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 6, 2019	2019_736689_0024	012660-19, 012661-19, 013381-19, 015828-19	Complaint

Licensee/Titulaire de permis

Sharon Farms & Enterprises Limited
108 Jensen Road LONDON ON N5V 5A4

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

Earls Court Village
1390 Highbury Avenue North LONDON ON N5Y 0B6

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

CASSANDRA ALEKSIC (689), AMBERLY COWPERTHWAITE (435), RHONDA KUKOLY (213)

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): July 24, 25, 26, 29, 31, August 1, 2, 6, 7, 8, 9, 12, 13, 14, 15, 16 & 19, 2019.

The following Complaint intakes were completes within this inspection:

Log #013381-19 / IL-68204-LO/IL-68176-LO related to care concerns and
Log #015828-19 / L-69303-LO related to care concerns.

The following Follow-up intakes were completed within this inspection related to Compliance Orders (CO) from Complaint Inspection #2019_605213_0021:
Log #012661-19 for CO #001 related to compliance with staff providing proof of a criminal record check; and
Log #012660-19 for CO #002 related to compliance with qualifications of personal support workers.

During the course of the inspection, the inspector(s) spoke with Responsive Health Management Nurse Consultant, the Executive Director, the Director of Care, the Acting Director of Care, the Assistant Director of Care, the Staff Development Coordinator, the Resident Assessment Instrument Coordinator, the Behavioural Supports Ontario Lead, Office Manager, Nursing Administrative Assistant, Recreation staff, Director of Facility Services, Pharmacy Operations Manager, Regional Supervising Coroner, the Executive Director, Nursing Administrator and HR Coordinator from Staff Relief Health Services Incorporated, Registered Nurses, Registered Practical Nurses, Personal Support Workers,staff providing personal support services, students, residents, and family members.

The inspector(s) also made observations of residents, activities and care, resident/staff interactions and medication administration. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed. The inspectors also reviewed the written staffing schedules of the home, staff qualification records and reviewed quality improvement plans.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Falls Prevention
Hospitalization and Change in Condition
Medication
Personal Support Services
Reporting and Complaints
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **12 WN(s)**
- **4 VPC(s)**
- **11 CO(s)**
- **2 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. 215.	CO #001	2019_605213_0021	213

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. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that no staff performed their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 24 to make mandatory reports.
5. The protections afforded by section 26.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76 (2).

The Long-Term Care Homes Act, 2007, 2007, c. 8, s. 76 (7) states "Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention.
2. Mental health issues, including caring for persons with dementia.
3. Behaviour management.
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations.
5. Palliative care.
6. Any other areas provided for in the regulations."

O. Reg. 79/10 defines: "staff", in relation to a long-term care home, means persons who work at the home,
(a) as employees of the licensee,
(b) pursuant to a contract or agreement with the licensee, or
(c) pursuant to a contract or agreement between the licensee and an employment agency or other third party; ("personnel").

The Ministry of Long-Term Care (MOLTC) received a complaint on a specific date through the MOLTC Actionline outlining concerns related to the orientation of agency staff. On a specific date, the complainant stated that they arrived at the home around at a specific time and that the agency Registered Practical Nurse (RPN) on the floor had not yet provided the morning medications. The complainant stated that the agency staff member was supposed to be oriented that day, however, the staff who was supposed to orient them did not show up.

On a specific date, Director of Care (DOC) #100 stated that the agency provided staff education on their end and the staff would come into the home one hour earlier than their shift to shadow a scheduled staff member. The DOC stated that agency orientation was completed by the home related to policies. The DOC stated that Nurse Consultant (NC) #106 would have spoken to Nursing Administrator (NA) #119 from Staff Relief Health Care Services Incorporated (Staff Relief) who was the educator for the agency staff and would have provided the education to the staff.

On a specific date, Assistant Director of Care (ADOC) #103 stated that on a specific date they had received a call from staff in the home stating that the agency RPN needed

orientation to the building prior to them starting their shift. The ADOC stated that RPN #140 agreed to orient agency RPN #139 and assisted with the medication pass. The ADOC stated that the orientation checklist was normally completed and signed off by the staff member saying that the agency went through orientation. ADOC #103 stated that they could not find the orientation checklist for agency RPN #139. The ADOC stated that the agency staff received orientation from Staff Relief regarding electronic documentation, pharmacy and specific products that the home uses, such as Point Click Care (PCC). When asked when agency RPN #139's first shift in the home was, the ADOC stated the specific date. When asked how the home ensured that the agency staff received orientation prior to performing their responsibilities, the ADOC stated that review of the residents' bill of rights, and the Long-Term Care Homes Act (LTCHA) would have been completed by the agency for their staff.

On a specific date, Nursing Administrator (NA) #119 from Staff Relief Health Care Services Incorporated stated that they worked for the agency providing direct recruitment, onboarding, training and orientation for the registered and non-registered staff contracted to the home. When asked what the agreement was related to the training that was provided to Staff Relief employees who provided services at Earls Court Village, the NA stated that they would use their judgement to provide an appropriate level of training to staff and if they needed a full shift or more of training and orientation, then they would contact Earls Court Village and arrange for that. The NA stated that the amount of training was based on the employees' level of experience and qualifications. They stated that when the staff went to the home they received floor specific orientation. NA #119 stated that the mandatory training items provided by Staff Relief to their employees was specific to long-term care homes but was not specific to Earls Court Village. When asked if Earls Court Village provided Staff Relief with specific policies or orientation materials prior to staff coming into the home, the NA stated no, they were never provided materials or protocols to train staff.

The Visit Count Report for Earls Court provided by Staff Relief Health Care Services Incorporated showed a total of forty-nine registered and non-registered staff that had confirmed shifts in the home from during a specific time frame.

On a specific date, Agency RPN #108 stated that they worked in the home as an agency RPN from Staff Relief. When asked if they had received orientation, the agency RPN stated that they shadowed a nurse on their shift and if they had questions they could follow up with the DOC. When asked if they received orientation in the home prior to starting their shift, they said that Staff Relief provided general orientation, but it was not

specific to the home.

On a specific date, Agency Staff Member #121 stated that they worked for Staff Relief and provided personal support services in the home. When asked what responsibilities they completed for residents while working in the home, the Agency Staff Member stated that they were able to assist with mechanical lifts and provided residents baths. When asked about orientation they had received in the home prior to working, the Agency Staff Member stated that they learned from another agency staff member through shadowing. When asked if the home had reviewed any policies specific to their responsibilities in the home, including the prevention of abuse and neglect policy or minimizing of retraining residents, the Agency Staff Member stated no.

On a specific date, Agency Staff Member #123 stated that they worked in the home pursuant to a contract with Staff Relief. The Agency Staff Member stated they worked at Earls Court Village providing one to one care for a specific resident. When asked what types of responsibilities or duties they completed when working in the home, the Agency Staff Member stated that they provided direct care to the resident. When asked if they had received training or orientation from the home, the Agency Staff Member stated no, they did not.

On a specific date, Agency Staff Member #124 stated that they worked in the home pursuant to a contract with Staff Relief and it was their first day working. When asked if they had reviewed the homes policies and procedures, the Agency Staff Member stated that they did not review any documents or policies.

On a specific date, Personal Support Workers (PSWs) #111 and #113 stated that they were working in the home on a specific date. They stated that there was an agency staff member working in the home during the morning shift and the medications were administered late due to the regular staff not being available to provide orientation to the agency staff. The PSWs stated they had remembered the day because the agency staff told them that they were not performing any duties in the home because they had not received orientation.

On a specific date, Executive Director (ED) #125 stated that for agency staff who provided services in the home received orientation on site and were provided policies with the expectation that they would adhere to and follow them. When asked if there was a package that was given to the agency with this information, the ED stated that they provided the agency with training documents. The ED stated that Staff Development

Coordinator (SDC) #130 completed the general orientation for staff over two days at the home. They stated that it was completed as a group for the month for those who had been hired. When asked what training was completed for agency staff, the ED stated that some had, and some have not had the group training.

On a specific date, Nurse Consultant (NC) #106 stated that for agency staff that were providing services, they would set up eight hours of orientation, be set up in PCC and only get staff back in the home who have received orientation. When asked if they had provided training documents that the agency was supposed to use to provide orientation to the agency staff of the home's policies, NC #106 stated that they were not sure what process the agency or the home had in place related to orientation. When asked about a checklist for orientation, the NC stated that they were not sure what checklist was in place. When informed that the ED stated that the home provided a training document to the agency with the policies and procedures that employees were to review before starting, the NC stated that it was not the process they had arranged and that agency staff were supposed to receive training and orientation before they started. When asked what the responsibilities of non-registered agency staff were for providing one to one services in the home, the NC stated that they expected staff to do the same duties and were expected to know the residents and what care to provide. Inspectors informed the NC that Agency Staff Member #124 had no orientation on their first day of work in the home on a specific date. The NC stated that they provided certain agency staff access and information for orientation, but there should not be agency staff working in the home who had not been orientated and this was not the home's expectation.

There were no training records on file or documented evidence to support that the required mandatory training was completed by any of the agency employees who worked in the home during the specific time frame.

The home's "Scheduling Agency Utilization" policy with revision date May 9, 2019 stated the following:
-Agency staff are provided a general orientation to the Home's philosophy, mission, vision and values, Resident Bill of Rights, the Home's abuse policy, Emergency plan, AODA, OH&S policies and other key policies and protocols, and other topics included in the LTCHA and Regulation 79/10.

The licensee failed to ensure that no staff, including staff working in the home pursuant to a contract or agreement, performed their responsibilities before receiving training and orientation. [s. 76. (2)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts. 2007, c. 8, s. 195 (12); 2017, c. 25, Sched. 5, s. 23.

Findings/Faits saillants :

1. The licensee has failed to comply every order made under the Long-Term Care Homes Act 2007.

The Long-Term Care Homes Act, 2007 s. 75 (1), (2) and (3) state: Every licensee of a long-term care home shall ensure that screening measures are conducted in accordance with the regulations before hiring staff and accepting volunteers. The screening measures shall include police record checks, unless the person being screened is under 18 years of age. For the purposes of subsection (1), a staff member who is agency staff, as that term is defined in subsection 74 (2), is considered to be hired when he or she first works at the home.

O. Reg. 79/10 defines: "staff", in relation to a long-term care home, means persons who work at the home,
(a) as employees of the licensee,
(b) pursuant to a contract or agreement with the licensee, or
(c) pursuant to a contract or agreement between the licensee and an employment agency or other third party; ("personnel").

The following Compliance Order (#001) was issued June 26, 2019 in inspection #2019_605213_0021 with a compliance date of July 31, 2019:

The licensee must be compliant with O. Reg. 79/10, s. 215.
Specifically, the licensee must:
a) Create a quality improvement plan that includes a hiring protocol to ensure that all staff hired have provided the licensee with proof of a criminal reference check that includes a vulnerable sector screen. The protocol must include the hiring procedure, responsible persons, timelines and tools to be used when applicable.
b) Ensure and verify that every new staff member hired has provided the licensee with proof of a criminal reference check, that includes a vulnerable sector screen and was conducted by a police force.
c) Proof of this criminal reference check will be kept in the employee's file.

A record review was completed of the quality improvement plan provided by Nurse Consultant #106 from Responsive Health Management. The quality improvement plan included the information required by the Compliance Order for future employees of the home. The plan did not include any reference to agency staff.

The Visit Count Report for Earls Court provided by Staff Relief Health Care Services Incorporated was reviewed for a specific time frame. Four different Staff Relief employees provided personal support services for the first time at Earl's Court Village during this time frame.

In an interview with the Executive Director (ED) #125 on a specific date, the ED said that they did not keep employee files in the home for agency staff, that was the responsibility of the employment agency, Staff Relief. The ED also stated that they did not request or review proof of a criminal reference check for agency staff, that it was the responsibility of the agency.

In an interview with Staff Relief Staff Relief Human Resources Coordinator #120 on a specific date, they said that they ensured the Staff Relief employees had a vulnerable sector screen.

In an interview with Staff Relief Nursing Administrator (NA) #119 from the employment agency on a specific date, the NA stated that they kept employee files for the agency employees of Staff Relief who provided services at Earl's Court Village and that the home had never requested any information related to criminal reference checks, if they had, they would have provided it.

The "Health Care Service Agreement", "between Staff Relief Health Care Services Inc.

and Sharon Village Care Homes (Earl Court Village LTC)", dated December 18, 2018 was reviewed. The agreement stated:
Covenants of Staff Relief
During the term, Staff Relief shall:
Maintain an individual file for each worker containing the following:
i) Professional credentials
ii) Police checks (vulnerable screening)
iii) Medical clearance i.e. TB tests, flu shots, etc.
iv) Reference check
v) Current CPR certificate

The licensee did not comply with Compliance Order #002 part b), issued June 26, 2019 in inspection 2019_605213_0021, with a compliance date of July 31, 2019. They did not ensure and verify that every new staff member hired had provided the licensee with proof of a police record check, that included a vulnerable sector screen and was conducted by a police force, for all four Staff Relief employees who provided personal support services for the first time in the home during a specific time frame. [s. 101. (3)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 47. Qualifications of personal support workers

Findings/Faits saillants :

1. The licensee has failed to ensure that on and after January 1, 2016, every person hired by the licensee as a personal support worker or to provide personal support services had successfully completed a personal support worker program that met requirements and had provided the licensee with proof of graduation issued by the education provider. O.Reg. 79/10 s. 47 (2) states: The personal support worker program must meet the Personal Support Worker (PSW) Program Standard published by the Ministry of Training, Colleges and Universities and must be a minimum of 600 hours in duration, counting both classified time and practical experience time.

O. Reg. 79/10 s. 47 (3)(a) states: The licensee may hire a personal support worker or to provide personal support services who, in the opinion of the Director of Nursing and Personal Care, has adequate skills and knowledge to perform the duties of a personal support worker, and who has the appropriate current certificate of registration with the College of Nurses of Ontario. O. Reg. 79/10 s. 47 (3)(c) states: The licensee may hire a personal support worker or to provide personal support services who, in the opinion of the Director of Nursing and Personal Care, has adequate skills and knowledge to perform the duties of a personal support worker, and is enrolled in an educational program for registered nurses (RN) or registered practical nurses (RPN).

O. Reg. 79/10 defines: "staff", in relation to a long-term care home, means persons who work at the home,
(a) as employees of the licensee,
(b) pursuant to a contract or agreement with the licensee, or
(c) pursuant to a contract or agreement between the licensee and an employment agency or other third party; ("personnel").

The following order was issued June 26, 2019 in inspection #2019_60213_0021, with a compliance date of July 31, 2019:
The licensee must be compliant with O.Reg. 79/10, s. 47 (1), (2), and (3).
Specifically, the licensee must:
a) Create a quality improvement plan that includes a hiring protocol to ensure that all new staff hired have provided the licensee with qualifications to provide personal support services that meet the requirements identified in O. Reg. 79/10, s. 47. The protocol must include the hiring procedure, responsible persons, timelines and tools to be used when applicable.
b) Ensure and verify that every new Personal Support Worker (PSW) hired has successfully completed a PSW program that meets the PSW Program Standard published by the Ministry of Training, Colleges and Universities and has provided the licensee with proof of graduation issued by the education provider. A copy of this proof is to be kept in the employee's file.
c) Ensure that all new staff hired as a PSW or to provide personal support services who is a registered nurse or registered practical nurse, in the opinion of the Director of Nursing and Personal Care, has adequate skills and knowledge to perform the duties of a PSW and has the appropriate current certificate of registration with the college of nurses of Ontario. A copy of proof of this registration is to be kept in the employee's file.
d) Ensure that all new staff hired as a PSW or to provide personal support services who either is a registered nurse or registered practical nurse and does not hold a current

certificate or registration with the College of Nurses of Ontario or is a person who does not have a PSW certificate from a program that meets the PSW Program Standard published by the Ministry of Training, Colleges and Universities, in the opinion of the Director of Nursing and Personal Care, has adequate skills and knowledge to perform the duties of a PSW and is enrolled in an educational program for registered nurses or registered practical nurses. A copy of proof of this registration is to be kept in the employee's file.

The Visit Count Report for Earls Court provided by Staff Relief Health Care Services Incorporated was reviewed for a specific time frame. Twenty-nine different Staff Relief employees provided personal support services at Earl's Court Village during this time frame.

In an interview with Agency Staff Member #123 by Inspector #689 on a specific date, they said that they had been working in the home for approximately one month providing direct personal care to residents. They stated that they had a nursing degree from their home country which was outside of Canada. The Agency Staff Member said that they did not complete any schooling in Ontario for PSW or Registered Nurse (RN)/Registered Practical Nurse (RPN).

In an interview with Agency Staff Member #124 by Inspector #689 on a specific date, the Agency Staff Member stated that it was their first day working in the home and that they were responsible for direct resident care that day. They said that they were a registered nurse outside of Canada and were not enrolled in a PSW or nursing program.

Staff Relief Health Care Services Inc. provided information to Inspectors related to the education and qualifications of nineteen Staff Relief staff who had provided personal support services at Earl's Court during a specific time frame. Staff Relief reported that nine were registered nurses in countries outside of Canada and none of those nine staff had a PSW Certificate or proof of enrollment in an RN or RPN program.

On a specific date, Executive Director (ED) #125 said that they did not keep employee files in the home for agency staff; that was the responsibility of the employment agency, Staff Relief. When asked how the home ensured that agency staff who provided personal support services in the home had successfully completed a personal support worker program that met requirements identified in the legislation, the ED said the primary way was that they had a contract with the agency, Staff Relief, which spelled out that requirement and that they were to meet those requirements. When asked if they were

aware that there were agency staff who provided personal support services in the home who did not possess PSW qualifications, were not enrolled in an RN or RPN program and only had registered nurse qualifications oversees, the ED said no, they were not aware.

In an interview with the Staff Relief Nursing Administrator (NA) #119 from the employment agency on a specific date, the NA stated that they kept employee files for the agency employees of Staff Relief who provided services at Earl's Court Village and that the home had never requested any information related to the Staff Relief employees, that if they had, they would have provided it.

The "Health Care Service Agreement", "between Staff Relief Health Care Services Inc. and Sharon Village Care Homes (Earl Court Village LTC)", dated December 18, 2018 was reviewed. The agreement stated:
Covenants of Staff Relief
During the term, Staff Relief shall:
Maintain an individual file for each worker containing the following:
i) Professional credentials
ii) Police checks (vulnerable screening)
iii) Medical clearance i.e. TB tests, flu shots, etc.
iv) Reference check
v) Current CPR certificate

The licensee did not comply with Compliance Order #002 issued June 26, 2019 in inspection 2019_605213_0021, with a compliance date of July 31, 2019. The licensee also failed to comply with O. Reg. 79/10 s. 47 when nine Staff Relief agency staff members providing personal support services in the home did not have either PSW certification; or had the appropriate current certificate of registration with the College of Nurses of Ontario; or were enrolled in an educational program for registered nurses or registered practical nurses. [s. 47.]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 002 – The above written notification is also being referred to the Director for further action by the Director.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times.

The Ministry of Long-Term Care (MOLTC) received a complaint on a specific date through the MOLTC Actionline outlining concerns related to the home not having a registered nurse (RN) on duty. The complainant stated that on on specific dates in July 2019, there was no RN in the building on the day shifts.

The home's "Staffing Compliment" documented within the Staffing Evaluation dated June 28, 2018, indicated on days, evenings and nights there was to be one registered nurse (RN) on duty each shift.

The home's "Detail Employee Report" was reviewed and documented the staffing levels in the home from July 1 to July 31, 2019. These documents showed the home did not have a RN working in the building as outlined on the home's "Staffing Compliment" on the following dates:
- July 6, 2019 – day shift
- July 7, 2019 – day shift

- July 20, 2019 – day and evening shifts
- July 27, 2019 – evening shift

On a specific date, Registered Practical Nurse (RPN) #101 stated that on July 20 and 21, 2019, there was no RN working in the building on the day shift.

On a specific date, RN #105 stated that as an example when a RN called in sick, agency staff would be called to cover the shift, and they were RPNs. The RN stated that there have been many days when there was no RN in the building.

On a specific date, Director of Care (DOC) #100 stated that the home had concerns with having a RN in the home at all times. DOC #100 stated that the issue had started in July. When asked if the home had been replacing the RN with RPNs, DOC #100 stated sometimes acting Director of Care (aDOC) #138 would come in and sometimes the Assistant Director of Care (ADOC) #103 would come in, but not always.

On a specific date, Behavioural Support Ontario (BSO) RPN #107 stated that they have been in charge when there has been no RN in the building. The BSO RPN stated that they had heard some families voice concerns about there being no RN in the building and some staff have told them that they could not be in charge because they were not a RN. When asked how often it was happening, the BSO RPN stated that it had happened more than once, and there was no RN in the building on July 20, 2019. The BSO RPN stated that the home usually had an issue with not having an RN in the building on the weekends.

On a specific date, Nurse Administrative Assistant (NAA) #116 stated they developed the staff schedule. When asked what they would do if there was no RN scheduled in the building, the NAA stated that they would tell the Executive Director (ED) and DOC verbally which would be specifically on the weekends. When asked if there had been shifts with no RN in the building, the NAA stated that every other weekend and during the week was difficult.

On a specific date, Executive Director (ED) #125 stated that the home had not met the requirement to have a registered nurse on duty and present in the home at all times for July 2019.

Review of the home's "Scheduling Working Short" policy, with revision date May 9, 2019 stated the following under the heading "Short of Registered Nurse (RN):

"If the Home is unable to fill the RN shift with an RN, it will be filled with an RPN".

On a specific date, Nurse Consultant (NC) #106 stated that they explained to the team that they should not be using the RN on call like it was an emergency, because it was no longer an emergency.

Based on these interviews and record review the licensee failed to ensure that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty, and present in the home at all times in July 2019. [s. 8. (3)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: 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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

s. 6. (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 and others who provided care to the resident.

A) A complaint was received by the Ministry of Long-Term Care on a specific date, related to resident #030's treatments.

Resident #030 was observed in the dining room on a specific date with treatments provided. On that date, the resident said that their treatment was the same as prior to their admission. The resident said that sometimes they did not have treatments had to ask the staff to administer the treatments.

The health records for resident #030 were reviewed. The resident's current plan of care in Point Click Care (PCC) stated, "Administer [treatment] as per physician order". This intervention was initiated on admission. The Medication Reconciliation and Physician Order Form on admission did not include any reference to the use of the treatment. There was a "New Admission Communication Form" in the chart that provided information about the treatment. There was a physician's order in the paper chart dated on a specific date related to the assessment of the treatment. There was a fax from [the physician] on a specific date that stated, "An order was sent to you [on a specific date] for an assessment of [the treatment] for [the resident]. I cannot find the order written in the physician's order form and I need it for the three month review so I have an order for the doctor to sign concerning [the treatment] the resident is to receive. Could [a specialist/therapist] please come to write that order?"; this was signed by a Registered Practical Nurse (RPN). In the Physician's Orders in the paper chart, there was a Three Month Medication Review signed by the physician on a later date that stated in handwriting the treatment type but no specific details and a hand written note stating "[a specialist/therapist] to advise".

There was no direction to Personal Support Workers (PSW) in the plan of care, Kardex or tasks in Point of Care (POC) in PCC to direct staff related to the treatment or related tasks for resident #030. There was no direction that the resident used the treatment, the type, directions or when to administer the treatment.

In an interview with the Resident Assessment Instrument (RAI) Coordinator (RAI-C) #110 and the Assistant Director of Care (ADOC) #103 on a specific date, the Inspector asked how staff would know what the residents treatment would be or how it should have been delivered. The RAI-C reviewed resident #030's health records in PCC and said that there should have been a physician's order for the treatment and there was none. The

Inspector asked how PSWs would know to how and when to administer the treatment. The RAI-C said that there should have been a task in POC in PCC.

Resident #005 was observed on specific dates with the treatment administered. The physician's orders, care plan and tasks in POC were reviewed for the resident in PCC. The physician's orders included directions for the use of the treatment. There was no direction in the plan of care or POC to direct PSWs that the resident used the treatment, the type, or when to administer the treatment.

Resident #026 was observed in the lounge on specific dates with the treatment administered. The physician's orders, care plan and tasks in POC were reviewed for the resident in PCC. There was no physician's order for routine use of the treatment. The medical directives included specific directions when to initiate the treatment. The Medical Directives electronic Medication Administration Record (eMAR) was reviewed and the direction related to the treatment was not signed for and there were no treatments documented during a specific time frame. There was no direction in the plan of care or POC to direct PSWs that the resident used the treatment, the type, or when to administer the treatment.

Resident #027 was observed in the lounge on specific dates with the treatment administered. The physician's orders, care plan and tasks in POC were reviewed for the resident in PCC. The physician's orders included directions for the use of the treatment. The electronic Medication Administration Record (eMAR) was reviewed and the direction related to the treatment was not signed for and there were no treatments documented during a specific time frame. There was no direction in the plan of care or POC to direct PSWs that the resident used the treatment, the type, or when to administer the treatment.

Resident #033 was observed in their room on a specific date with the treatment administered. The physician's orders, care plan and tasks in POC were reviewed for the resident in PCC. There was no physician's order for routine use of the treatment. The medical directives included specific directions when to initiate the treatment. The Medical Directives electronic Medication Administration Record (eMAR) was reviewed and the direction related to the treatment was not signed for and there were no treatments documented during a specific time frame. There was no direction in the plan of care or POC to direct PSWs that the resident used the treatment, the type, or when to administer the treatment.

On a specific date, Inspector #213 observed resident #031 in their room using an assisted device with the treatment present but not administered. In an interview on a specific date, Registered Practical Nurse (RPN) #142 stated that there was no order for the treatment for resident #031, that it was only used as needed for specific instances. The RPN said the resident had occasionally needed the treatment for specific instances and that someone had administered the treatment on resident #031 that morning. RPN #142 said they checked that the resident and removed the treatment that the PSW administered during that morning. PSW #113 said that they administered the treatment that morning. When the Inspector asked PSW #113 if they had reported to the RPN that they administered the treatment to resident #031 that morning, the PSW said no. When asked how staff knew to administer the treatment, the RPN said they had a medical directive for the treatment which was a standard in the home.

On a specific date, resident #031 was observed in the lounge with the treatment present but not administered. Inspector #213 asked PSW #114 if the resident required the treatment and they stated that they needed it PRN (as needed). The PSW stated that the resident did have the treatment present and if needed could administer it. Inspector #213 asked PSW #143 if resident #031 had the treatment administered that morning, and the PSW stated that they did have the treatment administered earlier that morning when they came on at the beginning of their shift. The PSW stated that once they took the resident to the lounge, they then removed the treatment. The PSW said that they believed that the treatment needed to be administered for a specific direction of use.

The physician's orders, care plan and tasks in POC were reviewed for resident #031 in PCC. There was no physician's order or medical directives for routine use of the treatment. The paper chart was reviewed and there was an "Individual Medication Order Set" for resident #031 on a specific date signed by the physician. One of the orders included specific direction of use for the treatment. There was no documentation of the treatment directions during a specific time frame. There was no direction in the plan of care or POC to direct PSWs that the resident used the treatment, the type, or when to administer the treatment.

The home's policy related to [the treatment] with a reviewed date of April 24, 2019 stated that to initiate [the treatment], the following must be in place:
-obtain a physician's order
-to qualify for funding, an up-to-date treatment report was required with specific guidelines
-to document the following: that the treatment was checked on each shift on the eMAR;

the residents tolerance to the treatment; routine for removing and/or administering [the treatment] on the eMAR
There was nothing in the policy related to who can initiate the treatment, documentation of the actual administration of the treatment, the documentation of any assessment related to the treatment, or that the treatment should be included in a resident's plan of care or tasks in point of care documentation.

In an interview with the RAI Coordinator (RAI-C) #110 and the ADOC #103 on a specific date, the Inspector asked what the expectation was for the use of the treatment, the ADOC said that there should have been physician's order. When asked what the expectation was for the application of the treatment PRN, the ADOC said that it should have only been administered or removed by a registered staff after an assessment.

B) During the inspection, Inspectors became aware that resident #008 had an incident in the home on a specific date, ambulance was called, Cardiopulmonary Resuscitation (CPR) was initiated, the resident was transferred to hospital and passed away on that same date.

The health record, both paper and electronic, for resident #008 was reviewed in Point Click Care (PCC). The "Code Status" in PCC stated: "Level one- Palliative (Comfort Measures Only)". The paper chart did not include a form "Advance Directives/Consent to Plan of Treatment" or a form "Advanced Care Directives, Management of Life Threatening Illness", that indicated the resident and/or substitute decision maker's (SDM) wishes related to the level of treatment that should be used in the event of sudden onset of a life threatening illness. The paper chart also did not include the form "Do Not Resuscitate Confirmation Form" to direct the practice of Paramedics and Firefighters after a specific date.

A blank form "Advance Directives/Consent to Plan of Treatment" was reviewed and stated:
"Level One – Supportive/Comfort Care: This includes, but is not limited to, the provision of measures available within the resources of the home such as: relief of pain, treatment of fever, suctioning, mouth care, positioning, oral fluids, oxygen administration (if available). Diagnostic interventions and transfer to hospital will not normally be utilized for residents who request this level of care directives. DO NOT RESUSCITATE allowing a natural death".
"Level Two – Limited Therapeutic Care: Care measures will include all procedures utilized in Level One – Supportive/Comfort Care (i.e. Oxygen, x-rays, hypodermoclysis),

as well as the administration of antibiotics and/or other procedures which can be performed at the home. DO NOT RESCUSCITATE allowing a natural death".
"Level Three – Transfer to Acute Care Hospital with NO CPR: If symptoms indicate, the resident would be transferred to an acute care hospital for treatment. Assessment would e made in at the acute care hospital emergency department and decision made whether to admit the resident or return him/her to the home. DO NOT RESCUSCITATE allowing a natural death".
"Level Four – Transfer to Acute Care with CPR: Resident would e treated aggressively. Transfer to an acute care hospital will be arranged immediately. Cardiopulmonary resuscitation (CPR) will be provided by qualified staff, if available, and by ambulance personnel."

In an interview with the acting Director of Care (aDOC) #138 on a specific date, the aDOC said that Advanced Care Directives (ACD), including Do Not Resuscitate (DNR) status were to be determined at the time of admission, during annual care conferences and any time a resident or family wished there to be a change. On a specific date, the aDOC said that they recalled being phoned at home while on vacation by the Executive Director (ED) #125 inquiring about the aDOC's recollection of resident #008's requested level of ACD and DNR status. The aDOC said that they recalled resident #008's level of ACD was a level one and that the resident was a DNR. The aDOC said that they recalled this because they were involved when resident #008 had a previous incident and was transferred to hospital.

In an interview with ED #125 on a specific date, the ED said that they were present during the incident on a specific date, and that paramedics arrived and completed CPR. The ED said that there was no ACD or DNR forms in the resident's chart and there should have been one. They said that some time prior, it appeared that the registered staff sent the originals of the forms to the hospital. They said that the forms were not present in the home on the date of the incident, when paramedics arrived. The ED said that the paramedics asked if there was a DNR and because the home could not produce the form, the paramedics protocol was to start CPR.

The ED also shared that after the incident, they directed a summer student to complete an audit in the home for the presence of ACD and DNR forms for all residents. The audit results were provided to Inspectors. The audit showed:
Resident #007 had an ACD of level four and a DNR form was present
Resident #015 did not have an ACD form and a DNR form was present
Resident #017 had an ACD of level three that was not dated and a DNR form was

present
Resident #022 did not have an ACD indicated and a DNR form was present

When asked on a specific date what had been done related to the results of the audit and the missing information, the ED said that the aDOC was currently working on it. When asked on a specific date what had been done related to the results of the audit and the missing information, the aDOC said that they were working on it and had not been to a specific home area yet to follow up on resident #007 and the conflicting information.

On a specific date, a record review was completed by Inspectors of ACD and DNR forms in paper charts as well as code status in PCC. The record review showed:
Resident #007 who was hospitalized at the time, had an ACD of level four and a DNR form was present, the code status in PCC was level four.
Resident #014 who was admitted on a specific date, did not have an ACD form or DNR form and the code status in PCC was blank.
Resident #015 who was admitted on a specific date, had an ACD of both level one and level two checked off with a hand-written note indicating family had chosen level one and the code status in PCC indicated level two.
Resident #021 who passed away on a specific date, did not have an ACD form or DNR form and the code status in PCC indicated level three.
Resident #024 who was admitted on a specific date, had an ACD of level one, there was no DNR form and the code status in PCC was blank.
Resident #025 who was admitted on a specific date, had an ACD of level two, there was no DNR form and the code status in PCC was blank.

In an interview with Registered Practical Nurse (RPN) #144 on a specific date, regarding resident #007, they said they would look in PCC and in the paper chart for information related to ACD and DNR status. The RPN reviewed the ACD and DNR forms for the resident and stated that forms did not match. They stated that it was confusing, that they would not know what to do in an emergency situation and they would have to call the DOC.

In an interview with RPN #146 on a specific date, regarding resident #015, the Inspector asked where they would look for information related to ACD and DNR, the RPN said in PCC or in the paper chart. The RPN reviewed the blank ACD and completed DNR form for the resident and stated that if nothing was checked off then they would treat the resident as a level four. The Inspector pointed out that resident #015 had a completed DNR form. The RPN said that they would call the family but if they were not able to be

contacted, then they would do a combination of both. The RPN was not able to elaborate what was involved, but they needed something to go by.

The home's "End of Life Care Program" procedure dated reviewed May 2019 stated: "During the admission and annual resident care review and whenever there is a change in levels of care, the physician and unit supervisor will review residents' wishes as per end of life directives. The physician will then document the outcome on the interdisciplinary notes and enter the DNR/allow natural death or CPR on medical plan of care. The procedure also stated "advance care planning provides the interdisciplinary care team with guidance relating to the care the person will receive. It is the responsibility of the interdisciplinary care team to follow the Advance Care Plan Directives".

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 care to the resident related to the use of treatments for resident #005, 026, 027, 030, 031 and 033 and related to Advanced Care Directives and Do Not Resuscitate status for residents #007, 014, 015, 021, 024 and 025. [s. 6. (1) (c)]

2. The licensee failed to ensure that the staff and others who provided direct care to a resident were kept aware of the contents of the resident's plan of care and had convenient and immediate access to it.

O. Reg. 79/10 defines: "staff", in relation to a long-term care home, means persons who work at the home,
(a) as employees of the licensee,
(b) pursuant to a contract or agreement with the licensee, or
(c) pursuant to a contract or agreement between the licensee and an employment agency or other third party; ("personnel").

The Ministry of Long-Term Care (MOLTC) received a complaint on a specific date through the MOLTC Actionline outlining concerns related to the orientation of agency staff.

On a specific date, Personal Support Workers (PSWs) #111, #112 and #113 stated that they had been working with more agency staff on the weekends who were not familiar with the care needs of the residents. The PSWs stated that the agency staff members did not have access to Point Click Care (PCC).

On a specific date, Agency Staff Member #121 stated that they worked for Staff Relief and provided personal support services in the home. The Agency Staff Member stated they did not have a login or completed any documentation in PCC for resident care provided. They stated that the PSWs they worked with would complete the documentation for them.

On a specific date, Agency Staff Member #123 stated that they worked for Staff Relief and provided personal support services in the home. They stated they worked with resident #009 providing care on a specific date. The Agency Staff Member stated that they dressed the resident, changed their bed linens, provided feeding assistance, assisted them with walking, changed their brief if there was one, but did not provide baths. When asked if they documented in PCC the care provided to the resident, the Agency Staff Member stated they documented specific care on paper and then provided it to the nursing staff. When asked where they would look to know what care the resident required, the Agency Staff Member stated that they would ask the nursing staff. The Agency Staff Member stated they did not know the residents' plan of care as they did not have access.

Review of documentation survey report V2 showed no documentation by Agency Staff Member #123 for resident #009 on that specific date.

On a specific date, Agency Staff Member #124 stated that they worked for Staff Relief and provided personal support services in the home. The Agency Staff Member stated that it was there first day of work at Earls Court Village providing direct care to residents. The Agency Staff Member stated that they did not have access to the computer and thought that PSW #148 would document for them. The Agency Staff Member stated they would watch the staff with the residents and could ask the registered staff to know what care the residents required. They stated that they did not have access to the residents' plan of care and was not sure where it would be.

On a specific date, Inspector #689 observed Agency Staff Member #124 providing feeding assistance to resident #011 in the dining area. At this time, PSW #115 stated that it was Agency Staff Member #124's first day and they did not have PCC access or login and was not completing any documentation of care that was provided.

Review of documentation survey report V2 showed no documentation by Agency Staff Member #124 for resident #011 on that specific date.

On a specific date, Executive Director (ED) #125 stated the responsibilities of non-registered agency staff when providing personal support services in the home, whether the PSW was from an agency or their own hire, was the same. The ED stated that agency staff including registered and non-registered staff providing direct care to residents would have access to the residents' plan of care, logins, and were expected to document in PCC. The ED stated that they expected that agency staff working one to one with residents would review the plan of care to know what behaviours the resident exhibited, their triggers, strategies and interventions appropriate for their behaviours. The ED stated that they were available twenty-four hours a day, seven days a week to provide access to agency staff.

On a specific date, Nurse Consultant (NC) #106 stated the expectation was the same for non-registered agency staff and PSWs hired in the home and that providing personal support services, whether one to one care or floor duties, they had to meet the needs of the residents. The NC stated that they were expected to know what care was to be provided to the residents. The NC stated that they provided certain agency staff with access and information on orientation, but there should not be agency staff working in the home that did not have access.

The licensee failed to ensure that agency staff members who provided direct care to residents were kept aware of the contents of the resident's plan of care and had convenient and immediate access to it. [s. 6. (8)]

3. The licensee has failed to ensure that the provision of the care set out in the plan of care, the outcomes of the care set out in the plan of care and the effectiveness of the plan of care were documented.

A complaint was received by the Ministry of Long-Term Care on a specific date, related to treatments not being administered.

Resident #026 was observed in the lounge on a specific date with a treatment administered. The electronic Medication Administration Record (eMAR), electronic Treatment Administration Record (eTAR) and Medical Directives Administration Record (MDAR), vital signs and tasks in Point of Care (POC) were reviewed for resident #026 in Point Click Care (PCC). The medical directives included specific administration guidelines for the treatment. The Medical Directives electronic Medication Administration Record (eMAR) was reviewed and the direction related to the treatment was not signed for as administered and there was no documentation of the treatment during a specific

time frame.

Resident #027 was observed in the lounge on a specific date with a treatment administered. The eMAR, eTAR and MDAR, vital signs and tasks in POC were reviewed for resident #027 in PCC. The physician's orders included directions for use of the treatment. The eMAR was reviewed and the direction related to the treatment was not signed for as administered and there was no documentation of the treatment during a specific time frame.

Resident #033 was observed in their room on a specific date with with a treatment administered. The eMAR, eTAR and MDAR, vital signs and tasks in POC were reviewed for resident #033 in PCC. The medical directives included specific administration guidelines for the treatment. The Medical Directives eMAR was reviewed and the direction related to the treatment was not signed for as administered and there was no documentation of the treatment during a specific time frame. Health records in PCC showed that the treatment was documented once during the time frame with specific directions of administration. There was no direction in the plan of care or POC to direct Personal Support Workers (PSWs) that the resident used the treatment, the type, or when to administer the treatment.

On a specific date, Inspector #213 observed resident #031 in their room using an assistive device with the treatment present but not administered. In an interview on a specific date, Registered Practical Nurse (RPN) #142 stated that there was no order for the treatment for resident #031, that it was only used as needed for specific instances. The RPN said the resident occasionally needed the treatment and someone had administered the treatment to resident #031 that morning. PSW #113 said that they administered the treatment during care that morning.

On a specific date, resident #031 was observed in the lounge with the treatment present but not administered. Inspector #213 asked PSW #114 if the resident required the treatment and they stated that they needed it PRN (as needed), and if the resident needed it they would administer it. Inspector #213 asked PSW #143 if resident #031 had the treatment administered that morning and the PSW stated that the resident had the treatment administered when they came on at the beginning of their shift. The PSW stated when the resident was in the lounge their treatment was removed based on a specific direction.

The eMAR, eTAR and MDAR, vital signs and tasks in POC were reviewed for resident

#031 in PCC. The paper chart was also reviewed and there was an "Individual Medication Order Set" for resident #031 on a specific date, signed by the physician. One of the orders included specific guidelines for the administration of the treatment. There was no documentation of the treatment in the eMAR, Medical Directives or in Vital Signs in PCC during a specific time frame.

The home's policy related to [the treatment] with a reviewed date of April 24, 2019 stated to document the following:
- the checking of [the treatment] each shift on the eMAR
- resident tolerance to [the treatment], comfort level
- routine for removing and/or administering [the treatment] on the eMAR
There was nothing in the policy related to documentation of the actual administration of the treatment, the documentation of any assessment related to the treatment including whether the treatment should be included in a resident's plan of care or tasks in point of care documentation.

In an interview with the Resident Assessment Instrument Coordinator (RAI-C) #110 and the Assistant Director of Care (ADOC) #103 on a specific date, the ADOC said that it was their expectation that there should have been a physician's order, and the assessment and use of the treatment should have been documented.

The licensee has failed to ensure that the provision of the care set out in the plan of care, the outcomes of the care set out in the plan of care and the effectiveness of the plan of care related to the use of treatments were documented for resident #026, 027, 030, 031 and 033. [s. 6. (9)]

Additional Required Actions:

CO # - 005, 006, 007 will be served on the licensee. Refer to the "Order(s) of the Inspector".
DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that, every alleged, suspected or witnessed incident that the licensee knew of, or that was reported to the licensee, was immediately investigated for anything else provided for in the regulations and that appropriate action was taken in response to every such incident; and any requirements that were provided for in the regulations for investigating and responding as required under clauses (a) and (b) were complied with.

Ontario Regulation 79/10 s.107 (1)(2) states every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of an unexpected or sudden death, including a death resulting from an accident or suicide, followed by the report.

Ontario Regulation 79/10 s.107 (3)(4) states that the licensee shall ensure that the Director is informed of an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition no later than one business day after the occurrence of the incident, followed by the report.

Specifically, the licensee has failed to ensure that the incident that the licensee knew of was immediately investigated and appropriate action was taken related to a critical incident which resulted in a sudden and unexpected death.

The Ministry of Long-Term Care (MOLTC) received a complaint on a specific date outlining concerns related to care of resident #001 as well as an incident on a specific date. During the inspection, inspectors were made aware of another incident involving resident #008 that had occurred on a specific date, which resulted in the resident being transferred to hospital.

Review of the Ministry of Long-Term Care's (MOLTC) Critical Incident System (CIS) reporting site in August 2019, identified no CIS reports were submitted for resident #008 related to the incident.

Progress notes in Point Click Care (PCC) showed the following:
-On a specific date, resident #008 had been assessed by the attending physician for a newly developed condition as well as a cough with decreased oxygen saturation and the resident requested to be sent to the hospital.
-On a specific date, the Acting Director of Care (aDOC) #138 had called resident #008's family on three different identified times to inform them of the resident's health status and that the resident was being sent to the hospital at their request.
-On a specific date, resident #008 had returned from the hospital and that medication reconciliation was completed by the Registered Nurse (RN) as well as the physician.
-On a specific date, resident #008 had an incident while being assisted by staff. Resident #008 was immediately attended to, code blue was announced, and procedures completed. The note showed that the RN called the resident's family as they were a level one Advanced Care Directive (ACD) and the family wanted the resident to be sent to the hospital. Resident #008 was unresponsive and upon paramedic arrival, Cardiopulmonary Resuscitation (CPR) was initiated and the resident was transferred to the hospital. Resident #008's family was called to inform them that CPR was completed and the resident was sent to the hospital.
-On a specific date, Resident #008 was reported to be on a ventilator with unstable respirations.
-On a specific date, the staff were made aware that resident #008 had passed away in hospital.

Risk Management in PCC showed an incident report on a specific date, identifying that resident #008 had an incident. The report stated that the resident was unresponsive after the code blue was called, and procedures were initiated. The report stated that the resident was a level one ADC, the RN called the family and they wished for the resident to be sent to the hospital after paramedics arrived and CPR completed.

Resident #008's health records were reviewed in PCC and showed in the "Code Status" section "**Level one- Palliative (Comfort Measures Only)" and physician orders stated "**Level one- Palliative (Comfort Measures Only)" ordered by Physician #141 on a specific date, with an end date of "Indefinite". There was no "Advance Directives/Consent to Plan of Treatment" found in resident #008's paper chart.

On a specific date, Personal Support Worker (PSW) #113 stated that on the date of the incident, Registered Practical Nurse (RPN) #142, Executive Director #125, and PSW #132 were present. The PSW stated that resident #008 was sick for a specific time frame prior to the incident and was sent to the hospital and returned to the home.

On a specific date, RPN #142 stated that they would look directly on the computer to find a resident's level of care in relation to their code status. RPN #142 said that the advance care directive was also reviewed during the three month medication review where the physician would sign to renew or change. RPN #142 reviewed the resident's paper chart, including their three month medication review for a specific time frame, confirmed that there was no ACD and questioned why it was not there. The RPN said that they would expect that the medication review would always include an advance directive. RPN #142 stated that they were present during the incident occurring on a specific date. RPN #142 stated that resident #008 was being assisted by staff when PSW #132 called for their help and RPN #142 assisted resident #008 and a code blue was called. RPN #142 stated that they performed procedures on resident #008 and there was discussion about the resident's code level. RPN #142 stated that they reported that the resident was not to have CPR initiated. RPN #142 stated that they thought that resident #008's original copies of their advance directives and Do Not Resuscitate (DNR) were sent to the hospital with the resident previously. They said that the home did not have the paper work to provide the paramedics and they initiated CPR. When asked what CPR included when the paramedics arrived at the home, RPN #142 stated it included chest compressions and the "electric one" which delivered a shock. RPN #142 stated that the resident's DNR form was signed the day of the incident because they could not find their DNR form in the paper chart. The RPN said that they called the family but at that time they were not yet informed if the home was going to do CPR or not. RPN #142 stated that when the paramedics arrived it was chaos and they completed CPR. RPN #142 stated that they could see the "loop holes" because of the missing paper work.

On a specific date, Registered Nurse (RN) #133 stated that they would look in the residents paper chart or PCC to know what a resident's wishes were for their code level. They stated that if they had to call the paramedics, they would need to have the original

papers out for them to see. RN #133 said that they were familiar with the incident related to resident #008 on a specific date. They said that the Executive Director (ED) #125 was also present. The RN stated that RPN #142 who was working on the floor reported to them that the resident was on comfort measures and had a DNR. RN #133 stated that they called resident #008's family and they had told them to send the resident to the hospital. The RN stated that the paramedics arrived and asked for the level of care for resident #008 and requested to see the original document, however the RN and ED #125 did not have the forms and were not in the residents paper chart. RN #133 said that they signed a DNR form and gave it to the paramedics. When asked if the family member who was called that day had consented to CPR for resident #008, RN #133 stated no, and that they were mad because there was no paper to identify this.

On a specific date, Acting Director of Care (aDOC) #138 said when a resident was first admitted to the home, they would talk with the interdisciplinary team and obtain the resident's expectations related to their level of care. Acting DOC #138 stated that they would expect that the medication list, transfer sheet with diagnosis and family information, advanced care directives as well as a DNR form be sent to the hospital with a resident. When asked if they send an original copy of these documents or a photocopy, the aDOC stated that it should be a copy. The aDOC stated that a resident's level of care and code status was identified with a significant change or they would have a care conference with the family and it would be discussed at that time. When asked where they would expect staff to look to find resident's care level, aDOC #138 stated that it was in the front of everyone's chart in a paper copy. The aDOC said that they were familiar and involved with an incident related to resident #008's transfer to hospital on a specific date prior to the incident in their role as nurse manager at the time. The aDOC stated that Agency Registered Practical Nurse (RPN) #109 was working on that date when resident #008 was sent to hospital and that the physician filled out the residents transfer sheets. The aDOC said they assisted with the paper work for the transfer and that resident #008's wishes for their care level and resuscitation status was a DNR. When asked if they recalled if there was a DNR and advance care directive in resident #008's chart on that date, aDOC #138 stated that they recalled Agency RPN #109 telling them resident #008's level of care.

On a specific date, Executive Director (ED) #125 stated that any critical change would trigger an incident report in Risk Management to be initiated. ED #125 said that a choking incident or if a resident lost consciousness would trigger an incident report to be initiated. The ED stated that due to the timing and nature of the report, they would always be reviewed by the Director of Care (DOC). ED #125 said that they were familiar with

resident #008, and were present for the code blue. ED #125 said that the incident occurred at a specific time and that resident #008 was found in the lounge unresponsive and was unsure who had found them. ED #125 stated that upon their arrival to the floor, they identified that resident #008 was a DNR, family was contacted and they had requested that the resident be sent to the hospital. When asked what they meant when they stated that they identified resident #008 was a DNR, the ED stated that there should have been a DNR, however, resident #008 had been sent to the hospital within a specific time frame prior and that it had appeared that the only copy the home had on file was taken with the resident at that time. ED #125 said that there was no DNR form in the home between the date of the previous hospitalization to the time of the incident for resident #008. ED #125 stated that since the Emergency Medical Services (EMS) did not have a physical form, they started CPR on resident #008. The ED said they were not sure who had sent the original forms with resident #008 during the previous hospitalization, and would expect that a copy of the paper work had been sent. When asked if the family consented to CPR being initiated during the phone call during the code blue, ED #125 stated that they did not know. ED #125 stated that they called aDOC #138 at home on the date of the incident in order to complete a new DNR form as there was no DNR form found in resident #008's chart. When asked if the substitute decision maker consented to the CPR that was performed on the date of the incident, ED #125 sated that they would have to speak with RN #133 to know. When asked if resident #008 had a significant change in condition as a result of this incident, ED #125 stated that resident #008 never returned and that resident #008 passed away in hospital as a result of the incident. When asked if there was any follow up with resident #008's Power of Attorney (POA), ED #125 stated that there should have been but that they did not know. ED #125 said that resident #008's plan of care was not followed when they received CPR and had a known DNR form.

On a specific date, Inspectors asked what was done in response to the incident involving resident #008, ED #125 stated that the home did an immediate audit to make sure each resident had the ACD and DNR documents required in their charts. The audit results were provided to inspectors. On a specific date, when asked what was done with the results of the audit and the identified missing documents, the ED said that the DOC was currently working on it. When asked if the investigation into the incident would include speaking to the agency staff #109 who was identified to have sent the original copy of the advance care directive and DNR to the hospital with resident #008 during their previous hospitalization, ED #125 stated yes.

On a specific date, RPN #142 stated that no one had talked to them about the incident

that had occurred on a specific date and that they were expecting that someone would come talk to them about the incident.

On a specific date, Agency RPN #109 said they transferred resident #008 to the hospital on a date prior to the incident. Agency RPN #109 stated that they did not complete the transfer paper work as they were busy administering medications and that the RN completed them. When asked who gave the ambulance resident #008's documents, Agency RPN #109 stated that they were unsure but believed it was aDOC #138, and stated it was not them. When asked if Agency RPN #109 knew what documents or if they were copies or originals of the documents, Agency RPN #109 stated that they did not know. The Agency RPN said that no one from the home had talked to them in relation to resident #008's original documents being sent with them to the hospital on that date.

Review of the homes "Resident Death or Transfer Record" did not document resident #008's death on a specific date. Review of PCC admissions, transfers and deaths report showed that 22 residents passed away in 2019 and of those, four were documented on the homes "Resident Death or Transfer Record".

On a specific date, aDOC #138 stated that there was a list of deaths in the home, however, they did not know if it had been filled out. When asked if they would expect that all residents transferred out of the home or had passed away in the home be identified on the list of deaths in the home, the aDOC stated yes. The aDOC said that the Registered Nurse (RN) or Registered Practical Nurse (RPN) on the unit would complete the Institutional Patient Death Record (IPDR) when a resident passed away. When asked how aDOC #138 would fill out the required questions asked in the IPDR, they stated that they would look at the last few IPDRs, however if any residents had passed away in hospital they would not have an IPDR completed.

On a specific date, RN #133 stated that IPDRs used to be completed by the RN's, but RNs were working on a unit now and not working as the building RN so they did not know. When asked if they would expect that the registered staff on each floor of the home would submit an IPDR for any resident that passed away on their floor during their shift, RN #133 stated yes as it would not be them completing it for another floor. When asked if all the names of all residents who passed away were listed in the death or transfer log, RN #133 stated sometimes they were and sometimes they were not.

The licensee had failed to ensure that the incident in which resident #008 was administered CPR with a known DNR, with no ACD on file in the home resulting in

subsequent hospitalization and death, was immediately investigated and appropriate action taken to ensure the safety and dignity of choice of residents. [s. 23. (1)]

Additional Required Actions:

CO # - 008 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of an incident that caused an injury to a resident for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition, no later than one business day after the occurrence of the incident, followed by the report required.

A) On a specific date, Inspectors became aware that resident #008 had an incident in the home on a specific date, ambulance was called, Cardiopulmonary Resuscitation (CPR) was initiated, the resident was transferred to hospital and passed away on that same date.

Progress notes and Risk Management in Point Click Care (PCC) for resident #008 on a specific date, showed that they had an incident while being assisted by staff. The note stated that resident #008 was immediately assisted by staff, code blue was announced, and procedures were completed. The note stated that the resident was unresponsive and upon paramedic arrival, Cardiopulmonary Resuscitation (CPR) was initiated and the resident was transferred to the hospital. A progress note on a specific date documented that staff were made aware that resident #008 had passed away in hospital on the date

of the incident.

During an interview on a specific date, Registered Nurse (RN) #129 stated that the Director of Care (DOC) or Assistant Director of Care (ADOC) would initiate and submit Critical Incident System (CIS) reports in the home.

During an interview on a specific date, Staff Development Coordinator (SDC) #130 stated that the mangers would complete CIS reports in the home.

During an interview on a specific date, Executive Director (ED) #125 stated that resident #008 had a significant change in condition and never returned to the home as a result of the incident. The ED stated that it was their expectation that registered staff or nurse managers would immediately submit CIS reports for the home to the Ministry of Long-Term Care (MOLTC). ED#125 stated that they did not believe that the incident in which resident #008 was found, transferred to hospital and passed away was reported to MOLTC.

Review of the Ministry of Health and Long-Term Care (MOHLTC) Critical Incident System (CIS) reporting site identified no CIS reports were submitted for resident #008. (435)

B) During an inspection related to a sudden and unexpected death, Institutional Patient Death Records (IPDR) were reviewed and an IPDR for resident #029 was found completed on a specific date. The IPDR stated:
1. Accidental death? "Yes" was checked off.
5. Is the death both sudden and unexpected? "Yes" was checked off. There was also a hand written note beside question number five stating: "Coroner called, Dr. [physician's name and phone number]. No concerns".

The health record for resident #029 was reviewed and showed that the resident had an incident on a specific date, resulting in injuries and was transferred to hospital. Treatment to the injuries were applied. On a specific date, the resident became symptomatic of specific illness. On a specific date, a progress note stated that staff had found the resident very lethargic and was not opening their eyes. Respirations were shallow and gasping with ten second period of apnea, eyes were fixed, oxygen saturation 72 per cent, and staff could not get a pulse or blood pressure. Pulse taken manually 60, called power of attorney and informed of condition, explained condition was very poor, interventions were not effective, and staff asked what they would like to do at that time, "send to the hospital or do CPR [Cardiopulmonary Resuscitation]". The resident had

advanced care directives level three, moderate care, transfer to hospital without CPR. Called 911, and got instruction to do CPR, placed resident on the floor and did chest compressions. Paramedics arrived and took over CPR. ECG [Electrocardiogram] monitor showed no blood pressure, no pulse, and the screen was flat.

On a specific date, the physician documented in progress notes:
The patient had been having rapid decline in function since an incident during a specific time frame, with injuries that required transfer to the emergency room. CAT [Computerized Axial Tomography] scan of specific areas did not show any acute abnormality. Based on this information, death certification was filled with the immediate cause of death, secondary to the incident due to underlying causes.

The Ministry of Long-Term Care (MOLTC) Critical Incident System (CIS) was reviewed and there were no reports of resident #029 having an incident with a transfer to hospital and a significant change in condition or an unexpected death.

In an interview with the Executive Director (ED) #125 on a specific date, the ED said that the incident with a transfer to hospital with injuries should have been reported to the MOLTC in a CIS as that would be considered an incident that resulted in a transfer to hospital and a significant change in condition. The ED also agreed that a sudden or unexpected death also should have been reported to the MOHLTC in a CIS.

Review of the home's "Critical Incidents" policy, #E-45, with a revised date of May 3, 2019, stated the following:
"The Director of Care or designate will be responsible for communicating all critical incidents to the Ministry of Health and Long-Term Care."

The licensee failed to ensure that the Director was informed within one business day of the incident in which resident #008 was sent to the hospital and passed away, and for the incident in which resident #029 was taken to a hospital and passed away on a specific date. (213) [s. 107. (3) 4.]

Additional Required Actions:

CO # - 009 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident.

The Ministry of Long-Term Care (MOLTC) received a complaint on a specific date, through the MOLTC Actionline outlining concerns related to the care of resident #001 including medications not being administered to residents.

The home's medication incident binder titled "Medication Errors Tracking Trends & Analysis" was reviewed and documented a medication incident occurring on a specific date. The medication incident showed that resident #013 was administered another resident's medications as the residents looked alike and had responded to the other resident's name. The medication incident report was electronically signed by Acting Director of Care (aDOC) #138.

Progress notes in Point Click Care (PCC) for resident #013 with a specific date and time stated treatment directions for the resident to account for an additional medication dose during lunch medication rounds and that the family and doctor were notified of the error.

On a specific date, Pharmacy Operations Manager (POM) #135 stated that they were familiar with the medication incident involving resident #013.

On a specific date, acting Director of Care (aDOC) stated that resident #013 was provided another residents medications.

The licensee has failed to ensure that no drug was used by or administered to resident #013 unless the drug was prescribed for the resident on a specific date. [s. 131. (1)]

2. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

The Ministry of Long-Term Care (MOLTC) received a complaint on a specific date through the MOLTC Actionline outlining concerns related to the care of resident #001 including medications not being administered to residents. The complainant stated that they went into the home on a specific date around 1045 hours and the staff member informed the complainant that they had not yet provided the morning medications at that time.

Review of the medication incident binder titled "Medication Errors Tracking Trends & Analysis" showed 18 hand written medication incident reports for resident #001, resident #002, resident #003, and 15 other identified residents. The 18 medication incident reports, with a specific incident date, documented that the residents scheduled 0630, 0700, 0730, and 0800 hour medications were administered late.

Review of resident #001's medication administration audit report on the incident date, identified six ordered medications scheduled between 0730 and 0800 hours with an administration time of 1104 and 1105 hours. Further review of resident #001's medication administration audit report on a specific date, identified five ordered medications scheduled at 0800 hours with an administration time of 1156 hours. Review of resident #001's medication administration audit report on another specific date, identified six ordered medications scheduled at 0800 hours with an administration time of 0951 hours.

Review of resident #002's medication administration audit report on the incident date, identified nine ordered medications scheduled between 0730 and 0800 hours with an administration time of 1133 hours and 1136 hours. Further review of resident #002's medication administration audit report on another specific date, identified eight ordered medications scheduled at 0800 hours with an administration time of 1030, 1039, and 1040 hours.

Review of resident #003's medication administration audit report on the incident date, identified six ordered medications scheduled at 0800 hours with an administration time of 1026 and 1031 hours. Further review of resident #003's medication administration audit

report on another specific date, identified seven ordered medications scheduled at 0800 hours with an administration time of 1021 and 1022 hours.

On a specific date, Registered Nurse (RN) #129 stated that they considered a medication incident to be if a resident did not receive their medication at the right time. RN #129 stated that as per the home's process, an incident report was to be filled out if a medication incident occurred.

On a specific date, Acting Director of Care (aDOC) #138 stated that the standard practice guidelines for medication administration was an hour before an hour after the scheduled time. When asked what the home's policy titled "Medication Incident index I.D. F-45" meant when it stated that a medication incident could be constituted as "Drug at Wrong Time", aDOC #138 stated when a resident was to take a medication at 0800 hours and they were administered the medication before 0700 or after 0900 hours.

Also included in the binder was a medication incident on a specific date, which documented that resident #012 was not able to receive their full medication dose as there was no other supply available. Review of resident #012's electronic Medication Administration Record (eMAR) identified "Other / See Nurse Notes" on the specific date which stated the medication order. Review of resident #012's progress notes in Point Click Care (PCC) identified no progress notes documented on the specific date related to resident #012's medication administration incident.

On a specific date, Pharmacy Operations Manager (POM) #135 stated that resident #012 had not received their medications as ordered on a specific date.

The licensee has failed to ensure that drugs were administered to residents #001, #002, #003, and #012 in accordance with the directions for use specified by the prescriber when they were documented to be administered late or at the scheduled times on the identified dates. [s. 131. (2)]

Additional Required Actions:

CO # - 010 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): 4. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The Ministry of Long-Term Care (MOLTC) received a complaint on a specific date through the MOLTC Actionline outlining concerns related to the care of resident #001 including medications not being administered to residents. The complainant stated that they went into the home on a specific date around 1045 hours and the staff member informed the complainant that they had not yet provided the morning medications at that time.

Review of resident #001's medication administration audit report for the date of the incident, identified six medications scheduled to be administered at 0800 hours, were documented as administered at 1104 and 1105 hours.

Review of resident #002's medication administration audit report for the date of the incident, identified nine medications scheduled to be administered at 0730 and 0800 hours, were documented as administered at 1133 and 1136 hours.

Review of resident #003's medication administration audit report for the date of the incident, identified six medications scheduled to be administered at 0800 hours, were documented as administered at 1026 and 1031 hours.

The medication incident binder titled "Medication Errors Tracking Trends & Analysis" was reviewed and showed 18 hand written medication incident reports for resident #001, #002, #003, and 15 other identified residents. The 18 medication incident reports, with the specific incident date, documented that the residents scheduled 0630, 0700, 0730, and 0800 hours medications were administered late. The reports were signed by Acting Director of Care #138, and dated after the incident. Also included in the binder was medication incident report on a specific date which documented that resident #013 was administered another resident's medications.

On a specific date, Acting Director of Care (aDOC) #138 stated that they would expect that the resident, the resident's Power Of Attorney (POA) or Substitute Decision Maker (SDM), the Director of Nursing and Personal Care (DONPC), the Medical Director, the prescriber of the drugs and the pharmacy service provider be notified when a medication incident occurred. The aDOC stated that they would expect that residents be notified if a medication incident occurred as soon as they were made aware of it or when staff were aware of it. The aDOC stated that they expected that medication incident reports would be completed electronically, and that the pharmacy service provider would be notified right away via the computer. The aDOC stated that they would consider medications that were scheduled for administration at 0700 and 0800 hours, but were administered at

1026, 1104, and 1136 hours to be a medication incident. Acting DOC #138 reviewed the medication incident binder and stated that there were 19 medication incidents that had occurred in July 2019. When asked if there were medication incidents on a specific date related to resident #001, #002 and #003, the aDOC stated yes. The aDOC stated that the family members of resident #001, #002 and #003 were made aware of the medication incidents after the incident date, but could not confirm if the residents were notified. The aDOC stated that the Medical Director and the prescriber of the drugs were notified of the incidents after the incident date. The aDOC was not sure if the pharmacy was notified for the 18 hand written medication incidents. The aDOC stated that they were not sure what medications were administered late to resident #001, #002, and #003 on the date of the medication incident. Acting DOC #138 stated that they did not take immediate actions to assess and maintain the health status for resident #001, #002 and #003 on July 6, 2019, as they were not made aware of the incidents until a date after the incident. When asked how they made sure that there were no negative outcomes to resident #001, #002 and #003 when they became aware of the incidents, aDOC #138 did not have an answer.

On a specific date, Executive Director (ED) #125 stated that they would expect that a medication incident report to not have been completed a month after an incident occurred and that it would be difficult for staff to maintain the safety and heath of the residents if the incident was not identified in a timely manner to take action. ED #125 stated that they would want to know any error made to provide education to the staff so they understand the nature of the incident and to take corrective action. The ED stated that if the incident report was completed one month after, it would be hard to address in a timely manner with the staff.

On a specific date, Pharmacy Operations Manager (POM) #135 stated they would expect that when a medication incident occurred in the home that it would be reported to the Director of Care (DOC) and that they would immediately contact pharmacy for immediate interventions. POM #135 stated that they expected to be informed of medication incidents by a submitted report as soon as possible over an online system. The POM stated that they used to receive hand written medication incident reports from the home, however, they had switched over to the online system. POM #135 stated that they had been made aware of four medication incidents that occurred in July 2019. The POM stated that they were not made aware of 18 hand written medication incident reports for incidents with late medication administration occurring on a specific date. The POM stated that they were aware of an incident involving resident #013 on a specific date, and would expect to be notified of the medications that were incorrectly administered to the

resident as the information was not documented in the report that was submitted by the home. POM #135 stated that they were not provided information if there were negative outcomes to resident #013 or who the staff member was who made the error on that date.

A specific Medication Incident report provided by POM #135 was not identified in the medication incident binder provided to inspectors. The medication incident related to resident #007 was reviewed and showed specific directions for the administration of their medication and when to inform the physician. The note stated that agency RPN #109 did not call physician to adjust the residents dosage and that it was considered to be a medication error. The report showed that the physician, the family/resident, and the presciber were not notified of the medication incident.

On a specific date, Agency Registered Practical Nurse (RPN) #109 stated that they were not made aware that a medication incident related to resident #007 had occurred on the specific date.

Review of the home's medication administration policy titled "Medication Administration – Medication Incident F-45" with a revised date of May 3, 2019, indicated that the "Standard" for the policy included a system for the immediate reporting of medication incidents and follow up action(s). The policy noted under the "procedure" section that a medication incident constituted any involvement in the dispensing or administration, which included "wrong drug" and "drug at wrong time". The policy continued to include the following actions:
-All medication incidents to be acted on immediately and actions taken to assess and maintain the incidents
-Assess the severity level including the current status of the resident and any potential risk and immediate actions were taken to assess and maintain the resident's health
-Notify the attending physician and the member of the drug if different from the attending physician immediately if there appeared to be a serious problem, otherwise on the next doctor visit
-Report the medication incident to the resident (if cognitive), the substitute decision member, the Director of Care, the Medical Director, prescriber and the pharmacy service provider
-Document the incident in the electronic progress notes with assessment of the resident nothing changes in mental status, physical status and behavioural changes
-Monitor and record observations in the electronic progress notes. Follow any specific orders given by the physician for monitoring

-Complete the Medication Incident Report in the electronic Medication Incident Reporting System (MIRS) which the system would automatically notify the next person in the process
-Complete Ministry of Health critical incident report using the electronic Critical Incident System (CIS) where applicable
-The Medication Incident Reports to be analyzed by the Nurse Manager, the consultant pharmacist to determine whether pharmacy and/or nursing procedures required modification.
The outcome of the policy stated that medication incidents were to be reported immediately and that there was to be documentation and follow-up on all medication errors.

The licensee had failed to ensure that 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 and 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 for the five medication incidents that occurred. [s. 135. (1)]

Additional Required Actions:

CO # - 011 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a care conference of the interdisciplinary team providing a resident's care was held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct were given an opportunity to participate fully in the conferences; and a record kept of the date, the participants and the results of the conferences.

In an interview with the acting Director of Care (aDOC) #138 on a specific date, they said that Advanced Care Directives and Do Not Resuscitate directions were obtained on admission and during six week and annual care conferences, as well as any other time when the resident and or family requested a change. The aDOC shared that care conferences were to be documented in Point Click Care (PCC) in the progress notes.

Record review of progress notes for resident #008 in PCC showed that the resident was admitted to the home on a specific date, and there was no documentation of any conference having been completed during the sixteen weeks resident #008 resided in the home.

Record review of progress notes for resident #015 in PCC showed that the resident was admitted to the home on a specific date, and the only care conference documentation showed that it was completed twenty-one weeks after admission.

Record review of progress notes for resident #016 in PCC showed that the resident was admitted to the home on a specific date and there was no documentation of any conference having been completed during the fifteen weeks resident #016 resided in the home.

In an interview with the Executive Director (ED) #125 on a specific date, they said that care conferences were to be completed annually, within six weeks of admission and as needed. The ED said that care conferences were scheduled and arranged by Office Manger (OM) #137. The ED said that since resident #008 was admitted on a specific date and passed away on a specific date, they should have had a care conference prior to their death, within six weeks after the admission.

In an interview with the Office Manager (OM) #137 on a specific date, they said that they did not schedule care conferences. The OM said that they were once asked to call families about care conference dates and that the Resident Assessment Instrument Coordinator (RAI-C) #110 scheduled care conferences in the home.

In an interview with the Resident Assessment Instrument Coordinator (RAI-C) #110 on a specific date, they said they had just recently taken over the organization and scheduling of care conferences because they had identified that as a gap in the home. They said that care conferences were to be completed annually and on admission and were to be documented in progress notes in PCC. The RAI-C said that an audit was recently completed that identified a number of residents who did not have an annual or admission care conference completed.

The licensee has failed to ensure that a care conference of the interdisciplinary team providing a resident's care was held within six weeks following the resident's admission for resident #008, #015 and #016. [s. 27. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that, (a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; (b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and (c) a record is kept of the date, the participants and the results of the conferences, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was investigated and resolved where possible and where the complaint alleged harm or risk of harm to one or more residents, the investigation commenced immediately.

The licensee also failed to ensure that a response was made to the person who made the complaint, indicating what the licensee was done to resolve the complaint, or that the licensee believed the complaint to be unfounded and the reasons for the belief.

The licensee also failed to ensure that a documented record was kept in the home that included:
- The nature of each verbal or written complaint;
- The date the complaint was received;
- The type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
- The final resolution, if any;
- Every date on which any response was provided to the complainant and a description

of the response; and
- Any response made in turn by the complainant.

The Ministry of Long-Term Care (MOLTC) received a complaint on a specific date through the MOLTC Actionline outlining concerns related to treatments not being completed. The complainant reported that they spoke to a staff member the week prior who indicated that resident #030 was not provided specific treatments. The complainant reported that they had addressed their concerns with management, but nothing was done.

The home's "Client Service Response Forms" policy with a revision date May 1, 2019 was reviewed. The policy indicated:
"Document and maintain a record of the following on the CSR form: the nature of each verbal or written complaint; the date the complaint was received; the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; the final resolution, if any; every date on which any response was provided to the complainant and a description of the response; any response made in turn by the complainant."

In an interview with the Executive Director (ED) #125 on a specific date, Inspector #213 requested to review the home's complaint documentation. The ED provided a binder which contained Client Service Response (CSR) Monthly Tracking Tool records. There was no documentation related to the complaint.

On a specific date, Office Manager (OM) #137 stated there was a concern brought forth a week prior related to resident #030's treatments. The OM stated they brought the complaint to the ED who informed the OM to talk to the nurse on the floor.

On a specific date, Executive Director (ED) #125 stated they were familiar with a concern brought forth related to resident #030's treatments. The ED stated that the concerns were brought forth to the home within the last two weeks and was considered a verbal complaint. The ED stated that they spoke to the complainant and brought forth the information to the Resident Assessment Instrument Coordinator (RAI-C) who spoke to the resident about the concerns. When asked when the discussion happened, the ED stated early last week or the week before. The ED stated that they would expect that there should have been a documented record related to the complaint and it should have been investigated.

On a specific date, Resident Assessment Instrument Coordinator (RAI-C) #110 stated that the complaint was discussed during a morning management meeting the week prior that resident #030 had brought up a concern their treatments. When asked if there was any investigation or documentation related to the concerns or complaint, the RAI-C stated not that they were aware of and they did not personally investigate it.

In an interview on a specific date, Inspectors asked what was done about resident #030's concerns when they were first made aware of the situation prior to the Inspectors bringing it to the home's attention, ED #125 stated they were not aware if an investigation was completed. ED #125 confirmed that the home did not have any records of an investigation or documentation in the home's CSR for the complaint that was brought forward related to resident #030 treatments.

The licensee has failed to ensure that the verbal complaint made to the home concerning the treatments for resident #030 was investigated, documented, investigated or responded to. [s. 101.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows: 1) The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 (A response shall be made to the person who made the complaint) provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately; 2) a documented record is kept that includes the nature of the verbal complaint, the date the complaint was received, the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required, the final resolution, every date on which any response was provided to the complainant and a description of the response; or any response made in turn by the complainant, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 234. Staff records

Findings/Faits saillants :

1. The licensee has failed to ensure that a record was kept for each staff member of the home that included at least the following with respect to the staff member:
1. The staff member's qualifications, previous employment and other relevant experience.
2. Where applicable, a verification of the staff member's current certificate of registration with the College of the regulated health profession of which he or she is a member, or verification of the staff member's current registration with the regulatory body governing his or her profession.
3. Where applicable, the results of the staff member's police record check under subsection 75 (2) of the Act.
4. Where applicable, the staff member's declarations under subsection 215 (4).

The Visit Count Report for Earls Court provided by the employment agency was reviewed for a specific time frame. Forty-one different Staff Relief employees provided personal support services at Earl's Court Village during this time frame. Eight different Registered Practical Nurses employed by the agency provided nursing services in the home during this time frame.

In an interview with the Executive Director (ED) #125 on a specific date, the ED said that they did not keep employee files in the home for agency staff, that was the responsibility of the employment agency.

In an interview with the Nursing Administrator (NA) #119 from the employment agency on a specific date, the NA stated that they keep employee files for the agency employees of the agency who provided services at Earl's Court Village and that the home had never requested any information related to the agencies employees, that if they had, they would have provided it.

The "Health Care Service Agreement", between the employment agency and Sharon Village Care Homes (Earl Court Village LTC), dated December 18, 2018 was reviewed. The agreement stated:
Covenants of [the employment agency]

During the term, [the employment agency] shall:
Maintain an individual file for each worker containing the following:
vi) Professional credentials
vii) Police checks (vulnerable screening)
viii) Medical clearance i.e. TB tests, flu shots, etc.
ix) Reference check
x) Current CPR certificate

The licensee has failed to ensure that a record was kept for each staff member of the home that included staff member's qualifications, previous employment and other relevant experience, a verification of the staff member's current certificate of registration with the College of the regulated health profession of which he or she is a member, or verification of the staff member's current registration with the regulatory body governing his or her profession, the results of the staff member's police record check and the staff member's declarations under subsection 215 when applicable; for all Registered Practical Nurses and over forty one staff providing personal support services in the home during a specific time frame. [s. 234.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a record is kept for each staff member of the home that included at least the following with respect to the staff member: The staff member's qualifications, previous employment and other relevant experience; where applicable, a verification of the staff member's current certificate of registration with the College of the regulated health profession of which he or she is a member, or verification of the staff member's current registration with the regulatory body governing his or her profession; where applicable, the results of the staff member's police record check under subsection 75 (2) of the Act; and where applicable, the staff member's declarations under subsection 215 (4), to be implemented voluntarily.

Issued on this 20th day of September, 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

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

Ordre(s) de l'inspecteur

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) :	CASSANDRA ALEKSIC (689), AMBERLY COWPERTHWAITE (435), RHONDA KUKOLY (213)
Inspection No. / No de l'inspection :	2019_736689_0024
Log No. / No de registre :	012660-19, 012661-19, 013381-19, 015828-19
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Sep 6, 2019
Licensee / Titulaire de permis :	Sharon Farms & Enterprises Limited 108 Jensen Road, LONDON, ON, N5V-5A4
LTC Home / Foyer de SLD :	Earls Court Village 1390 Highbury Avenue North, LONDON, ON, N5Y-0B6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Rob Bissonnette

To Sharon Farms & Enterprises Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

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

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. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:

1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 24 to make mandatory reports.
5. The protections afforded by section 26.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Order / Ordre :

The licensee must be compliant with LTCHA 2007 s. 76(2).

Specifically, the licensee must:
a) Create a quality improvement plan that includes a protocol to ensure that all new persons working in the home pursuant to a contract or agreement between the licensee and an employment agency or other third party (hereon out referred to as "agency staff"), receive orientation/training before performing their responsibilities. The protocol must include the contract with the employment agency or other third party and that it meets the requirements of LTCHA 2007 s. 76(2) and 76(7), how the home will ensure that agency staff meet the requirements of LTCHA 2007 s. 76(2) and 76(7), recording and record keeping of training/orientation provided, the keeping of agency staff files in the home, responsible persons, timelines and tools to be used when applicable.
b) Review and revise the contract with Staff Relief Health Services Inc and any

other employment agency or third party to ensure that it meets the requirements of LTCHA 2007 s. 76(2) and 76(7).
c) Ensure and verify that every new agency staff receives orientation/training before performing their responsibilities related to the following:
1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 24 to make mandatory reports.
5. The protections afforded by section 26.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76 (2).
12. Fire prevention and safety.
13. Emergency and evacuation procedures.
14. Infection prevention and control.
15. Abuse recognition and prevention.
16. Mental health issues, including caring for persons with dementia.
17. Behaviour management.
18. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations.
A record of this training is to be kept in the agency staff person's file in the home.

d) Ensure and verify that every agency staff providing personal support services or nursing services in the home, receives orientation/training related to the following:
1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 24 to make mandatory reports.
5. The protections afforded by section 26.
6. The long-term care home's policy to minimize the restraining of residents.

7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76 (2).
12. Fire prevention and safety.
13. Emergency and evacuation procedures.
14. Infection prevention and control.
15. Abuse recognition and prevention.
16. Mental health issues, including caring for persons with dementia.
17. Behaviour management.
18. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations.
A record of this training is to be kept in the agency staff person's file in the home.

e) A written record is kept of all training including staff names, dates and training content, to ensure that all agency staff received the training.

Grounds / Motifs :

1. The licensee has failed to ensure that no staff performed their responsibilities before receiving training in the areas mentioned below:
   1. The Residents' Bill of Rights.
   2. The long-term care home's mission statement.
   3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
   4. The duty under section 24 to make mandatory reports.
   5. The protections afforded by section 26.
   6. The long-term care home's policy to minimize the restraining of residents.
   7. Fire prevention and safety.
   8. Emergency and evacuation procedures.
   9. Infection prevention and control.
   10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
   11. Any other areas provided for in the regulations. 2007, c. 8, s. 76 (2).

The Long-Term Care Homes Act, 2007, 2007, c. 8, s. 76 (7) states "Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:

1. Abuse recognition and prevention.
2. Mental health issues, including caring for persons with dementia.
3. Behaviour management.
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations.
5. Palliative care.
6. Any other areas provided for in the regulations."

O. Reg. 79/10 defines: "staff", in relation to a long-term care home, means persons who work at the home,
(a) as employees of the licensee,
(b) pursuant to a contract or agreement with the licensee, or
(c) pursuant to a contract or agreement between the licensee and an employment agency or other third party; ("personnel").

The Ministry of Long-Term Care (MOLTC) received a complaint on a specific date through the MOLTC Actionline outlining concerns related to the orientation of agency staff. On a specific date, the complainant stated that they arrived at the home around at a specific time and that the agency Registered Practical Nurse (RPN) on the floor had not yet provided the morning medications. The complainant stated that the agency staff member was supposed to be oriented that day, however, the staff who was supposed to orient them did not show up.

On a specific date, Director of Care (DOC) #100 stated that the agency provided staff education on their end and the staff would come into the home one hour earlier than their shift to shadow a scheduled staff member. The DOC stated that agency orientation was completed by the home related to policies. The DOC stated that Nurse Consultant (NC) #106 would have spoken to Nursing Administrator (NA) #119 from Staff Relief Health Care Services Incorporated (Staff Relief) who was the educator for the agency staff and would have provided the education to the staff.

On a specific date, Assistant Director of Care (ADOC) #103 stated that on a specific date they had received a call from staff in the home stating that the agency RPN needed orientation to the building prior to them starting their shift. The ADOC stated that RPN #140 agreed to orient agency RPN #139 and assisted with the medication pass. The ADOC stated that the orientation checklist was normally completed and signed off by the staff member saying that the agency went through orientation. ADOC #103 stated that they could not find the orientation checklist for agency RPN #139. The ADOC stated that the agency staff received orientation from Staff Relief regarding electronic documentation, pharmacy and specific products that the home uses, such as Point Click Care (PCC). When asked when agency RPN #139's first shift in the home was, the ADOC stated the specific date. When asked how the home ensured that the agency staff received orientation prior to performing their responsibilities, the ADOC stated that review of the residents' bill of rights, and the Long-Term Care Homes Act (LTCHA) would have been completed by the agency for their staff.

On a specific date, Nursing Administrator (NA) #119 from Staff Relief Health Care Services Incorporated stated that they worked for the agency providing direct recruitment, onboarding, training and orientation for the registered and non-registered staff contracted to the home. When asked what the agreement was related to the training that was provided to Staff Relief employees who provided services at Earls Court Village, the NA stated that they would use their judgement to provide an appropriate level of training to staff and if they needed a full shift or more of training and orientation, then they would contact Earls Court Village and arrange for that. The NA stated that the amount of training was based on the employees' level of experience and qualifications. They stated that when the staff went to the home they received floor specific orientation. NA #119 stated that the mandatory training items provided by Staff Relief to their employees was specific to long-term care homes but was not specific to Earls Court Village. When asked if Earls Court Village provided Staff Relief with specific policies or orientation materials prior to staff coming into the home, the NA stated no, they were never provided materials or protocols to train staff.

The Visit Count Report for Earls Court provided by Staff Relief Health Care Services Incorporated showed a total of forty-nine registered and non-registered staff that had confirmed shifts in the home from during a specific time frame.

On a specific date, Agency RPN #108 stated that they worked in the home as an agency RPN from Staff Relief. When asked if they had received orientation, the agency RPN stated that they shadowed a nurse on their shift and if they had questions they could follow up with the DOC. When asked if they received orientation in the home prior to starting their shift, they said that Staff Relief provided general orientation, but it was not specific to the home.

On a specific date, Agency Staff Member #121 stated that they worked for Staff Relief and provided personal support services in the home. When asked what responsibilities they completed for residents while working in the home, the Agency Staff Member stated that they were able to assist with mechanical lifts and provided residents baths. When asked about orientation they had received in the home prior to working, the Agency Staff Member stated that they learned from another agency staff member through shadowing. When asked if the home had reviewed any policies specific to their responsibilities in the home, including the prevention of abuse and neglect policy or minimizing of retraining residents, the Agency Staff Member stated no.

On a specific date, Agency Staff Member #123 stated that they worked in the home pursuant to a contract with Staff Relief. The Agency Staff Member stated they worked at Earls Court Village providing one to one care for a specific resident. When asked what types of responsibilities or duties they completed when working in the home, the Agency Staff Member stated that they provided direct care to the resident. When asked if they had received training or orientation from the home, the Agency Staff Member stated no, they did not.

On a specific date, Agency Staff Member #124 stated that they worked in the home pursuant to a contract with Staff Relief and it was their first day working. When asked if they had reviewed the homes policies and procedures, the Agency Staff Member stated that they did not review any documents or policies.

On a specific date, Personal Support Workers (PSWs) #111 and #113 stated that they were working in the home on a specific date. They stated that there was an agency staff member working in the home during the morning shift and the medications were administered late due to the regular staff not being available to provide orientation to the agency staff. The PSWs stated they had remembered

the day because the agency staff told them that they were not performing any duties in the home because they had not received orientation.

On a specific date, Executive Director (ED) #125 stated that for agency staff who provided services in the home received orientation on site and were provided policies with the expectation that they would adhere to and follow them. When asked if there was a package that was given to the agency with this information, the ED stated that they provided the agency with training documents. The ED stated that Staff Development Coordinator (SDC) #130 completed the general orientation for staff over two days at the home. They stated that it was completed as a group for the month for those who had been hired. When asked what training was completed for agency staff, the ED stated that some had, and some have not had the group training.

On a specific date, Nurse Consultant (NC) #106 stated that for agency staff that were providing services, they would set up eight hours of orientation, be set up in PCC and only get staff back in the home who have received orientation. When asked if they had provided training documents that the agency was supposed to use to provide orientation to the agency staff of the home's policies, NC #106 stated that they were not sure what process the agency or the home had in place related to orientation. When asked about a checklist for orientation, the NC stated that they were not sure what checklist was in place. When informed that the ED stated that the home provided a training document to the agency with the policies and procedures that employees were to review before starting, the NC stated that it was not the process they had arranged and that agency staff were supposed to receive training and orientation before they started. When asked what the responsibilities of non-registered agency staff were for providing one to one services in the home, the NC stated that they expected staff to do the same duties and were expected to know the residents and what care to provide. Inspectors informed the NC that Agency Staff Member #124 had no orientation on their first day of work in the home on a specific date. The NC stated that they provided certain agency staff access and information for orientation, but there should not be agency staff working in the home who had not been orientated and this was not the home's expectation.

There were no training records on file or documented evidence to support that the required mandatory training was completed by any of the agency employees

who worked in the home during the specific time frame.

The home's "Scheduling Agency Utilization" policy with revision date May 9, 2019 stated the following:
-Agency staff are provided a general orientation to the Home's philosophy, mission, vision and values, Resident Bill of Rights, the Home's abuse policy, Emergency plan, AODA, OH&S policies and other key policies and protocols, and other topics included in the LTCHA and Regulation 79/10.

The licensee failed to ensure that no staff, including staff working in the home pursuant to a contract or agreement, performed their responsibilities before receiving training and orientation.

The severity of this issue was determined to be a level 2 as there was minimal risk. The scope of the issue was a level 3 as it was widespread and had the potential to affect a large number of the home's residents. The home had a compliance level of 3 as they had a history with this section of the LTCHA that included:
Written Notification (WN), and Voluntary Plan of Correction (VPC) issued March 20, 2017 issued in inspection 2017_607523_0001 (689)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 01, 2019

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts. 2007, c. 8, s. 195 (12); 2017, c. 25, Sched. 5, s. 23.

Order / Ordre :

The licensee must be compliant with LTCHA 2007 s. 101(3) and O. Reg. 79/10, s. 215.

Specifically, the licensee must:
a) Create a quality improvement plan that includes a protocol to ensure that all new persons working in the home pursuant to a contract or agreement between the licensee and an employment agency or other third party (hereon out referred to as "agency staff"), have provided the licensee with proof of a police record check that includes a vulnerable sector screen and is completed within six months of the agency staff start date in the home. The protocol must include the contact with the employment agency or other third party and that it meets the requirements of O.Reg. 79/10, s. 215, how the home will ensure that agency staff meet the requirements of O.Reg. 79/10, s. 215, the keeping of agency staff files in the home, responsible persons, timelines and tools to be used when applicable.
b) Review and revise the contract with Staff Relief Health Services Inc. and any other employment agency or third party to ensure that it meets the requirements of O.Reg. 79/10 s. 215.
c) Ensure and verify that every new agency staff provides the licensee with proof of a police record check, that includes a vulnerable sector screen and was conducted by a police force within six months of the agency staff start date in the home. A copy of this proof is to be kept in the agency staff person's file in the home.
d) Ensure and verify that every agency staff working in the home has provided the licensee with proof of a police record check, that includes a vulnerable sector screen and was conducted by a police force. A copy of this proof is to be kept in the agency staff person's file in the home.

Grounds / Motifs :

1. The licensee has failed to comply every order made under the Long-Term Care Homes Act 2007.

The Long-Term Care Homes Act, 2007 s. 75 (1), (2) and (3) state: Every licensee of a long-term care home shall ensure that screening measures are conducted in accordance with the regulations before hiring staff and accepting volunteers. The screening measures shall include police record checks, unless the person being screened is under 18 years of age. For the purposes of

subsection (1), a staff member who is agency staff, as that term is defined in subsection 74 (2), is considered to be hired when he or she first works at the home.

O. Reg. 79/10 defines: "staff", in relation to a long-term care home, means persons who work at the home,
(a) as employees of the licensee,
(b) pursuant to a contract or agreement with the licensee, or
(c) pursuant to a contract or agreement between the licensee and an employment agency or other third party; ("personnel").

The following Compliance Order (#001) was issued June 26, 2019 in inspection #2019_605213_0021 with a compliance date of July 31, 2019:
The licensee must be compliant with O. Reg. 79/10, s. 215.
Specifically, the licensee must:
a) Create a quality improvement plan that includes a hiring protocol to ensure that all staff hired have provided the licensee with proof of a criminal reference check that includes a vulnerable sector screen. The protocol must include the hiring procedure, responsible persons, timelines and tools to be used when applicable.
b) Ensure and verify that every new staff member hired has provided the licensee with proof of a criminal reference check, that includes a vulnerable sector screen and was conducted by a police force.
c) Proof of this criminal reference check will be kept in the employee's file.

A record review was completed of the quality improvement plan provided by Nurse Consultant #106 from Responsive Health Management. The quality improvement plan included the information required by the Compliance Order for future employees of the home. The plan did not include any reference to agency staff.

The Visit Count Report for Earls Court provided by Staff Relief Health Care Services Incorporated was reviewed for a specific time frame. Four different Staff Relief employees provided personal support services for the first time at Earl's Court Village during this time frame.

In an interview with the Executive Director (ED) #125 on a specific date, the ED

said that they did not keep employee files in the home for agency staff, that was the responsibility of the employment agency, Staff Relief. The ED also stated that they did not request or review proof of a criminal reference check for agency staff, that it was the responsibility of the agency.

In an interview with Staff Relief Staff Relief Human Resources Coordinator #120 on a specific date, they said that they ensured the Staff Relief employees had a vulnerable sector screen.

In an interview with Staff Relief Nursing Administrator (NA) #119 from the employment agency on a specific date, the NA stated that they kept employee files for the agency employees of Staff Relief who provided services at Earl's Court Village and that the home had never requested any information related to criminal reference checks, if they had, they would have provided it.

The "Health Care Service Agreement", "between Staff Relief Health Care Services Inc. and Sharon Village Care Homes (Earl Court Village LTC)", dated December 18, 2018 was reviewed. The agreement stated:
Covenants of Staff Relief
During the term, Staff Relief shall:
Maintain an individual file for each worker containing the following:
i) Professional credentials
ii) Police checks (vulnerable screening)
iii) Medical clearance i.e. TB tests, flu shots, etc.
iv) Reference check
v) Current CPR certificate

The licensee did not comply with Compliance Order #002 part b), issued June 26, 2019 in inspection 2019_605213_0021, with a compliance date of July 31, 2019. They did not ensure and verify that every new staff member hired had provided the licensee with proof of a police record check, that included a vulnerable sector screen and was conducted by a police force, for all four Staff Relief employees who provided personal support services for the first time in the home during a specific time frame.

The severity of this issue was a level 1 as there was minimal risk to the residents. The scope was level 4, widespread, as 4 out of 4 (100 per cent) of

reviewed agency staff reviewed did not provide the licensee with proof of a police record check. Compliance history was a level 3 as the home did not have a history of non-compliance in this subsection of the legislation a Written Notification and a Director Referral was issued May 24, 2018 in inspection #2018_722630_0007. (213)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 04, 2019

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 003

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

Linked to Existing Order / Lien vers ordre existant: 2019_605213_0021, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 47. Qualifications of personal support workers

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s. 47 (1), (2), and (3).

Specifically the licensee must:
a) Create a quality improvement plan that includes a protocol to ensure that all persons working in the home as a Personal Support Worker (PSW) or providing personal support services, pursuant to a contract or agreement between the licensee and an employment agency or other third party (hereon out referred to as "agency staff"), have provided the licensee with qualifications to provide personal support services that meet the requirements identified in O.Reg. 79/10, s. 47. The protocol must include the contact with the employment agency or other third party and that it meets the requirements of O.Reg. 79/10, s. 47, how the home will ensure that agency staff meet the requirements of O.Reg. 79/10, s. 47, the keeping of agency staff files in the home, responsible persons, timelines and tools to be used when applicable.
b) Review and revise the contract with Staff Relief Health Services Inc. and any other employment agency or third party to ensure that it meets the requirements of O.Reg. 79/10 s. 47 and s. 234.
c) Ensure and verify that every agency staff has successfully completed a PSW program that meets the PSW Program Standard published by the Ministry of Training, Colleges and Universities and has provided the licensee with proof of graduation issued by the education provider. A copy of this proof is to be kept in the agency staff person's file in the home.
c) Ensure and verify that every agency staff, who is a registered nurse or registered practical nurse, in the opinion of the Director of Nursing and Personal Care, has adequate skills and knowledge to perform the duties of a PSW and has the appropriate current certificate of registration with the college of nurses of Ontario. A copy of this proof is to be kept in the agency staff person's file in the home.
d) Ensure and verify that every agency staff, who either is a registered nurse or registered practical nurse and does not hold a current certificate or registration with the College of Nurses of Ontario or is a person who does not have a PSW certificate from a program that meets the PSW Program Standard published by the Ministry of Training, Colleges and Universities, in the opinion of the Director of Nursing and Personal Care, has adequate skills and knowledge to perform the duties of a PSW and is enrolled in an educational program for registered nurses or registered practical nurses. A copy of this proof is to be kept in the agency staff person's file in the home.

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Grounds / Motifs :

1. The licensee has failed to ensure that on and after January 1, 2016, every person hired by the licensee as a personal support worker or to provide personal support services had successfully completed a personal support worker program that met requirements and had provided the licensee with proof of graduation issued by the education provider. O.Reg. 79/10 s. 47 (2) states: The personal support worker program must meet the Personal Support Worker (PSW) Program Standard published by the Ministry of Training, Colleges and Universities and must be a minimum of 600 hours in duration, counting both classified time and practical experience time.

O. Reg. 79/10 s. 47 (3)(a) states: The licensee may hire a personal support worker or to provide personal support services who, in the opinion of the Director of Nursing and Personal Care, has adequate skills and knowledge to perform the duties of a personal support worker, and who has the appropriate current certificate of registration with the College of Nurses of Ontario. O. Reg. 79/10 s. 47 (3)(c) states: The licensee may hire a personal support worker or to provide personal support services who, in the opinion of the Director of Nursing and Personal Care, has adequate skills and knowledge to perform the duties of a personal support worker, and is enrolled in an educational program for registered nurses (RN) or registered practical nurses (RPN).

O. Reg. 79/10 defines: "staff", in relation to a long-term care home, means persons who work at the home,
(a) as employees of the licensee,
(b) pursuant to a contract or agreement with the licensee, or
(c) pursuant to a contract or agreement between the licensee and an employment agency or other third party; ("personnel").

The following order was issued June 26, 2019 in inspection #2019_60213_0021, with a compliance date of July 31, 2019:
The licensee must be compliant with O.Reg. 79/10, s. 47 (1), (2), and (3). Specifically, the licensee must:
a) Create a quality improvement plan that includes a hiring protocol to ensure that all new staff hired have provided the licensee with qualifications to provide personal support services that meet the requirements identified in O. Reg. 79/10, s. 47. The protocol must include the hiring procedure, responsible

persons, timelines and tools to be used when applicable.
b) Ensure and verify that every new Personal Support Worker (PSW) hired has successfully completed a PSW program that meets the PSW Program Standard published by the Ministry of Training, Colleges and Universities and has provided the licensee with proof of graduation issued by the education provider. A copy of this proof is to be kept in the employee's file.
c) Ensure that all new staff hired as a PSW or to provide personal support services who is a registered nurse or registered practical nurse, in the opinion of the Director of Nursing and Personal Care, has adequate skills and knowledge to perform the duties of a PSW and has the appropriate current certificate of registration with the college of nurses of Ontario. A copy of proof of this registration is to be kept in the employee's file.
d) Ensure that all new staff hired as a PSW or to provide personal support services who either is a registered nurse or registered practical nurse and does not hold a current certificate or registration with the College of Nurses of Ontario or is a person who does not have a PSW certificate from a program that meets the PSW Program Standard published by the Ministry of Training, Colleges and Universities, in the opinion of the Director of Nursing and Personal Care, has adequate skills and knowledge to perform the duties of a PSW and is enrolled in an educational program for registered nurses or registered practical nurses. A copy of proof of this registration is to be kept in the employee's file.

The Visit Count Report for Earls Court provided by Staff Relief Health Care Services Incorporated was reviewed for a specific time frame. Twenty-nine different Staff Relief employees provided personal support services at Earl's Court Village during this time frame.

In an interview with Agency Staff Member #123 by Inspector #689 on a specific date, they said that they had been working in the home for approximately one month providing direct personal care to residents. They stated that they had a nursing degree from their home country which was outside of Canada. The Agency Staff Member said that they did not complete any schooling in Ontario for PSW or Registered Nurse (RN)/Registered Practical Nurse (RPN).

In an interview with Agency Staff Member #124 by Inspector #689 on a specific date, the Agency Staff Member stated that it was their first day working in the home and that they were responsible for direct resident care that day. They said

that they were a registered nurse outside of Canada and were not enrolled in a PSW or nursing program.

Staff Relief Health Care Services Inc. provided information to Inspectors related to the education and qualifications of nineteen Staff Relief staff who had provided personal support services at Earl's Court during a specific time frame. Staff Relief reported that nine were registered nurses in countries outside of Canada and none of those nine staff had a PSW Certificate or proof of enrollment in an RN or RPN program.

On a specific date, Executive Director (ED) #125 said that they did not keep employee files in the home for agency staff; that was the responsibility of the employment agency, Staff Relief. When asked how the home ensured that agency staff who provided personal support services in the home had successfully completed a personal support worker program that met requirements identified in the legislation, the ED said the primary way was that they had a contract with the agency, Staff Relief, which spelled out that requirement and that they were to meet those requirements. When asked if they were aware that there were agency staff who provided personal support services in the home who did not possess PSW qualifications, were not enrolled in an RN or RPN program and only had registered nurse qualifications oversees, the ED said no, they were not aware.

In an interview with the Staff Relief Nursing Administrator (NA) #119 from the employment agency on a specific date, the NA stated that they kept employee files for the agency employees of Staff Relief who provided services at Earl's Court Village and that the home had never requested any information related to the Staff Relief employees, that if they had, they would have provided it.

The "Health Care Service Agreement", "between Staff Relief Health Care Services Inc. and Sharon Village Care Homes (Earl Court Village LTC)", dated December 18, 2018 was reviewed. The agreement stated:
Covenants of Staff Relief
During the term, Staff Relief shall:
Maintain an individual file for each worker containing the following:
i) Professional credentials
ii) Police checks (vulnerable screening)

iii) Medical clearance i.e. TB tests, flu shots, etc.
iv) Reference check
v) Current CPR certificate

The licensee did not comply with Compliance Order #002 issued June 26, 2019 in inspection 2019_605213_0021, with a compliance date of July 31, 2019. The licensee also failed to comply with O. Reg. 79/10 s. 47 when nine Staff Relief agency staff members providing personal support services in the home did not have either PSW certification; or had the appropriate current certificate of registration with the College of Nurses of Ontario; or were enrolled in an educational program for registered nurses or registered practical nurses.

The severity of this issue was a level 3 as there was actual risk to the residents and this noncompliance is a Key Risk Indicator. The scope was level 2, a pattern, as ten out of nineteen (53 per cent) of reviewed agency PSW staff did not have required qualifications. Compliance history was a level 5 as the home had the following non-compliance issued:
Compliance Order was issued June 26, 2019 in inspection #2019_605213_0021.
Compliance Order was issued April 11, 2019 in inspection #2019_605213_0013.
(213)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Oct 04, 2019

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

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

The licensee must be compliant with LTCHA 2007 s. 8(3).

Specifically, the licensee must:
a) Ensure that at least one registered nurse, who is both an employee of the licensee and a member of the regular nursing staff of the home, is on duty and present in the home at all times.
b) Review and revise the policy "Scheduling Working Short".
c) Review and revise the home's staffing plan and staffing complement related to registered nursing (RN) staffing based on an evaluation of RN staffing in the home to include:
1. Written staff schedules to document and demonstrate the initial schedule, changes made to the schedule and the staff who physically worked in the home as an RN for every RN shift required.
2. Staff replacement process when there is a sick call, short-term and long-term absence for full time, regular part time and casual staff.
3. Permanent and temporary posting process for RN shifts/lines.
4. Responsibilities, responsible persons, timelines and plan for a quarterly evaluation of RN staffing in the home.
5. A written record of the review and revisions made, date, persons who participated and all required elements of the staffing plan as noted above.

Grounds / Motifs :

1. The licensee has failed to ensure that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times.

The Ministry of Long-Term Care (MOLTC) received a complaint on a specific date through the MOLTC Actionline outlining concerns related to the home not having a registered nurse (RN) on duty. The complainant stated that on on specific dates in July 2019, there was no RN in the building on the day shifts.

The home's "Staffing Compliment" documented within the Staffing Evaluation dated June 28, 2018, indicated on days, evenings and nights there was to be one registered nurse (RN) on duty each shift.

The home's "Detail Employee Report" was reviewed and documented the staffing levels in the home from July 1 to July 31, 2019. These documents showed the home did not have a RN working in the building as outlined on the home's "Staffing Compliment" on the following dates:
- July 6, 2019 – day shift
- July 7, 2019 – day shift
- July 20, 2019 – day and evening shifts
- July 27, 2019 – evening shift

On a specific date, Registered Practical Nurse (RPN) #101 stated that on July 20 and 21, 2019, there was no RN working in the building on the day shift.

On a specific date, RN #105 stated that as an example when a RN called in sick, agency staff would be called to cover the shift, and they were RPNs. The RN stated that there have been many days when there was no RN in the building.

On a specific date, Director of Care (DOC) #100 stated that the home had concerns with having a RN in the home at all times. DOC #100 stated that the issue had started in July. When asked if the home had been replacing the RN with RPNs, DOC #100 stated sometimes acting Director of Care (aDOC) #138 would come in and sometimes the Assistant Director of Care (ADOC) #103 would come in, but not always.

On a specific date, Behavioural Support Ontario (BSO) RPN #107 stated that they have been in charge when there has been no RN in the building. The BSO RPN stated that they had heard some families voice concerns about there being no RN in the building and some staff have told them that they could not be in

charge because they were not a RN. When asked how often it was happening, the BSO RPN stated that it had happened more than once, and there was no RN in the building on July 20, 2019. The BSO RPN stated that the home usually had an issue with not having an RN in the building on the weekends.

On a specific date, Nurse Administrative Assistant (NAA) #116 stated they developed the staff schedule. When asked what they would do if there was no RN scheduled in the building, the NAA stated that they would tell the Executive Director (ED) and DOC verbally which would be specifically on the weekends. When asked if there had been shifts with no RN in the building, the NAA stated that every other weekend and during the week was difficult.

On a specific date, Executive Director (ED) #125 stated that the home had not met the requirement to have a registered nurse on duty and present in the home at all times for July 2019.

Review of the home's "Scheduling Working Short" policy, with revision date May 9, 2019 stated the following under the heading "Short of Registered Nurse (RN): "If the Home is unable to fill the RN shift with an RN, it will be filled with an RPN".

On a specific date, Nurse Consultant (NC) #106 stated that they explained to the team that they should not be using the RN on call like it was an emergency, because it was no longer an emergency.

Based on these interviews and record review the licensee failed to ensure that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty, and present in the home at all times in July 2019.

The severity of this issue was determined to be a level 3 as there was actual risk of harm. The scope of the issue was a level 1 as it was isolated. The home had a level 2 compliance history as they had no history of noncompliance with this section of the LTCHA. (689)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Oct 04, 2019

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 005

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 LTCHA 2007 s. 6(1)(c).

Specifically, the licensee must:
a) Ensure that there is a written plan of care for resident #005, 026, 027, 030, 031, 033 and all other residents who require the administration of treatments, that sets out clear directions to staff and others who provide care to the resident related to the use of those treatments.
b) Ensure that there is a written plan of care for residents #014, 015, 017, 021, 024, 025 and all other residents in the home, that sets out clear directions to staff and others who provide care to the resident related to related to Advanced Care Directives and Do Not Resuscitate status.
c) Review and revise as necessary, the [treatments] policy.
d) Review and revise as necessary, all of the home's policies related to admission, transfers to hospital, care conferences, end of life care, etc., specifically related to advanced care directives.
e) Ensure that all registered staff providing service in the home (including agency staff) receive training related to the home's policy and process for the initiation and use of treatments in the home, including assessments and required documentation.
f) Ensure that all staff providing personal support services in the home (including agency staff) receive training related to a Personal Support Worker's role in treatments and scope of practice, including reporting and documentation requirements, methods of treatment delivery, use of treatments, how and when to administer treatments, and documentation.
g) Ensure that all staff providing nursing and personal support services in the home (including agency staff) receive training related to the home's policy and process for the determination and implementation of advanced care directives and required documentation.
h) Ensure that training related to advanced care directives and treatment use for registered staff and personal support staff is included in the new staff orientation content.
i) A written record is kept of all training related to treatments and advanced care directives, including staff names, dates and training content, to ensure that all staff, including agency staff, received the training.

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 and others who provided care to the resident.

A) A complaint was received by the Ministry of Long-Term Care on a specific date, related to resident #030's treatments.

Resident #030 was observed in the dining room on a specific date with treatments provided. On that date, the resident said that their treatment was the same as prior to their admission. The resident said that sometimes they did not have treatments had to ask the staff to administer the treatments.

The health records for resident #030 were reviewed. The resident's current plan of care in Point Click Care (PCC) stated, "Administer [treatment] as per physician order". This intervention was initiated on admission. The Medication Reconciliation and Physician Order Form on admission did not include any reference to the use of the treatment. There was a "New Admission Communication Form" in the chart that provided information about the treatment. There was a physician's order in the paper chart dated on a specific date related to the assessment of the treatment. There was a fax from [the physician] on a specific date that stated, "An order was sent to you [on a specific date] for an assessment of [the treatment] for [the resident]. I cannot find the order written in the physician's order form and I need it for the three month review so I have an order for the doctor to sign concerning [the treatment] the resident is to receive. Could [a specialist/therapist] please come to write that order?"; this was signed by a Registered Practical Nurse (RPN). In the Physician's Orders in the paper chart, there was a Three Month Medication Review signed by the physician on a later date that stated in handwriting the treatment type but no specific details and a hand written note stating "[a specialist/therapist] to advise".

There was no direction to Personal Support Workers (PSW) in the plan of care, Kardex or tasks in Point of Care (POC) in PCC to direct staff related to the treatment or related tasks for resident #030. There was no direction that the resident used the treatment, the type, directions or when to administer the treatment.

In an interview with the Resident Assessment Instrument (RAI) Coordinator (RAI-C) #110 and the Assistant Director of Care (ADOC) #103 on a specific

date, the Inspector asked how staff would know what the residents treatment would be or how it should have been delivered. The RAI-C reviewed resident #030's health records in PCC and said that there should have been a physician's order for the treatment and there was none. The Inspector asked how PSWs would know to how and when to administer the treatment. The RAI-C said that there should have been a task in POC in PCC.

Resident #005 was observed on specific dates with the treatment administered. The physician's orders, care plan and tasks in POC were reviewed for the resident in PCC. The physician's orders included directions for the use of the treatment. There was no direction in the plan of care or POC to direct PSWs that the resident used the treatment, the type, or when to administer the treatment.

Resident #026 was observed in the lounge on specific dates with the treatment administered. The physician's orders, care plan and tasks in POC were reviewed for the resident in PCC. There was no physician's order for routine use of the treatment. The medical directives included specific directions when to initiate the treatment. The Medical Directives electronic Medication Administration Record (eMAR) was reviewed and the direction related to the treatment was not signed for and there were no treatments documented during a specific time frame. There was no direction in the plan of care or POC to direct PSWs that the resident used the treatment, the type, or when to administer the treatment.

Resident #027 was observed in the lounge on specific dates with the treatment administered. The physician's orders, care plan and tasks in POC were reviewed for the resident in PCC. The physician's orders included directions for the use of the treatment. The electronic Medication Administration Record (eMAR) was reviewed and the direction related to the treatment was not signed for and there were no treatments documented during a specific time frame. There was no direction in the plan of care or POC to direct PSWs that the resident used the treatment, the type, or when to administer the treatment.

Resident #033 was observed in their room on a specific date with the treatment administered. The physician's orders, care plan and tasks in POC were reviewed for the resident in PCC. There was no physician's order for routine use of the treatment. The medical directives included specific directions when to

initiate the treatment. The Medical Directives electronic Medication Administration Record (eMAR) was reviewed and the direction related to the treatment was not signed for and there were no treatments documented during a specific time frame. There was no direction in the plan of care or POC to direct PSWs that the resident used the treatment, the type, or when to administer the treatment.

On a specific date, Inspector #213 observed resident #031 in their room using an assisted device with the treatment present but not administered. In an interview on a specific date, Registered Practical Nurse (RPN) #142 stated that there was no order for the treatment for resident #031, that it was only used as needed for specific instances. The RPN said the resident had occasionally needed the treatment for specific instances and that someone had administered the treatment on resident #031 that morning. RPN #142 said they checked that the resident and removed the treatment that the PSW administered during that morning. PSW #113 said that they administered the treatment that morning. When the Inspector asked PSW #113 if they had reported to the RPN that they administered the treatment to resident #031 that morning, the PSW said no. When asked how staff knew to administer the treatment, the RPN said they had a medical directive for the treatment which was a standard in the home.

On a specific date, resident #031 was observed in the lounge with the treatment present but not administered. Inspector #213 asked PSW #114 if the resident required the treatment and they stated that they needed it PRN (as needed). The PSW stated that the resident did have the treatment present and if needed could administer it. Inspector #213 asked PSW #143 if resident #031 had the treatment administered that morning, and the PSW stated that they did have the treatment administered earlier that morning when they came on at the beginning of their shift. The PSW stated that once they took the resident to the lounge, they then removed the treatment. The PSW said that they believed that the treatment needed to be administered for a specific direction of use.

The physician's orders, care plan and tasks in POC were reviewed for resident #031 in PCC. There was no physician's order or medical directives for routine use of the treatment. The paper chart was reviewed and there was an "Individual Medication Order Set" for resident #031 on a specific date signed by the physician. One of the orders included specific direction of use for the treatment.

There was no documentation of the treatment directions during a specific time frame. There was no direction in the plan of care or POC to direct PSWs that the resident used the treatment, the type, or when to administer the treatment.

The home's policy related to [the treatment] with a reviewed date of April 24, 2019 stated that to initiate [the treatment], the following must be in place:
-obtain a physician's order
-to qualify for funding, an up-to-date treatment report was required with specific guidelines
-to document the following: that the treatment was checked on each shift on the eMAR; the residents tolerance to the treatment; routine for removing and/or administering [the treatment] on the eMAR
There was nothing in the policy related to who can initiate the treatment, documentation of the actual administration of the treatment, the documentation of any assessment related to the treatment, or that the treatment should be included in a resident's plan of care or tasks in point of care documentation.

In an interview with the RAI Coordinator (RAI-C) #110 and the ADOC #103 on a specific date, the Inspector asked what the expectation was for the use of the treatment, the ADOC said that there should have been physician's order. When asked what the expectation was for the application of the treatment PRN, the ADOC said that it should have only been administered or removed by a registered staff after an assessment.

B) During the inspection, Inspectors became aware that resident #008 had an incident in the home on a specific date, ambulance was called, Cardiopulmonary Resuscitation (CPR) was initiated, the resident was transferred to hospital and passed away on that same date.

The health record, both paper and electronic, for resident #008 was reviewed in Point Click Care (PCC). The "Code Status" in PCC stated: "Level one- Palliative (Comfort Measures Only)". The paper chart did not include a form "Advance Directives/Consent to Plan of Treatment" or a form "Advanced Care Directives, Management of Life Threatening Illness", that indicated the resident and/or substitute decision maker's (SDM) wishes related to the level of treatment that should be used in the event of sudden onset of a life threatening illness. The paper chart also did not include the form "Do Not Resuscitate Confirmation

Form" to direct the practice of Paramedics and Firefighters after a specific date.

A blank form "Advance Directives/Consent to Plan of Treatment" was reviewed and stated:
"Level One – Supportive/Comfort Care: This includes, but is not limited to, the provision of measures available within the resources of the home such as: relief of pain, treatment of fever, suctioning, mouth care, positioning, oral fluids, oxygen administration (if available). Diagnostic interventions and transfer to hospital will not normally be utilized for residents who request this level of care directives. DO NOT RESUSCITATE allowing a natural death".
"Level Two – Limited Therapeutic Care: Care measures will include all procedures utilized in Level One – Supportive/Comfort Care (i.e. Oxygen, x-rays, hypodermoclysis), as well as the administration of antibiotics and/or other procedures which can be performed at the home. DO NOT RESCUSCITATE allowing a natural death".
"Level Three – Transfer to Acute Care Hospital with NO CPR: If symptoms indicate, the resident would be transferred to an acute care hospital for treatment. Assessment would e made in at the acute care hospital emergency department and decision made whether to admit the resident or return him/her to the home. DO NOT RESCUSCITATE allowing a natural death".
"Level Four – Transfer to Acute Care with CPR: Resident would e treated aggressively. Transfer to an acute care hospital will be arranged immediately. Cardiopulmonary resuscitation (CPR) will be provided by qualified staff, if available, and by ambulance personnel."

In an interview with the acting Director of Care (aDOC) #138 on a specific date, the aDOC said that Advanced Care Directives (ACD), including Do Not Resuscitate (DNR) status were to be determined at the time of admission, during annual care conferences and any time a resident or family wished there to be a change. On a specific date, the aDOC said that they recalled being phoned at home while on vacation by the Executive Director (ED) #125 inquiring about the aDOC's recollection of resident #008's requested level of ACD and DNR status. The aDOC said that they recalled resident #008's level of ACD was a level one and that the resident was a DNR. The aDOC said that they recalled this because they were involved when resident #008 had a previous incident and was transferred to hospital.

In an interview with ED #125 on a specific date, the ED said that they were present during the incident on a specific date, and that paramedics arrived and completed CPR. The ED said that there was no ACD or DNR forms in the resident's chart and there should have been one. They said that some time prior, it appeared that the registered staff sent the originals of the forms to the hospital. They said that the forms were not present in the home on the date of the incident, when paramedics arrived. The ED said that the paramedics asked if there was a DNR and because the home could not produce the form, the paramedics protocol was to start CPR.

The ED also shared that after the incident, they directed a summer student to complete an audit in the home for the presence of ACD and DNR forms for all residents. The audit results were provided to Inspectors. The audit showed:
Resident #007 had an ACD of level four and a DNR form was present
Resident #015 did not have an ACD form and a DNR form was present
Resident #017 had an ACD of level three that was not dated and a DNR form was present
Resident #022 did not have an ACD indicated and a DNR form was present

When asked on a specific date what had been done related to the results of the audit and the missing information, the ED said that the aDOC was currently working on it. When asked on a specific date what had been done related to the results of the audit and the missing information, the aDOC said that they were working on it and had not been to a specific home area yet to follow up on resident #007 and the conflicting information.

On a specific date, a record review was completed by Inspectors of ACD and DNR forms in paper charts as well as code status in PCC. The record review showed:
Resident #007 who was hospitalized at the time, had an ACD of level four and a DNR form was present, the code status in PCC was level four.
Resident #014 who was admitted on a specific date, did not have an ACD form or DNR form and the code status in PCC was blank.
Resident #015 who was admitted on a specific date, had an ACD of both level one and level two checked off with a hand-written note indicating family had chosen level one and the code status in PCC indicated level two.
Resident #021 who passed away on a specific date, did not have an ACD form

or DNR form and the code status in PCC indicated level three.
Resident #024 who was admitted on a specific date, had an ACD of level one, there was no DNR form and the code status in PCC was blank.
Resident #025 who was admitted on a specific date, had an ACD of level two, there was no DNR form and the code status in PCC was blank.

In an interview with Registered Practical Nurse (RPN) #144 on a specific date, regarding resident #007, they said they would look in PCC and in the paper chart for information related to ACD and DNR status. The RPN reviewed the ACD and DNR forms for the resident and stated that forms did not match. They stated that it was confusing, that they would not know what to do in an emergency situation and they would have to call the DOC.

In an interview with RPN #146 on a specific date, regarding resident #015, the Inspector asked where they would look for information related to ACD and DNR, the RPN said in PCC or in the paper chart. The RPN reviewed the blank ACD and completed DNR form for the resident and stated that if nothing was checked off then they would treat the resident as a level four. The Inspector pointed out that resident #015 had a completed DNR form. The RPN said that they would call the family but if they were not able to be contacted, then they would do a combination of both. The RPN was not able to elaborate what was involved, but they needed something to go by.

The home's "End of Life Care Program" procedure dated reviewed May 2019 stated: "During the admission and annual resident care review and whenever there is a change in levels of care, the physician and unit supervisor will review residents' wishes as per end of life directives. The physician will then document the outcome on the interdisciplinary notes and enter the DNR/allow natural death or CPR on medical plan of care. The procedure also stated "advance care planning provides the interdisciplinary care team with guidance relating to the care the person will receive. It is the responsibility of the interdisciplinary care team to follow the Advance Care Plan Directives".

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 care to the resident related to the use of treatments for resident #005, 026, 027, 030, 031 and 033 and related to Advanced Care Directives and Do Not Resuscitate status

for residents #007, 014, 015, 021, 024 and 025.

The severity of this issue was a level 3 as there was actual risk of harm to the residents. The scope was level 3, widespread, as 15 out of 21 (71 per cent) of residents plans of care did not show clear direction. Compliance history was a level 3 as the home had a history of non-compliance in this subsection of the legislation, including:
Compliance Order issued May 24, 2018 in inspection #2018_722630_0007
Voluntary Plan of Correction issued July 11, 2017 issued in inspection #2017_263524_0013 (213)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Nov 29, 2019

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 006

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

Order / Ordre :

The licensee must be compliant with LTCHA 2007 s. 6(8).

Specifically, the licensee must:
a) Create a quality improvement plan that includes a protocol to ensure that all new persons working in the home pursuant to a contract or agreement between the licensee and an employment agency or other third party (hereon out referred to as "agency staff"), receive access to electronic documentation (including care plan, Kardex, point of care, progress notes, electronic medication and treatment administration, etc.; applicable to the person's responsibilities), and appropriate associated training in the use of these systems, before performing their responsibilities. The protocol must include recording and record keeping of the access provided and associated training including dates, the keeping of agency staff files in the home, responsible persons, timelines and tools to be used when applicable.
b) Ensure and verify that every agency staff providing personal support services or nursing services in the home, receives access to electronic documentation systems (including care plan, Kardex, point of care, progress notes, electronic medication and treatment administration, etc.; applicable to the person's responsibilities) and appropriate associated training in the use of these systems. A written record is kept of all training including staff names, dates and training content, to ensure that the staff had received the training.

Grounds / Motifs :

1. The licensee failed to ensure that the staff and others who provided direct care to a resident were kept aware of the contents of the resident's plan of care and had convenient and immediate access to it.

O. Reg. 79/10 defines: "staff", in relation to a long-term care home, means persons who work at the home,
(a) as employees of the licensee,
(b) pursuant to a contract or agreement with the licensee, or
(c) pursuant to a contract or agreement between the licensee and an employment agency or other third party; ("personnel").

The Ministry of Long-Term Care (MOLTC) received a complaint on a specific date through the MOLTC Actionline outlining concerns related to the orientation of agency staff.

On a specific date, Personal Support Workers (PSWs) #111, #112 and #113 stated that they had been working with more agency staff on the weekends who were not familiar with the care needs of the residents. The PSWs stated that the agency staff members did not have access to Point Click Care (PCC).

On a specific date, Agency Staff Member #121 stated that they worked for Staff Relief and provided personal support services in the home. The Agency Staff Member stated they did not have a login or completed any documentation in PCC for resident care provided. They stated that the PSWs they worked with would complete the documentation for them.

On a specific date, Agency Staff Member #123 stated that they worked for Staff Relief and provided personal support services in the home. They stated they worked with resident #009 providing care on a specific date. The Agency Staff Member stated that they dressed the resident, changed their bed linens, provided feeding assistance, assisted them with walking, changed their brief if there was one, but did not provide baths. When asked if they documented in PCC the care provided to the resident, the Agency Staff Member stated they documented specific care on paper and then provided it to the nursing staff. When asked where they would look to know what care the resident required, the Agency Staff Member stated that they would ask the nursing staff. The Agency Staff Member stated they did not know the residents' plan of care as they did not have access.

Review of documentation survey report V2 showed no documentation by

Agency Staff Member #123 for resident #009 on that specific date.

On a specific date, Agency Staff Member #124 stated that they worked for Staff Relief and provided personal support services in the home. The Agency Staff Member stated that it was there first day of work at Earls Court Village providing direct care to residents. The Agency Staff Member stated that they did not have access to the computer and thought that PSW #148 would document for them. The Agency Staff Member stated they would watch the staff with the residents and could ask the registered staff to know what care the residents required. They stated that they did not have access to the residents' plan of care and was not sure where it would be.

On a specific date, Inspector #689 observed Agency Staff Member #124 providing feeding assistance to resident #011 in the dining area. At this time, PSW #115 stated that it was Agency Staff Member #124's first day and they did not have PCC access or login and was not completing any documentation of care that was provided.

Review of documentation survey report V2 showed no documentation by Agency Staff Member #124 for resident #011 on that specific date.

On a specific date, Executive Director (ED) #125 stated the responsibilities of non-registered agency staff when providing personal support services in the home, whether the PSW was from an agency or their own hire, was the same. The ED stated that agency staff including registered and non-registered staff providing direct care to residents would have access to the residents' plan of care, logins, and were expected to document in PCC. The ED stated that they expected that agency staff working one to one with residents would review the plan of care to know what behaviours the resident exhibited, their triggers, strategies and interventions appropriate for their behaviours. The ED stated that they were available twenty-four hours a day, seven days a week to provide access to agency staff.

On a specific date, Nurse Consultant (NC) #106 stated the expectation was the same for non-registered agency staff and PSWs hired in the home and that providing personal support services, whether one to one care or floor duties, they had to meet the needs of the residents. The NC stated that they were

expected to know what care was to be provided to the residents. The NC stated that they provided certain agency staff with access and information on orientation, but there should not be agency staff working in the home that did not have access.

The licensee failed to ensure that agency staff members who provided direct care to residents were kept aware of the contents of the resident's plan of care and had convenient and immediate access to it.

The severity of this issue was determined to be a level 3 as there was actual risk. The scope of the issue was a level 3 as it was widespread. The home had a compliance level of 2, as there was no previous history of non-compliance with this legislation. (689)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 01, 2019

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

Order # / Ordre no : 007

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. (9) The licensee shall ensure that the following are documented:

1. The provision of the care set out in the plan of care.
2. The outcomes of the care set out in the plan of care.
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Order / Ordre :

The licensee must be compliant with LTCHA 2007 s. 6(9).

Specifically, the licensee must:
a) Review and revise as necessary, the policy related to the specific treatments.
b) Ensure that all registered staff providing service in the home (including agency staff) receive training related to the home's policy and process for the initiation and use of treatments in the home, including assessments and required documentation.
c) Ensure that all staff providing personal support services in the home (including agency staff) receive training related to a Personal Support Worker's role in the treatments and scope of practice, including reporting and documentation requirements, methods of treatment delivery, use of treatments, how and when to administer treatments and documentation.
d) Ensure that training related to the treatments for registered and personal support staff is included in the new staff orientation content.
e) A written record is kept of all training including staff names, dates and training content, to ensure that all staff including agency staff received the training.

Grounds / Motifs :

1. The licensee has failed to ensure that the provision of the care set out in the plan of care, the outcomes of the care set out in the plan of care and the effectiveness of the plan of care were documented.

A complaint was received by the Ministry of Long-Term Care on a specific date,

related to treatments not being administered.

Resident #026 was observed in the lounge on a specific date with a treatment administered. The electronic Medication Administration Record (eMAR), electronic Treatment Administration Record (eTAR) and Medical Directives Administration Record (MDAR), vital signs and tasks in Point of Care (POC) were reviewed for resident #026 in Point Click Care (PCC). The medical directives included specific administration guidelines for the treatment. The Medical Directives electronic Medication Administration Record (eMAR) was reviewed and the direction related to the treatment was not signed for as administered and there was no documentation of the treatment during a specific time frame.

Resident #027 was observed in the lounge on a specific date with a treatment administered. The eMAR, eTAR and MDAR, vital signs and tasks in POC were reviewed for resident #027 in PCC. The physician's orders included directions for use of the treatment. The eMAR was reviewed and the direction related to the treatment was not signed for as administered and there was no documentation of the treatment during a specific time frame.

Resident #033 was observed in their room on a specific date with with a treatment administered. The eMAR, eTAR and MDAR, vital signs and tasks in POC were reviewed for resident #033 in PCC. The medical directives included specific administration guidelines for the treatment. The Medical Directives eMAR was reviewed and the direction related to the treatment was not signed for as administered and there was no documentation of the treatment during a specific time frame. Health records in PCC showed that the treatment was documented once during the time frame with specific directions of administration. There was no direction in the plan of care or POC to direct PSWs that the resident used the treatment, the type, or when to administer the treatment.

On a specific date, Inspector #213 observed resident #031 in their room using an assistive device with the treatment present but not administered. In an interview on a specific date, Registered Practical Nurse (RPN) #142 stated that there was no order for the treatment for resident #031, that it was only used as needed for specific instances. The RPN said the resident occasionally needed

the treatment and someone had administered the treatment to resident #031 that morning. PSW #113 said that they administered the treatment during care that morning.

On a specific date, resident #031 was observed in the lounge with the treatment present but not administered. Inspector #213 asked PSW #114 if the resident required the treatment and they stated that they needed it PRN (as needed), and if the resident needed it they would administer it. Inspector #213 asked PSW #143 if resident #031 had the treatment administered that morning and the PSW stated that the resident had the treatment administered when they came on at the beginning of their shift. The PSW stated when the resident was in the lounge their treatment was removed based on a specific direction.

The eMAR, eTAR and MDAR, vital signs and tasks in POC were reviewed for resident #031 in PCC. The paper chart was also reviewed and there was an "Individual Medication Order Set" for resident #031 on a specific date, signed by the physician. One of the orders included specific guidelines for the administration of the treatment. There was no documentation of the treatment in the eMAR, Medical Directives or in Vital Signs in PCC during a specific time frame.

The home's policy related to [the treatment] with a reviewed date of April 24, 2019 stated to document the following:
- the checking of [the treatment] each shift on the eMAR
- resident tolerance to [the treatment], comfort level
- routine for removing and/or administering [the treatment] on the eMAR
There was nothing in the policy related to documentation of the actual administration of the treatment, the documentation of any assessment related to the treatment including whether the treatment should be included in a resident's plan of care or tasks in point of care documentation.

In an interview with the Resident Assessment Instrument Coordinator (RAI-C) #110 and the Assistant Director of Care (ADOC) #103 on a specific date, the ADOC said that it was their expectation that there should have been a physician's order, and the assessment and use of the treatment should have been documented.

The licensee has failed to ensure that the provision of the care set out in the plan of care, the outcomes of the care set out in the plan of care and the effectiveness of the plan of care related to the use of treatments were documented for resident #026, 027, 030, 031 and 033.

The severity of this issue was a level 2 as there was minimal risk of harm to the residents. The scope was level 3, widespread, as 7 out of 8 (88 per cent) of residents did not have oxygen use documented. Compliance history was a level 3 as the home had a history of non-compliance in this subsection of the legislation, including:
Compliance Order issued May 24, 2018 in inspection #2018_722630_0007 (213)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 29, 2019

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 008

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 23. (1) Every licensee of a long-term care home shall ensure that,

(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:

(i) abuse of a resident by anyone,

(ii) neglect of a resident by the licensee or staff, or

(iii) anything else provided for in the regulations;

(b) appropriate action is taken in response to every such incident; and

(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Order / Ordre :

The licensee must be compliant with LTCHA, 2007, s. 23:

Specifically, the licensee shall:
a) Ensure all management staff working in the home receive training related to the process of completing an investigation related to Critical Incidents as per O.Reg. 107, including but not limited to, appropriate actions, how to conduct interviews with applicable persons, actions to prevent reoccurrence, follow up with residents and/or their substitute decision-makers and documentation required.
b) Ensure all management staff and registered staff working in the home, including agency staff, are trained related to the electronic completion of Institutional Patient Death Records (IPDR). This information must also be included in the new staff orientation content.
c) Ensure all management staff and registered staff working in the home, including agency staff, are trained related to the keeping of an accurate and timely Death Registry in the home as per the Office of the Chief Coroner's "Memorandum #13-04A (To be read in conjunction with Memo #11-11)" dated September 16, 2013.
d) Ensure all deaths are recorded in the home's Death Registry as per the Office of the Chief Coroner's "Memorandum #13-04A (To be read in conjunction with Memo #11-11)" dated September 16, 2013.
e) A written record is kept of all training related to the process to complete an investigation, IPDR's, keeping an accurate Death Registry including staff names, dates and training content, to ensure that all management and registered staff, including agency staff, received the training.

Grounds / Motifs :

1. The licensee has failed to ensure that, every alleged, suspected or witnessed incident that the licensee knew of, or that was reported to the licensee, was immediately investigated for anything else provided for in the regulations and that appropriate action was taken in response to every such incident; and any requirements that were provided for in the regulations for investigating and responding as required under clauses (a) and (b) were complied with.

Ontario Regulation 79/10 s.107 (1)(2) states every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of an unexpected or sudden death, including

a death resulting from an accident or suicide, followed by the report.

Ontario Regulation 79/10 s.107 (3)(4) states that the licensee shall ensure that the Director is informed of an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition no later than one business day after the occurrence of the incident, followed by the report.

Specifically, the licensee has failed to ensure that the incident that the licensee knew of was immediately investigated and appropriate action was taken related to a critical incident which resulted in a sudden and unexpected death.

The Ministry of Long-Term Care (MOLTC) received a complaint on a specific date outlining concerns related to care of resident #001 as well as an incident on a specific date. During the inspection, inspectors were made aware of another incident involving resident #008 that had occurred on a specific date, which resulted in the resident being transferred to hospital.

Review of the Ministry of Long-Term Care's (MOLTC) Critical Incident System (CIS) reporting site in August 2019, identified no CIS reports were submitted for resident #008 related to the incident.

Progress notes in Point Click Care (PCC) showed the following:
-On a specific date, resident #008 had been assessed by the attending physician for a newly developed condition as well as a cough with decreased oxygen saturation and the resident requested to be sent to the hospital.
-On a specific date, the Acting Director of Care (aDOC) #138 had called resident #008's family on three different identified times to inform them of the resident's health status and that the resident was being sent to the hospital at their request.
-On a specific date, resident #008 had returned from the hospital and that medication reconciliation was completed by the Registered Nurse (RN) as well as the physician.
-On a specific date, resident #008 had an incident while being assisted by staff. Resident #008 was immediately attended to, code blue was announced, and procedures completed. The note showed that the RN called the resident's family as they were a level one Advanced Care Directive (ACD) and the family wanted

the resident to be sent to the hospital. Resident #008 was unresponsive and upon paramedic arrival, Cardiopulmonary Resuscitation (CPR) was initiated and the resident was transferred to the hospital. Resident #008's family was called to inform them that CPR was completed and the resident was sent to the hospital.
-On a specific date, Resident #008 was reported to be on a ventilator with unstable respirations.
-On a specific date, the staff were made aware that resident #008 had passed away in hospital.

Risk Management in PCC showed an incident report on a specific date, identifying that resident #008 had an incident. The report stated that the resident was unresponsive after the code blue was called, and procedures were initiated. The report stated that the resident was a level one ADC, the RN called the family and they wished for the resident to be sent to the hospital after paramedics arrived and CPR completed.

Resident #008's health records were reviewed in PCC and showed in the "Code Status" section "**Level one- Palliative (Comfort Measures Only)" and physician orders stated "**Level one- Palliative (Comfort Measures Only)" ordered by Physician #141 on a specific date, with an end date of "Indefinite". There was no "Advance Directives/Consent to Plan of Treatment" found in resident #008's paper chart.

On a specific date, Personal Support Worker (PSW) #113 stated that on the date of the incident, Registered Practical Nurse (RPN) #142, Executive Director #125, and PSW #132 were present. The PSW stated that resident #008 was sick for a specific time frame prior to the incident and was sent to the hospital and returned to the home.

On a specific date, RPN #142 stated that they would look directly on the computer to find a resident's level of care in relation to their code status. RPN #142 said that the advance care directive was also reviewed during the three month medication review where the physician would sign to renew or change. RPN #142 reviewed the resident's paper chart, including their three month medication review for a specific time frame, confirmed that there was no ACD and questioned why it was not there. The RPN said that they would expect that the medication review would always include an advance directive. RPN #142

stated that they were present during the incident occurring on a specific date. RPN #142 stated that resident #008 was being assisted by staff when PSW #132 called for their help and RPN #142 assisted resident #008 and a code blue was called. RPN #142 stated that they performed procedures on resident #008 and there was discussion about the resident's code level. RPN #142 stated that they reported that the resident was not to have CPR initiated. RPN #142 stated that they thought that resident #008's original copies of their advance directives and Do Not Resuscitate (DNR) were sent to the hospital with the resident previously. They said that the home did not have the paper work to provide the paramedics and they initiated CPR. When asked what CPR included when the paramedics arrived at the home, RPN #142 stated it included chest compressions and the "electric one" which delivered a shock. RPN #142 stated that the resident's DNR form was signed the day of the incident because they could not find their DNR form in the paper chart. The RPN said that they called the family but at that time they were not yet informed if the home was going to do CPR or not. RPN #142 stated that when the paramedics arrived it was chaos and they completed CPR. RPN #142 stated that they could see the "loop holes" because of the missing paper work.

On a specific date, Registered Nurse (RN) #133 stated that they would look in the residents paper chart or PCC to know what a resident's wishes were for their code level. They stated that if they had to call the paramedics, they would need to have the original papers out for them to see. RN #133 said that they were familiar with the incident related to resident #008 on a specific date. They said that the Executive Director (ED) #125 was also present. The RN stated that RPN #142 who was working on the floor reported to them that the resident was on comfort measures and had a DNR. RN #133 stated that they called resident #008's family and they had told them to send the resident to the hospital. The RN stated that the paramedics arrived and asked for the level of care for resident #008 and requested to see the original document, however the RN and ED #125 did not have the forms and were not in the residents paper chart. RN #133 said that they signed a DNR form and gave it to the paramedics. When asked if the family member who was called that day had consented to CPR for resident #008, RN #133 stated no, and that they were mad because there was no paper to identify this.

On a specific date, Acting Director of Care (aDOC) #138 said when a resident

was first admitted to the home, they would talk with the interdisciplinary team and obtain the resident's expectations related to their level of care. Acting DOC #138 stated that they would expect that the medication list, transfer sheet with diagnosis and family information, advanced care directives as well as a DNR form be sent to the hospital with a resident. When asked if they send an original copy of these documents or a photocopy, the aDOC stated that it should be a copy. The aDOC stated that a resident's level of care and code status was identified with a significant change or they would have a care conference with the family and it would be discussed at that time. When asked where they would expect staff to look to find resident's care level, aDOC #138 stated that it was in the front of everyone's chart in a paper copy. The aDOC said that they were familiar and involved with an incident related to resident #008's transfer to hospital on a specific date prior to the incident in their role as nurse manager at the time. The aDOC stated that Agency Registered Practical Nurse (RPN) #109 was working on that date when resident #008 was sent to hospital and that the physician filled out the residents transfer sheets. The aDOC said they assisted with the paper work for the transfer and that resident #008's wishes for their care level and resuscitation status was a DNR. When asked if they recalled if there was a DNR and advance care directive in resident #008's chart on that date, aDOC #138 stated that they recalled Agency RPN #109 telling them resident #008's level of care.

On a specific date, Executive Director (ED) #125 stated that any critical change would trigger an incident report in Risk Management to be initiated. ED #125 said that a choking incident or if a resident lost consciousness would trigger an incident report to be initiated. The ED stated that due to the timing and nature of the report, they would always be reviewed by the Director of Care (DOC). ED #125 said that they were familiar with resident #008, and were present for the code blue. ED #125 said that the incident occurred at a specific time and that resident #008 was found in the lounge unresponsive and was unsure who had found them. ED #125 stated that upon their arrival to the floor, they identified that resident #008 was a DNR, family was contacted and they had requested that the resident be sent to the hospital. When asked what they meant when they stated that they identified resident #008 was a DNR, the ED stated that there should have been a DNR, however, resident #008 had been sent to the hospital within a specific time frame prior and that it had appeared that the only copy the home had on file was taken with the resident at that time. ED #125 said

that there was no DNR form in the home between the date of the previous hospitalization to the time of the incident for resident #008. ED #125 stated that since the Emergency Medical Services (EMS) did not have a physical form, they started CPR on resident #008. The ED said they were not sure who had sent the original forms with resident #008 during the previous hospitalization, and would expect that a copy of the paper work had been sent. When asked if the family consented to CPR being initiated during the phone call during the code blue, ED #125 stated that they did not know. ED #125 stated that they called aDOC #138 at home on the date of the incident in order to complete a new DNR form as there was no DNR form found in resident #008's chart. When asked if the substitute decision maker consented to the CPR that was performed on the date of the incident, ED #125 sated that they would have to speak with RN #133 to know. When asked if resident #008 had a significant change in condition as a result of this incident, ED #125 stated that resident #008 never returned and that resident #008 passed away in hospital as a result of the incident. When asked if there was any follow up with resident #008's Power of Attorney (POA), ED #125 stated that there should have been but that they did not know. ED #125 said that resident #008's plan of care was not followed when they received CPR and had a known DNR form.

On a specific date, Inspectors asked what was done in response to the incident involving resident #008, ED #125 stated that the home did an immediate audit to make sure each resident had the ACD and DNR documents required in their charts. The audit results were provided to inspectors. On a specific date, when asked what was done with the results of the audit and the identified missing documents, the ED said that the DOC was currently working on it. When asked if the investigation into the incident would include speaking to the agency staff #109 who was identified to have sent the original copy of the advance care directive and DNR to the hospital with resident #008 during their previous hospitalization, ED #125 stated yes.

On a specific date, RPN #142 stated that no one had talked to them about the incident that had occurred on a specific date and that they were expecting that someone would come talk to them about the incident.

On a specific date, Agency RPN #109 said they transferred resident #008 to the hospital on a date prior to the incident. Agency RPN #109 stated that they did

not complete the transfer paper work as they were busy administering medications and that the RN completed them. When asked who gave the ambulance resident #008's documents, Agency RPN #109 stated that they were unsure but believed it was aDOC #138, and stated it was not them. When asked if Agency RPN #109 knew what documents or if they were copies or originals of the documents, Agency RPN #109 stated that they did not know. The Agency RPN said that no one from the home had talked to them in relation to resident #008's original documents being sent with them to the hospital on that date.

Review of the homes "Resident Death or Transfer Record" did not document resident #008's death on a specific date. Review of PCC admissions, transfers and deaths report showed that 22 residents passed away in 2019 and of those, four were documented on the homes "Resident Death or Transfer Record".

On a specific date, aDOC #138 stated that there was a list of deaths in the home, however, they did not know if it had been filled out. When asked if they would expect that all residents transferred out of the home or had passed away in the home be identified on the list of deaths in the home, the aDOC stated yes. The aDOC said that the Registered Nurse (RN) or Registered Practical Nurse (RPN) on the unit would complete the Institutional Patient Death Record (IPDR) when a resident passed away. When asked how aDOC #138 would fill out the required questions asked in the IPDR, they stated that they would look at the last few IPDRs, however if any residents had passed away in hospital they would not have an IPDR completed.

On a specific date, RN #133 stated that IPDRs used to be completed by the RN's, but RNs were working on a unit now and not working as the building RN so they did not know. When asked if they would expect that the registered staff on each floor of the home would submit an IPDR for any resident that passed away on their floor during their shift, RN #133 stated yes as it would not be them completing it for another floor. When asked if all the names of all residents who passed away were listed in the death or transfer log, RN #133 stated sometimes they were and sometimes they were not.

The licensee had failed to ensure that the incident in which resident #008 was administered CPR with a known DNR, with no ACD on file in the home resulting in subsequent hospitalization and death, was immediately investigated and

appropriate action taken to ensure the safety and dignity of choice of residents.

The severity of this issue was a level 3 as there was actual risk of harm to the residents. The scope was level 2, pattern, as 2 out of 3 (67 per cent) of incidents were not investigated and appropriate actions taken. Compliance history was a level 3 as the home had a history of non-compliance in this subsection of the legislation, including:
Voluntary Plan of Correction issued May 24, 2018 in inspection #2018_722630_0007 (435)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Nov 01, 2019

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 009

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):

1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
   i. a breakdown or failure of the security system,
   ii. a breakdown of major equipment or a system in the home,
   iii. a loss of essential services, or
   iv. flooding.
3. A missing or unaccounted for controlled substance.
4. Subject to subsection (3.1), an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital.
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Order / Ordre :

The licensee must be compliant with O. Reg 79/10 s. 107.

Specifically, the licensee must:
a) Ensure that all registered staff providing service in the home (including agency staff) receive training related to the home's policy and process related to critical incident reporting and the requirements of O. Reg 79/10 s. 107.
b) Ensure that all management staff in the home receive training related to the home's policy and process related to critical incident reporting and the requirements of O. Reg 79/10 s. 107.
c) Ensure that training related to critical incident reporting for registered staff is included in the new staff orientation content.
d) A written record is kept of all training related to critical incident reporting, including staff names, dates and training content, to ensure that all staff, including agency staff, received the training.

Grounds / Motifs :

1. The licensee has failed to ensure that the Director was informed of an incident that caused an injury to a resident for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition, no later than one business day after the occurrence of the incident, followed by the report required.

A) On a specific date, Inspectors became aware that resident #008 had an incident in the home on a specific date, ambulance was called, Cardiopulmonary Resuscitation (CPR) was initiated, the resident was transferred to hospital and passed away on that same date.

Progress notes and Risk Management in Point Click Care (PCC) for resident #008 on a specific date, showed that they had an incident while being assisted by staff. The note stated that resident #008 was immediately assisted by staff, code blue was announced, and procedures were completed. The note stated that the resident was unresponsive and upon paramedic arrival, Cardiopulmonary Resuscitation (CPR) was initiated and the resident was transferred to the hospital. A progress note on a specific date documented that staff were made aware that resident #008 had passed away in hospital on the date of the incident.

During an interview on a specific date, Registered Nurse (RN) #129 stated that the Director of Care (DOC) or Assistant Director of Care (ADOC) would initiate and submit Critical Incident System (CIS) reports in the home.

During an interview on a specific date, Staff Development Coordinator (SDC) #130 stated that the mangers would complete CIS reports in the home.

During an interview on a specific date, Executive Director (ED) #125 stated that resident #008 had a significant change in condition and never returned to the home as a result of the incident. The ED stated that it was their expectation that registered staff or nurse managers would immediately submit CIS reports for the home to the Ministry of Long-Term Care (MOLTC). ED#125 stated that they did not believe that the incident in which resident #008 was found, transferred to hospital and passed away was reported to MOLTC.

Review of the Ministry of Health and Long-Term Care (MOHLTC) Critical Incident System (CIS) reporting site identified no CIS reports were submitted for resident #008. (435)

B) During an inspection related to a sudden and unexpected death, Institutional Patient Death Records (IPDR) were reviewed and an IPDR for resident #029 was found completed on a specific date. The IPDR stated:
1. Accidental death? "Yes" was checked off.
5. Is the death both sudden and unexpected? "Yes" was checked off. There was also a hand written note beside question number five stating: "Coroner called, Dr. [physician's name and phone number]. No concerns".

The health record for resident #029 was reviewed and showed that the resident had an incident on a specific date, resulting in injuries and was transferred to hospital. Treatment to the injuries were applied. On a specific date, the resident became symptomatic of specific illness. On a specific date, a progress note stated that staff had found the resident very lethargic and was not opening their eyes. Respirations were shallow and gasping with ten second period of apnea, eyes were fixed, oxygen saturation 72 per cent, and staff could not get a pulse or blood pressure. Pulse taken manually 60, called power of attorney and informed of condition, explained condition was very poor, interventions were not effective, and staff asked what they would like to do at that time, "send to the

hospital or do CPR [Cardiopulmonary Resuscitation]". The resident had advanced care directives level three, moderate care, transfer to hospital without CPR. Called 911, and got instruction to do CPR, placed resident on the floor and did chest compressions. Paramedics arrived and took over CPR. ECG [Electrocardiogram] monitor showed no blood pressure, no pulse, and the screen was flat.

On a specific date, the physician documented in progress notes:
The patient had been having rapid decline in function since an incident during a specific time frame, with injuries that required transfer to the emergency room. CAT [Computerized Axial Tomography] scan of specific areas did not show any acute abnormality. Based on this information, death certification was filled with the immediate cause of death, secondary to the incident due to underlying causes.

The Ministry of Long-Term Care (MOLTC) Critical Incident System (CIS) was reviewed and there were no reports of resident #029 having an incident with a transfer to hospital and a significant change in condition or an unexpected death.

In an interview with the Executive Director (ED) #125 on a specific date, the ED said that the incident with a transfer to hospital with injuries should have been reported to the MOLTC in a CIS as that would be considered an incident that resulted in a transfer to hospital and a significant change in condition. The ED also agreed that a sudden or unexpected death also should have been reported to the MOHLTC in a CIS.

Review of the home's "Critical Incidents" policy, #E-45, with a revised date of May 3, 2019, stated the following:
"The Director of Care or designate will be responsible for communicating all critical incidents to the Ministry of Health and Long-Term Care."

The licensee failed to ensure that the Director was informed within one business day of the incident in which resident #008 was sent to the hospital and passed away, and for the incident in which resident #029 was taken to a hospital and passed away on a specific date. (213)

The severity of this issue was a level 2 as there was minimal risk of harm to the residents. The scope was level 2, a pattern, as 2 out of 3 (67 per cent) of incidents were not investigated and appropriate actions taken. Compliance history was a level 3 as the home had a history of non-compliance in this subsection of the legislation, including:
Voluntary Plan of Correction issued January 4, 2018 in inspection #2017_607523_0034 (689)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 01, 2019

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

Order # / Ordre no : 010

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Order / Ordre :

The licensee must be compliant with O. Reg.79/10 s.131(2).

Specifically, the licensee shall:
a) Ensure that all newly hired registered staff working in the home, including agency staff, receive training related to the medication system prior to performing their duties.
b) A written record is kept of all training related to the medication system, including staff names, dates and training content, to ensure that all new registered staff, including agency staff, received the training.
c) Develop and implement a weekly audit to ensure the timely administration of scheduled medications used in the home. The audit must include who is responsible, audit dates, timelines, corrective actions taken and outcomes of the analysis.
d) A written record is kept of all audit materials.

Grounds / Motifs :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

The Ministry of Long-Term Care (MOLTC) received a complaint on a specific date through the MOLTC Actionline outlining concerns related to the care of resident #001 including medications not being administered to residents. The complainant stated that they went into the home on a specific date around 1045 hours and the staff member informed the complainant that they had not yet provided the morning medications at that time.

Review of the medication incident binder titled "Medication Errors Tracking

Trends & Analysis" showed 18 hand written medication incident reports for resident #001, resident #002, resident #003, and 15 other identified residents. The 18 medication incident reports, with a specific incident date, documented that the residents scheduled 0630, 0700, 0730, and 0800 hour medications were administered late.

Review of resident #001's medication administration audit report on the incident date, identified six ordered medications scheduled between 0730 and 0800 hours with an administration time of 1104 and 1105 hours. Further review of resident #001's medication administration audit report on a specific date, identified five ordered medications scheduled at 0800 hours with an administration time of 1156 hours. Review of resident #001's medication administration audit report on another specific date, identified six ordered medications scheduled at 0800 hours with an administration time of 0951 hours.

Review of resident #002's medication administration audit report on the incident date, identified nine ordered medications scheduled between 0730 and 0800 hours with an administration time of 1133 hours and 1136 hours. Further review of resident #002's medication administration audit report on another specific date, identified eight ordered medications scheduled at 0800 hours with an administration time of 1030, 1039, and 1040 hours.

Review of resident #003's medication administration audit report on the incident date, identified six ordered medications scheduled at 0800 hours with an administration time of 1026 and 1031 hours. Further review of resident #003's medication administration audit report on another specific date, identified seven ordered medications scheduled at 0800 hours with an administration time of 1021 and 1022 hours.

On a specific date, Registered Nurse (RN) #129 stated that they considered a medication incident to be if a resident did not receive their medication at the right time. RN #129 stated that as per the home's process, an incident report was to be filled out if a medication incident occurred.

On a specific date, Acting Director of Care (aDOC) #138 stated that the standard practice guidelines for medication administration was an hour before an hour after the scheduled time. When asked what the home's policy titled "Medication

Incident index I.D. F-45" meant when it stated that a medication incident could be constituted as "Drug at Wrong Time", aDOC #138 stated when a resident was to take a medication at 0800 hours and they were administered the medication before 0700 or after 0900 hours.

Also included in the binder was a medication incident on a specific date, which documented that resident #012 was not able to receive their full medication dose as there was no other supply available. Review of resident #012's electronic Medication Administration Record (eMAR) identified "Other / See Nurse Notes" on the specific date which stated the medication order. Review of resident #012's progress notes in Point Click Care (PCC) identified no progress notes documented on the specific date related to resident #012's medication administration incident.

On a specific date, Pharmacy Operations Manager (POM) #135 stated that resident #012 had not received their medications as ordered on a specific date.

The licensee has failed to ensure that drugs were administered to residents #001, #002, #003, and #012 in accordance with the directions for use specified by the prescriber when they were documented to be administered late or at the scheduled times on the identified dates.

The severity of this issue was a level 3 as there was actual risk to the residents. The scope was level 2, a pattern, as 7 out of 16 (44 per cent) of medication administration reviewed were not administered as prescribed. Compliance history was a level 3 as the home had a history of non-compliance in this subsection of the legislation, including:
Compliance Order issued May 24, 2018 in inspection #2018_722630_0007
Voluntary Plan of Correction issued April 13, 2017 issued in inspection #2017_736537_0015 (435)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 01, 2019

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # /
Ordre no : 011

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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

(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).

Order / Ordre :

The licensee must be compliant with O. Reg.79/10 s.135(1).

Specifically, the licensee shall:
a) Ensure that every medication incident occurring in the home are documented together with a written record of the immediate actions taken to assess and maintain the resident's health, reported to the resident, the resident's substitute decision-maker (as applicable), the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or a registered nurse in the extended class attending the resident and the pharmacy service provider, and kept in the home.
b) Ensure that all registered staff working in the home, including agency staff, receive training related to the process of completing electronic Medication Incident Reports, including a review of the home's policy and procedure "Medication Administration- Medication Incident Index I.D. F-45".
c) Ensure the Nurse Manager(s), Director of Care (DOC), the Acting Director of Care (aDOC) and the Assistant Director of Care (ADOC), or designates, are trained related to their role and responsibilities of medication incidents including documentation, analysis and required actions.
d) Ensure a summary of the medication incident reports are documented and reviewed monthly, as per the medication incident policy titled "Medication Administration- Medication Incident Index I.D. F-45".
e) A written record is kept of all training related to medication incidents as stated above, including staff names, dates and training content, are kept in the home.

Grounds / Motifs :

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 and 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.

The Ministry of Long-Term Care (MOLTC) received a complaint on a specific date through the MOLTC Actionline outlining concerns related to the care of resident #001 including medications not being administered to residents. The complainant stated that they went into the home on a specific date around 1045

hours and the staff member informed the complainant that they had not yet provided the morning medications at that time.

Review of resident #001's medication administration audit report for the date of the incident, identified six medications scheduled to be administered at 0800 hours, were documented as administered at 1104 and 1105 hours.

Review of resident #002's medication administration audit report for the date of the incident, identified nine medications scheduled to be administered at 0730 and 0800 hours, were documented as administered at 1133 and 1136 hours.

Review of resident #003's medication administration audit report for the date of the incident, identified six medications scheduled to be administered at 0800 hours, were documented as administered at 1026 and 1031 hours.

The medication incident binder titled "Medication Errors Tracking Trends & Analysis" was reviewed and showed 18 hand written medication incident reports for resident #001, #002, #003, and 15 other identified residents. The 18 medication incident reports, with the specific incident date, documented that the residents scheduled 0630, 0700, 0730, and 0800 hours medications were administered late. The reports were signed by Acting Director of Care #138, and dated after the incident. Also included in the binder was medication incident report on a specific date which documented that resident #013 was administered another resident's medications.

On a specific date, Acting Director of Care (aDOC) #138 stated that they would expect that the resident, the resident's Power Of Attorney (POA) or Substitute Decision Maker (SDM), the Director of Nursing and Personal Care (DONPC), the Medical Director, the prescriber of the drugs and the pharmacy service provider be notified when a medication incident occurred. The aDOC stated that they would expect that residents be notified if a medication incident occurred as soon as they were made aware of it or when staff were aware of it. The aDOC stated that they expected that medication incident reports would be completed electronically, and that the pharmacy service provider would be notified right away via the computer. The aDOC stated that they would consider medications that were scheduled for administration at 0700 and 0800 hours, but were administered at 1026, 1104, and 1136 hours to be a medication incident. Acting

DOC #138 reviewed the medication incident binder and stated that there were 19 medication incidents that had occurred in July 2019. When asked if there were medication incidents on a specific date related to resident #001, #002 and #003, the aDOC stated yes. The aDOC stated that the family members of resident #001, #002 and #003 were made aware of the medication incidents after the incident date, but could not confirm if the residents were notified. The aDOC stated that the Medical Director and the prescriber of the drugs were notified of the incidents after the incident date. The aDOC was not sure if the pharmacy was notified for the 18 hand written medication incidents. The aDOC stated that they were not sure what medications were administered late to resident #001, #002, and #003 on the date of the medication incident. Acting DOC #138 stated that they did not take immediate actions to assess and maintain the health status for resident #001, #002 and #003 on July 6, 2019, as they were not made aware of the incidents until a date after the incident. When asked how they made sure that there were no negative outcomes to resident #001, #002 and #003 when they became aware of the incidents, aDOC #138 did not have an answer.

On a specific date, Executive Director (ED) #125 stated that they would expect that a medication incident report to not have been completed a month after an incident occurred and that it would be difficult for staff to maintain the safety and heath of the residents if the incident was not identified in a timely manner to take action. ED #125 stated that they would want to know any error made to provide education to the staff so they understand the nature of the incident and to take corrective action. The ED stated that if the incident report was completed one month after, it would be hard to address in a timely manner with the staff.

On a specific date, Pharmacy Operations Manager (POM) #135 stated they would expect that when a medication incident occurred in the home that it would be reported to the Director of Care (DOC) and that they would immediately contact pharmacy for immediate interventions. POM #135 stated that they expected to be informed of medication incidents by a submitted report as soon as possible over an online system. The POM stated that they used to receive hand written medication incident reports from the home, however, they had switched over to the online system. POM #135 stated that they had been made aware of four medication incidents that occurred in July 2019. The POM stated that they were not made aware of 18 hand written medication incident reports for

incidents with late medication administration occurring on a specific date. The POM stated that they were aware of an incident involving resident #013 on a specific date, and would expect to be notified of the medications that were incorrectly administered to the resident as the information was not documented in the report that was submitted by the home. POM #135 stated that they were not provided information if there were negative outcomes to resident #013 or who the staff member was who made the error on that date.

A specific Medication Incident report provided by POM #135 was not identified in the medication incident binder provided to inspectors. The medication incident related to resident #007 was reviewed and showed specific directions for the administration of their medication and when to inform the physician. The note stated that agency RPN #109 did not call physician to adjust the residents dosage and that it was considered to be a medication error. The report showed that the physician, the family/resident, and the presciber were not notified of the medication incident.

On a specific date, Agency Registered Practical Nurse (RPN) #109 stated that they were not made aware that a medication incident related to resident #007 had occurred on the specific date.

Review of the home's medication administration policy titled "Medication Administration – Medication Incident F-45" with a revised date of May 3, 2019, indicated that the "Standard" for the policy included a system for the immediate reporting of medication incidents and follow up action(s). The policy noted under the "procedure" section that a medication incident constituted any involvement in the dispensing or administration, which included "wrong drug" and "drug at wrong time". The policy continued to include the following actions:
-All medication incidents to be acted on immediately and actions taken to assess and maintain the incidents
-Assess the severity level including the current status of the resident and any potential risk and immediate actions were taken to assess and maintain the resident's health
-Notify the attending physician and the member of the drug if different from the attending physician immediately if there appeared to be a serious problem, otherwise on the next doctor visit
-Report the medication incident to the resident (if cognitive), the substitute

decision member, the Director of Care, the Medical Director, prescriber and the pharmacy service provider
-Document the incident in the electronic progress notes with assessment of the resident nothing changes in mental status, physical status and behavioural changes
-Monitor and record observations in the electronic progress notes. Follow any specific orders given by the physician for monitoring
-Complete the Medication Incident Report in the electronic Medication Incident Reporting System (MIRS) which the system would automatically notify the next person in the process
-Complete Ministry of Health critical incident report using the electronic Critical Incident System (CIS) where applicable
-The Medication Incident Reports to be analyzed by the Nurse Manager, the consultant pharmacist to determine whether pharmacy and/or nursing procedures required modification.
The outcome of the policy stated that medication incidents were to be reported immediately and that there was to be documentation and follow-up on all medication errors.

The licensee had failed to ensure that 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 and 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 for the five medication incidents that occurred.

The severity of this issue was a level 3 as there was actual risk of harm to the residents. The scope was level 3, widespread, as 24 out of 24 (100 per cent) of medication incidents reviewed did not include the required information. Compliance history was a level 3 as the home had a history of non-compliance in this subsection of the legislation, including:
Compliance Order issued May 24, 2018 in inspection #2018_722630_0007
Voluntary Plan of Correction issued July 11, 2017 issued in inspection #2017_263524_0015
Voluntary Plan of Correction issued April 13, 2017 issued in inspection

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

#2017_736537_0015 (435)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Nov 01, 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

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

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 6th day of September, 2019

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : Cassandra Aleksic

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