducted observations of residents, observed the provision of care and services to residents, observed resident and staff interactions and made observations of resident home areas.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
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
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 229. (4)	CO #001	2017_463616_0003	625

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

A Critical Incident System (CIS) report was submitted to the Director for a fall that occurred in the winter of 2017 that resulted in resident #012 sustaining an injury.

On a date in July 2017, Inspector #625 observed resident #012 with a focus on falls prevention interventions in place. The resident was observed using an assistive device for mobility with a safety device in use and a second safety device present but not in use.

On the same date in July 2017, Inspector #625 interviewed Personal Support Worker (PSW) #112 who stated that they had applied the second safety device in the morning but they were not sure if it was in use as there was nowhere to find the information as the current care plans and Kardex were too generic and not specific enough to provide that information.

The same day, the Inspector interviewed PSW # 113 who stated the resident used three specific safety devices.

On two additional dates in July 2017, the Inspector observed resident #012 using an assistive device for mobility with a safety device in place. The second safety device previously observed by the Inspector was not present during these observations.

Inspector #625 reviewed the Point of Care (POC) tasks in place on a date in July 2017, which included monitoring of three safety devices, but did not include monitoring of the safety device that was previously observed to be present but not in use.

Inspector reviewed the Kardex in place on a date in July 2017, which listed the safety device that was previously observed to be present but not in use and referenced the use of another type of safety device but did not identify what the specific device was.

Inspector reviewed the care plan in place on a date in July 2017, which listed two safety devices in use due to the ineffective use of a third safety device.

On a date in July 2017, Inspector #625 interviewed the Resident Assessment Instrument (RAI) Coordinator #102 who identified that:
- the use of one specific safety device in use when the resident used their assistive device for mobility was listed in the Kardex and care plan but not in the POC tasks;
- the use of an unspecified particular type of safety device when the resident used their assistive device for mobility was listed in the Kardex, an unspecified particular type of safety device was listed on the POC tasks and a specified particular safety device in use was listed in the care plan; and
- the use of a third safety deviece was not listed in the Kardex, was listed in the POC tasks as in use and was listed in the care plan as not in use having been ineffective.
The Coordinator stated that the plan of care did not provide clear direction to staff on which safety device the resident used.

On a date in July 2017, during an interview with Inspector #625, the Associate Director of Care (ADOC) identified the same discrepancies in the documents as previously identified by the RAI Coordinator. The ADOC stated that the current plan of care did not provide clear direction to staff on which safety device the resident used, specifically related to the residents use of a three different specific safety devices.

Following the ADOC and RAI Coordinator interviews, on a date in July 2017, Inspector #625, the ADOC and the RAI Coordinator attended the resident and observed the resident using their assistive device for mobility with one safety device present but without a second safety device present.

During an interview with PSWs #113 and #114, they stated that the POC tasks should list safety devices used and that is where the PSWs would go to find out if the resident used one. They stated that resident #012 did not have a specific type of safety device as it was

not listed in the POC tasks. [s. 6. (1) (c)]

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

On a date in March 2017, a Critical Incident System (CIS) report was submitted to the Director for an incident of alleged staff to resident abuse that involved resident #017. The report identified that a witness reported resident #017 stated PSW #114 had abused them and the witness had observed the PSW abuse the resident.

On a date in July 2017, during an interview with Inspector #196, the Executive Director (ED) stated that the investigation into the incident had been completed and it was determined that PSW #114 had provided improper care to resident #017 by themselves when a second staff person was required.

The Inspector reviewed the care plan that was in effect at the time of the incident in March of 2017. The care plan identified that the resident required support for an activity of daily living as evidenced by the resident's health status related to a disease diagnosis and that staff were required to provide the assistance with two staff. [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 that ensures that:
- the written plan of care for each resident sets out clear directions to staff and others who provide direct care to the resident; and
- the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment were kept clean and sanitary.

On two dates in July 2017, Inspector #621 observed two pieces of resident #014's room furnishings to be soiled and stained.

On a date in July 2017, Inspector #196 observed one piece of resident #014's room furnishings to have dried white debris present.

During an interview with resident #014 on a date in July 2017, they reported to Inspector #621 that housekeeping staff cleaned their room daily, which sometimes included wiping debris off of one furnishing, but that they had not seen the staff do a more thorough cleaning of the furnishing. Additionally, resident #014 identified that, to their knowledge, the other furnishing had not been cleaned by housekeeping since they moved in.

During an interview on a date in July, 2017, Housekeeping Aide #110 reported to Inspector #621 that when they cleaned a resident room they checked the furniture and completed any spot cleaning required. If however, a piece of furniture required a deeper cleaning they reported that they would take the item to another area of the home to complete this task. The Housekeeping Aide observed resident #014's two furnishings and confirmed with the Inspector that both were soiled and required cleaning.

During an interview with Environmental Services Manager (ESM) #111 on a date in July 2017, they reported to Inspector #621 that housekeeping staff were responsible for light cleaning of furniture surfaces as part of the housekeeping duties in residents' rooms. Additionally, they reported that if a resident had their own furniture that later required

deeper cleaning, the home would contact the family to address the issue, due to the potential damage if the home performed deep cleaning on the items. The ESM observed two specific furnishings found in resident #014's room, and confirmed to Inspector #621 that both were visibly soiled. Further, the ESM reported to the Inspector that one of the furnishings was the property of the home, but was not sure whether the second furnishing was property of the resident or the home and whether the resident's family had been notified.

During an interview with the Executive Director (ED) on a date in July 2017, they reported to Inspector #621 that it was their expectation that, if there was furniture owned by the resident and/or their family which required deeper cleaning, that the resident and/or their substitute decision maker (SDM) would be contacted by the unit nursing staff to discuss further options. The ED confirmed to the Inspector that there was no documentation identifying that nursing staff notified resident #014's family that one furnishing required more thorough cleaning than the home could provide. [s. 15. (2) (a)]

2. The home has failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

On a date in July 2017, during a tour of the home, Inspector #625 observed the mechanical tub chair in the Spa/Bathing Room on a resident home area to have the finish worn off. On another date in July 2017, the Inspector observed the mechanical lift tub chairs in all four resident home area Spa/Bathing Rooms to have scratches and/or cracks in the finish of the seats, gouges in the seats and/or peeling and worn handle bars.

On a date in July 2017, Inspector #625 observed the bathtub mechanical lifts to be in poor condition including:
- in one resident home area Spa/Bathing Room, the lift seat had gouges (approximately 8 centimeters (cm) x 1 cm and 4 cm x 1 cm), a cracked finish covering approximately two thirds of the front of the seat, small scratches (approximately 1 cm in length x 0.1 cm) covering approximately one half of the front of the seat;
- in a second resident home area Spa/Bathing Room, the lift seat had four gouges (two on front of the seat approximately 8 cm x 1 cm; two on back of seat approximately 6 cm x 1 cm and 9 cm x 1 cm) and generalized cracking in the surface of the finish over the front, back and sides of the seat;
- in a third resident home area Spa/Bathing room the lift had the finish peeling on approximately two thirds of the length of the resident handles; gouges on the seat

(approximately 6 cm x 1 cm, 5 cm x 1 cm and 4 cm x 1 cm), multiple small scratches on the front and side of the seat, a worn finish in the middle of the front of the seat of an irregular shape approximately 10 cm x 5 cm; and
- in a fourth resident home area Spa/Bathing Room the seat finish was worn off in an area on the back and side approximately 20 cm x 5 cm; a gouge in the seat back approximately 6 cm x 1 cm, generalized cracks in finish over the entire width of the front seat.

During interviews with Inspector #625 on a date in July 2017, the ESM viewed the bathtub mechanical lift in one resident home area Spa/Bathing Room and acknowledged that the seat finish had worn off in some areas, the seat had scratches and that there was damage to the integrity of the seat surface. The ESM stated that the lifts were 12 years old and acknowledged that that the finish and seats were in poor condition and that they may require replacement. During a second interview with the Inspector on a date in July 2017, the ESM viewed the bathtub mechanical lift in another resident home area Spa/Bathing Room and acknowledged that the resident handle finish was peeling and worn, there were gouges on the seat and the finish had worn off in some areas. [s. 15. (2) (c)]

3. On a date in July 2017, Inspector #621 observed the linoleum flooring in resident #014's room to be discoloured, with the seam lines separating and the linoleum lifting on the left side of the toilet.

On a date in July 2017, Inspector #196 observed stains present on the flooring underneath the window in resident #014's room.

During an interview with resident #014 on a date in July 2017, they reported to Inspector #621 that the marks on the flooring next to their window, and linoleum damage in the bathroom had been present since the day they moved in.

During an interview on a date in July 2017, Housekeeping Aide #110 reported to Inspector #621 that during the cleaning of resident rooms, if they discovered any maintenance issues, they would report them on their daily worksheet and submit that information to the Environmental Services Manager (ESM) for further review. The Housekeeping Aide confirmed that there were stains and damage present to the flooring in both resident #014's bedroom and bathroom, and that they had not yet reported these concerns to the ESM.

During an interview with the ESM on a date in July 2017, they reported to Inspector #621 that they were aware of the damaged flooring in resident #014's bathroom and bedroom and confirmed to the Inspector that the floor was damaged in both areas of resident #014's room. [s. 15. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures that:
- the home, furnishings and equipment are kept clean and sanitary; and
- the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that 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 was specifically designed for skin and wound assessment.

During observations of resident #010 on three dates in July 2017, Inspector #625 observed areas of altered skin integrity on two parts of the resident's body.

On a date in July 2017, Inspector #625 reviewed the resident's health care record including the current care plan and progress notes and was not able to locate any reference to the areas of altered skin integrity observed on the resident's two body parts.

On a date in July 2017, the Inspector interviewed Registered Practical Nurse (RPN) #101 who viewed the resident's body parts with the Inspector and stated that two areas of altered skin integrity were present and should be captured in a progress note and possibly an electronic skin assessment. The RPN stated that a progress note or skin assessment had not been completed for the altered skin integrity identified.

On a date in July 2017, Inspector #625 interviewed the Associate Director of Care (ADOC) who acknowledged that the resident did have altered skin integrity on a specific part of their body. The ADOC stated that the altered skin integrity on the resident should have had a skin assessment completed by the RPN using a clinically appropriate assessment instrument. The ADOC identified that the RPN should have followed the home's "Skin and Wound Care Program (Wounds)" (undated) algorithm which included assessment of the alteration in skin integrity.

On a date in July 2017, Inspector #625 reviewed the home's algorithm titled "Skin and Wound Care Program (WOUNDS)" (undated) that identified that, when a new wound was identified, the wound was to be assessed.

During a phone interview with the Acting DOC on a date in August 2017, they stated to the Inspector that the clinically appropriate assessment instrument that was specifically designed for skin and wound assessments used in the home were the "Initial Skin Tear Assessment" or the "Initial Wound Assessment", depending on the type of wound identified. The Acting DOC acknowledged that the resident had not had skin assessments completed for the skin impairments previously observed by the Inspector. [s. 50. (2) (b) (i)]

2. During observations of resident #011 on two dates in July 2017, Inspector #625 observed two areas of altered skin integrity on a specific part of the resident's body. On a

third date in July 2017, the Inspector observed three areas of altered skin integrity on the specific part of the resident's body.

On a date in July 2017, Inspector #625 reviewed the resident's health care record including the current care plan and progress notes and was not able to locate any reference to the impairment to the resident's skin integrity on the specific body part.

On a date in July 2017, the Inspector interviewed RPN #101 who viewed the resident's body part with the Inspector and stated that alterations to the resident's skin integrity were present and characteristics of the alterations should have been documented.

On a date in July 2017, the Inspector reviewed a progress note documented by RPN #101 entered on the previous date, after the interview with Inspector #625. The note read that the resident had alterated skin integrity on a specific part of their body and that there was no documentation related to the altered skin integrity.

On a date in July 2017, Inspector #625 interviewed the ADOC who viewed the resident's body part with the Inspector and acknowledged that the resident did have three areas of altered skin integrity on that part of their body. The ADOC stated that the resident had impairments in their skin integrity and should have had a skin assessment completed by the RPN using a clinically appropriate assessment instrument. The ADOC identified that the RPN should have followed the the home's "Skin and Wound Care Program (Wounds)" (undated) algorithm, which included assessment of the altered skin integrity.

On a date in July 2017, Inspector #625 reviewed the home's algorithm titled "Skin and Wound Care Program (WOUNDS)" (undated) that identified that, when a new wound was identified, the wound was to be assessed.

During a phone interview with the Acting DOC on a date in August 2017, they stated to the Inspector that the clinically appropriate assessment instrument that was specifically designed for skin and wound assessments used in the home were the "Initial Skin Tear Assessment" or the "Initial Wound Assessment", depending on the type of wound identified. The Acting DOC acknowledged that the resident had not had skin assessments completed for the skin impairments previously identified at the time they had been observed by the Inspector. [s. 50. (2) (b) (i)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents that had a weight change of 5 per cent body weight, or more, over one month; a change of 7.5 per cent body weight, or more, over three months; or a change of 10 per cent of body weight, or more, over six months; were assessed using an interdisciplinary approach, and that actions were taken and outcomes evaluated.

On a date in July 2017, during a census record review completed by Inspectors #621 and #625, resident #005 was identified to have had a significant weight change. The next day Inspector #621 further reviewed resident #005's weight record, which identified that between specific dates over a period of four months in 2017, there was a significant weight change. Additionally, Inspector #621 reviewed resident #005's health record and was unable to find documentation identifying that a referral to the Registered Dietitian

(RD) had been made for the significant weight change.

In an interview on a date in July 2017, the RD confirmed that resident #005 had a significant weight change over four consecutive months in 2017. The RD identified that the home had an electronic nutrition referral form for registered staff to complete when nutrition issues, including significant weight changes, were identified. The RD reported to Inspector #621 that a referral had not been made by registered nursing staff to the RD to assess the significant weight change recorded on a date in the spring of 2017, and consequently the resident was not assessed by the RD until a number of days later, when they had discovered the significant weight change.

During interviews with Registered Nurse (RN) #104 on a date in July 2017, PSW #106 and PSW #107, reported to Inspector #621 that residents were weighed during the first week of each month by the PSW staff, and these weights were then entered into the "weights and vitals" section of the resident's electronic medical record (EMR) by either an RN or RPN. Additionally, RN #104 reported to the Inspector that if a significant weight change was identified in the weight record of the EMR, that the nurse would request a PSW to re-weigh the resident. RN #104 identified that if the re-weigh confirmed a significant weight change, then the nurse would make a referral using the electronic referral form to the RD for further assessment.

RN #104 confirmed to Inspector #621 that resident #005's weight record identified a significant weight change over the four consecutive months in 2017, and that a subsequent referral to the RD had not been made, and should have.

During an interview on a date in July 2017, the Executive Director (ED) reported to Inspector #621 that it was their expectation that registered nursing staff were communicating significant weight changes using an interdisciplinary referral process to the RD and acknowledged that currently there was only one RPN in the building that was completing electronic referrals to the RD for nutrition issues on a consistent basis. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures that that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of five per cent of body weight, or more, over one month;
2. A change of seven and one-half per cent of body weight, or more, over three months;
3. A change of ten per cent of body weight, or more, over six months; or
4. Any other weight change that compromises the resident's health status, to be implemented voluntarily.

WN #5: 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. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was documented, together with a record of the immediate actions taken to assess and maintain the resident's health.

Inspector #196 reviewed the licensee's medication incidents including the following:
- A report dated a specific date in January 2017, that identified that resident #025 was administered resident #023's medications;
- A report dated a specific date in March 2017, that identified that resident #021 had not received a medication; and
- A report dated a specific date in June 2017, when resident #024 was administered an incorrect dose of a scheduled medication.

A review of the policy titled "LTC - Medication Incidents - CARE13-O30.01" last reviewed July 31, 2016, identified that "For all resident-related medication incidents, there will be a

brief factual description of the incident, treatment, and intervention documented in the interdisciplinary progress notes. The Resident's condition will be monitored and documented for 24 hours or as per Physician Order".

During an interview with the Acting Director of Care (DOC) on a date in July 2017, they stated that:
- With respect to the medication error involving resident #025, there was no documentation of monitoring of the resident in the progress notes;
- With respect to the medication error involving resident #021, there was no documentation of monitoring of the resident in the progress notes; and
- With respect to the medication error involving resident #024, there was no documentation of monitoring of the resident in the progress notes after the discovery of the medication error.

The Acting DOC acknowledged that a record of the immediate actions taken to assess and maintain the resident's health had not been documented. [s. 135. (1) (a)]

2. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction 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.

Inspector #196 reviewed the licensee's medication incidents including the following:
- A report dated a date in January 2017, that identified that resident #025 was administered resident #023’s medications. The report indicated that the family and pharmacy had not been notified of the error;
- A report dated a date in March 2017, that identified that resident #021 had not received a medication. The report indicated that the physician, family and pharmacy had not been notified of the error;
- A report dated a date in April 2017, that identified that, in the morning, resident #022 was administered medications, which were scheduled to be administered at bedtime. The report indicated that the pharmacy had not been notified of the error; and
- A report dated a date in June 2017, when resident #024 was administered an incorrect dose of a scheduled medication. The report indicated that the physician and pharmacy had not been notified of the error.

A review of the policy titled "LTC - Medication Incidents - CARE13-O30.01” last reviewed

July 31, 2016, identified that "The Physician/Nurse Practitioner (NP)/Substitute Decision Maker (SDM)/family will be informed of all Resident-related incidents. The Nurse will determine whether the Physician/NP/SDM/family requires notification immediately, within the next 12 hours or at the next visit."

During an interview with the Acting Director of Care (DOC) on a date in July 2017, they stated that:
- With respect to the medication error involving resident #025, there was no record of notification of the resident's family in the progress notes;
- With respect to the medication error involving resident #021, there was no record of notification of the resident's substitute decision-maker (SDM) or physician in the progress notes;
- With respect to the medication error involving resident #022, the incident report identified that the pharmacy was not notified of the incident and there was no record of notification of the pharmacy in the progress notes; and
- With respect to the medication error involving resident #024, there was no record of notification of the physician and pharmacy in the progress notes.

The Acting DOC acknowledged that, with respect to reporting medication incidents to residents' SDMs, attending physician/registered nurse in the extended class and/or the pharmacy service provider, they had not been notified.

During an interview with Inspector #625 on a date in July 2017, Pharmacy Manager #115 stated that the pharmacy service provider had not been notified of the medication errors involving residents #021, #022 and #023/#025. [s. 135. (1) (b)]

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

Inspector #196 reviewed the home's medication incidents as part of the Resident Quality Inspection.

During an interview with Inspector #196 on a date in July 2017, Pharmacist #117 stated that medication incidents were discussed at "Multidisciplinary Resident Care Committee" meetings.

A review of the "Multidisciplinary Resident Care Committee Minutes" dated March 30, 2017, identified that the previous meeting had been held on December 1, 2016. The minutes also identified, under the topic "Managing Medications/Pharmacy" that incident reports, incidents and errors were to be discussed. The Action/Outcome related to this topic did not indicate that medication incidents and errors were reviewed and regrets from Pharmacist #117 were noted.

During an interview with Inspector #196 on a date in July 2017, the Acting DOC stated that a full review of the medication incidents that had occurred in the home since January 2017 had not occurred and a written record of any quarterly review of all medication incidents and adverse drug reactions that had occurred in the home since the time of the last review had not been completed. [s. 135. (3)]

Additional Required Actions:

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

- A quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; and a written record is kept of everything provided for in clauses (a) and (b), to be implemented voluntarily.

WN #6: 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, where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, that the plan, policy, protocol, procedure, strategy or system was complied with.

Ontario Regulation 79/10, s. 65. (2) (f) identifies that the recreational and social activities program includes assistance and support to permit residents to participate in activities that may be of interest to them if they are not able to do so independently.

During an interview with resident #011's family member #119 on a date in July 2017, they indicated to Inspector #625 that the home's staff did not encourage the resident to attend activities and provide assistance to attend them. The family member commented that the family identified activities the resident wanted to attend on the resident's "PWC Activities Calendar", but that the home's staff did not always get the resident for the activities they had identified, it was "hit or miss".

During an interview with resident #011's family member #120 on a date in July 2017, they acknowledged that the family identified the resident's interest in specific activities on the "PWC Activities Calendar". They stated that a Recreation Aide had advised them to do this so that the activities the resident wanted to attend would be known to staff.

Inspector #625 reviewed the home's policy titled "LTC - Recreation Program - CARE16-P10" effective August 31, 2016, that identified "Residents' quality of life will be enhanced by opportunities to participate in a variety of recreation programs. Programs will meet their needs and choices…".

Inspector #625 reviewed the home’s policy titled "LTC - Recreation Program - CARE16-O10.01" effective August 31, 2016, that identified “Resident -specific programs and individualized therapeutic recreation interventions will be developed and documented for each Resident on the Resident's care plan” and "Resident-specific program interventions will be developed or changed based on Residents' needs and interests".

On a date in July 2017, Inspector #625 reviewed the resident’s current care plan, with a focus on recreation activities. The care plan identified that the resident required support to engage in meaningful recreation and leisure due to specific characteristics.

On a date in July 2017, Inspector #625 reviewed the "PWC Activities Calendar" posted in the resident’s room and noted 12 activities that the resident was interested in attending were identified by the family over 16 days.

On a date in July 2017, the Inspector reviewed the "Multi-Day Participation Report" for the 16 days in July 2017. The report identified that the resident had been approached regarding only one of the identified activities but had been sleeping and did not attend the activity.

During an interview with PSWs #121, #122 and #123 on a date in July 2017, they stated to the Inspector that the resident’s family identified activities on the "PWC Activities Calendar" that they believe the resident would enjoy attending and that the recreation staff or nursing staff would take the resident to attend the activities.

During an interview with Inspector #625 on a date in July 2017, Recreation Aide/Volunteer Coordinator #116 reviewed the resident's "PWC Activities Calendar" with the Inspector and indicated that the resident’s family had identified activities the resident wanted to attend on the calendar and that Recreation Aides would check the resident’s calendar to see what the resident wanted to participate in. The Aide acknowledged that, on the July 2017 calendar, 12 activities were identified by the family to as activities the resident wanted to attend. The Aide also confirmed that the “Multi-Day Participation Report” for the specified period identified that the resident was approached for only one activity and was sleeping. The Aide acknowledged that it did not appear that the resident was provided with the opportunities to pursue recreational activities of their choice.

During a phone interview with Program Manager #118 on a date in August 2017, they confirmed that all 12 of the activities identified by the resident’s family had been held. They indicated that, if the resident had only been approached by staff to attend one of

the 12 activities they had expressed an interest in attending, that the resident was not provided with the support they required to attend and participate in recreational programs of their choosing. [s. 8. (1) (a),s. 8. (1) (b)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that, when making a report to the Director under subsection 23 (2) of the Act, the licensee included the following material in writing with respect to an alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report: the names of any staff members or other persons who were present at or discovered the incident.

On a date in March 2017, a Critical Incident System (CIS) report, was submitted to the Director for an incident of alleged abuse from staff to resident #017.

A review of the CIS report by Inspector #196 identified that the report did not include the names of the persons who were present and discovered the incident.

On a date in July 2017, Inspector #196 conducted an interview with the Executive Director (ED). They acknowledged that the names of the person who had reported the incident to the Director of Care (DOC) and the name of the person who had discovered the incident were not included in the submitted CIS report and it should have been. [s. 104. (1) 2.]

Issued on this 15th day of September, 2017

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

Original report signed by the inspector.