Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 15, 2018	2017_482640_0021	026012-17	Resident Quality Inspection

Licensee/Titulaire de permis

488491 Ontario Inc.
689 YONGE STREET MIDLAND ON L4R 2E1

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

AVALON RETIREMENT CENTRE
355 BROADWAY AVENUE ORANGEVILLE ON L9W 3Y3

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

HEATHER PRESTON (640), KATHLEEN MILLAR (527), LEAH CURLE (585)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 20, 21, 22, 23, 24, 27, 28 and 29, 2017.

During the course of the inspection, the following Compliance Orders and Critical Incident inquiries were inspected;

Compliance Orders (CO):
-CO #001 related to neglect of residents by staff
-CO #002 related to pain assessments of residents
-CO #003 related to security of drug supply
-CO #004 related to registered staff training of medication policy/protocol
-CO #005 related to direct care staff training for pain management
-CO #006 related to medication administration as specified by prescriber
-CO #007 related to analysis of medication incidents
-CO #008 related to quarterly review of medication incidents

Inquiries;
Critical Incidents:
- Log #0011348-17 related to staff to resident physical abuse
- Log #014621-17 related to staff to resident physical abuse
- Log #021437-17 related to resident to resident responsive behaviour

During the course of the inspection, the inspector(s) spoke with Residents, families, Resident Council President, Family Council President, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), housekeeping aides, dietary aides, Registered Dietitian (RD), Environmental Services Manager (ESM), Food Service Manager (FSM), Restorative Care Coordinator (RCC), Behaviour Support Lead (BSO), Wound and Skin Lead, Falls Lead, Infection Prevention and Control Lead, Staff Educators, Co-Directors of Care, Director of Care (DOC) and the Administrator. The Inspectors also toured the facility,
reviewed the home's policies and procedures, reviewed clinical records and observed the provision of care.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Dignity, Choice and Privacy
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Residents' Council
Safe and Secure Home
Skin and Wound Care

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

- **11 WN(s)**
- **7 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 130.	CO #003	2017_482640_0011	640
O.Reg 79/10 s. 131. (1)	CO #004	2017_482640_0011	640
O.Reg 79/10 s. 131. (2)	CO #006	2017_482640_0011	640
O.Reg 79/10 s. 135. (2)	CO #007	2017_482640_0011	640
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2017_482640_0011	640
O.Reg 79/10 s. 221. (1)	CO #005	2017_482640_0011	640
O.Reg 79/10 s. 52. (2)	CO #002	2017_482640_0011	640

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee failed to ensure that, (a) all medications incidents and adverse drug reactions were documented, reviewed and analyzed; (b) corrective action was taken as necessary; and a written record was kept of everything required under clauses (a) and (b).

During review of the home's morning report minutes, the Long Term Care Homes (LTCH) Inspector observed on October 10, 2017, report that a hydromorphone tablet had been found loose in a medication cart by RN #117 and an investigation had been started.
Policy Resident Rights, Care and Services - Medication Management - Medication Incident, Version 2, with a revised date of July 20, 2017, directed staff to complete an incident report for any preventable event associated with the prescribing, ordering, dispensing, storing, labeling, administering or distribution of a drug or the transcribing of a prescription. An act of omission or commission. The policy directed staff to initiate and complete the internal medication incident report and forward to the DOC, attending physician and the Pharmacist.
During review of the medication incident binder, as provided by the home, the LTCH Inspector was unable to locate the corresponding medication incident report.
During an interview with the Director of Care (DOC), they confirmed it was expected that when a medication was found, a medication incident report was required to be completed and follow by an investigation.
During an interview with RN #117, they confirmed they had found a hydromorphone 3 milligram (mg) tablet loose in a medication cart, under a medication bin on October 8, 2017, and they had not completed a medication incident report and did not have any notes of investigation of the event. [s. 135. (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 O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home. O. Reg. 79/10, s. 114 (2).

Findings/Faits saillants :

1. Where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system was (b) complied with.
In accordance with Regulation, s.114 (2), which required the licensee to ensure that the interdisciplinary programs including medication management program were developed and implemented in the home to ensure that written policies and protocols were developed for the medication management system to ensure the acquisition, dispensing, receipt, storage, administration, destruction and disposal of all drugs used in the home. O. Reg. 79/10, s.114

The licensee failed to ensure the policies and protocols were developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

1) Following the observation, by the Long Term Care Homes (LTCH) Inspector, of medication administration by RPN #115 on an identified date in November 2017, the LTCH Inspector reviewed the medication cart with the RPN. The following was found to be expired and remained in use; specific eye drops (gtts) for resident #019, with an opened date of October 11, 2017. According to the RPN, this medication was to be discarded after six weeks, therefore it should have been discarded November 22, 2017, specific eye gtts for resident #020 had no date of being opened, therefore staff were unaware as to when it was required to be discarded, resident #022 had specific eye gtts with no date opened on the vial therefore staff were unaware as to when it was required to be discarded, resident #003's specific eye gtts had expired and was still in use and specific eye gtts for resident #021 which had an opened date of October 31, 2017. These eye drops were to be discarded November 28, 2017.
The home's policy entitled Resident Rights, Care and Services - Medication Management - Drug Storage and revised October 7, 2013, directed staff to ensure that discontinued or

outdated medications be removed immediately from the medication cart, refrigerator, or government stock cupboards. Also included was a document from Silver Fox Pharmacy, the home's pharmacy service provider, entitled Recommended Expiry Dates. This document directed staff to discard opthalmic/otic products 28 days after they were opened. Specifically for a specified eye drops, they were to be discarded after 42 days once opened.
During an interview with the Director of Care, they confirmed that it was an expectation of the home that eye drops be labeled with the date they were opened and discarded as per the direction from the pharmacy service provider's directive.

2) Following the observation, by the Long Term Care Homes (LTCH) Inspector, of medication administration by RPN #115 on an identified date in November 2017, the LTCH Inspector reviewed the medication cart with the RPN. RPN #115 and the LTCH Inspector counted the controlled substances. Resident #023's controlled substance card contained seven pills. The individual controlled substance count sheet had eight remaining. RPN #115 stated they had given it earlier but did not document as per the home's policy.
Resident #017's controlled substance card had 28 pills remaining. The individual controlled substance count sheet had 29 remaining. The RPN stated they had administered two tablets earlier and miscounted on the count sheet.
Resident #024's individual controlled substance count sheet noted 11 pills remaining. The resident's controlled substance card held 10 tablets. RPN #115 identified they had administered the medication earlier and failed to document as per the home's policy.
The home's policy entitled Resident Rights, Care and Services - Medication Management - Narcotics and Controlled Substances with a revised date of October 7, 2013, directed staff to record all narcotics on the Medication Administration Record and complete a count when a narcotic was administered at the time of administration.
During an interview with RN #118, they informed the LTCH Inspector it was an expectation of the home that all controlled substances be documented on the individual controlled substance count sheet immediately following the administration of the medication.
The licensee failed to ensure that staff complied with the home's Medication Management policies and procedures. [s. 114. (2)]

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 LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every resident had their personal health information within the meaning of the Personal Health Information Protection Act, 2004, kept confidential in accordance with that Act, and to have access to their records of personal health information, including their plan of care, in accordance with that Act.

1) On an identified date in November 2017, at 0930, 1115 and 1330 hours on a home area, the Long Term Care Homes (LTCH) Inspector observed Point of Care (POC) tablets open and unattended by staff. Several residents were sitting in this area and the area was a well traveled hallway by staff, residents and visitors. On the screen, there were private and personal health information about several residents including their

names and planned interventions for care.
The Director of Care (DOC) and RN #105 both observed the tablets and confirmed the tablets should be closed, locked and not in view of anyone other than staff.
On an identified date in November 2017, at 0940 hours the LTCH Inspector observed the electronic Medication Administration Record (eMAR) screen on a medication cart open for view of anyone. There were names and medications for several residents on the screen. RPN #115 confirmed the cart to be theirs and that the screen was open and available to be viewed by anyone. They confirmed the screen should be closed and kept private at all times.
On an identified date in November 2017, at 1245 hours, the LTCH Inspector observed the computer screen at a nurse's station, to be open with resident personal health information available to anyone to view. RPN #115 was interviewed and informed the LTCH Inspector they had left it open in error and it was an expectation of the home that the computer screens be locked to prevent access to personal health information by anyone. During an interview with RN #118, they confirmed that all computer screens, tablets and eMAR screens must be kept confidential, closed and locked at all times when not in use by staff.
2) During interview of RN #133 as part of the medication management inspection, the RN informed the LTCH Inspector that when medications had been administered, the empty pouches with resident name, medication names, dosages and other personal health information, were placed in a plastic bag and put under the desk at the nurse's station. The pharmacy service provider picked them up from there approximately twice weekly.
During an interview with the DOC, the DOC observed the placement of the plastic bag containing empty medication pouches on the floor under the desk at the nurse's station. The DOC confirmed this was a breach in protecting the confidentiality of the resident's personal health information. The bags were expected to be placed in the locked medication room for pick up and destruction by the pharmacy service provider. [s. 3. (1) 11. iv.]

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 resident has their personal health information within the meaning of the Personal Health Information Protection Act, 2004, kept confidential in accordance with that Act, and to have access to their records of personal health information including their plan of care, in accordance with that Act, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was
complied with.

In accordance with Ontario Regulation 79/10, s. 48. (1) required every licensee of a long-term care home to ensure that the following interdisciplinary programs are developed and implemented in the home: 1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

1) The home's program, "Falls Prevention and Management, Version 3", last revised May 27, 2016, directed Registered staff to:
i) ensure that a resident who has a fall has a follow up progress note completed for at

least three shifts following the incident; and
ii) has Head Injury Routine (HIR) initiated if head injury is evident. All unwitnessed falls will result in a HIR being initiated unless resident is capable of reliably communicating they did not hit their head.

On an identified date in October 2017, resident #008 experienced an unwitnessed fall that resulted in injury. The HIR was initiated.
Review of the resident's clinical record revealed on an identified date in October 2017, a fall follow-up note was not completed; nor was HIR completed on the two scheduled times during the shift. Interview with RN #130 reported registered staff were to complete a fall follow-up note on multiple shifts after a fall and confirmed that the fall follow-up note and HIR were not completed as required on an identified date in October 2017. Interview with Restorative Care Coordinator #104 confirmed the home's policy related to falls management was not complied with after resident #008 experienced a fall that resulted in injury. (585)

2) On an identified date in October 2017, resident #008 had an unwitnessed fall and sustained an injury. The resident had pain and was given treatment. A pain assessment using a clinically appropriate assessment instrument was completed. Later that day staff documented the administration of treatment based on a pain scale that was lower.
The home's policy entitled Resident Rights, Care and Services – Required Programs – Pain Management – Program, Version 3 with a revision date of March 3, 2016, directed staff to complete a comprehensive pain assessment, the home's clinically appropriate assessment tool specifically designed for the assessment of pain, when a resident had worsening pain, unrelieved pain, a pain score of 2 or 3 on RAI MDS or a score of 4/10 on verbal self-report of pain.
The clinical record was reviewed by the Long Term Care Homes (LTCH) Inspector and there were no pain assessments completed on three occasions in October and November 2017.
During an interview with RN #117, the home's Pain Lead, they confirmed that for all noted occasions, it was an expectation of the home that a clinically appropriate assessment instrument specifically designed for the assessment of pain be conducted for any pain score of four or higher as per the home's policy. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure that all doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

A) On November 20, 2017, during an initial tour of the home, a doorway leading in from outside of the home in the zone 4 centre stairwell was found unlocked. From the outside of the building, the door could be opened, as confirmed by the DOC. The doorway was also adjacent to the main entrance of the building; therefore, could be accessed by any person who may attempt to enter the building. On November 22, 2017, at 1350 hours, the same doorway was found unlocked and unsupervised. Interview with the Administrator confirmed that from the outside, the door led to inside the building into a stairwell which was a non-resident area. The Administrator reported the door was to to remain locked; however, was not properly latching shut and therefore was not closed and locked.

B) On November 20, 2017, during the initial tour of the home, a door leading into the home's electrical room was found unlocked and unsupervised. During the inspection, residents attended recreational programming and various activities in the fiesta room, which was located in the basement near the electrical room. Interview with restorative care staff #104 confirmed the electrical room was a non-residential area and was to be kept closed and locked when it was not supervised by staff. [s. 9. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

The licensee failed to ensure that, b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (ii) received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

1. On an identified date in November 2017, the staff identified that resident #006 had altered skin integrity.
The clinical record was reviewed and there were no skin and wound care interventions implemented until later in November 2017 as noted in the written plan of care.
The home's policy called "Skin and Wound Care Program", Version #3, revised July 20, 2017, directed registered staff to ensure that the resident with actual alteration in skin integrity, which included pressure ulcers, received immediate interventions to promote healing, to reduce or relieve pain and to prevent infection according to current best practice and wound care algorithms.

RPN #103 and #106 were interviewed and they indicated that the skin and wound care implemented were to provide treatment to the altered skin integrity and reposition the resident every two hours. Both RPNs confirmed that the treatment was implemented on an identified date in November 2017, but the other interventions were not implemented until a few days later.
The Co-DOC #116 indicated that once the altered skin integrity was identified they initiated the treatment and needed time for the team to discuss other strategies that would be best for the resident.
The DOC was interviewed and confirmed that the skin and wound care interventions should have been implemented sooner for the resident.
The home failed to ensure that resident #006 had interventions implemented immediately, which resulted in the resident's altered skin integrity worsening. [s. 50. (2) (b) (ii)]

2. The licensee failed to ensure that, (d) any resident who was dependent on staff for repositioning was repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated.

Resident #006 had an altered skin integrity assessment on an identified date in November 2017. On a specific date in November 2017, the resident had the altered skin integrity reassessed by RN #105, who identified that it had worsened.
The clinical record was reviewed and the written plan of care directed PSWs to implement specific interventions and they were to provide turning and repositioning every two (2) hours.
The resident was observed by LTCH Inspector #527 on four separate dates and times. The position the resident was observed to be in did not match the plan of care regarding positioning.
PSWs #127 and #128 were interviewed and identified that they were expected to turn and reposition the resident every two hours as the resident was not able to turn or reposition themselves. The PSWs also confirmed that they were expected to follow the specific interventions.
The DOC was interviewed and confirmed that the PSWs were expected to turn and reposition the resident every two hours and follow the specific interventions.
The home failed to ensure that resident #006, who was dependent on staff for repositioning, was repositioned every two hours or more frequently as required. [s. 50. (2) (d)]

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 (b) that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (ii) receive immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required and;
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated, to be implemented voluntarily.

WN #7: 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 order made or agreement entered into under this Act and those Acts. 2007, c. 8, s. 195 (12).

Findings/Faits saillants :

1. The licensee failed to ensure that as a condition of every license that the licensee complied with this Act, the Local Health System Integration Act, 2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every order made or agreement entered into under this Act and those Acts.

1) As a result of a complaint inspection number 2017_482640_0011 conducted in June and July 2017, the home was issued with a Compliance Order (CO) related to s. 131 (1) wherein medications had been administered without being prescribed for the resident. CO #004 required the home to ensure all registered staff reviewed the home's policies and procedures related to medication administration, the use of medical directives, obtaining and transcription of physician orders prior to the administration of medication. During the Resident Quality Inspection conducted in November 2017, a Follow Up

Inspection related to COs issued in July 2017 was conducted concurrently. The home was unable to provide evidence to support that the required education had occurred.
On November 21, 2017, at 1320 hours, Long Term Care Homes (LTCH) Inspector #640 requested that the Administrator ensure the training documentation was provided to the LTCH Inspector.
During the exit debrief held November 29, 2017, the home was unable to provide the evidence that the required training of all registered staff had occurred and were unable to verify the requirement was met.

2) During the course of the Resident Quality Inspection, the LTCH Inspector conducted a Follow Up Inspection related to Compliance Order (CO) #007 related to s. 135 (2), wherein medication incidents were not documented, analyzed and corrective taken and documented, from Complaint inspection #2017_482640_0011.
The home was required to ensure all registered staff reviewed the home's policy related to medication incidents, develop and implement a process to ensure immediate investigation into the root cause of the error and the appropriate action was taken to correct any practice that resulted in the error and the plan was required to address the necessary actions to take when a pattern of medication errors was identified for any one registrant.
The LTCH Inspector reviewed the evidence binder provided by the home related to the COs issued to the home as a result of the Complaint Inspection. The LTCH Inspector was unable to identify the documentation and/or evidence to support that these required orders had been complied with.
During review with the DOC, they confirmed the home did not have the required evidence to support the three required actions.

3) A Follow Up inspection to Complaint Inspection #2017_482640_0011, related to Compliance Order (CO) #008, regarding s. 135 (3), wherein the licensee was required to provide a written record of the quarterly review of medication incidents, analysis of the medication incidents and the changes made to the program as a result of the quarterly review was kept and to develop and implement an audit tool to ensure the implemented changes were effective.
The Long Term Care Homes (LTCH) Inspector reviewed the evidence binder provided by the home and was unable to identify all required elements of the CO had been complied with.
During a review with the Director of Care, they confirmed the two elements had not been completed as required. [s. 101. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the licensee comply with this Act, the Local Health System Integration Act, 2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every order made or agreement entered into under this Act and those Acts, to be implemented voluntarily.

WN #8: 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. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:

4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee who was required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident and failed to do so: 4. Analysis and follow-up action, including, ii. the long-term actions planned to correct the situation and prevent recurrence.

The home was declared by Public Health to be in an acute respiratory infection (ARI) outbreak from October 12, to November 1, 2017; September 6 to 16, 2017; and May 12 to 21, 2017. In addition, the home was also declared by Public Health to be in an enteric outbreak from June 9 to 15, 2017. The home reported the incidents to the Director within the required timeframe; however there were no updates and/or long-term actions planned by the home to correct the situation and prevent recurrence.
The home's infection prevention and control information was reviewed for each of the outbreaks and identified there were more residents infected throughout the course of each outbreak than what was originally reported to the Director. In addition, the information reported to the Director was not kept up-to-date and there were no long term actions identified to prevent re-occurrence of outbreaks.

The IPAC Lead/Co-DOC #118 and the Administrator were interviewed and confirmed that the information reported to the Director and finalized in the critical incidents (CI) did not include accurate information, such as, the number of infected residents, and/or long term actions to prevent re-occurrence. [s. 107. (4) 4. ii.]

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 the report to the Director includes analysis and follow-up action, including, ii. the long-term actions planned to correct the situation and prevent recurrence, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(e) that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 229 (2).

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

s. 229. (6) The licensee shall ensure that the information gathered under subsection (5) is analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks. O. Reg. 79/10, s. 229 (6).

Findings/Faits saillants :

1. The licensee failed to ensure, that the written record (d) included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

During a review of the home's annual evaluation of the Infection Prevention and Control program, the Long Term Care Home (LTCH) Inspector #527 was unable to identify the date that many of the changes were implemented. Most of the changes made to the IPAC program had a "Date Due" as ongoing on the written record.
The IPAC Lead/Co-DOC #118 and Administrator were interviewed and confirmed the date was not included in the annual evaluation for many of the changes implemented.
The home failed to ensure that the IPAC annual evaluation of their program included dates that the changes were implemented. [s. 229. (2) (e)]

2. The licensee failed to ensure that all staff participated in the implementation of the infection prevention and control program.

A) During the initial tour of the home LTCH Inspector #585 and #640 identified the following:
- LTCH Inspector #585 observed on November 20, 2017: in two resident rooms, a bar of soap was in the shared bathroom; an unlabelled blue basin was on the floor in a tub

room; a second Tub room had a white soiled urinal and pink basin on the floor, both items were unlabelled; and there were two isolation carts outside two resident rooms and neither room had any isolation signage. LTCH Inspector #585 also observed on November 20, 2017 in the resident washroom outside the nursing Station on the second floor, a soiled brief sitting on the toilet tank.
- On November 20, 2017, LTCH Inspector #640 observed a resident room which had no signage and outside a second resident room, the signage identified contact isolation and there was no personal protective equipment (PPE) supplies available outside the room.
- On November 27, 2017, LTCH Inspector interviewed housekeeping aide #129 and they identified that although they had the training related to infection prevention and control, that they did not wear their PPE when cleaning a contact isolation room, but knew they were expected to wear a gown and gloves when cleaning the residents' room.
PSW #108 was interviewed and confirmed that all resident equipment was supposed to be labeled and not left on the floor; soiled briefs were not to be left on toilets and should be placed in the soiled garbage; that PPE equipment was expected to be accessible for them to use when caring for residents and if a resident was needing isolation the registered staff would place the correct signage.
RPN #106 was also interviewed and confirmed that residents' basins and urinals should be placed in their rooms and labeled; that PPE equipment should be stocked and accessible to staff when providing care to residents; and they would place the correct isolation precaution signs on resident doors.

B) The home's policy called "Hand Hygiene Program", and effective September 16, 2013, directed that all staff would comply with the hand hygiene program.
The LTCH Inspector #527 reviewed the hand hygiene audits completed, which identified there was a trend in staff not performing the four (4) moments of hand hygiene according to the Best Practices for Hand Hygiene in All Health Care Settings, December 2010. The home's hand hygiene rate was 79.75 percent (%) as reported to the Infection Prevention and Control (IPAC) Committee on October 24, 2017.
PSWs #127 and #128 were observed leaving a resident's room after providing care and they did not perform hand hygiene. PSW #134 was observed on November 28, 2017, in the dining room at lunch and was not performing hand hygiene before serving food and fluids to residents. The PSW had also cleaned up a spill on another residents table and didn't perform hand hygiene before serving food to other residents; and the PSW was not performing hand hygiene in between feeding residents. RPN #106 and #115 were observed on November 28, 2017, during medication administration and they were not performing hand hygiene in between residents.
The IPAC Lead/Co-DOC #118 was interviewed and confirmed, based on their hand

hygiene audits, that staff were not complying with the four moments of hand hygiene and identified that they identified that staff were not performing hand hygiene after leaving resident's environment.

C) The home was in an Enteric Outbreak from June 9 to 15, 2017, which involved residents from the first floor.
The home's policy called "Operation of Homes - Infection Control - Outbreak Management System", and effective September 16, 2013, directed staff to cancel any scheduled programs. In addition, the home was provided with an "Enteric Outbreak Checklist for Long Term Care and Retirement Homes", from the Wellington-Dufferin-Guelph Public Health department, which directed the home to suspend communal meetings within and outside the home.
On June 12, 2017, several residents were transported externally to an activity. Some of these residents were from the affected unit.
The Restorative Care Coordinator, the Life Enrichment Coordinator and the Behavioural Support Ontario (BSO) PSW were interviewed and they confirmed that they were expected to cancel all internal and external activities.
The home failed to ensure that all staff participated in the implementation of the infection prevention and control program. [s. 229. (4)]

3. The licensee failed to ensure that the information gathered under subsection (5) was analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks.

The home has experienced five (5) infectious disease outbreaks during 2017. They gathered information on each shift, on each unit related to residents' infections; however the home was unable to provide documentation of the monthly analysis and review, which was completed over this past year (2017) to detect trends for the purpose of reducing the incidence of infections and outbreaks.
The Infection, Prevention and Control (IPAC) Lead/Co-DOC #118 Lead was interviewed on November 27 and 28, 2017 and confirmed that they review the daily line list of residents' infections from each unit. The IPAC Lead indicated that they did not review the information on a monthly basis and have initiated Risk Management meetings on a monthly basis starting October 2017 where this information would be reviewed and then quarterly at the IPAC meetings.
LTCH Inspector #527 reviewed the October 2017 Risk Management meeting minutes, but there was no analysis of the IPAC information to identify trends for the purpose of reducing the incidence of infections.

The home failed to ensure that the IPAC information gathered was analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks. [s. 229. (6)]

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 all staff participate in the implementation of the Infection Prevention and Control program, and;
that the information gathered under subsection (5) is analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks, and; to ensure, that the written record includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that sets out, (c) clear directions to staff and others who provide direct care to the resident.

Resident #006 was assessed on an identified date in November 2017, and it was identified the resident had altered skin integrity. A skin and wound assessment was completed by nursing on the same date.
The clinical record was reviewed and the Restorative Care notes on an identified date in November 2017, indicated that they had informed the family that the staff were using specific equipment for transfers as it was more comfortable for the resident. However, the written plan of care directed staff to remove the specific equipment once transferred to reduce the risk of further alteration in skin integrity.

The resident was observed on three identified dates in November 2017, and the specific equipment had been removed after transfer. When the resident was observed by the LTCH Inspector on two identified dates in November 2017, the resident had the specific equipment in place after being transferred.
RPN #106 and PSW #107 were interviewed on an identified date in November 2017, and confirmed that they were informed by Restorative Care that they were to use specific equipment when transferring the resident because it was more comfortable and less friction on the resident's skin.
The DOC was interviewed and they confirmed that the staff were expected to remove the specific equipment from the resident to prevent friction and to promote healing.
The home failed to ensure that the written plan of care for resident #006 set out clear directions to the staff and others who provided direct care to the resident. [s. 6. (1) (c)]

2. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

Resident #006 had a specific assessment in September 2017 by Restorative Care and as a result the recommendation was that the resident be place in specialized seating for comfort. The Occupational Therapist (OT) recommended specific equipment. The OT subsequently implemented a change to the equipment. When the OT assessed the resident again on an identified date in November 2017, the OT recommended further specific equipment as the resident developed altered skin integrity.
RPN #103 was interviewed and indicated that the resident's specialized equipment had restraining qualities.
RPN #112 spoke to LTCH Inspector #527 and indicated that the resident had specialized equipment that was a PASD.
The RPNs and PSW #107 were not aware of the Restorative Care and OT recommendations and were not aware that the specialized equipment and the assessment identified the resident needed the equipment for comfort.
The DOC confirmed that the resident required the specialized equipment for comfort and that the equipment a PASD.
The home failed to ensure that the staff and others involved in the different aspects of care and assessments of resident #006 were integrated, consistent and complemented each other. [s. 6. (4) (a)]

3. The licensee failed to ensure that staff and others involved in the different aspects of

care of the resident collaborated with each other, in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

On an identified date in November 2017, during morning and afternoon nourishment passes, resident #005 was observed holding an adaptive device that contained a beverage. PSW #107 reported when staff felt it may be appropriate to use an adaptive device, the home's process was to inform the charge nurse who would then send a referral to the home's restorative care staff.
The clinical record was reviewed and revealed resident #005 had certain medical issues. Their written plan of care, including the dietary kardex were reviewed and did not include an intervention to use an adaptive device. Review of a recent quarterly restorative assessment, completed on an identified date in November 2017, by restorative care staff #111, did not identify the use of the adaptive device. A quarterly nutritional assessment, completed on an identified date in November 2017, by the Registered Dietitian (RD) identified the resident used an adaptive device for eating; however, did not include an adaptive device for drinking to promote independence with eating.
Restorative care staff #111 was interviewed and reported they were not aware staff were providing the resident fluid in an adaptive device and indicated the resident would require an assessment to determine if the intervention was appropriate.
The licensee failed to ensure that staff and others involved in different aspects of care of the resident collaborated with each other in the development and implementation of resident #005's plan of care related to the use of adaptive devices. [s. 6. (4) (b)]

4. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (b) the resident's care needs changed or care set out in the plan was no longer necessary.

On an identified date in October 2017, resident #008 had an unwitnessed fall and sustained an injury. The resident had pain and was given treatment. Later that day, staff documented the administration of treatment based on decreased pain.
The clinical record was reviewed by the Long Term Care Homes (LTCH) Inspector and noted treatments were administered for pain on six separate occasions in October 2017 and eight occasions in November 2017.
The LTCH Inspector reviewed the written plan of care that was in place at the time, and the plan of care had not been revised to include the new pain associated with the fall and subsequent injury.
According to the Pain Lead, RN #117, during an interview with the LTCH Inspector, staff

were expected to review and revise the plan of care to include the new pain related to the injury. The plan of care was not revised related to the resident's care needs changing with the onset of new pain related to the injury. [s. 6. (10) (b)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a written record was kept relating to each annual evaluation of the pain program included the date of the evaluation the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The Long Term Care Homes (LTCH) Inspector reviewed the home's annual evaluation of the pain management program. The licensee failed to ensure that changes made to the program included the date those changes were implemented as part of the written record of the annual evaluation of the pain management program.
Interview with the Pain Lead for the home, RN #117, confirmed to the LTCH Inspector that changes made to the pain management program did not include the dates of implementation of those changes in the written record of the annual review. [s. 30. (1) 4.]

2. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Resident #006 had altered skin integrity and one of the interventions was to turn and reposition the resident every two hours.
The clinical record was reviewed and LTCH Inspector #527 was unable to locate any documentation related to the turning and repositioning of resident #006.
The home's policy called "Skin and Wound Care Program", Version #3, revised July 20, 2017, directed PSWs to document the turning schedule in Point of Care (POC) in the home's electronic health record. The policy also directed the registered staff to ensure that the turning schedule was added to POC for PSW documentation.
The POC notes from October and November 2017 were reviewed and the turning schedule was not added to POC and there was no documentation of the resident's turning and repositioning every two hours.
The DOC was interviewed and confirmed that the registered staff were expected to include the turning and repositioning in POC for the PSWs and this did not occur, therefore the PSWs did not document the resident's turning schedule.
The home failed to ensure that any actions taken with respect to resident #006 under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented. [s. 30. (2)]

Issued on this 25th day of January, 2018

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

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

Ministére de la Santé et des Soins de longue durée

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) :	HEATHER PRESTON (640), KATHLEEN MILLAR (527), LEAH CURLE (585)
Inspection No. / No de l'inspection :	2017_482640_0021
Log No. / No de registre :	026012-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jan 15, 2018
Licensee / Titulaire de permis :	488491 Ontario Inc. 689 YONGE STREET, MIDLAND, ON, L4R-2E1
LTC Home / Foyer de SLD :	AVALON RETIREMENT CENTRE 355 BROADWAY AVENUE, ORANGEVILLE, ON, L9W-3Y3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jodi Napper-Campbell

To 488491 Ontario Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2017_482640_0011, CO #008;

Pursuant to / Aux termes de :

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

Order / Ordre :

1) Ensure there is a process in place to verify that all medication incidents have been identified and documented and,
2) all medication incidents are followed up by an investigation and action taken accordingly.

Grounds / Motifs :

1. The non-compliance was issued as a Compliance Order (CO) due to a severity level of minimum risk (1), scope of isolated (1) and a compliance history in the previous three years as ongoing non-compliance despite previous action taken by the ministry including the issuance of an order (4) in Complaint Inspection #2017_482640_0011 whereby the licensee failed to document, review, analyze and take action for all medication incidents that occurred.

The licensee failed to ensure that, (a) all medications incidents and adverse drug reactions were documented, reviewed and analyzed; (b) corrective action was taken as necessary; and a written record was kept of everything required under clauses (a) and (b).

During review of the home's morning report minutes, the Long Term Care Homes (LTCH) Inspector observed on October 10, 2017, report that a

hydromorphone tablet had been found loose in a medication cart by RN #117 and an investigation had been started.

Policy Resident Rights, Care and Services - Medication Management - Medication Incident, Version 2, with a revised date of July 20, 2017, directed staff to complete an incident report for any preventable event associated with the prescribing, ordering, dispensing, storing, labeling, administering or distribution of a drug or the transcribing of a prescription. An act of omission or commission. The policy directed staff to initiate and complete the internal medication incident report and forward to the DOC, attending physician and the Pharmacist.
During review of the medication incident binder, as provided by the home, the LTCH Inspector was unable to locate the corresponding medication incident report.

During an interview with the Director of Care (DOC), they confirmed it was expected that when a medication was found, a medication incident report was required to be completed and follow by an investigation.
During an interview with RN #117, they confirmed they had found a hydromorphone 3 milligram (mg) tablet loose in a medication cart, under a medication bin on October 8, 2017, and they had not completed a medication incident report and did not have any notes of investigation of the event. [s. 135. (2)]
(640)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 12, 2018

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 114. (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home. O. Reg. 79/10, s. 114 (2).

Order / Ordre :

The licensee must ensure;

1) An auditing process is developed and implemented to ensure there are no expired medications available in the medication cart and,
2) The home's policy related to the destruction of discontinued narcotic medications is complied with.

Grounds / Motifs :

1. This Compliance Order (CO) was issued as a result of a severity level of minimal harm or potential for actual harm (2), a scope of pattern (2) and a compliance history over the previous three years of previous related non-compliance despite previous action taken by the ministry (4) from Complaint Inspection # 2017_482640_0011 related to medication management.

1. Where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system was (b) complied with.
In accordance with Regulation, s.114 (2), which required the licensee to ensure that the interdisciplinary programs including medication management program were developed and implemented in the home to ensure that written policies and protocols were developed for the medication management system to ensure the acquisition, dispensing, receipt, storage, administration, destruction and disposal of all drugs used in the home. O. Reg. 79/10, s.114

The licensee failed to ensure the policies and protocols were developed,

implemented, evaluated and updated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

1) Following the observation, by the Long Term Care Homes (LTCH) Inspector, of medication administration by RPN #115 on an identified date in November 2017, the LTCH Inspector reviewed the medication cart with the RPN. The following was found to be expired and remained in use; specific eye drops (gtts) for resident #019, with an opened date of October 11, 2017. According to the RPN, this medication was to be discarded after six weeks, therefore it should have been discarded November 22, 2017, specific eye gtts for resident #020 had no date of being opened, therefore staff were unaware as to when it was required to be discarded, resident #022 had specific eye gtts with no date opened on the vial therefore staff were unaware as to when it was required to be discarded, resident #003's specific eye gtts had expired and was still in use and specific eye gtts for resident #021 which had an opened date of October 31, 2017. These eye drops were to be discarded November 28, 2017.

The home's policy entitled Resident Rights, Care and Services - Medication Management - Drug Storage and revised October 7, 2013, directed staff to ensure that discontinued or outdated medications be removed immediately from the medication cart, refrigerator, or government stock cupboards. Also included was a document from Silver Fox Pharmacy, the home's pharmacy service provider, entitled Recommended Expiry Dates. This document directed staff to discard opthalmic/otic products 28 days after they were opened. Specifically for a specified eye drops, they were to be discarded after 42 days once opened.

During an interview with the Director of Care, they confirmed that it was an expectation of the home that eye drops be labeled with the date they were opened and discarded as per the direction from the pharmacy service provider's directive.

2) Following the observation, by the Long Term Care Homes (LTCH) Inspector, of medication administration by RPN #115 on an identified date in November 2017, the LTCH Inspector reviewed the medication cart with the RPN. RPN #115 and the LTCH Inspector counted the controlled substances. Resident #023's controlled substance card contained seven pills. The individual controlled substance count sheet had eight remaining. RPN #115 stated they had given it earlier but did not document as per the home's policy. Resident #017's controlled substance card had 28 pills remaining. The

individual controlled substance count sheet had 29 remaining. The RPN stated they had administered two tablets earlier and miscounted on the count sheet. Resident #024's individual controlled substance count sheet noted 11 pills remaining. The resident's controlled substance card held 10 tablets. RPN #115 identified they had administered the medication earlier and failed to document as per the home's policy.

The home's policy entitled Resident Rights, Care and Services - Medication Management - Narcotics and Controlled Substances with a revised date of October 7, 2013, directed staff to record all narcotics on the Medication Administration Record and complete a count when a narcotic was administered at the time of administration.

During an interview with RN #118, they informed the LTCH Inspector it was an expectation of the home that all controlled substances be documented on the individual controlled substance count sheet immediately following the administration of the medication.
The licensee failed to ensure that staff complied with the home's Medication Management policies and procedures. [s. 114. (2)] (640)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 12, 2018

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
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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 15th day of January, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector / Nom de l'inspecteur : Heather Preston

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