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 prévue le Loi de 2007 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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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Aug 17, 2018;	2018_737640_0011 (A1) (Appeal\Dir#: DR# 094)	032992-16, 035115-16, 006404-17, 007557-17, 011971-17, 003311-18, 006198-18	Critical Incident System

Licensee/Titulaire de permis

Collingwood Nursing Home Limited
250 Campbell Street COLLINGWOOD ON L9Y 4J9

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

Collingwood Nursing Home
250 Campbell Street COLLINGWOOD ON L9Y 4J9

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

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Amended by Wendy Lewis (Director) - (A1)(Appeal\Dir#: DR# 094)

Amended Inspection Summary/Résumé de l'inspection modifié

NOTE: This report has been revised to reflect a decision of the Director on a review of the Inspector's order(s): CO#003,CO#004.
The Director's review was completed on August 17, 2018.
Order(s) CO#004 was/were rescinded to reflect the Director's review DR# 094
Order(s) CO#003 was/were rescinded and substituted with a Director Order to reflect the Director's review DR# 094.
A copy of the Director Order is attached.

Issued on this 17 day of August 2018 (A1)(Appeal\Dir#: DR# 094)

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

Original report signed by the inspector.

Ontario

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

Amended by Wendy Lewis (Director) - (A1)(Appeal/Dir# DR# 094)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): April 19, 20, 24, 25, 26, 30, May 1 and 2, 2018

This inspection was conducted in conjunction with a Complaint inspection #2018_737640_0010

Critical Incidents inspected as follows:

CI Intake #006404-17 related to allegation of staff to resident verbal abuse

CI Intake #006198-18 related to misappropriation of controlled substances

CI Intake #032992-16 related to fall with injury

CI Intake #035115-16 related to fall with injury

CI Intake #003311-18 related to alleged staff to resident emotional abuse

CI Intake #011971-17 related to medication error

CI Intake #007557-17 related to fall with injury

During the course of the inspection the Inspector toured the home, observed the provision of care, interviewed residents, families, staff, reviewed clinical records

and reviewed policy and procedures.

During the course of the inspection, the inspector(s) spoke with residents, family members, PSWs, registered practical nurses, registered nurses, Skin and Wound Lead, Falls Prevention Lead, Prevention of Abuse Lead, Continence Lead, Assistant Director of Care, Director of Care and the Administrator.

The following Inspection Protocols were used during this inspection:

Critical Incident Response

Falls Prevention

Medication

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Skin and Wound Care

Sufficient Staffing

During the course of the original inspection, Non-Compliances were issued.
- **13 WN(s)**
- **7 VPC(s)**
- **4 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. 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 :

A) Where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system was (b) complied with.

In accordance with Regulation, s.48, which required the licensee to ensure that the interdisciplinary programs including fall prevention programs were developed and implemented in the home and each program must meet the requirements set out in section 30, where there must be a written description of the program that included its goals and objectives and relevant policies, procedures and protocols. O. Reg. 79/10, s.48

1) In October 2016 and January 2017, resident #003 had been assessed to be at high risk for falls.

On a specified date in December 2016 the resident fell onto the floor and sustained an injury which required a higher level of care.

The Long-Term Care Homes (LTCH) Inspector reviewed the clinical record to include the written plan of care related to falls prevention and noted resident #003's plan of care did not include the specific interventions as described in the home's policy.

The home's policy "Falls Prevention Program", policy #4.1.12 with a revised date of July 2015, directed that when a resident was at high risk for falls, the plan of care was to include specific interventions based on the assessed needs of the resident.

During interviews with the LTCH Inspector, RPN #106 and RN #101 both stated it was expected that a resident identified at high risk for falls, have the specific interventions implemented The RN #101 indicated that when updating the plan of care with the new risk level, the appropriate interventions included in the policy were to be implemented.

The plan of care did not include the specific interventions related to the level of fall risk as recommended in the home's "Falls Prevention Program" policy.

During an interview with RN #101, they acknowledged staff had not followed policy when they did not include in the plan of care, the interventions to prevent falls as

per the home's policy.

2) Following a fall, the "Falls Prevention Program" policy directed staff to complete a post falls assessment for 72 hours after the fall to identify and changes in condition.

Resident #003 fell on a specified date in December 2016.

The LTCH Inspector and the Assistant Director of Care (ADOC) reviewed the resident's clinical record and discovered that the post fall assessments had not been completed as per the home's policy "Falls Prevention Program" on several dates in December 2016.

During an interview with the ADOC, the Falls Program Lead for the home, they acknowledged that staff had not followed the home's policy related to post fall assessments.

3) On a specified date in April 2017, resident #006 fell from their bed and sustained an injury which required a higher level of care.

The home's policy "Falls Prevention Program", policy #4.1.12 with a revised date of July 2015, directed staff to complete a detailed Falls Incident Analysis and Risk Management Report.

The Assistant Director of Care (ADOC), the home's Falls Prevention Lead, identified the clinically appropriate assessment instrument for post fall assessment was the Falls Incident Analysis form.

The ADOC informed the Long-Term Care Homes (LTCH) Inspector it was expected that when a resident had fallen that staff complete their assessment using the home's Fall Incident Analysis form and following the fall, the assessments were to be completed for a full 72 hours following the incident.

The policy also directed staff to complete a post fall assessment for 72 hours to identify any changes in the resident's condition.

The LTCH Inspector reviewed resident #006's clinical record and found there was no Fall Incident Analysis form or Risk Management form completed for this fall.

There were two shifts during the required 72 hour post fall assessment period where staff did not complete a post fall assessment.

The home's policy "Emergency Care", policy #18.0 with a revised date of October 2016, directed staff to complete other specific assessments.

The LTCH Inspector reviewed the clinical record for resident #006 and identified that the resident's other specific assessments had not followed the homes policy. Staff failed to assess the resident for the last 24 hours of part "d", the full 72 hours post incident.

During an interview with the Assistant Director of Care (ADOC), they acknowledged that staff had not followed policy in completing all required assessments.

B) Where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system was (b) complied with.

In accordance with Regulation, s.114, the licensee was required to ensure that written policies and protocols were developed for the medication management program to ensure the accurate acquisition, dispensing, receipt, storage, administration and destruction and disposal of all drugs used in the home. O. Reg. 79/10, s.114 (2).

1. The home's policy "Destruction and Disposal of Surplus Drugs", policy #3-009, with no date of revision, directed staff when any substance to be destroyed was to be entered on the Narcotic and Controlled Drugs For Destruction Form at the time of setting aside for destruction.

On a specified date in March 2018, the Director of Care (DOC) emptied the drug destruction bin to allow for the installation of a new lock. Found in the bin was a plastic container housing two different controlled substances. The Narcotic and Controlled Drugs For Destruction Form was reviewed from the time of the last drug destruction completed just prior and the two controlled substances had not been logged on the form.

During an interview with RPN #103, the RPN who had placed the controlled

substance in the bin, they confirmed they had not documented the controlled substance on the form as required by policy.

The DOC acknowledged staff had not followed the home's policy and failed to document the medication placed in the drug destruction bin as required.

2. The home's policy "Disposal of Used Controlled Drug Patches", policy #3-010, with no date of revision, directed staff to place a removed controlled medication in patch form onto a Controlled Drug Patch Disposal Tool.

On a specified date in February 2018, the DOC and the Pharmacist performed drug destruction. During the review of the contents of the drug destruction bin, they found seven papers with controlled substance patches attached.

The DOC informed the Long-Term Care Homes (LTCH) Inspector the patches were on various pieces of paper, some were on the forms and many were on partial pieces of scrap paper.

During an interview with the DOC, they informed the LTCH Inspector that in the home's safe were controlled substances that had been temporarily removed from the drug destruction bin. One of the medications was the used controlled substance patch which had been attached to a half sheet of scrap paper and not on the required form as per the home's policy.

The DOC acknowledged that staff had not complied with the home's policy regarding the use of the correct form for used narcotic patches.

3. The home's policy "Disposal of Used Controlled Drug Patches", policy #3-010 with no date of revision, directed staff that all Controlled Drug Patch Disposal Tools with patches attached should be stored with controlled medications awaiting destruction and entered on the Narcotics and Controlled Drugs Surplus Form.

On a specified date in February 2018 the DOC and the Pharmacist performed drug destruction. During the review of the contents of the drug destruction bin, they found seven papers with used controlled substance patches attached.

During an interview with the DOC, they informed the LTCH Inspector that during the process of drug destruction, all patches as noted above were not documented on the Narcotics and Controlled Drugs Surplus Form as required by the home's

policy.

The DOC acknowledged that staff had not complied with the home's policy regarding narcotic patch form completion.

4. The home's policy "Destruction and Disposal of Surplus Drugs", policy #3-009, with no date of revision, directed that a "drop-box" may be used for storage of controlled drugs for destruction and the drop-box must be;

i) Locked
ii) Secured to a wall or floor
iii) In a locked room, and
iv) the key to be kept by the DOC (or ADOC) and by Pharmacy only.

During the inspection regarding missing narcotics, the LTCH Inspector was informed by the Administrator, the DOC and the ADOC that the key for the locked drop-box for the storage of controlled drugs for destruction was kept in the Administrator's office in the safe kept on the Administrator's desk. The Administrator, the DOC and the ADOC had the combination to open that safe and had access to the key to the drop-box.

During an review of the policy with the DOC, they acknowledged the home had not complied with the policy regarding the key to the drug destruction box.

5. The home's policy "Medication Incident/Near Incident Program", policy #6-001 with no date of revision, directed staff to record the incident in the resident's electronic medical record and to include all details;

(a) Name and status of person discovering the incident
(b) The name of the drug involved
(c) Any adverse reactions and
(d) Notification of appropriate personnel

During a review of the clinical record of residents #001 and #004 by the LTCH Inspector, there were no progress notes regarding the medication incidents as described on the Medication Incident Report.

The information was reviewed with the DOC who acknowledged that staff had not complied with the home's policy regarding the documentation of medication

incidents.

6. The home's policy "Medication Incident/Near Incident Program", policy #6-001 with no date of revision, directed staff to report all medication errors to the resident/SDM, pharmacy, Medical Director, prescriber and the Director of Care immediately.

During an interview of RPN #103 regarding a controlled substance found in resident #001's bed on a specified date in February 2018, they informed the LTCH Inspector they had not notified the resident's physician regarding the omitted medication.

The RPN acknowledged they had not followed the home's policy and should have notified the resident's physician. [s. 8. (1) (b)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that a resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument was specifically designed for skin and wound assessment.

On a specified date in April 2017, resident #006 fell from their bed and sustained an injury which required a higher level of care.

The home's policy "Wound and Skin Care Program", policy #4.16.1 with a revised date of October 2013, directed staff to complete an initial assessment and weekly there after using the "Weekly Wound Assessment" tool in PCC. The policy was directed specifically at pressure ulcer management however, the Assistant Director of Care informed the Long-Term Care Homes (LTCH) Inspector that all wounds, including lacerations and bruising were to be initially assessed and assessed and documented weekly thereafter.

The Long-Term Care Homes (LTCH) Inspector reviewed the clinical record which contained a "Weekly Wound Assessment – Bates Jensen" form with a specified date in April 2017 at a specific time. On the form were a list of seven separate

areas of altered skin integrity including the injury sustained as a result of a fall.

At the bottom of the list of areas of altered skin integrity was a description of one of the areas. There were no other descriptions of the other six areas on this form or any other form or component of the clinical record.

During an interview with RN #101, the Skin and Wound Lead for the home, they informed the LTCH Inspector they only documented and assessed the worst of all the areas of altered skin integrity. That was their practice for all residents with multiple areas. There was no progress note or other assessment form done for the other areas of altered skin integrity.

During an interview with the Director Of Care and Clinical Consultant they acknowledged the injury was not assessed initially, not assessed in the week and that all areas of altered skin integrity were to be assessed individually and completely using the home's clinically appropriate assessment tool specifically designed for the assessment of altered skin integrity, not just the worst.[s. 50. (2) (b) (i)]

2. The licensee failed to ensure that a resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was reassessed at least weekly by a member of the registered nursing staff.

On a specified date in April 2017, resident #006 fell from their bed and sustained an injury that required a higher level of care.

The home's policy "Wound and Skin Care Program", policy #4.16.1 with a revised date of October 2013, directed staff to complete an initial assessment and weekly there after using the "Weekly Wound Assessment" tool in PCC. The policy was directed specifically at pressure ulcer management however, the Assistant Director of Care informed the Long-Term Care Homes (LTCH) Inspector that all wounds, including lacerations and bruising were to be assessed and documented weekly thereafter.

The Long-Term Care Homes (LTCH) Inspector reviewed the clinical record which contained a "Weekly Wound Assessment – Bates Jensen" form with a specified date in April 2017. On the form were a list of seven separate areas of altered skin integrity including the altered skin integrity sustained as a result of the fall.

At the bottom of the list of altered skin integrity was a description of one specific area of altered skin integrity. There were no other descriptions of the other six areas of altered skin integrity on this form or any other form or component of the clinical record.

A second "Weekly Wound Assessment – Bates Jensen" was completed ten days following the injury from the fall. The contents of the form were identical to the one completed 10 days prior, as above.

During an interview with RN #101, they confirmed for resident #006, there were no weekly wound assessments as required.

During an interview with the Director Of Care(DOC) and Clinical Consultant they acknowledged the altered skin integrity was not assessed in a week and that all areas of altered skin integrity were to be assessed weekly using the home's weekly assessment form. It was expected that all individual areas of altered skin integrity be assessed and documented on a weekly basis. [s. 50. (2) (b) (iv)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee failed to ensure that all medication incidents were were documented, reviewed and analyzed.

During an inspection, the Long-Term Care Homes (LTCH) Inspector reviewed the medication management program.

The home's policy "Medication Errors", policy #8.7 with a revised date of October 2009, directed that the Director of Care (DOC) and the consultant Pharmacist were responsible for investigating any medication error, cause of the error and follow-up action for preventing further errors.

The policy included specific steps for a resident medication error that directed the DOC, in consultation with the Physician, Consultant Pharmacist and nursing staff would investigate all circumstances that resulted in the error and take the required remedial action.

1) During the inspection the LTCH Inspector reviewed a medication error report for the missing controlled substances. The form contained little information regarding the specific substances that were missing, what the immediate action was, the pharmacy follow up, severity/outcome was blank. There were to be four signatures on the bottom of the page as per the home's policy, one for pharmacy, the staff member, discovering the incident, the Medical Director and the DOC. The only signature was the DOC. The nurse who discovered the missing controlled substances was not named on the document nor had they signed the form.

2) On a specified date in January 2018, resident # 004 had been administered

resident #013's 0800 medication.

According to the clinical record and RN #101, resident #004 suffered no ill effects as a result.

As above, there were no notes of analysis, investigation or corrective action.

3) On a specified date in February 2018, controlled substance was found in a resident's bed. As above, there were no notes of analysis, investigation or corrective action.

During an interview with the DOC, they informed the LTCH Inspector they do not analyze or investigate the medication incidents. They had thought that their pharmacy service provider might but had no documentation that any analysis or investigation had occurred for the above three and any other medication incident.

The DOC acknowledged they do no analyze or investigate the medication incidents that occur in the home. [s. 135. (2)]

Additional Required Actions:

(A1)(Appeal/Dir# DR# 094)
The following order(s) have been rescinded:CO# 003

WN #4: 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. (6) For the purposes of this section a drug is considered to be destroyed when it is altered or denatured to such an extent that its consumption is rendered impossible or improbable. O. Reg. 79/10, s. 136 (6).

Findings/Faits saillants :

The licensee failed to ensure that when drug destruction occurs that the drug is altered or denatured to such an extent that its consumption was rendered impossible or improbable.

1. On a specified date in March 2018, RN #101 and the home's Pharmacist conducted drug destruction for several controlled substances.

According to the home's policy, "Narcotic and Controlled Drugs Destruction Form", the manner of destruction for oral medications was to be the addition of liquid to the medication pail to create a slurry.

The home's policy "Surplus and Discontinued Medication", policy #8.4 with a revised date of October 2009, directed staff to place all medications that become surplus to be removed from packaging, placed in the bucket and once the container was full, the nursing staff were to cover the medications with water and tightly close the lid.

During an interview with RN #101, they informed the Long-Term Care Homes (LTCH) Inspector that the discontinued controlled substances were placed in a sharps container which was sealed at the end of the process. The RN told the LTCH Inspector there was no liquid added to the sharps container after the discontinued controlled substances were placed in the container.

2. During review of the discontinued/refused routine medications with RPN #105, the RPN showed the LTCH Inspector the bucket that staff were to use. At the top of the bucket were multiple strip packs containing medications.

The LTCH Inspector reviewed the container with the ADOC who confirmed the medications were to be removed from the pouches and that the medications could otherwise not be rendered impossible or improbable to consume.

The ADOC acknowledged the medications could not be denatured.

3. During review of the discontinued/refused routine medications with RPNs #105 and #103, they told the LTCH Inspector when the bucket was full of discontinued medications, unless there was a bottle of liquid to discontinue and pour over the

pills, there was no fluid added to the bucket, the lid was locked on and the bucket would be picked up by their service provider.

The ADOC was interviewed regarding the process of adding the water and acknowledged that staff were not adding liquid to the bucket as required. [s. 136. (6)]

Additional Required Actions:

(A1)(Appeal/Dir# DR# 094)
The following order(s) have been rescinded:CO# 004

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care
Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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

Findings/Faits saillants :

1. The licensee failed to ensure that care set out in the plan of care was based on an assessment of the resident.

On a specified date in October 2016, resident #003 had a fall risk assessment and was assessed to be at high risk for falls.

The written plan of care at the time, identified the resident to be at low risk for falls and required the green leaf indicating low risk. The plan of care had not included any interventions related to the actual assessment of the resident being at high risk for falls.

During an interview with RN #101, they acknowledged the written plan of care did not accurately reflect the most recent falls risk assessment of high risk for falls when the plan of care was reviewed and therefore did not contain the appropriate interventions related to the assessment. [s. 6. (2)]

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

a) On a specified date in October 2016, resident #003 had a fall risk assessment and was assessed to be at high risk for falls.

The written plan of care in place at the time identified the resident to be at low risk for falls and required the green leaf indicating low risk.

On a specified date in December 2016, resident #003 fell which resulted in a significant injury. They required a higher level of care.

In January 2017 resident #003 had an assessment and was assessed to be at high risk for falls. The plan of care reflected the new fall risk level. There were no changes made to the interventions related to the focus of falls, fall risk and the significant injury. The intervention in place was the same as above.

The home's policy "Falls Prevention Program", policy #4.1.12 with a revised date of July 2015, directed staff to identify residents at risk for falls, initiate preventative approaches, complete a Falls Risk Assessment quarterly, and initiate a plan of care to implement strategies for all residents who were at high risk for falls, document and update the plan of care quarterly.

During an interview with RN #101, they acknowledged the resident had been assessed as high risk for falls and the written plan of care had not been revised based on the assessments. The RN acknowledged that based on the significant injury and a high fall risk, the written plan of care had not been reviewed and revised to reflect the resident's care needs to include appropriate interventions related to the significant injury and high risk for falls.

b) On a specified date in April 2017, resident #006 fell from their bed, resulting in injury that required a higher level of care.

The home's policy "Wound and Skin Care Program", policy #4.16.1 with a revised date of October 2013, under the heading "Wound Assessment and Prevention" directed staff to evaluate the resident and resident outcomes and update the plan of care.

The Long-Term Care Homes (LTCH) Inspector reviewed the clinical record of resident #006, specifically the written plan of care for March 2017, and the significant injury and management of care for the altered skin integrity was not included in the resident's plan of care.

During an interview with the Director of Care (DOC), they informed the LTCH Inspector it was an expectation of the home that all changes in resident care, needs and treatments were to be included in the plan of care.

The DOC acknowledged, the fall resulting in a significant injury was not included in the resident's plan of care. [s. 6. (10) (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 the licensee must ensure that care set out in the plan of care is based on an assessment of the resident [s. 6. (10) (b)], to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007, 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. Without in any way restricting the generality of the duty provided for in section 19, the licensee failed to ensure that there was in place a written policy to promote zero tolerance of abuse and neglect of residents and that the policy was complied with.

For the purposes of the definition of "verbal abuse" within the Long-Term Care Homes Act 2007, section 2.(1), verbal abuse means any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminished a resident's sense of well-being, dignity or self-worth, that was made by anyone other than a resident.

The home's policy "Abuse and Neglect Prevention", policy #4.1.2 with a revised date of June 2015, included the definition of verbal abuse. The policy included that staff had an obligation to report any incident of resident abuse and all staff were to uphold the right of others to live free from abuse and neglect.

According to information provided on the Critical Incident System (CIS) form and the home's investigative notes, in March 2017, PSW #111 was observed by PSW #112 to be rude and made derogatory remarks to resident #008.

PSW #112 failed to report the incident immediately to their supervisor and did not report until two days after the incident.

During an interview with the Director of Care (DOC), they informed the Long-Term Care Homes (LTCH) Inspector that upon completion of the investigation, the home determined PSW #111 to have imposed verbal abuse upon resident #008. The home took action.

The DOC acknowledged staff failed to follow the home's policy regarding resident abuse and the reporting of those allegations of abuse to the manager. [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 the licensee must ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents and that the policy is complied with, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe transferring and positioning devise or techniques when assisting residents.

On a specified date in April 2017, resident #006 fell off the bed and sustained an injury that required a higher level of care.

Resident #006 was assessed to require specific interventions to prevent a fall from the bed.

On a specified in April 2017, PSW #107 was providing care and had not used the specific intervention to prevent a fall.

During an interview with the Assistant Director of Care (ADOC), the Falls Prevention Lead for the home, they informed the Long-Term Care Homes (LTCH) Inspector it was expected that the specific interventions were to be implemented.

The ADOC acknowledged that staff had not provided specific interventions to prevent a fall for resident #006. [s. 36.]

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 the licensee must ensure that staff use safe transferring and positioning devises or techniques when assisting residents, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident fell, the resident was assessed using a clinically appropriate assessment instrument that was specifically designed for falls.

On a specified date in April 2017, resident #006 fell from their bed and sustained a significant injury that required higher level of care.

The home's policy "Falls Prevention Program", policy #4.1.12 with a revised date of July 2015, directed staff to complete a detailed Falls Incident Analysis and Risk Management Report. The Assistant Director of Care (ADOC), the home's Falls Prevention Lead, identified the clinically appropriate assessment instrument for post fall assessment was the Falls Incident Analysis form.

The ADOC informed the Long-Term Care Homes (LTCH) it was expected that when a resident had fallen that staff completed their assessment using the home's Fall Incident Analysis form.

The LTCH Inspector reviewed resident #006's clinical record and discovered there was no Fall Incident Analysis form completed or a Risk Management for this fall.

During an interview with the ADOC, they acknowledged that staff had not completed the clinically appropriate assessment of resident #006 following their fall. [s. 49. (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 the licensee must ensure that when a resident falls, the resident is assessed using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 116 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who was a member of the staff of the home, met annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

During the inspection the Long-Term Care Homes (LTCH) Inspector requested a copy of the annual evaluation of the Medication Management program for the home for the previous year of 2017. The DOC was not able to locate any documentation regarding an annual evaluation.

The DOC gave the LTCH Inspector a document but it was not identified as the annual evaluation and did not have a date. On the last page of the document were eight signatures. Included were the Administrator and the DOC and other staff. The signature of the pharmacy service provider was not included. The ADOC confirmed that none of the signatures were that of the registered dietitian.

During an interview with the DOC, they acknowledged the home did not complete an annual evaluation of the medication management program as required for the years 2016 and 2017 that were inspected. [s. 116. (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 the licensee must ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meet annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were stored in an area or a medication cart that was used exclusively for drugs and drug-related supplies.

During an inspection regarding the missing narcotics, it came to the attention of the Long-Term Care Homes (LTCH) Inspector that prior to the installation of a new lock on the drug destruction bin, there were items removed from that bin by the Director of Care (DOC) and the items were placed in the home's safe in the Administrator's office.

There were two different controlled substances that the DOC informed the LTCH Inspector they had placed in the home's safe on a specified date in March 2018. 28 days later, the two controlled substances remained in the safe in the Administrator's office.

The home's policy "Medication Storage", policy #4-002 with no date of revision, directed that all medications were to be kept locked in the medication cart or medicine cabinet or room, that was used exclusively for that purpose.

Held in the safe were the home's extra keys and other items that required safe keeping. The Administrator, DOC and the ADOC all had knowledge of the code to open the safe. The Administrator, DOC, ADOC and the Ward Clerk all had keys to access the administration area of the home. During an interview with the DOC, they informed the LTCH Inspector, the door separating the Administrator's office from the remaining administration area was not ever locked, although the door had the ability to be locked with a separate key.

The LTCH Inspector interviewed the Administrator who was aware the medications had been placed in the safe but had believed they would be removed and returned to the drug destruction bin within 24 hours of being placed there. The Administrator was not aware the controlled substances remained in the safe. They acknowledged the narcotic medications were to be appropriately stored in the drug destruction box in the medication room. [s. 129. (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 the licensee must ensure that drugs are stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies, to be implemented voluntarily.

WN #11: 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.

1) On a specified date in February 2018, RN #101 found a controlled substance in resident #001's bed.

Resident #001 was prescribed the controlled substance to be administered twice daily.

The Long-Term Care Homes (LTCH) Inspector reviewed the clinical record of resident #001 and found all required administration dates and times were documented and signed as administered for the month of February 2018.

The LTCH Inspector interviewed the Assistant Director of Care (ADOC) who informed that staff were to observe the resident consuming/ingesting the medications prior to documenting administration and signing the Medication Administration Record (MAR).

The ADOC acknowledged that staff had documented and signed that the controlled substance had been administered, as ordered by the prescriber, when the medication had been left in the resident's bed.

2) On a specified date in June 2017, resident #002 received an incorrect dose of a narcotic analgesic and required a higher level of assessment and observation.

The LTCH Inspector reviewed the clinical record and found the MAR had not been signed off for any narcotic analgesic for the date noted on Critical Incident Sysem (CIS) form.

During an interview with the DOC, they acknowledged the resident received a medication dosage that was not in accordance with the directions of the prescriber, and the MAR had not been signed as given. [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 the licensee must ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with LTCHA, 2007, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee failed to ensure the results of an investigation and every action taken in response to every such incident of alleged, suspected or witnessed incident of abuse of a resident by anyone was report to the Director.

On a specified date in February 2018, resident #003's family member reported to staff that resident #003 had made allegations of abuse by staff. As a result, the home submitted a Critical Incident System (CIS) form to the Director under the category of "Alleged Abuse/Neglect of a resident" regarding the comments and allegation.

The Long-Term Care Homes (LTCH) Inspector reviewed the incident with the Director of Care (DOC) and the Critical Incident (CI) Report had not been updated with the results of any investigation that occurred and every action taken as a result of the allegations.

The DOC acknowledged they had not submitted an amendment to the CI report as required. [s. 23. (2)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

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

1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).

2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,

i. a breakdown or failure of the security system,

ii. a breakdown of major equipment or a system in the home,

iii. a loss of essential services, or

iv. flooding.

O. Reg. 79/10, s. 107 (3).

3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).

4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed of a resident who had an incident that caused an injury for which the resident was taken to the hospital and that resulted in a significant change in the resident's health condition.

On a specified date in April 2017, resident #006 fell off their bed and sustained a significant injury that required a higher level of care.

Resident #006 required specific assessments and observation as a result of the injury, altered skin integrity care and other assessments for several days following the incident and the plan of care updated to reflect the occurrence and the outcome.

According to the home's policy "Critical Incidents", policy #4.1.6 with a revised date of December 2013, directed staff to inform the director within one business day of becoming aware of the incident followed by a full report within 10 days of becoming aware of the incident.

The critical incident was initially reported to the Director two days following the incident and injury.

The Director of Care (DOC) acknowledged the incident was reported late to the Director. [s. 107. (3)]

Issued on this 17 day of August 2018 (A1)(Appeal/Dir# DR# 094)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de soins de longue durée

Central West Service Area Office
500 Weber Street North,
WATERLOO, ON, N2L-4E9
Telephone: (888) 432-7901
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WATERLOO, ON, N2L-4E9
Téléphone: (888) 432-7901
Télécopieur: (519) 885-9454

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : Amended by Wendy Lewis (Director) - (A1) (Appeal/Dir# DR# 094)

Inspection No. / No de l'inspection : 2018_737640_0011 (A1)(Appeal/Dir# DR# 094)

Appeal/Dir# / Appel/Dir#: DR# 094 (A1)

Log No. / No de registre : 032992-16, 035115-16, 006404-17, 007557-17, 011971-17, 003311-18, 006198-18 (A1)(Appeal/Dir# DR# 094)

Type of Inspection / Genre d'inspection: Critical Incident System

Report Date(s) / Date(s) du Rapport : Aug 17, 2018;(A1)(Appeal/Dir# DR# 094)

Licensee / Titulaire de permis : Collingwood Nursing Home Limited
250 Campbell Street, COLLINGWOOD, ON, L9Y-4J9

LTC Home / Foyer de SLD : Collingwood Nursing Home
250 Campbell Street, COLLINGWOOD, ON, L9Y-4J9

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Peter Zober

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To Collingwood Nursing Home Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee must be compliant with r. (8) (1) (b) of the LTCHA.

Specifically, the licensee must:

a) Ensure that staff providing direct care follow the contents of the home's policy "Falls Prevention Program", that when any resident is at high risk for falls, the plan of care is reviewed and revised to include specific interventions based on the assessed needs of the resident.

b) Ensure that the registered staff complete post fall assessments, Fall Incident Analysis form and Risk Management for resident #003 and any other resident who has fallen, as per the home's policy "Falls Prevention Program".

c) Ensure that registered staff implement the home's policy "Emergency

Care", policy to complete the head injury routine as directed in the policy specifically to complete neurological and other vital signs according to the timelines specified in that policy up to and including the full 72 hours.

d) Ensure that registered staff implement the home's policy "Destruction and Disposal of Surplus Drugs" specifically:
When any substance is to be destroyed it is to be entered on the Narcotic and Controlled Drugs For Destruction Form at the time of setting aside for destruction.

e) Ensure that registered staff implement the home's policy "Disposal of Used Controlled Drug Patches" specifically:
Place a used controlled medication patch onto a Controlled Drug Patch Disposal Tool and store the completed form with the controlled surplus medications after entering the information into the Narcotics and Controlled Drugs Surplus form.

f) Ensure the home implements the home's policy "Destruction and Disposal of Surplus Drugs", specifically as it relates to the key to be kept by the DOC (or ADOC) and by Pharmacy only, location of the surplus drugs and the specific locked box for used controlled drugs.

g) Ensure that staff implement the home's policy "Medication Incident/Near Incident Program", related to the required documentation regarding a medication incident/near incident and the required reporting.

Grounds / Motifs :

1. A) Where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system was (b) complied with.

In accordance with Regulation, s.48, which required the licensee to ensure that the interdisciplinary programs including fall prevention programs were developed and implemented in the home and each program must meet the requirements set out in section 30, where there must be a written description of the program that included its goals and objectives and relevant policies, procedures and protocols. O. Reg. 79/10,

s.48

1) In October 2016 and January 2017, resident #003 had been assessed to be at high risk for falls.

On a specified date in December 2016 the resident fell onto the floor and sustained an injury which required a higher level of care.

The Long-Term Care Homes (LTCH) Inspector reviewed the clinical record to include the written plan of care related to falls prevention and noted resident #003's plan of care did not include the specific interventions as described in the home's policy.

The home's policy "Falls Prevention Program", policy #4.1.12 with a revised date of July 2015, directed that when a resident was at high risk for falls, the plan of care was to include specific interventions based on the assessed needs of the resident.

During interviews with the LTCH Inspector, RPN #106 and RN #101 both stated it was expected that a resident identified at high risk for falls, have the specific interventions implemented The RN #101 indicated that when updating the plan of care with the new risk level, the appropriate interventions included in the policy were to be implemented.

The plan of care did not include the specific interventions related to the level of fall risk as recommended in the home's "Falls Prevention Program" policy.

During an interview with RN #101, they acknowledged staff had not followed policy when they did not include in the plan of care, the interventions to prevent falls as per the home's policy.

2) Following a fall, the "Falls Prevention Program" policy directed staff to complete a post falls assessment for 72 hours after the fall to identify and changes in condition.

Resident #003 fell on a specified date in December 2016.

The LTCH Inspector and the Assistant Director of Care (ADOC) reviewed the resident's clinical record and discovered that the post fall assessments had not been completed as per the home's policy "Falls Prevention Program" on several dates in

December 2016.

During an interview with the ADOC, the Falls Program Lead for the home, they acknowledged that staff had not followed the home's policy related to post fall assessments.

3) On a specified date in April 2017, resident #006 fell from their bed and sustained an injury which required a higher level of care.

The home's policy "Falls Prevention Program", policy #4.1.12 with a revised date of July 2015, directed staff to complete a detailed Falls Incident Analysis and Risk Management Report.

The Assistant Director of Care (ADOC), the home's Falls Prevention Lead, identified the clinically appropriate assessment instrument for post fall assessment was the Falls Incident Analysis form.

The ADOC informed the Long-Term Care Homes (LTCH) Inspector it was expected that when a resident had fallen that staff complete their assessment using the home's Fall Incident Analysis form and following the fall, the assessments were to be completed for a full 72 hours following the incident.

The policy also directed staff to complete a post fall assessment for 72 hours to identify any changes in the resident's condition.

The LTCH Inspector reviewed resident #006's clinical record and found there was no Fall Incident Analysis form or Risk Management form completed for this fall. There were two shifts during the required 72 hour post fall assessment period where staff did not complete a post fall assessment.

The home's policy "Emergency Care", policy #18.0 with a revised date of October 2016, directed staff to complete other specific assessments.

The LTCH Inspector reviewed the clinical record for resident #006 and identified that the resident's other specific assessments had not followed the homes policy. Staff failed to assess the resident for the last 24 hours of part "d", the full 72 hours post incident.

During an interview with the Assistant Director of Care (ADOC), they acknowledged that staff had not followed policy in completing all required assessments.

B) In accordance with Regulation, s.114, the licensee was required to ensure that written policies and protocols were developed for the medication management program to ensure the accurate acquisition, dispensing, receipt, storage, administration and destruction and disposal of all drugs used in the home. O. Reg. 79/10, s.114 (2).

1. The home's policy "Destruction and Disposal of Surplus Drugs", policy #3-009, with no date of revision, directed staff when any substance to be destroyed was to be entered on the Narcotic and Controlled Drugs For Destruction Form at the time of setting aside for destruction.

On a specified date in March 2018, the Director of Care (DOC) emptied the drug destruction bin to allow for the installation of a new lock. Found in the bin was a plastic container housing two different controlled substances. The Narcotic and Controlled Drugs For Destruction Form was reviewed from the time of the last drug destruction completed just prior and the two controlled substances had not been logged on the form.

During an interview with RPN #103, the RPN who had placed the controlled substance in the bin, they confirmed they had not documented the controlled substance on the form as required by policy.

The DOC acknowledged staff had not followed the home's policy and failed to document the medication placed in the drug destruction bin as required.

2. The home's policy "Disposal of Used Controlled Drug Patches", policy #3-010, with no date of revision, directed staff to place a removed controlled medication in patch form onto a Controlled Drug Patch Disposal Tool.

On a specified date in February 2018, the DOC and the Pharmacist performed drug destruction. During the review of the contents of the drug destruction bin, they found seven papers with controlled substance patches attached.

The DOC informed the Long-Term Care Homes (LTCH) Inspector the patches were on various pieces of paper, some were on the forms and many were on partial pieces

of scrap paper.

During an interview with the DOC, they informed the LTCH Inspector that in the home's safe were controlled substances that had been temporarily removed from the drug destruction bin. One of the medications was the used controlled substance patch which had been attached to a half sheet of scrap paper and not on the required form as per the home's policy.

The DOC acknowledged that staff had not complied with the home's policy regarding the use of the correct form for used narcotic patches.

3. The home's policy "Disposal of Used Controlled Drug Patches", policy #3-010 with no date of revision, directed staff that all Controlled Drug Patch Disposal Tools with patches attached should be stored with controlled medications awaiting destruction and entered on the Narcotics and Controlled Drugs Surplus Form.

On a specified date in February 2018 the DOC and the Pharmacist performed drug destruction. During the review of the contents of the drug destruction bin, they found seven papers with used controlled substance patches attached.

During an interview with the DOC, they informed the LTCH Inspector that during the process of drug destruction, all patches as noted above were not documented on the Narcotics and Controlled Drugs Surplus Form as required by the home's policy.

The DOC acknowledged that staff had not complied with the home's policy regarding narcotic patch form completion.

4. The home's policy "Destruction and Disposal of Surplus Drugs", policy #3-009, with no date of revision, directed that a "drop-box" may be used for storage of controlled drugs for destruction and the drop-box must be;

i) Locked
ii) Secured to a wall or floor
iii) In a locked room, and
iv) the key to be kept by the DOC (or ADOC) and by Pharmacy only.

During the inspection regarding missing narcotics, the LTCH Inspector was informed by the Administrator, the DOC and the ADOC that the key for the locked drop-box for

the storage of controlled drugs for destruction was kept in the Administrator's office in the safe kept on the Administrator's desk. The Administrator, the DOC and the ADOC had the combination to open that safe and had access to the key to the drop-box.

During an review of the policy with the DOC, they acknowledged the home had not complied with the policy regarding the key to the drug destruction box.

5. The home's policy "Medication Incident/Near Incident Program", policy #6-001 with no date of revision, directed staff to record the incident in the resident's electronic medical record and to include all details;

(a) Name and status of person discovering the incident
(b) The name of the drug involved
(c) Any adverse reactions and
(d) Notification of appropriate personnel

During a review of the clinical record of residents #001 and #004 by the LTCH Inspector, there were no progress notes regarding the medication incidents as described on the Medication Incident Report.

The information was reviewed with the DOC who acknowledged that staff had not complied with the home's policy regarding the documentation of medication incidents.

6. The home's policy "Medication Incident/Near Incident Program", policy #6-001 with no date of revision, directed staff to report all medication errors to the resident/SDM, pharmacy, Medical Director, prescriber and the Director of Care immediately.

During an interview of RPN #103 regarding a controlled substance found in resident #001's bed on a specified date in February 2018, they informed the LTCH Inspector they had not notified the resident's physician regarding the omitted medication.

The RPN acknowledged they had not followed the home's policy and should have notified the resident's physician. [s. 8. (1) (b)]

The severity of this non-compliance was determined to be actual harm/risk (3), a scope of widespread (3) and a compliance history of previous related non-compliance (3) that included:

- 2017_484646_0016 - a written notice issued on November 28, 2017 and,
- 2015_340566_0016 - a written notice issued October 27, 2015.

(640)

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

Aug 24, 2018

Order # /
Ordre no : 002

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

Pursuant to / Aux termes de :

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,

(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

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

Order / Ordre :

The licensee must be compliant withr. 50 (2) (b) (i) and (iv) of the LTCHA.

Specifically the licensee must:

a) Ensure that any resident who exhibits altered skin integrity receive a skin assessment by a registered staff member using a clinically appropriate assessment instrument specifically designed for skin and wound assessment.
b) Ensure that any resident who exhibits altered skin integrity, be reassessed at least weekly by a member of the registered nursing staff.

Grounds / Motifs :

1. 1. The licensee failed to ensure that a resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument was specifically designed for skin and wound assessment.

On a specified date in April 2017, resident #006 fell from their bed and sustained an injury which required a higher level of care.

The home's policy "Wound and Skin Care Program", policy #4.16.1 with a revised date of October 2013, directed staff to complete an initial assessment and weekly there after using the "Weekly Wound Assessment" tool in PCC. The policy was directed specifically at pressure ulcer management however, the Assistant Director of Care informed the Long-Term Care Homes (LTCH) Inspector that all wounds, including lacerations and bruising were to be initially assessed and assessed and documented weekly thereafter.

The Long-Term Care Homes (LTCH) Inspector reviewed the clinical record which contained a "Weekly Wound Assessment – Bates Jensen" form with a specified date in April 2017 at a specific time. On the form were a list of seven separate areas of altered skin integrity including the injury sustained as a result of a fall.

At the bottom of the list of areas of altered skin integrity was a description of one of the areas. There were no other descriptions of the other six areas on this form or any other form or component of the clinical record.

During an interview with RN #101, the Skin and Wound Lead for the home, they informed the LTCH Inspector they only documented and assessed the worst of all the areas of altered skin integrity. That was their practice for all residents with multiple areas. There was no progress note or other assessment form done for the other areas of altered skin integrity.

During an interview with the Director Of Care and Clinical Consultant they acknowledged the injury was not assessed initially, not assessed in the week and that all areas of altered skin integrity were to be assessed individually and completely using the home's clinically appropriate assessment tool specifically designed for the assessment of altered skin integrity, not just the worst.[s. 50. (2) (b) (i)]

2. The licensee failed to ensure that a resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was reassessed at least weekly by a member of the registered nursing staff.

On a specified date in April 2017, resident #006 fell from their bed and sustained an injury that required a higher level of care.

The home's policy "Wound and Skin Care Program", policy #4.16.1 with a revised date of October 2013, directed staff to complete an initial assessment and weekly there after using the "Weekly Wound Assessment" tool in PCC. The policy was directed specifically at pressure ulcer management however, the Assistant Director of Care informed the Long-Term Care Homes (LTCH) Inspector that all wounds, including lacerations and bruising were to be assessed and documented weekly thereafter.

The Long-Term Care Homes (LTCH) Inspector reviewed the clinical record which contained a "Weekly Wound Assessment – Bates Jensen" form with a specified date in April 2017. On the form were a list of seven separate areas of altered skin integrity including the altered skin integrity sustained as a result of the fall.

At the bottom of the list of altered skin integrity was a description of one specific area of altered skin integrity. There were no other descriptions of the other six areas of altered skin integrity on this form or any other form or component of the clinical record.

A second "Weekly Wound Assessment – Bates Jensen" was completed ten days following the injury from the fall. The contents of the form were identical to the one completed 10 days prior, as above.

During an interview with RN #101, they confirmed for resident #006, there were no weekly wound assessments as required.

During an interview with the Director Of Care(DOC) and Clinical Consultant they acknowledged the altered skin integrity was not assessed in a week and that all areas of altered skin integrity were to be assessed weekly using the home's weekly assessment form. It was expected that all individual areas of altered skin integrity be assessed and documented on a weekly basis. [s. 50. (2) (b) (iv)]

The severity of this issue was determined to be minimal harm or potential for actual harm (2), a scope of pattern (2) and a compliance history of ongoing non-compliance despite previous action taken by the ministry (4) that included:

- 2017_484646_0016 a voluntary plan of correction (VPC) was issued November 27, 2017.

(640)

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

Aug 24, 2018

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

(A1)(Appeal/Dir# DR# 094)
The following Order has been rescinded:

Order # / Ordre no : 003
Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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

(A1)(Appeal/Dir# DR# 094)
The following Order has been rescinded:

Order # / Ordre no : 004
Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 136. (6) For the purposes of this section a drug is considered to be destroyed when it is altered or denatured to such an extent that its consumption is rendered impossible or improbable. O. Reg. 79/10, s. 136 (6).

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

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

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

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

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

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

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

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

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 17 day of August 2018 (A1)(Appeal/Dir# DR# 094)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by Wendy Lewis (Director) - (A1) (Appeal/Dir# DR# 094)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

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Service Area Office / Bureau régional de services : Central West