Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d’inspection prévue 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 Rapport	Inspection No / No de l’inspection	Log # / No de registre	Type of Inspection / Genre d’inspection
Sep 19, 2019	2019_788721_0032	016108-19, 016348-19	Complaint

Licensee/Titulaire de permis

Henley Place Limited
200 Ronson Drive Suite 305 TORONTO ON M9W 5Z9

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

Henley Place
1961 Cedarhollow Boulevard LONDON ON N5X 0K2

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

MEAGAN MCGREGOR (721), AMBERLY COWPERTHWAITE (435)

Inspection Summary/Résumé de l’inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): September 3, 4, 5 and 6, 2019.

Complaint IL-69384-LO/IL-69696-LO/Log #016108-19 and Complaint IL-69506-LO/Log #016348-19 were inspected during the course of this inspection related to concerns of resident's care needs not being met.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), an Associate Director of Care (ADOC), a Programs Manager, a Registered Nurse (RN), two Registered Practical Nurses (RPNs), three Personal Support Workers (PSWs) and residents.

The Inspectors also observed residents and the care provided to them, reviewed clinical records and plans of care for the identified residents and reviewed the homes relevant policies.

This inspection was conducted concurrently with Critical Incident System Inspection #2019_788721_0033.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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

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

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

Specifically failed to comply with the following:

s. 6. (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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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 who provided direct care to residents.

On two specific dates, the Ministry of Long-Term Care (MOLTC) Action Line received complaint IL-69384-LO, IL-69696-LO and IL-69506-LO in which complainants reported concerns of resident's care needs not being met.

A) A review of resident #002's Care Plan in PointClickCare (PCC) showed specific interventions related to their bathing schedule and preference for bathing.

A review of resident #002's electronic Treatment Administration Record (eTAR) in PCC showed a "prescriber written" order scheduled daily at a specific time indicating PSW's were to apply specific interventions with specific products related to bathing.

A review of resident #002's Tasks section in PCC showed specific interventions related to bathing including specific times the interventions were to be completed.

During an interview on a specific date, when asked how they would know what a resident's bathing needs were, PSW #106 told Inspector #721 what resident #002's

bathing needs were and did not mention the same interventions as the "prescriber written" order indicating that PSW's were to apply specific interventions with specific products related to bathing daily at a specific time.

During an interview on a specific date, when asked how they would know what a residents bathing needs were, RPN #107 stated it would be indicated on the bath list which was kept at the nursing station. When asked what resident #002's bathing needs were, RPN #107 told Inspector #721 what resident #002's bathing needs were and did not mention the same interventions as the "prescriber written" order indicating that PSW's were to apply specific interventions with specific products related to bathing at a specific time.

On a specific date, Inspector #721 and #435 reviewed the bath list within the bath binder at a specific home area nursing station which did not mention the same interventions for resident #002 as the "prescriber written" order indicating that PSW's were to apply specific interventions with specific products related to bathing at a specific time.

During an interview on a specific date, ADOC #108 reviewed resident #002’s clinical record with Inspector #721. When asked how staff would know what a residents bathing needs were, ADOC #108 stated they would look at the resident’s care plan, kardex and bath schedule in the home area. When it was identified that resident #002's care plan and the "prescriber written" order showed different interventions related to their bathing needs, Inspector #721 asked ADOC #108 if they considered this order to provide clear direction to staff on the residents needs and ADOC #108 stated no.

B) A review of resident #002’s Care Plan in PCC showed specific interventions related to a specific device and repositioning and indicated that the resident liked to get up at a specific time of day.

Inspector #721 observed resident #002 on five specific dates and times throughout the course of the inspection when interventions related to a specific device and repositioning were not in place as indicated in their Care Plan.

A review of resident #002’s electronic Medication Administration Record (eMAR) in PCC showed a "prescriber written" order scheduled daily at specific times indicating specific interventions related to a specific device and repositioning. It was documented that resident #002 was “sleeping” at one of the times of day this order was scheduled for on 20 of 31 days in a specific month.

A review of resident #002’s Tasks section in PCC showed specific interventions related to a specific device and repositioning that were scheduled daily at specific times that was different from the "prescriber written" order scheduled daily at specific times indicating specific interventions related to a specific device and repositioning.

During an interview on a specific date, when asked how they would know what a resident’s repositioning needs were, PSW #106 said there were tasks on POC that prompt them. When asked what resident #002’s repositioning needs were, PSW #106 told Inspector #721 what resident #002's repositioning needs were and did not mention the same interventions as the "prescriber written" order indicating that specific interventions related to a specific device and repositioning were to be in place at specific times.

During an interview on a specific date, when asked how they would know what a resident’s repositioning needs were, RPN #107 said it would be indicated on their care plan. When asked what resident #002’s repositioning needs were, RPN #107 told Inspector #721 what resident #002's repositioning needs were and they mentioned the same interventions as the "prescriber written" order indicating that specific interventions related to a specific device and repositioning were to be in place at specific times. When asked if resident #002 was awake and the specific interventions related to the specific device and repositioning were able to be implemented at one of the times of day this order was scheduled for, RPN #107 stated “I don’t think so” and that the interventions were implemented at a specific time of day that was different from the time of day indicated in their order.

During an interview on a specific date, ADOC #108 reviewed resident #002’s clinical record with Inspector #721. When asked how staff would know what a resident’s repositioning needs were, ADOC #108 stated they would look at the resident’s care plan and kardex. ADOC #108 identified that resident #002's care plan and the "prescriber written" order showed different interventions related to a specific device and repositioning and that their care plan indicated they liked to get up at a specific time of day. When asked if resident #002 was awake and if the specific interventions related to the specific device and repositioning were able to be implemented at one of the times of day this order was scheduled for, ADOC #108 said they weren't.

The licensee has failed to ensure that there was a written plan of care for resident #002 that set out clear directions for bathing needs, specific devices and repositioning to staff

who provided direct care this resident. [s. 6. (1) (c)]

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

On two specific dates, the MOLTC Action Line received complaint IL-69384-LO, IL-69696-LO and IL-69506-LO in which complainants reported concerns of resident’s care needs not being met.

A) A review of resident #002’s Care Plan in PCC showed a specific intervention related to their bathing preference.

A review of resident #002’s Tasks section in PCC showed a specific intervention related to bathing. It was documented that specific interventions related to their bathing preference were not implemented as indicated in their care plan on seven of nine bath days in a specific time period.

During an interview on a specific date, when asked how they would know what a residents bathing needs were, PSW #106 said it would be indicated on Point of Care (POC) what their bathing preference was. When asked what resident #002’s bathing needs were, PSW #106 told Inspector #721 what their bathing needs were and they indicated the same bathing preference as indicated in their care plan.

During an interview on a specific date, when asked how they would know what a residents bathing needs were, RPN #107 stated it would be indicated on the bath list which was kept at the nursing station. When asked what resident #002’s bathing needs were, RPN #107 told Inspector #721 what their bathing needs were and they indicated the same bathing preference as indicated in their care plan.

On a specific date, Inspector #721 and #435 reviewed the bath list within the bath binder at a specific home area nursing station which indicated a specific intervention related to resident #002's bathing preference which was the same as indicated in their care plan.

During an interview on a specific date, ADOC #108 reviewed resident #002’s clinical record with Inspector #721. When asked how staff would know what a residents bathing needs were, ADOC #108 stated they would look at the resident’s care plan, kardex and bath schedule in the home area. When it was identified that the specific interventions related to resident #002's bathing preference were not implemented as indicated in their

care plan on seven of nine bath days in a specific time period, Inspector #721 asked ADOC #108 why and ADOC #108 stated they didn’t know and they would expect the specific interventions related to resident #002's bathing preference to be in place as indicated in the care plan.

B) A review of resident #002’s Assessments section in PCC showed a specific assessment completed on a specific date, which indicated specific interventions related to toileting.

A review of resident #002’s Care Plan in PCC showed specific interventions related to toileting.

A review of resident #002’s Tasks section in PCC showed specific interventions related to toileting that were the same as indicated in their care plan.

During an interview on a specific date, when asked how they would know what a resident’s toileting needs were, PSW #106 stated it would be indicated on POC. When asked what resident #002’s toileting needs were, PSW #106 told Inspector #721 what resident #002's toileting needs were and did not mention the same interventions as indicated in their care plan, tasks and assessment.

During an interview on a specific date, when asked how they would know what a resident’s toileting needs were, RPN #107 stated it would be based on an assessment of their toileting needs. When asked what resident #002’s toileting needs were, RPN #107 told Inspector #721 what resident #002's toileting needs were and did not mention the same interventions as indicated in their care plan, tasks and assessment.

During an interview on a specific date, ADOC #108 reviewed resident #002’s clinical record with Inspector #721. When asked how staff would know what a resident’s toileting needs were, ADOC #108 stated they would look at the resident’s care plan and kardex. When Inspector #721 told ADOC #108 it was identified through staff interviews that the specific interventions related to resident #002's toileting needs were not being implemented as indicated in their care plan, ADOC #108 said they expected interventions to be implemented as stated in resident #002's care plan and that if staff realized these interventions weren't effective anymore this should be updated in their care plan.

C) A review of resident #003’s Care Plan in PCC showed a specific intervention related to their bathing preference.

A review of resident #003's Tasks section in PCC showed a specific intervention related to bathing. It was documented that specific interventions related to their bathing preference were not implemented as indicated in their care plan on four of nine bath days in a specific time period.

During an interview on a specific date, when asked how they would know what a residents bathing needs were, PSW #106 said it would be indicated on Point of Care (POC) what their bathing preference was. When asked what resident #003's bathing needs were, PSW #106 told Inspector #721 what their bathing needs were and they indicated the same bathing preference as indicated in their care plan.

During an interview on a specific date, when asked how they would know what a residents bathing needs were, RPN #107 stated it would be indicated on the bath list which was kept at the nursing station. When asked what resident #003's bathing needs were, RPN #107 told Inspector #721 what their bathing needs were and they indicated the same bathing preference as indicated in their care plan.

On a specific date, Inspector #721 and #435 reviewed the bath list within the bath binder at a specific home area nursing station which indicated a specific intervention related to resident #003's bathing preference which was the same as indicated in their care plan.

During an interview on a specific date, ADOC #108 reviewed resident #003's clinical record with Inspector #721. When asked how staff would know what a residents bathing needs were, ADOC #108 stated they would look at the resident's care plan, kardex and bath schedule in the home area. When it was identified that the specific interventions related to resident #002's bathing preference were not implemented as indicated in their care plan on four of nine bath days in a specific time period, Inspector #721 asked ADOC #108 why and ADOC #108 stated they didn't know and they would expect the specific interventions related to resident #002's bathing preference to be in place as indicated in the care plan.

The licensee has failed to ensure that the care set out in the plan of care related to bathing and toileting needs for resident #002 and bathing needs for resident #003 was provided to the residents as specified in their plans. [s. 6. (7)]

3. The licensee has failed to ensure that the provision of the care set out in resident's plans of care were documented.

On two specific dates, the MOLTC Action Line received complaint IL-69384-LO, IL-69696-LO and IL-69506-LO in which complainants reported concerns of resident's care needs not being met.

A review of resident #002, #003 and #004's Tasks section in PCC did not show any documentation of care being provided as scheduled during a specific time frame on two identified dates.

During an interview on a specific date, when asked where they would document that care was provided to residents, PSW #106 said it would be documented on POC. When asked what they would document if they were unable to provide care, PSW #106 stated they would notify registered staff. When asked if there was ever a time when they would not complete documentation of care in POC, PSW #106 stated "yes, when we are short".

During an interview on a specific date, when asked where PSW staff would document that care was provided to residents, RPN #107 stated they would document on POC and that there were times when a lot of documentation was being missed. When asked what was documented when care was not provided, RPN #107 stated they would document a multi-disciplinary note.

A review of resident #002, #003 and #004's progress notes in PCC did not show any documentation indicating whether care was provided on the two identified dates where there was no documentation of care provided under the Tasks section in PCC.

During an interview on a specific date, ADOC #108 reviewed resident #002, #003, and #004's clinical records with Inspector #721 and #435. When asked where they would expect staff to document that care was provided, ADOC #108 stated they expected them to document on POC after they had done the care. When asked what they would expect staff to document if care was not provided, ADOC #108 stated PSW staff would have to tell the nurse and the nurse would have to document this under the progress notes. When asked what it meant when staff didn't document anything under a scheduled task, ADOC #108 said that it meant the care wasn't done. ADOC #108 reviewed the resident's documentation survey reports from a specific month with Inspector #721 and confirmed that there was no documentation of care provided to these residents during a specific time frame on two identified dates. When asked why there was no documentation of care provided on the identified scheduled dates and times, ADOC #108 stated that "either

they didn't get a chance to document or they didn't do it".

The licensee failed to ensure that the provision of the care set out in resident #002, #003 and #004's plans of care were documented on two identified dates during a specific time frame. [s. 6. (9) 1.]

Additional Required Actions:

CO # - 001, 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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 where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, protocol or procedure, the policy, protocol, or procedure was complied with.

In accordance with Ontario Regulation 79/10 s. 48 the licensee was required to ensure that a pain management program to identify pain in residents and manage pain were developed and implemented.

Specifically, staff did not comply with the licensee's policy titled "PAIN", "Policy Number: 04-27", which is part of the licensee's pain program.

On two specific dates, the MOLTC Action Line received complaint IL-69384-LO,

IL-69696-LO and IL-69506-LO in which complainants reported concerns of resident's care needs not being met.

Review of a progress note from a specific date, documented that upon assessment resident #004 had pain in a specific location that had not improved. Review of progress notes dated five days after they initially complained of pain, documented that resident #004 was complaining and showing signs of worsening pain in the same specific location and an x-ray was ordered to rule out fracture. A progress note dated six days after they initially complained of pain, documented that resident #004 had increasing pain and was not responding to medications and they requested to be sent to the hospital. A progress note dated two days after they requested to be sent to hospital, documented that the writer was informed that resident #004 had a fracture requiring surgical intervention.

Review of resident #004's eMAR documented that resident #004 had received a specific dosage of a specific medication as needed (PRN) for pain on 25 identified occurrences in the month prior to their transfer to hospital.

Review of resident #004's eMAR documented that resident #004 had received a specific dosage of specific medications PRN for pain on 40 identified occurrences in the month after they returned from hospital.

Review of the home's policy titled "PAIN", "Policy Number: 04-27", documented under "Procedure" the following:
- 9. Each time a PRN pain medication was given staff were to complete the Pain Flow Sheet prior to the administration of PRN pain medication and then again 30 minutes to one hour after medication administration. For cognitively well residents the numeric scale was to be used; for cognitively impaired residents the PAINAD scale was to be used.

During an interview with ADOC #108, when asked if they were familiar with the Pain Flow Record identified in the homes Pain Policy #04-27, ADOC #108 stated that they had never seen the document before. When asked if they would expect a Pain Flow Sheet be completed for all residents receiving PRN pain medications, ADOC #108 stated they would as per the policy. When asked if they would expect resident #004 to have a Pain Flow Sheet completed as per the homes policy when the resident was receiving PRN pain medications, prior to being sent to the hospital, ADOC #108 stated yes. When asked if any other resident's requiring PRN pain medications would have a Pain Flow Sheet completed, ADOC #108 stated no.

Review of resident #002's eMAR documented that resident #004 had been administered a specific dosage of specific medications PRN for pain on a specific date and time.

Review of resident #006' eMAR documented that resident #006 had been administered a specific dosage of specific medications PRN for pain on a specific date and time.

During review, no Pain Flow Sheets were found in the clinical records of resident #004, #002 and #006.

The licensee has failed to ensure that the home's pain policy was complied with when resident #002, #004 and #006, did not have Pain Flow Sheet's completed prior to the administration of their identified PRN pain medications, or again 30 minutes to one hour after the administration. [s. 8. (1)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 17th day of October, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MEAGAN MCGREGOR (721), AMBERLY COWPERTHWAITE (435)
Inspection No. / No de l'inspection :	2019_788721_0032
Log No. / No de registre :	016108-19, 016348-19
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Sep 19, 2019
Licensee / Titulaire de permis :	Henley Place Limited 200 Ronson Drive, Suite 305, TORONTO, ON, M9W-5Z9
LTC Home / Foyer de SLD :	Henley Place 1961 Cedarhollow Boulevard, LONDON, ON, N5X-0K2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Kelly Kummerfield

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To Henley Place Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee must be compliant with s.6(1) of the LTCHA.

Specifically, the licensee must:
a) Ensure that there is a written plan of care for resident #002 and any other resident that sets out clear directions to staff and others who provide direct care to residents related to bathing and repositioning needs.

Grounds / Motifs :

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 who provided direct care to residents.

On two specific dates, the Ministry of Long-Term Care (MOLTC) Action Line received complaint IL-69384-LO, IL-69696-LO and IL-69506-LO in which complainants reported concerns of resident's care needs not being met.

A) A review of resident #002's Care Plan in PointClickCare (PCC) showed specific interventions related to their bathing schedule and preference for bathing.

A review of resident #002's electronic Treatment Administration Record (eTAR) in PCC showed a "prescriber written" order scheduled daily at a specific time indicating PSW's were to apply specific interventions with specific products related to bathing.

A review of resident #002's Tasks section in PCC showed specific interventions related to bathing including specific times the interventions were to be completed.

During an interview on a specific date, when asked how they would know what a resident's bathing needs were, PSW #106 told Inspector #721 what resident #002's bathing needs were and did not mention the same interventions as the "prescriber written" order indicating that PSW's were to apply specific interventions with specific products related to bathing daily at a specific time.

During an interview on a specific date, when asked how they would know what a residents bathing needs were, RPN #107 stated it would be indicated on the bath list which was kept at the nursing station. When asked what resident #002's bathing needs were, RPN #107 told Inspector #721 what resident #002's bathing needs were and did not mention the same interventions as the "prescriber written" order indicating that PSW's were to apply specific interventions with specific products related to bathing at a specific time.

On a specific date, Inspector #721 and #435 reviewed the bath list within the bath binder at a specific home area nursing station which did not mention the same interventions for resident #002 as the "prescriber written" order indicating that PSW's were to apply specific interventions with specific products related to bathing at a specific time.

During an interview on a specific date, ADOC #108 reviewed resident #002's clinical record with Inspector #721. When asked how staff would know what a residents bathing needs were, ADOC #108 stated they would look at the resident's care plan, kardex and bath schedule in the home area. When it was identified that resident #002's care plan and the "prescriber written" order showed different interventions related to their bathing needs, Inspector #721 asked ADOC #108 if they considered this order to provide clear direction to staff on the residents needs and ADOC #108 stated no.

B) A review of resident #002's Care Plan in PCC showed specific interventions related to a specific device and repositioning and indicated that the resident liked to get up at a specific time of day.

Inspector #721 observed resident #002 on five specific dates and times throughout the course of the inspection when interventions related to a specific device and repositioning were not in place as indicated in their Care Plan.

A review of resident #002's electronic Medication Administration Record (eMAR) in PCC showed a "prescriber written" order scheduled daily at specific times indicating specific interventions related to a specific device and repositioning. It was documented that resident #002 was “sleeping” at one of the times of day this order was scheduled for on 20 of 31 days in a specific month.

A review of resident #002's Tasks section in PCC showed specific interventions related to a specific device and repositioning that were scheduled daily at specific times that was different from the "prescriber written" order scheduled daily at specific times indicating specific interventions related to a specific device and repositioning.

During an interview on a specific date, when asked how they would know what a resident's repositioning needs were, PSW #106 said there were tasks on POC that prompt them. When asked what resident #002's repositioning needs were, PSW #106 told Inspector #721 what resident #002's repositioning needs were and did not mention the same interventions as the "prescriber written" order indicating that specific interventions related to a specific device and repositioning were to be in place at specific times.

During an interview on a specific date, when asked how they would know what a resident's repositioning needs were, RPN #107 said it would be indicated on their care plan. When asked what resident #002's repositioning needs were, RPN #107 told Inspector #721 what resident #002's repositioning needs were and they mentioned the same interventions as the "prescriber written" order indicating that specific interventions related to a specific device and repositioning were to be in place at specific times. When asked if resident #002 was awake and the specific interventions related to the specific device and repositioning were able to be implemented at one of the times of day this order was scheduled for, RPN #107 stated “I don't think so” and that the interventions were implemented at a specific time of day that was different from the time of day indicated in their order.

During an interview on a specific date, ADOC #108 reviewed resident #002's clinical record with Inspector #721. When asked how staff would know what a resident's repositioning needs were, ADOC #108 stated they would look at the resident's care plan and kardex. ADOC #108 identified that resident #002's care plan and the "prescriber written" order showed different interventions related to a specific device and repositioning and that their care plan indicated they liked to get up at a specific time of day. When asked if resident #002 was awake and if the specific interventions related to the specific device and repositioning were able to be implemented at one of the times of day this order was scheduled for, ADOC #108 said they weren't.

The licensee has failed to ensure that there was a written plan of care for resident #002 that set out clear directions for bathing needs, specific devices and repositioning to staff who provided direct care this resident.

The severity of this issue was determined to be a level 2 as there was minimal risk to the resident. The scope of the issue was a level 1 as it related to one of three (33%) residents reviewed. The home had a level 3 compliance history as they had previous non-compliance to the same subsection in the last 36 months that included:
- Written Notification (WN) and Voluntary Plan of Correction (VPC) issued January 8, 2019, (2018_674610_0024). (721)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Oct 25, 2019

Order # / Ordre no : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s.6(7) of the LTCHA.

Specifically, the licensee must:
a) Ensure that the care set out in the plan of care related to bathing and toileting is completed for resident #002 and #003 and any other resident as specified in their plan of care.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to residents as specified in the plan.

On two specific dates, the MOLTC Action Line received complaint IL-69384-LO, IL-69696-LO and IL-69506-LO in which complainants reported concerns of resident's care needs not being met.

A) A review of resident #002's Care Plan in PCC showed a specific intervention related to their bathing preference.

A review of resident #002's Tasks section in PCC showed a specific intervention related to bathing. It was documented that specific interventions related to their bathing preference were not implemented as indicated in their care plan on seven of nine bath days in a specific time period.

During an interview on a specific date, when asked how they would know what a residents bathing needs were, PSW #106 said it would be indicated on Point of Care (POC) what their bathing preference was. When asked what resident #002's bathing needs were, PSW #106 told Inspector #721 what their bathing

needs were and they indicated the same bathing preference as indicated in their care plan.

During an interview on a specific date, when asked how they would know what a residents bathing needs were, RPN #107 stated it would be indicated on the bath list which was kept at the nursing station. When asked what resident #002's bathing needs were, RPN #107 told Inspector #721 what their bathing needs were and they indicated the same bathing preference as indicated in their care plan.

On a specific date, Inspector #721 and #435 reviewed the bath list within the bath binder at a specific home area nursing station which indicated a specific intervention related to resident #002's bathing preference which was the same as indicated in their care plan.

During an interview on a specific date, ADOC #108 reviewed resident #002's clinical record with Inspector #721. When asked how staff would know what a residents bathing needs were, ADOC #108 stated they would look at the resident's care plan, kardex and bath schedule in the home area. When it was identified that the specific interventions related to resident #002's bathing preference were not implemented as indicated in their care plan on seven of nine bath days in a specific time period, Inspector #721 asked ADOC #108 why and ADOC #108 stated they didn't know and they would expect the specific interventions related to resident #002's bathing preference to be in place as indicated in the care plan.

B) A review of resident #002's Assessments section in PCC showed a specific assessment completed on a specific date, which indicated specific interventions related to toileting.

A review of resident #002's Care Plan in PCC showed specific interventions related to toileting.

A review of resident #002's Tasks section in PCC showed specific interventions related to toileting that were the same as indicated in their care plan.

During an interview on a specific date, when asked how they would know what a

resident’s toileting needs were, PSW #106 stated it would be indicated on POC. When asked what resident #002’s toileting needs were, PSW #106 told Inspector #721 what resident #002's toileting needs were and did not mention the same interventions as indicated in their care plan, tasks and assessment.

During an interview on a specific date, when asked how they would know what a resident’s toileting needs were, RPN #107 stated it would be based on an assessment of their toileting needs. When asked what resident #002’s toileting needs were, RPN #107 told Inspector #721 what resident #002's toileting needs were and did not mention the same interventions as indicated in their care plan, tasks and assessment.

During an interview on a specific date, ADOC #108 reviewed resident #002’s clinical record with Inspector #721. When asked how staff would know what a resident’s toileting needs were, ADOC #108 stated they would look at the resident’s care plan and kardex. When Inspector #721 told ADOC #108 it was identified through staff interviews that the specific interventions related to resident #002's toileting needs were not being implemented as indicated in their care plan, ADOC #108 said they expected interventions to be implemented as stated in resident #002's care plan and that if staff realized these interventions weren't effective anymore this should be updated in their care plan.

C) A review of resident #003’s Care Plan in PCC showed a specific intervention related to their bathing preference.

A review of resident #003’s Tasks section in PCC showed a specific intervention related to bathing. It was documented that specific interventions related to their bathing preference were not implemented as indicated in their care plan on four of nine bath days in a specific time period.

During an interview on a specific date, when asked how they would know what a residents bathing needs were, PSW #106 said it would be indicated on Point of Care (POC) what their bathing preference was. When asked what resident #003’s bathing needs were, PSW #106 told Inspector #721 what their bathing needs were and they indicated the same bathing preference as indicated in their care plan.

During an interview on a specific date, when asked how they would know what a residents bathing needs were, RPN #107 stated it would be indicated on the bath list which was kept at the nursing station. When asked what resident #003's bathing needs were, RPN #107 told Inspector #721 what their bathing needs were and they indicated the same bathing preference as indicated in their care plan.

On a specific date, Inspector #721 and #435 reviewed the bath list within the bath binder at a specific home area nursing station which indicated a specific intervention related to resident #003's bathing preference which was the same as indicated in their care plan.

During an interview on a specific date, ADOC #108 reviewed resident #003's clinical record with Inspector #721. When asked how staff would know what a residents bathing needs were, ADOC #108 stated they would look at the resident's care plan, kardex and bath schedule in the home area. When it was identified that the specific interventions related to resident #002's bathing preference were not implemented as indicated in their care plan on four of nine bath days in a specific time period, Inspector #721 asked ADOC #108 why and ADOC #108 stated they didn't know and they would expect the specific interventions related to resident #002's bathing preference to be in place as indicated in the care plan.

The licensee has failed to ensure that the care set out in the plan of care related to bathing and toileting needs for resident #002 and bathing needs for resident #003 was provided to the residents as specified in their plans.

The severity of this issue was determined to be a level 2 as there was minimal risk to the resident. The scope of the issue was a level 2 as it related to two of three (66%) residents reviewed. The home had a level 3 compliance history as they had previous non-compliance to the same subsection in the last 36 months that included:
- Written Notification (WN) and Voluntary Plan of Correction (VPC) issued June 29, 2019, (2017_263524_0012); and
- WN and VPC issued January 8, 2019, (2018_674610_0024). (721)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 25, 2019

Order # / Ordre no : 003 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s.8(1).

Specifically, the licensee must:
a) Complete a review of the home's pain management policy and ensure the policy is fully implemented and complied with. The home must keep a documented record of this review.
b) Training shall be provided to all registered nursing staff members on the home's pain management policy, specific but not limited to the procedure for completing pain flow sheets when administering as needed pain medication. The home must keep a documented record of the education provided.

Grounds / Motifs :

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 policy, protocol or procedure, the policy, protocol, or procedure was complied with.

In accordance with Ontario Regulation 79/10 s. 48 the licensee was required to ensure that a pain management program to identify pain in residents and manage pain were developed and implemented.

Specifically, staff did not comply with the licensee's policy titled “PAIN”, “Policy Number: 04-27”, which is part of the licensee's pain program.

On two specific dates, the MOLTC Action Line received complaint IL-69384-LO, IL-69696-LO and IL-69506-LO in which complainants reported concerns of resident's care needs not being met.

Review of a progress note from a specific date, documented that upon assessment resident #004 had pain in a specific location that had not improved. Review of progress notes dated five days after they initially complained of pain, documented that resident #004 was complaining and showing signs of worsening pain in the same specific location and an x-ray was ordered to rule out fracture. A progress note dated six days after they initially complained of pain, documented that resident #004 had increasing pain and was not responding to medications and they requested to be sent to the hospital. A progress note dated two days after they requested to be sent to hospital, documented that the writer was informed that resident #004 had a fracture requiring surgical intervention.

Review of resident #004's eMAR documented that resident #004 had received a specific dosage of a specific medication as needed (PRN) for pain on 25 identified occurrences in the month prior to their transfer to hospital.

Review of resident #004's eMAR documented that resident #004 had received a specific dosage of specific medications PRN for pain on 40 identified occurrences in the month after they returned from hospital.

Review of the home's policy titled "PAIN", "Policy Number: 04-27", documented under "Procedure" the following:
- 9. Each time a PRN pain medication was given staff were to complete the Pain Flow Sheet prior to the administration of PRN pain medication and then again 30 minutes to one hour after medication administration. For cognitively well residents the numeric scale was to be used; for cognitively impaired residents the PAINAD scale was to be used.

During an interview with ADOC #108, when asked if they were familiar with the Pain Flow Record identified in the homes Pain Policy #04-27, ADOC #108 stated that they had never seen the document before. When asked if they would expect a Pain Flow Sheet be completed for all residents receiving PRN pain

medications, ADOC #108 stated they would as per the policy. When asked if they would expect resident #004 to have a Pain Flow Sheet completed as per the homes policy when the resident was receiving PRN pain medications, prior to being sent to the hospital, ADOC #108 stated yes. When asked if any other resident's requiring PRN pain medications would have a Pain Flow Sheet completed, ADOC #108 stated no.

Review of resident #002's eMAR documented that resident #004 had been administered a specific dosage of specific medications PRN for pain on a specific date and time.

Review of resident #006' eMAR documented that resident #006 had been administered a specific dosage of specific medications PRN for pain on a specific date and time.

During review, no Pain Flow Sheets were found in the clinical records of resident #004, #002 and #006.

The licensee has failed to ensure that the home's pain policy was complied with when resident #002, #004 and #006, did not have Pain Flow Sheet's completed prior to the administration of their identified PRN pain medications, or again 30 minutes to one hour after the administration.

The severity of this issue was determined to be a level 2 as there was minimal risk to the resident. The scope of the issue was a level 3 as it related to three of three (100%) residents reviewed. The home had a level 3 compliance history as they had previous non-compliance to the same subsection in the last 36 months that included:
- Written Notification (WN) issued September 27, 2017, (2016_303563_0031);
- WN issued May 18, 2018, (2018_674610_0005); and
- WN issued January 7, 2019, (2018_674610_0023). (435)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 06, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l’envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l’envoi de la télécopie. Si un avis écrit de la décision du directeur n’est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l’expiration de ce délai.

Le/la titulaire de permis a le droit d’interjeter appel devant la Commission d’appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d’un ordre ou des ordres d’un inspecteur ou d’une inspectrice conformément à l’article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n’a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d’audience, il ou elle doit, dans les 28 jours de la signification de l’avis de la décision du directeur, donner par écrit un avis d’appel à la fois à :

la Commission d’appel et de révision des services de santé et au directeur

À l’attention du/de la registrateur(e)
Commission d’appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d’appel, la CARSS en accusera réception et fournira des instructions relatives au processus d’appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 19th day of September, 2019

Signature of Inspector / Signature de l’inspecteur :

Name of Inspector / Nom de l’inspecteur : Meagan McGregor

Service Area Office / Bureau régional de services : London Service Area Office