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
Feb 9, 2018	2018_682549_0002	019243-17	Resident Quality Inspection

Licensee/Titulaire de permis

City of Ottawa
Community and Social Services, Long Term Care Branch 200 Island Lodge Road
OTTAWA ON K1N 5M2

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

Carleton Lodge
55 Lodge Road, R.R. #2 NEPEAN ON K2C 3H1

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

RENA BOWEN (549), AMANDA NIXON (148), MICHELLE EDWARDS (655)

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): January 8, 9, 10, 11, 12, 15, 16, 17, 18 and 19, 2018

During the course of the Resident Quality Inspection the following logs were inspected:
Log # 015457-17- Critical Incident related to fall prevention
Log # 017582-17- Critical Incident related to suspected resident to resident sexual abuse.
Log # 018428-17- Complaint related to care being provided
Log # 023279-17- Critical Incident related to staff to resident abuse
Log # 025815-17- Critical Incident related to medication administration

During the course of the inspection, the inspector(s) spoke with residents, family members, the President of the Family Council, the President of Residents' Council, the RAI- Coordinator, a Ward Clerk, the Staffing Clerk, a Recreation Aide, the Recreation Coordinator, the Manager of Recreation and Leisure, Housekeeping Aides, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), the Program Manager of Resident Care (PMORC), the Program Manager of Personal Care (PMOPC), the Administrator and the Manager of Hospitality Services at Centre d'accueil Champlain.

The inspectors reviewed resident health care records, Restraint and Repositioning Records, medication error quarterly analysis, policies and procedures as required, Care Conference schedules and the licensee's investigation documentation. The inspectors toured non-resident and resident care areas in the home and observed a meal service, infection control practices, a medication administration pass, staff to resident interactions and resident to resident interactions.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **8 WN(s)**
- **4 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 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 has failed to ensure that the resident-staff communication and response system is easily accessed by residents, staff and visitors at all times.

On January 8, 2018 Inspector #655 observed that the resident–staff communication and response system (call bells) in the washrooms accessed by residents at the top of the hallway in each resident care unit were not easily accessible.

On January 18, 2018 Inspector #549 observed on the Goulbourn resident care unit at the top of the Stittsville Road hallway, two washrooms accessible to residents. PSW #134 indicated to the inspector that the washrooms are used by independent residents and residents that are assisted by staff.

Inspector #549 observed on the Rideau resident care unit at the top of the Manotick Road hallway, two washrooms accessible to residents. RPN # 119 indicated to the inspector that the washrooms are used by independent residents and residents that are assisted by staff.

Inspector #549 observed on the West Carleton resident care unit at the top of the Kinburn Road hallway, two washrooms accessible to residents. PSW #135 indicated to

the inspector that the washrooms are used by independent residents and residents that are assisted by staff.

Inspector #549 observed on the Nepean resident care unit at the top of the Fallowfield Road hallway, two washrooms accessible to residents. PSW #110 indicated that the washrooms are used by independent residents and residents that are assisted by staff.

On January 18, 2018 Inspector #549 observed that the call bell cords used to activate the call bell in each described resident washroom was either too short to reach the toilet, wrapped around the soap dispenser or tied up on itself so the cord could not reach the toilet.

Inspector #549 observed that residents would not physically be able to reach the call bell cord due to the distance between the toilet and the call bell cord on the wall. The distance was approximately five feet.

During an interview on January 18, 2018, the Program Manager of Personal Care (PMOPC) indicated to the inspector that the washrooms at the top of the resident care unit hallways are used by residents on a regular bases. The PMOPC looked at the call bell placement and the cord in the West Carleton resident care unit which is situated in the same location in all of the identified resident washrooms and indicated that the call bell is not easily accessible for use by residents.

As such, the licensee has failed to ensure that the resident-staff communication and response system is easily accessed by residents in the eight identified resident washrooms. [s. 17. (1) (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 the resident-staff communication and response system is accessible in the resident designated washroom at the top of the hallway in each of the resident care units, to be implemented voluntarily.

WN #2: 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 has failed to ensure that their written policy that promotes zero tolerance of abuse and neglect of residents is complied with.

The licensee submitted a Critical Incident Report (CIR) on a specific date in 2017 to the Ministry of Health and Long Term Care related to suspected sexual abuse of a resident by another resident. The CIR indicated that PSW#130 witnessed resident #046 touching resident #047 inappropriately.

During an interview on January 17, 2018, PSW #130 indicated to Inspector #549 that the incident that she witnessed between resident #046 and resident #047 occurred on specific date in 2017. PSW #130 also indicated to the inspector that she believed that the incident was sexual abuse however, did not report the incident immediately. PSW #130 indicated that she had gotten busy with other residents and forgot to report the incident.

PSW #130 was not scheduled to work on two specified dates in 2017. The PSW indicated to the inspector that she remembered the incident and reported it to the unit registered staff when she returned to work.

The licensee's policy No. 750.65 titled Abuse and Neglect, last revised June 2017 and in effect at the time of the incident, indicated under procedure: 1. Report immediately any suspicion or allegation of resident abuse to the Charge Nurse.

During an interview with the Program Manager of Resident Care (PMORC) on January 16, 2018 it was indicated to the inspector that the home's expectation is that PSW #130 comply with the licensee's Abuse and Neglect policy and report witnessed or suspected abuse immediately to the Charge Nurse.

As such, the licensee failed to ensure that the Abuse and Neglect policy No. 750.65 last revised June 2017, was complied with when PSW #130 did not reported her suspicion of the sexual abuse of resident #047 until three days after the incident occurred. [s. 20. (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 the written policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee had failed to ensure that a person who had reasonable ground to suspect that abuse of a resident by anyone has occurred or may occur, immediately report the suspicion and the information upon which it is based to the Director.

The licensee submitted a Critical Incident Report (CIR) on a specific date in 2017 to the Ministry of Health and Long Term Care related to suspected sexual abuse of a resident by another resident. The CIR indicated that PSW #130 reported on a specific date in 2017 that she witnessed resident #046 touching resident #047 inappropriately.

Inspector #549 reviewed the progress notes for resident #046 and #047 dated dated a specific date in 2017. The progress notes indicated that on a specific date in 2017 at PSW reported to the Charge Nurse that she found resident #046 touching co-resident inappropriately. The Charge RN called the on call manager to get further advice. The progress notes also indicated that the on call manager will call the unit manager tomorrow and follow up. The Program Manager of Resident Care (PMORC) was notified by the on call manager through email on the morning after he spoke to the evening Charge Nurse.

On January 17, 2018 Inspector #549 spoke with Manager #131 who was the on call manager on the identified date in 2017. Manager #131 indicated to the inspector that he became aware of the suspected sexual abuse of resident #047 on a specific date in 2017.

During the same telephone interview Manager #131 indicated that he was not aware at the time that he was required to notify the Director immediately of the suspected sexual abuse of resident #047 however is aware now.

As such the licensee has failed to ensure that a person who had reasonable ground to suspect that abuse of a resident by anyone has occurred, immediately report the suspicion and the information upon with it was based to the Director. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a person who has reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur, immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #4: 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. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
1. The circumstances precipitating the application of the physical device. O. Reg. 79/10, s. 110 (7).
2. What alternatives were considered and why those alternatives were inappropriate. O. Reg. 79/10, s. 110 (7).
3. The person who made the order, what device was ordered, and any instructions relating to the order. O. Reg. 79/10, s. 110 (7).
4. Consent. O. Reg. 79/10, s. 110 (7).
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of

this requirement, the licensee shall ensure that the following are documented: the person who applied the device and the time of application; all assessment, reassessment and monitoring, including the resident's response; every release of the device and all repositioning; and the removal or discontinuance of the device.

In accordance with O.Regulation 79/10, s.110(2), the licensee shall ensure that where there is a physical device in use as a restraint, that staff monitor the resident every hour in addition to a release and reposition at least every 2 hours.

1. Resident #028 was observed on two specific date in January 2018, to have a lap belt applied while seated in a wheelchair. It was confirmed through staff interviews, physician order and plan of care that the lap belt is used by the resident as a restraint to reduce the risk of injury from falling/sliding from the wheelchair. Staff including, RPN #112 and PSW #117 indicated that the resident wears the lap belt when up in the wheelchair, the resident is up in the wheelchair for breakfast and stays in the wheelchair until after lunch when the resident is taken to bed for a rest period. The resident will then rise in the afternoon and be positioned back into the wheelchair with the lap belt applied.

The records for restraint documentation, for resident #028, were reviewed a specific period in the month of January 2018. The Restraint and Repositioning Record was used during this time and provides for hourly recording of application, removal and positioning of a restraint device. It was demonstrated that the documentation maintained did not support all applications of the device, monitoring or repositioning as follows:

The Medication Administration Record for January 2018, whereby the registered nursing staff document that the resident's condition has been reassessed related to the use of a restraint, supports that the resident had a lap belt applied during the day shift on seven specific dates in January 2018; there is no documentation on the same dates to support the time of application, monitoring, repositioning or removal of the lap belt during the day shifts.

The Medication Administration Record for January 2018 supports that the resident had a lap belt applied during the evening shift on three specific dates in January 2018; there is no documentation on the same dates to support the time of application, monitoring, repositioning or removal of the lap belt during the evening shifts.

On nine specific dates in January 2018, the Restraint and Repositioning Record supports the application of a device at 0800 hours and removal at 1300 hours;

documentation is incomplete for all monitoring and repositioning as required between 0800 and 1300 hours.

On four specific dates in January 2018, the Restraint and Repositioning Record supports the application of a device at 1500 hours and removal at 1900 hours; documentation is incomplete for all monitoring and repositioning as required between 1500 and 1900 hours.

The application, monitoring, repositioning and release of the lap belt in use for resident #028 was not documented as described by the instances above. [s. 110. (7)]

2. Resident #006 was admitted to the home on a specific date in 2016 with multiple diagnoses. The Minimum Data Set (MDS) assessment dated a specific date in January 2018 indicated that the resident's cognitive skills for daily decision making is moderately impaired- decisions poor; cues or supervision required. The residents Cognitive Performance Scale (CPS) assessment also dated a specific date in January 2018 was assessed to be three.

Resident #006 was observed by Inspector #549 on two specific dates in January 2018 sitting in a wheelchair with a front closing lap belt applied. The resident was unable to release the lap belt when requested by Inspector #549.

Inspector #549 reviewed the resident's health care record on January 11, 2018. The health care record indicated that the resident had been assessed as being at risk for falls. The resident had six documented falls since admission in 2016.

The health care records also indicated that resident #006's Substitute Decision Maker (SDM) requested that a lap belt restraint be applied to the resident at all time when the resident is in the wheelchair. The resident's health care record contained a signed consent for the lap belt restraint and a physician's order for the lap belt restraint to be applied at all times when the resident is in the wheelchair.

During an interview on January 11, 2018 with RN #108 it was indicated to the inspector that the Personal Support Workers (PSW) are responsible for documenting the application of the lap belt restraint, the removal of the restraint, repositioning of the resident and the hourly monitoring of the resident. RN #108 also indicated that the documentation of the application, removal, repositioning and hourly monitoring of the lap belt restraint is kept in a binder at the information centre for the PSWs to access.

During an interview with PSW #110 on January 11, 2018, it was indicated to Inspector #549 that she documents on the Restraint and Repositioning Record every application and removal of resident #006's lap belt restraint and repositioning of the resident.

Inspector #549 reviewed the Restraint and Repositioning Record for resident #006 for the month of December 2017 and a specific period in the month of January 2018. It was noted by the inspector that the Restraint and Repositioning Record does not included the documentation of the hourly monitoring. The Program Manager of Personal Care (PMOPC) and RN #108 indicated that there is a specific form for hourly monitoring of residents who have restraints. PMOPC, RN#108 and the inspector reviewed resident #006's health care record and were unable to locate any documentation supporting the hourly monitoring of resident #006.

RPN #109, RN#108 and the inspector reviewed the Restraint and Repositioning Record for December 2017 and a specific period in the month of January 2018. The Restraint and Repositioning Record for December 2017 had no documentation for eight specific dates in December 2017 between 0700 and 1400 hours. On a different date in December 2017 there was no documentation indicating that the lap belt restraint was removed after the noon hour application. There is no documentation on five specific dates in January 2018 between 0700 and 1400 hours related to monitoring, application, removal or repositioning of the lap belt restraint.

During an interview with RPN#109 and RN#108 on January 11, 2018 it was indicated to Inspector #549 that resident #006 would have been in the wheelchair for breakfast and for lunch on those specified days. RPN #109 and RN #108 indicated that the resident is always up for breakfast and then goes back to bed after breakfast, is up for lunch then back to bed after lunch. RPN #109 also indicated that the resident had not been ill or out of the home during the specified days.

RN #108 and RPN #109 indicated to the inspector that the every application and removal of the lap belt restraint for resident #006 was not documented and every repositioning of resident #006 was not documented.

As such the licensee has failed to ensure that every application, removal, repositioning and monitoring of resident #006 lap belt restraint is documented. [s. 110. (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 every use of a physical device to restrain a resident under section 31 has the following documented : the person who applied the device and the time of application; all assessment, reassessment and monitoring, including the resident's response; every release of the device and all repositioning; and the removal or discontinuance of the device., to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that a care conference of the interdisciplinary team providing resident #021's care was held at least annually to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any.

During an interview on January 9, 2018, resident #021, who is capable of making his/her own care decisions indicated to Inspector #655 that he/she is not involved in decisions pertaining to his/her care. During the same interview, resident #021 indicated to Inspector

#655 that he/she had not participated in an annual care conference.

Inspector #655 reviewed the health care record belonging to resident #021. According to the health care record, resident #021 had a cognitive performance scale of one, indicative of a borderline intact level of cognition. On review of the health care record, Inspector #655 was unable to locate any documentation related to a care conference for resident #021.

During an interview on January 11, 2018, PSW #121 indicated to inspector #655 that resident #021 is involved in daily care decisions, and capable of communicating any concerns or preferences regarding daily care. PSW #121 was unable to speak to the resident's involvement in annual care conferences.

During an interview on January 12, 2018, RN #120 indicated to Inspector #655 that all residents are expected to receive a verbal invitation to attend a care conference of the interdisciplinary team providing the resident's care, and that the care conferences are expected to take place on an annual basis. At the same time, RN #120 was unable to locate any documentation to demonstrate that resident #021 participated in an annual care conference in 2017; or that a care conference had been held for resident #021 in the year 2017. RN #120 indicated to Inspector #655 that based on a review of the health care record, the last care conference for resident #021 was held in August, 2016.

During an interview on January 17, 2018, the Program Manager of Resident Care indicated to Inspector #655 that there had been no care conference for resident #021 in 2017; and confirmed that the last care conference for resident #021 took place in August, 2016.

The licensee failed to ensure that a care conference of the interdisciplinary team providing resident #021's care was held at least annually to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any. [s. 27. (1) (a)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that restraint by a physical device was included in the plan of care for resident #023.

On January 9, 2018, resident #023 was observed by Inspector #655 to be seated in a wheelchair with a front closure lap belt in place.

Inspector #655 reviewed the health care record belonging to resident #023. On review of resident #023's health care record, Inspector #655 was unable to locate any documentation related to the use of a lap belt for resident #023. There was no documentation that would indicate that the use of the lap belt had been ordered, and no record of related monitoring or assessments' related to the use of a lap belt. There was no indication on review of the resident's health care record that the lap belt was included in resident #023's plan of care.

During an interview on January 10, 2018, the spouse of resident #023 indicated to Inspector #655 that resident #023 wears a front closure lap belt for safety reasons. The spouse of resident #023 indicated to Inspector #655 that when he/she is not in the home, a front closure lap belt is applied for resident #023 because staff are unable to provide constant supervision. At the same time, the spouse of resident #023 indicated to Inspector #655 that the resident is not cognitively able to release the lap belt; and further indicated that a cloth is normally placed over the lap belt buckle to prevent the resident from releasing the lap belt.

During an interview on January 11, 2018, PSW #123 indicated to Inspector #655 that resident #023 wears a front closure lap belt to prevent the resident from attempting to get up from, or slide out of, the chair. According to PSW #123, the front closure lap belt is applied to resident #023 by PSW staff after morning care is provided. PSW #123 further indicated to Inspector #655 that the lap belt is primarily used when the resident's spouse is not at the home. During the interview, PSW #123 indicated to Inspector #655 that resident #023 is cognitively unable to unbuckle the lap belt.

During an interview on the same day, RN #120 indicated to Inspector #655 that resident #023 is not expected to be wearing a front closure lap belt. At the same time RN #120 described the use of a front-closure lap belt for resident #023 as a restraint; and indicated that the restraint of resident #023 by a front-closure lap belt was not part of the resident's plan of care. RN #120 indicated to Inspector #655 that there is no need for resident #023 to be restrained.

During an interview on January 17, 2018, the Program Manager of Personal Care indicated to Inspector #655 that resident #023 is not to be wearing a front-closure lap belt as it is not part of the resident's plan of care, noting that there was no order for its use. According to the Program Manager of Personal Care, staff are not to apply the lap belt; and are expected to remove the lap belt if it is observed to be in place. The Program Manager of Personal Care indicated to Inspector #655 that a family member of resident #023 applies the lap belt at times.

Over the course of the inspection, Inspector #655 observed resident #023 to be wearing a front-closure lap belt on three dates and times, in addition to the above-noted observation, at which time the spouse of resident #023 had not yet been to the home.

The licensee failed to ensure that the physical restraint of resident #023 by a front closure lap belt was included in the plan of care for resident #023. [s. 31. (1)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug was administered to resident #048 unless the drug was prescribed for the resident.

In a progress note dated November 7, 2017, it was indicated that on that day, resident #048 had been given a medication in error. According to the progress note, the night RN had administered a specific amount o f a controlled substance to resident #048 instead of the prescribed controlled substance and amount. The same incident was described in the licensee's internal medication incident report. According to the medication incident report, resident #048 was known to be allergic to the controlled substance at the time of the incident.

Inspector #655 reviewed the physician's orders and the resident's Medication Administration Record (MAR). According to the orders in place at the time of the incident, resident #048 was to receive a specific amount of a specific controlled substance, orally, every four hours when needed (prn). There were no orders for the controlled substance that was given to the resident. On the MAR, it was indicated that resident #048 was allergic to the controlled substance that she was administered.

During an interview on January 17, 2018, RN #108 and RPN #109 indicated to Inspector #655 that in January, 2017, resident #048 had been identified as having an allergy to the specific controlled substance when the resident exhibited symptoms such as pruritis; and as such the use of this specific controlled substance for this resident had been discontinued. RN #108 indicated to Inspector #655 that on November 7, 2017, resident #048 was given the wrong controlled substance instead of the controlled substance that was ordered for the resident.

During an interview on January 17, 2018, the Program Manager of Resident Care indicated to Inspector #655 that on a specific date in November 2017, a medication was administered to resident #048 that was not prescribed for the resident.

The licensee has failed to ensure that no drug was administered to resident #048 unless the drug was prescribed for the resident. [s. 131. (1)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction is reported to the Medical Director.

A Critical Incident Report (CIR) was submitted to the Director under the Long-Term Care Homes Act, 2007, on a specific date in October 2017. The CIR was related to a missing or unaccounted for controlled substance. The incident occurred on a specific date in October 2017, and involved resident #043.

Over the course of the inspection, Inspector #655 was provided with a copy of an internal incident report. According to the internal incident report, resident #043's transdermal patch was found to be missing from his/her body on a specific date in October 2017, at 2230 hours. According to the internal medication incident report, the resident had a history of removing the transdermal patch once applied. In the internal medication incident report it is further indicated that the on-call physician was notified at the time of

the incident; and the resident's attending physician was notified on a specific date in October 2017. Following the incident, the resident was to be monitored for pain. There was no indication in the medication incident report that the home's Medical Director had been notified of the incident.

Inspector #655 reviewed the health care record belonging to resident #043 and was unable to locate any documentation to demonstrate that the home's Medical Director had been notified of this incident.

Over the course of the inspection, Inspector #655 reviewed the processes in place related to medication incidents and adverse drug reactions that occur in the home with the Program Manager of Personal Care (PMOPC) and the Program Manager of Resident Care (PMORC). According to the PMORC , the home's Medical Director is notified of all medication incidents and/or adverse drug reactions that occur in the home as part of the quarterly review process, during Professional Practice Meetings.

During an interview on January 17, 2018, the PMORC indicated to Inspector #655 that the quarterly review of all medication incidents or adverse drug reactions that had occurred in the home since the time of the last review was intended to be undertaken, but was not undertaken, on December 15, 2017. According to the PMORC, the Medical Director was not made aware of the above-described medication incident involving resident #043. The PMORC indicated to Inspector #655 that unless the Medical Director was also the resident's attending physician, the Medical Director would not have been made aware of medication incidents involving a resident if they occurred in the home since the time of the last review.

The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the Medical Director. [s. 135. (1)]

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

Over the course of the inspection, the quarterly review process for all medication incidents and adverse drug reactions was reviewed with the PMORC and PMOPC.

According to both Managers, each medication incident is tracked by the PMORC using a

document titled "Carleton Lodge – Medication Incidents" (tracking document). This tracking document is utilized at Professional Practice Meetings which take place on a quarterly basis with all four of the licensee's homes; and once annually within each individual home. At the meetings, the document is used for the purpose of reviewing all medication incidents on a quarterly basis. The last Professional Practice Meeting took place on December 15, 2017; and before that, the previous most recent Professional Practice Meeting took place on September 18, 2017.

Inspector #655 reviewed the Professional Practice Meeting Minutes, dated December 15, 2017, and found no documentation that would indicate that there had been a quarterly review of all medication incidents that occurred in the home since the time of the last review (September, 2017). The medication incident tracking sheet was not included with the meeting minutes.

During an interview on January 16, 2018, the PMOPC indicated to Inspector #655 that he attended the Professional Practice Meeting on December 15, 2017. The PMOPC indicated to Inspector #655 that the PMORC was not available to attend the December 15, 2017, meeting; and therefore, the above-noted tracking document was not available and could not be utilized to complete the quarterly review process at the time.

According to the medication incident tracking document, at the time of the December 15, 2017, Professional Practice Meeting, 23 medication incidents had occurred in the home since the time of the last review.

During an interview on the same day, the PMORC indicated to Inspector #655 that all medication incidents and/or adverse drug reactions (23) occurring since September 18, 2017, were expected to be reviewed during the Professional Practice Meeting on December 15, 2017. According to the PMORC this review was not undertaken because she was not available to attend the meeting. The PMORC indicated to Inspector #655 that there was no quarterly review undertaken of the 23 medication incidents or adverse drug reactions occurring in the home between September 18 and December 15, 2017.

The licensee has failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions. [s. 135. (3)]

Issued on this 9th day of February, 2018

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

Original report signed by the inspector.