Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 11, 2017	2017_573581_0015	015881-17	Resident Quality Inspection

Licensee/Titulaire de permis

Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

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

Chartwell Brant Centre Long Term Care Residence
1182 NORTHSHORE BLVD. EAST BURLINGTON ON L7S 1C5

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

DIANNE BARSEVICH (581), CATHY FEDIASH (214), JESSICA PALADINO (586), LISA VINK (168)

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): August 23, 24, 25, 28, 29, 30, September 13 and 14, 2017.

During the course of this inspection the following was completed concurrently:
Inquiry
016524-17 related to unexpected death.

Critical Incident Report
032337-16 related staff to resident abuse.
034152-16 related to falls prevention.
020786-17 related to medication error.

Complaint
006379-17- related to staffing.
019442-17 related to pain management and end of life care.

During the course of the inspection, the inspector(s) spoke with Administrator, Associate Director of Care (ADOC), Registered Nurses (RN), Corporate Resident Care and Services Consultant, Registered Practical Nurses (RPN), Assistant Pharmacy Manager, Personal Support Workers (PSW), families and residents.

During the course of the inspection, the inspectors: toured the home, observed the provision of care and services, reviewed relevant policy and procedures, reviewed specific meeting minutes, relevant audits and clinical health records.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

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

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A. Review of the Minimum Data Set (MDS) admission assessment in March 2017, identified that resident #008 was incontinent of bladder. In June 2017, the MDS assessment indicated they were continent of bladder. Interview with RN #105 stated there was an improvement in their urinary continence between quarterly assessments as identified in Point of Care; however, was coded as no change and confirmed the assessments were not integrated and consistent with each other.

B. Review of the plan of care for resident #030 identified they fell and sustained an injury in November 2016. They also fell twice in October 2016, with no injuries. Review of the MDS assessment in December 2016, indicated they had a significant change in their status as they had a fall in the last 30 days and an injury in the last 180 days but did not identify they had a fall in the past 31-180 days. Review of the MDS assessment in March 2017, identified they had not fallen in the last 31-180 day or had an injury in the last 180 days. Interview and review of the clinical health record with RN #105 stated the resident had three falls within the past six months and an injury and confirmed that the MDS assessments, the Physician's note and progress notes were not integrated, consistent with and complemented each other. [s. 6. (4) (a)]

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

the resident as specified in the plan.

A. Review of the plan of care for resident #008 identified that the Physician ordered a device in May 2017 and was to be changed monthly. Review of the Treatment Administration Record (TAR) identified that the device was to be changed on an identified day each month and there was no documentation that identified the device was changed monthly. Interview with the resident stated that their device had not been changed since it was ordered in May 2017. Interview and review of the clinical health record with RPN #107 including the TAR confirmed that the device had not been changed since it was applied, that it was ordered to be changed monthly and the care set out in the plan of care was not provided to the resident as specified in the plan.

B. Resident #001 was observed in bed on three identified days in August 2017, with one assist rail on the left in the guard position and one assist rail on the right in the transfer position. Review of the Bed System Assessment completed in October 2016 and observation of the picture logo above the bed identified they required two assist rails raised in the guard position when the resident was in bed for bed mobility and positioning assistance. Interview with evening PSW #112 stated the resident only had one bed rail raised in the guard position and the other assist rail was in the transfer position as they self–transferred. Interview with RPN #107 stated that resident was assessed to have two bed rails raised in the guard position and confirmed they only had one bed rail raised in the guard position when in bed. The care set out in the plan of care was not provided to the resident as specified in the plan. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care was provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A. The home's policy, under Clinical and Resident Care Manual, with an identified title, policy number: LTC-CA-WQ-200-02-06, revision date: November 2014, identified that in the event a resident required a specific treatment, registered staff would obtain a physician order that outlined the requirements.

Resident #009 had a device ordered in March 2017, due to a specific diagnosis and twenty days later, it was ordered to be changed monthly and as needed. Review of the plan of care revealed there was no order for the specific treatment. Review of the progress notes identified the device had the specific treatment six times between an identified day in May and an identified day in July 2017 and was removed five days after the last treatment. Interview with RN #108 and ADOC both stated that an order was required when a resident needed the specific treatment. Review of the plan of care with RN #108 stated the resident received the treatment several times by registered staff while the device was applied and confirmed that resident #009 did not have an order for the specific treatment. The home's policy was not complied with.

B. The home's policy, under Clinical and Resident Care Manual, "Bed System Assessment", policy number: LTC-CA-ON-200-07-22, revision date: January 2016, directed registered staff that a Bed System Assessment would be completed with each annual assessment for all the residents using bed rails or indicating a desire to use a bed rail at the time of the assessment.

Review of the plan of care identified that resident #002 required two assist rails raised

when in bed for bed mobility and repositioning. Interview with RPN #100 stated the resident had two quarter rails raised when in bed. Review of the Bed System Assessment indicated that an initial assessment was completed on an identified day in March 2015, when the resident was admitted to the home but was not completed with each annual assessment. Interview with RN #113 confirmed that the Bed System Assessment was not completed annually and that the home's policy was not complied with.

C. The home's policy, under Clinical and Resident Care Manual, "Continence Care", policy number: LTC-CA-WQ-200-02-05, revision date: July 2016, directed staff to initiate the Continence Observation Form on the day of admission and place the form in the residents' washroom or other designated spot for ease of completion. The assessment would continue for five days and after the five days the form was reviewed by registered staff to determine the level of continence and a plan of care was developed and documented in response to the pattern of continence. If there was any significant change in the continence status of the resident during the quarter they would require a three day assessment.

i. Resident #008 was admitted to the home on an identified day in March 2017 and according to the MDS assessment in March 2017, was incontinent of bladder. On an identified day in May 2017, the physician ordered the device and the June 2017, MDS assessment indicated the resident was continent of bladder. Review of the plan of care identified that the Continence Observation Form was not initiated when the resident was admitted or when the device was applied as there was a significant change in their continence status. Interview with RPN #107 stated that the form should of been completed for seven days by the PSW staff upon admission and RN #108 confirmed that the three day Continence Observation Form should have been completed after the device was applied. They confirmed that the home did not comply with their policy when the forms were not completed.

ii. On an identified day in March 2017, resident #009 was admitted to the home. Review of the plan of care identified that the Continence Observation Form was initiated but not completed for the five days as required by the home's policy. On an identified day in July 2017, the resident's device was removed. Interview with PSW #118 stated that the resident was incontinent of bladder since the device was removed. Interview with RPN #107 confirmed that the Continence Observation Form was not fully completed when the resident was admitted and that it was not initiated when there was a change in the resident's continence status after the device was removed. They confirmed the home's

policy was not complied with. [s. 8. (1) (b)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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 failed to ensure that at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff was on duty and present at all times unless there was an allowable exception to this requirement (see definition/description for list of exceptions as stated in section 45. (1) and 45.1 of the Regulation).

Review of the registered nursing staffing schedule from September 26, to December 10, 2016, and May 1, to August 30, 2017, identified that a Registered Nurse (RN) that was a member of the regular nursing staff was not on duty on the following dates:
i. On October 30, 2016, on night shift;
ii. On November 7, 8, 16, 22, 24, 25, 28 and 29, 2016, on night shift;
iii. On November 17, 2016, on day shift;
iv. On December 4, 5, 6, 7, 8, 9 and 10, 2016, on day shift;
v. On May 14 and 23, 2017, on night shift;
vi. On June 20, 2017, on night shift;
vii. On July 3, 24, 25 and 27, 2017, on night shift; and,
viii. On August 6, 9, 14, 15 and 18, 2017, on night shift.

In an interview with the ADOC on August 29, 2017, they stated that agency RN staff was present on the above shifts but confirmed the home was unable to staff those shifts with an RN who was an employee of the home. (586) [s. 8. (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 at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff is on duty and present at all times unless there is an allowable exception to this requirement (see definition/description for list of exceptions as stated in section 45. (1) and 45.1 of the Regulation), to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that, was available in every area accessible by residents.

On August 23, 2017, it was identified that conference rooms on the third and fourth floors, adjacent to the elevators were unlocked, unattended and had their doors wide open. The rooms did not include a communication and response system or call bell. Discussion with the Administrator identified that residents and family members utilized these rooms and that to their recall they were not equipped with a call bell.

Not every area accessible to residents had a communication and response system. [s. 17. (1) (e)]

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 home is equipped with a resident-staff communication and response system that, is available in every area accessible by residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A written complaint letter dated on an identified day in August 2017, from a family member of resident #051, was sent to the home. A review of this complaint indicated that the family member had expressed concerns regarding the assessment and pain management of the resident on an identified day in July 2017, beginning at a specified time.

A review of the resident's progress notes on an identified day in July 2017, at a specific time, indicated that the physician was called in to see the resident and that the Power of Attorney (POA) now wished for specific interventions to be implemented. A review of the resident's clinical record from an identified day in July until an identified day in September 2017, was conducted. No documentation was identified regarding observations or assessments that had been conducted for resident #051 on an identified day in July 2017, for approximately 10 hours.

A review of the home's investigative notes indicated that RPN #121 and RN #122, were present and had assessed resident #051 on an identified day in July 2017, during the ten hour time period. They had both indicated in an electronic mail (e-mail) to the Administrator, their observations and assessment of resident #051 during their shifts on the identified day in July 2017 during the specified time period.

RPN #121 indicated that they assessed the resident's vitals throughout the course of their shift; administered scheduled medications; assessed the resident for an elevated temperature and administered medication; repositioned the resident several times throughout their shift; reassessed the resident's vital signs and indicated that there were no concerns. The staff member also indicated that at one point through the night, the family identified that the resident had a symptom and specific medications were administered. Documentation indicated that the staff member ensured the resident was comfortable before leaving their room. The staff member indicated that at an identified time, the resident's medical condition changed and discussions with the family regarding continuing with a specific intervention took place. The staff member indicated that at specified time, the family asked for the physician to be called. The staff member indicated that all medications, including when needed (PRN) medications had been prescribed and that the resident was comfortable. The staff member indicated that they called registered RN #122 to assist. RPN #121 indicated that following the administration of a specific medication, the resident was comfortable.

RN #122 indicated that at a specific time, they went to see resident #051 at the request of the resident's family. A family member, who was present, indicated that the resident was in distress. Documentation indicated that when RN #122 entered the resident's room, they observed and assessed the resident to be lying in their bed, in a specific position, a specific treatment was in place and the resident was resting. Documentation indicated that the resident's facial expression was calm, with no appearance of any pain or discomfort and their breathing pattern was even. Documentation indicated that there was absolutely no sign of any distress.

During an interview with the Administrator, DOC and the ADOC, the DOC confirmed that the actions taken by RPN #121 and RN #122, including assessments, reassessments, interventions and the resident's response to interventions, had not been documented in the resident's clinical record. [s. 30. (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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions and that where the condition or circumstances of the resident required, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

A. Review of the plan of care identified that resident #008 was admitted in March 2017 and a Bladder Continence Assessment was not completed. Review of the MDS admission assessment completed in March 2017, identified that resident #008 was incontinent of bladder and in June 2017, indicated they were continent after they had a specific device applied on an identified day in May 2017. Interview with RN #105 stated that a bladder continence assessment should have been completed when they were admitted and when they had a change in their continence after the specific device was applied. They confirmed that an assessment using a clinically appropriate instrument that was specifically designed for assessment of incontinence was not initiated on admission and when resident #008 urinary continence changed.

B. Review of the plan of care identified that resident #009 was admitted in March 2017, with a specific device. On an identified day in July 2017, the physician ordered the device to be removed. Review of MDS assessment in June 2017, identified the resident was continent of bladder. Interview with PSW #118 stated that the resident was incontinent of bladder after the device was removed. Interview with RN #113 stated that the Bladder Continence Assessment should have been completed when the resident's continence status changed after the device was removed and confirmed that an assessment using a clinically appropriate instrument that was specifically designed for assessment of incontinence was not completed. [s. 51. (2) (a)]

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 each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions and that where the condition or circumstances of the resident requires, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that restraining of a resident by a physical device under section 31 or 36 of the Act, was applied by staff in accordance with any manufacturer's instructions.

On an identified day in August 2017, resident #030 was observed seated in their wheelchair with a specific device applied in an identified manner. Review of the plan of care identified they required the device as a restraint and were unable to remove the device independently. Review of the manufacturer's instructions indicated how the device was to be applied. Interview with PSW #110 stated the resident was unable to remove the device independently and confirmed the device was not applied according to manufacturer's instructions. They adjusted the device to comply with the manufacturer's instructions.
The specific device was not applied in accordance with manufacturer's instructions. [s. 110. (1) 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 restraining of a resident by a physical device under section 31 or 36 of the Act, is applied by staff in accordance with any manufacturer's instructions, to be implemented voluntarily.

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. (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 failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A review of a Critical Incident System (CIS) submitted by the home and a Medication Incident Report completed by the home, indicated that on an identified day in May 2017, the physician discontinued an order for a specific medication on the quarterly Physician Medication Review form, for resident #050. The physician then wrote on the resident's medication order form an order for the specific medication at half of the original dose. This order was processed and the resident received the new order of the medication from an identified day in May until an identified day in June 2017. On an identified day in June 2017, the order was discontinued from the Point Click Care (PCC) system and from the Electronic Medication Administration Record (EMAR). On an identified day in August 2017, registered staff #101 identified, while checking the resident's new quarterly Physician Medication Review, that the specific medication prescribed with the lowered dosage for the resident was not listed on this form and that there had not been an order in the resident's clinical record to discontinue this medication. This medication was re-ordered by the physician on an identified day in August 2017.

A review of the resident's quarterly Physician Medication Review between an identified day in February until an identified day in July 2017, as well as a review of the resident's EMAR for May 2017, identified that the original dose medication had been discontinued by the physician on an identified day in May 2017. A review or the resident's Physician's Order form identified that on an identified day in May 2017, an order was prescribed by the physician to decrease the medication in half. A review of the documentation on the EMAR from an identified day in May 2017, until an identified day in June 2017, indicated that the medication was administered, as prescribed with the lower dosage.

A review of the EMAR from an identified day in June until an identified day in August 2017, indicated that no documentation for the administration of the medication that was decreased was noted.

During an interview with RPN #119 on an identified day in September 2017, they indicated that orders written on the quarterly Physician Medication Review form were to be faxed to the pharmacy as this form was not digital and did not transmit to the pharmacy digitally, when using the digital pen. The staff member indicated that the Physician Order Form was digital paper and transcribed automatically to the pharmacy when the order was written on this form using the digital pen. The staff member indicated that the pharmacy sent a confirmation notice through the PCC – Electronic physician's orders tab, which was listed in red and staff were to click and confirm that the medication had been discontinued. The staff member confirmed that they were not sure how to use this system and clicked and discontinued this confirmation notice on an

identified day in June 2017.

A telephone interview with the Assistant Pharmacy Manager on an identified day in September 2017, confirmed that the original medication orders were processed as ordered on an identified day in May 2017. On an identified day in June 2017, the pharmacy received another fax of the quarterly Physician Medication Review, which was dated on an identified day in May 2017. The Assistant Pharmacy Manager did not know why the review was faxed to the pharmacy again and that the pharmacy assistant discontinued the medication in error and had not checked the date of when the medication had been discontinued when they received this second fax and had not checked the strength of the medication that was discontinued. The Assistant Pharmacy Manager confirmed that the message sent to the home's PCC physician's orders for the nursing staff to confirm the discontinuation of the medication had been sent to the home on an identified day in June 2017 and that this medication was already discontinued at the pharmacy. The purpose of the confirmation in PCC was a done as a dual check. The Assistant Pharmacy Manager confirmed that the medication was not confirmed as discontinued in the home's PCC system by the nursing staff until 13 days after the confirmation message was posted in the system.

An interview with the DOC confirmed that the medication had not been administered as prescribed to resident #050, from an identified day in June until an identified day in August 2017. [s. 131. (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 drugs were administered to residents in accordance with the directions for use specified by the prescriber, 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).

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 :

1. The licensee failed to ensure that every medication incident which involved 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 (SDM), 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.

On request the home provided a copy of all medication incidents and adverse drug reaction reports for 2017. A review of the incident reports identified that that not all incidents were consistently documented, together with a record of the immediate actions taken to assess and maintain the resident's health, nor were they consistently reported to all required parties.

i. Resident #042 was involved in a medication incident in January 2017, which was identified the following shift. A review of the resident's record and medication incident

report did not include a record of the immediate actions taken to assess and maintain the resident's health, nor was the incident reported to all of the required persons, specifically the resident and their SDM, as set out in Ontario Regulation 79/10, which was confirmed by the Associate Director of Care (ADOC) following a review of the available documentation.
ii. Resident #043 was involved in a medication incident in March 2017, which was identified the following shift. A review of the resident's record and medication incident report did not include a record of the immediate actions taken to assess and maintain the resident's health related to the error, nor that the incident was reported to all of the required persons, specifically the resident, the SDM or physician, as set out in Ontario Regulation 79/10, which was confirmed by the ADOC following a review of the available documentation. A review of the incident reported identified a statement under the heading of corrective action, "inform SDM and physician"; however, documentation was not available that this was completed. [s. 135. (1)]

2. The licensee failed to ensure that all medication incidents and adverse drug reactions were documented, reviewed and analyzed, corrective action was taken as necessary and a written record was kept of everything required.

On request, the home provided a copy of all medication incidents and adverse drug reaction reports for 2017. A review of the incident report identified that that not all incidents were consistently reviewed, analyzed or corrective action documented.

Resident #044 was involved in a medication incident in June 2017, which was identified the following shift. A review of the resident's record and medication incident report did not include documentation of a review or analysis of the error or correction action, which was confirmed by the ADOC following a review of the available documentation. [s. 135. (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 every medication incident which involved a resident and every adverse drug reaction is: 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 (SDM), 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, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (3) The drugs must be destroyed by a team acting together and composed of,
(b) in every other case,
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) one other staff member appointed by the Director of Nursing and Personal Care. O. Reg. 79/10, s. 136 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that when a drug, which was not a controlled substance was to be destroyed, it was done by a team acting together and composed of: one member of the registered nursing staff appointed by the Director of Nursing and Personal Care and one other staff member appointed by the Director of Nursing.

Interview with the ADOC and Resident Care and Services Consultant identified the current process in place for the destruction of non controlled drugs included a registered staff member and a second staff. During a review of the Medication Destruction Record Forms on the first, second and fourth floors on an identified day in August 2017, it was identified that staff were not following the process in place and that drugs were destroyed by one staff member. It was communicated by the ADOC that it was suspected that in February 2017, when the home changed pharmacy service providers, that this was when the home failed to comply with the second staff member as there was a change in process. [s. 136. (3) (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 when a drug, which is not a controlled substance is to be destroyed, it was done by a team acting together and composed of: one member of the registered nursing staff appointed by the Director of Nursing and Personal Care and one other staff member appointed by the Director of Nursing, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's policy to promote zero tolerance of abuse and neglect of residents was complied with related to s. 20. (2) (d) the duty under section 24 to make mandatory reports.

The home’s policy, “Abuse Allegations and Follow-Up", policy number LTC-CA-WQ-100-05-02, last revised July 2016, indicated that all employees were required to report immediately to their respective supervisor/person in charge of the building when an abuse was witnessed, suspected, or at any time when information or knowledge of an allegation of an abuse was received or learned from any person. The policy also directed staff to ensure all physical assessments/examinations were recorded with clear descriptions and detailed; and all entries to be signed and dated with the time of the documentation.

On an identified day in October 2016, PSW #200 witnessed PSW #201 allegedly abuse resident #020. PSW #200 reported this to RPN #202. Thirteen days later, PSW #200 informed the Administrator of the incident, as they said no action had been taken in regard to it.

Review of the home’s internal investigation notes and interview with the Administrator confirmed that RPN #202 did not report the incident to their supervisor or the Administrator as per the home’s policy. Additionally, the Administrator confirmed that the RPN did not document their physical assessment of the resident after the allegation was made.

The home’s abuse prevention policy was not complied with. [s. 20. (1)]

Issued on this 20th day of October, 2017

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

Original report signed by the inspector.