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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 21, 2015	2015_334565_0015	T-1647-15	Resident Quality Inspection

Licensee/Titulaire de permis

SPECIALTY CARE INC
400 Applewood Crescent Suite 110 VAUGHAN ON L4K 0C3

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

CEDARVALE LODGE
121 Morton Avenue Keswick ON L4P 2M5

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

MATTHEW CHIU (565), BARBARA PARISOTTO (558), MONICA NOURI (193)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 3, 6, 7, 8, 9, 10, 13, 14, and 15, 2015.

The following Critical Incident Intakes were inspected concurrently with this Resident Quality Inspection: T-2158-15, T-2293-15 and T-2385-15.

During the course of the inspection, the inspector(s) spoke with the General Manager (GM), interim Director of Care (DOC), Director of Resident Programs and Admissions (DORPA), Environmental Manager (EM), Director of Wellness (DOW), Recreation Therapist (RT), Director of Dietary Services (DDS), Dietary Aide (DA), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSWs), Laundry Aides, housekeeper, residents, substitute decision maker (SDM) and family members.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

14 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 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

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 has failed to ensure that every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

Record review of the critical incident report, progress notes and the home’s investigation, and staff interviews revealed the following:
A) Interview with staff #110 revealed that on an identified date, resident #41 exhibited a responsive behaviour during care. Staff #113 used a derogatory name when referring to the resident in his/her presence.
B) Interview with staff #111 revealed that on an identified date, he/she witnessed staff #113 engaged in a verbal confrontation with resident #13. Following the confrontation, staff #111 described the resident as upset and irritated, and the resident said staff #113 was rude.
Interview with staff #113 revealed no insight into his/her behaviour.

Interview with the GM confirmed resident #41 and #13 were not treated with courtesy and respect by staff #113. [s. 3. (1) 1.]

2. The licensee has failed to ensure that every resident's right to 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 is respected.

The inspector observed the medication administration on an identified date and time. During this time, the computer screens with residents' personal health information were observed open and accessible multiple times while the nursing staff was administering medication in an identified resident home area. The information was visible to any passer by.
Interview with staff #100 and #115 indicated the computer screens should not be open and confirmed awareness of the home's policy to lock the screens when not in attendance. Interview with the DOC confirmed the home’s expectation to have the screen locked when nursing staff is not in the immediate vicinity. [s. 3. (1) 11.]

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's right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity is fully respected and promoted, to be implemented voluntarily.

WN #2: 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 has failed to ensure that any person who has reasonable grounds to suspect that abuse of a resident by anyone occurred, it is immediately reported to the Director.

Record review and staff interviews revealed that on an identified date, an alleged verbal abuse incident involving staff #113 and resident #13 occurred. The incident was reported to the Director when the initial critical incident report was completed and submitted two days after the incident. During the home's investigation commenced on the day following the incident, the GM became aware of two other previously occurred alleged verbal abuse incidents on another identified date between staff #113 and resident #40 and #41 respectively. These incidents were reported to the Director in the amendment of the critical incident report submitted three days after the initial report.

An interview with the GM confirmed the home's expectation to report immediately to the Director any suspicion of abuse of a resident by anyone that resulted in harm or risk of harm and that the above mentioned alleged abuse incidents were not reported immediately as required. [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 any person who has reasonable grounds to suspect abuse of a resident by anyone immediately reports it to the Director, to be implemented voluntarily.

WN #3: 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 has failed 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 require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

The home uses a PointClickCare assessment instrument that is specifically designed for assessment of incontinence. A review of resident #9's Minimum Data Set (MDS) assessments revealed the resident's continence had changed from continent to occasionally incontinent in 2013, and from occasionally incontinent to frequently incontinent in 2014. Record review of the resident's clinical assessment record indicated the resident did not receive an assessment of incontinence.

Interviews with PSW #104 and #120, and registered staff #105 and #115 confirmed the resident had incontinence. The registered staff members confirmed the resident did not receive an assessment of incontinence that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions. [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 require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that direct care staff were provided training in skin and wound care in 2014.

Staff #115 and #118 stated in an interview they did not remember receiving skin and wound care training in 2014. Review of staff training records for 2014 and interview with the GM confirmed that 62% of staff who provided direct care to residents did not receive training in skin and wound care in 2014 as required. [s. 221. (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 direct care staff are provided training in skin and wound care annually, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee has 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 resident #2's plan of care revealed the resident is to be offered a specified program by recreation staff once per week. Review of resident #2's multi-day participation report for two identified months in 2015 did not identify the specified program. Throughout the inspection, the specified program was not observed by the inspector.

Interviews with staff #106 and #124 confirmed the specified program was not offered weekly as set out in the plan of care. [s. 6. (7)]

2. The licensee has failed to ensure that staff who provide direct care to a resident are kept aware of the contents of the plan of care.

Review of resident #6's current plan of care indicated a specific intervention for oral care. The plan of care indicates the resident has own teeth.
Interview with staff #104, #119 and #112 revealed they were not aware the resident has his/her own teeth and the specific intervention for oral care. All interviewed staff stated the resident's plan of care is easily available on Point Of Care screens along the hallway and in paper form on the inside door of the resident's closet.
They confirmed a lack of awareness of the resident's plan of care related to oral care.

Interviews with staff #105 and the DOC confirmed the expectation for direct care staff to be aware of the residents' plan of care on their assignments. [s. 6. (8)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to secure outside areas that preclude exit by a resident, are equipped with locks to restrict unsupervised access to those areas by residents.

On an identified date, the inspector observed and staff interview with the EM confirmed a door in the dining room and another door in the TV room, leading to two separate secure outside patios, were unequipped with locks to restrict unsupervised access to those areas by residents.
Interview with EM indicated that the licensee was aware of the issue and was in process of arranging contractors for installing the locks to the above mentioned doors.
Meanwhile, the doors are connected to an alarm system to alert staff when they are open. [s. 9. (1) 1.1.]

WN #7: 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. (3) Every licensee shall ensure that the policy to promote zero tolerance of abuse and neglect of residents is communicated to all staff, residents and residents' substitute decision-makers. 2007, c. 8, s. 20 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents is communicated to all residents and SDMs.

Interview with the GM revealed the home's policy to promote zero tolerance of abuse and neglect is communicated to residents and SDMs in the admission package provided on admission and posted in the home.
Review of the admission package and inspector's observations indicated the home's policy was not part of the admission package and was not posted in the home as previously indicated.

Interviews with the DOC and GM confirmed the home's Zero Tolerance of Abuse/Neglect policy was not communicated to residents and SDMs. [s. 20. (3)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #6 receives oral care to maintain the integrity of the oral tissue, including mouth care in the evening.

Review of the resident's current plan of care indicated the resident has own teeth and needs a specific intervention for oral care.
Interview with resident #6 indicated staff sometimes provide the specific intervention for oral care to him/her in the evenings, but not everyday. Interview with evening staff #119 indicated he/she never provides the specific intervention for oral care in the evening as he/she was not aware the resident had his/her own teeth. [s. 34. (1) (a)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the resident is provided with personal assistance required to safely eat and drink as comfortably and independently as possible.

A review of resident #2's plan of care revealed the resident is to be provided a specified nutritional supplement at the identified times everyday. The care plan stated to use a straw along with specified utensils and assistance when offering fluids to the resident. An interview with a family member and PSW #104 revealed the resident can drink beverages when a straw, specified utensils are used and assistance is provided. The inspector observed this practice during a lunch observation.
On an identified date and time, the inspector observed a full glass of supplement labeled for morning snack on the resident's bed side table without a straw in place.
At an identified time in the afternoon, the inspector observed the glass of supplement had been removed from the bed side. A family interview revealed the resident was provided the afternoon supplement and a staff member removed the entire morning supplement from the resident's room.

An interview with PSW #101 confirmed he/she did not provide the resident with a straw and the specified assistance as required to safely drink the morning supplement. [s. 73. (1) 9.]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff who provide direct care to residents, as a condition of continuing to have contact with residents, receive training in behaviour management in 2014.

Staff #103 stated in an interview he/she did not receive behaviour management training. Review of staff training records for 2014 and interview with GM confirmed that 47% of staff who provide direct care to residents did not receive training in behaviour management in 2014 as required. [s. 76. (7) 3.]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee has failed to ensure that the long-term care home's policy to promote zero tolerance of abuse and neglect of residents is posted in the home.

Observations and interview with the GM confirmed the home's Zero Tolerance of Abuse/Neglect policy was not posted in the home. [s. 79. (3) (c)]

2. The licensee has failed to ensure that the copies of the inspection reports for the past two years for the long-term care home are posted in the home.

Review of the posted inspection reports failed to locate inspection report 2013_168202_0046 dated September 19, 2013.

Interview with the GM confirmed this inspection report was not posted in the home. [s. 79. (3) (k)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's SDM and any other person specified by the resident were notified within 12 hours upon becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of the resident.

Record review and staff interview revealed on an identified date, staff #113 was involved in an alleged incident of verbal abuse involving resident #13. Interview with the GM revealed he/she was made aware of the incident on the next day. During the home's internal investigation of this incident, the GM became aware of two other alleged incidents of verbal abuse involving staff member #113 and residents #40 and #41 respectively which had previously occurred on another identified date.
The critical incident report involving resident #13 indicated the family had not been notified. The critical incident report was submitted two days after the incident. The amended critical incident report, submitted five days after the incident indicated all families had been notified of the three above mentioned incidents.

Interviews with DOW and the identified family members could not confirm all families had been notified of the incidents within 12 hours. [s. 97. (1) (b)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 126. Every licensee of a long-term care home shall ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. O. Reg. 79/10, s. 126.

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs remain in the original labeled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident.

On an identified date, the inspector observed the morning medication administration. At an identified time, an unlabeled paper cup with unidentifiable crushed drugs was observed in the first drawer of the medication cart. Interview with staff #100 indicated the crushed drugs were for an identified resident but he/she was called to attend to another resident and left them in the first drawer to be administered later. Staff #100 further administered the drugs to the resident.
The DOC stated the home's expectation is for registered staff to keep the drugs in the original package until administered to the resident. [s. 126.]

WN #14: 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).

s. 131. (4) A member of the registered nursing staff may permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical, if,
(a) the staff member has been trained by a member of the registered nursing staff in the administration of topicals; O. Reg. 79/10, s. 131 (4).
(b) the member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and O. Reg. 79/10, s. 131 (4).
(c) the staff member who administers the topical does so under the supervision of the member of the registered nursing staff. O. Reg. 79/10, s. 131 (4).

Findings/Faits saillants :

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

A review of resident #1’s MDS assessment completed on an identified date revealed the resident had a specified medical condition in the previous quarter. A review of the physician’s order on another identified date revealed an order for an identified drug to be administered once daily for seven days to treat the medical condition. A review of the medication administration record (MAR) revealed the prescribed drug was administered to the resident for 14 days.

Interview with staff #105 confirmed the drug have been administered to the resident seven days longer than it was prescribed. [s. 131. (2)]

2. The licensee has failed to ensure that the home's PSWs who administer the topicals in the home have been trained by a member of the registered nursing staff in the administration of topicals, the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and the staff member who administers the topical does so under the supervision of the member of the registered nursing staff.

Observations during the inspection and interviews with direct care staff, registered staff and DOC confirmed that PSWs administer the topicals in the home. They also confirmed that the home's PSWs have not been trained by a member of the registered nursing staff in the administration of topicals and the staff members who administer the topicals do not administer them under the supervision of a member of the registered nursing staff. [s. 131. (4)]

Issued on this 21st day of October, 2015

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

Original report signed by the inspector.