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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Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Jun 08, 2016;	2016_360111_0009 (A3)	002607-16	Follow up

Licensee/Titulaire de permis

CVH (No.6) GP Inc. as general partner of CVH (No.6) LP
c/o Southbridge Care Homes Inc. 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

Orchard Villa
1955 VALLEY FARM ROAD PICKERING ON L1V 3R6

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

LYNDA BROWN (111) - (A3)

Amended Inspection Summary/Résumé de l'inspection modifié

Please note

Amendment (3) completed to include a Directors Referral (DR) added to each Compliance Order and evidence under the Licensee Inspection Report was added to the Grounds for the Compliance Order #002 related to medications.
Thank you
Lynda Brown

Issued on this 16 day of June 2016 (A3)

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

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

LYNDA BROWN (111) - (A3)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): April 25-29, 2016 & May 2-4, 2016.

The following inspections were completed concurrently: Follow-ups to CO #002 (log # 002607-16) related to care set out in plan provided to the resident; CO #003 (log # 002608-16) related to safe transferring of residents; CO # 004 (log # 002609-16) related to medications being administered to residents in accordance to the directions provided by the presciber; Other (log # 000857-16) related to lingering offensive odours; Complaint (log # 035494-15) related to allegations of abuse and complaints; Critical Incident Report (log # 036317-15) related to unexpected death.

In addition, a Compliant inspection was completed by Inspector #571 (log # 011198-16) related to multiple care concerns and medications. Additional information is identified under inspection # 2016_328571_0011.

During the course of the inspection, the inspector(s) spoke with residents, families, the Director of Care (DOC), Resident Care Area Managers (RCAM), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Dietary Aides (DA), RAI Coordinators, Pharmacist, Program Assistant (PA), Maintenance, and Occupational Therapist (OT).

During the course of this inspection, observed/interviewed residents, observation of medication administration, medication rooms, a review of: Falls Prevention meeting minutes, medication incidents, staff training records,

complaints, and the home's investigations, a review of current and deceased resident health care records. There was also a review of the following home's policies- Falls Prevention and Management, and multiple Medication Administration policies.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Falls Prevention

Medication

Reporting and Complaints

Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **0 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 36.	CO #003	2015_365194_0028	111
LTCHA, 2007 s. 6. (2)	CO #002	2015_365194_0028	111

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 :

(A2)
1. The licensee has failed to ensure that the "Falls Prevention and Management Program" policy was complied with.

Under O.Reg. 79/10, s.48 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:1.A falls prevention and management program to reduce the incidence of falls and the risk of injury.

Re: Critical Incident Log # 036317-15 for resident #010:

Review of the home's policy "Falls Prevention and Management Program" (RESI-10-02-01) revised April 2013, indicated:
-the Interdisciplinary team: review the resident's falls risk assessment in order to establish an individualized care plan and communicate the care plan to all staff. Interventions must address the risk factors identified through the assessment process. Ensure that a Falls Prevention and Management Program is reviewed at the committee level.
-the registered staff: when a resident falls, complete a post fall assessment and update the care plan.

Review of the "Orchard Villa Fall Prevention and Management Committee Terms of Reference" (dated July 30, 2015) indicated the committee will identify high risk residents, analyze contributing factors to all falls, and propose interventions to minimize the risk of resident falls, injury, or transfer to acute care.

A critical incident report (CIR) was received by the Director on a specified date for an unexpected death. The CIR indicated on a specified date and time staff found resident #010 on the floor in room. The resident was transferred to hospital and returned from hospital the same day with injuries to specified areas. The resident's condition continued to deteriorate and the resident died four days later. The CIR indicated the resident was "deemed a high falls risk and had multiple previous falls".

Review of the care plan for resident #010 indicated the resident was at high risks for falls related to immobility, dementia, and responsive behaviours. The following interventions were in place at the time of the falls and included: check every hour for safety using Hourly Falls Checklist; place bed in lowest position possible; ensure falls mat is placed at bedside when in bed; ensure alarming device is

placed on mobility aid when up or in bed when returned to bed and staff to check alarming device every shift to ensure device is in place and working. Night shift to provide morning care, dress and bring to the nursing station every morning for close monitoring and seat near nursing station after meals, or when not in bed for close monitoring. The Falling Star Logo was not added to the resident's bed to indicate falls risk until after the fifth month.

Review of the progress notes for resident #010 during a six month period indicated the resident sustained a specified number of falls. 80% of the falls occurred from the resident's mobility aide and the last fall resulted in a serious injury to a specified area. Two of the interventions in place that were consistently used, were demonstrated as not effective as the resident continued to fall. The care plan did not indicate one of the interventions were use of Behaviour Supports Ontario (BSO).

Interview with RN #107(Falls Prevention Committee Lead) indicated the committee meets monthly to discuss falls statistics, provide staff training related to falls prevention, reviews and analyzes falls and provides strategies to prevent or reduce falls or injury. RN # 107 and the DOC indicated awareness of resident #010 having ongoing falls and stated "they were due to responsive behaviours". They both indicated the resident was a high risk for falls and was on the BSO program for responsive behaviours. The intervention indicated by staff as "followed by BSO" was not identified on the care plan. This intervention was discontinued after the second month of falls, despite the resident continuing to fall.

Interview of RPN #117 indicated all residents at high risk for falls are identified with a Falling Star logo at the head of the resident's bed, a list is also kept in front of the PSW's flow sheet binders and in front of nursing communication binders on each unit to indicate which residents are at high risk for falls. The RPN indicated further interventions would be identified on the resident care plan of interventions used to reduce falls/injury.

Interview with Occupational Therapist (OT) indicated completes "mobility equipment assessments" and "the seating and positioning includes residents who slide from wheelchairs". The OT indicated assessments are completed when "I get a referral sheet". The OT indicated the last mobility aide assessment completed for resident #010 was "approximately a year ago" when a referral was received for "sliding" in the mobility aide. The OT indicated "the issue was the cushion was not used properly inflated or lacking air". The OT indicated no other referrals were

received from nursing staff regarding this resident.

Review of the "Falls and Restraint Committee " meeting minutes indicated during the same six month period, only three meetings occurred. The minutes indicated the meetings were attended by RN's, RAI Coordinator, BSO lead, PT, Restorative care, and the Director of Quality Nursing (DQN). The meeting minutes indicated part of the meeting was to include a review of "fall statistics of the previous month by unit". There was no indication the fall statistics were analyzed for trends, especially when the monthly statistics demonstrated that two specified units had the highest number of falls each month. The minutes were also to include a review of "high risk residents" care plans by unit. Only one month's meetings (the fourth month) identified residents per unit as high risk for falls. Resident #010 was identified as a high risk of falls and indicated the trigger as a responsive behaviour. There was no indication of strategies to minimize the falls or risk of injury. The meeting also indicated “a trial of weekly falls meetings” was to occur for a six month period but there was no indication that this occurred.

A compliance order was issued as the severity was demonstrated in reviewing the progress notes for resident #010, during a six month period, the resident had sustained a specified number of falls. The last fall resulted in a serious injury and death. Eighty percent of the falls occurred from the resident's mobility aide due to "responsive behaviours". There was no indication that when the resident was being reassessed, and the care set out in the plan was not effective, different approaches were considered for resident #010 or that the interventions addressed the risk factors that were identified. Staff indicated the resident's falls were triggered by responsive behaviours, and was being monitored by BSO, despite the resident being discontinued from BSO after the second month and the resident continued to fall. Two interventions identified were demonstrated to not be effective in reducing the falls and there was no indication other interventions were considered. There was also no indication of referrals to other disciplines (i.e. PT or OT) was completed when 80% of the falls occurred from the resident's mobility aide. The scope was that although this was just one resident identified, the number of falls in the home (as demonstrated by the home's falls statistics and review of the Falls Prevention Committee Meeting minutes) indicated the committee had not reviewed the ongoing falls for resident #010, or any other residents identified as high risk residents, analyzed contributing factors to all falls, and proposed interventions to minimize the risk of resident falls, injury, or transfer to acute care, except for one of the months during the six month period. Review of the post fall assessments for resident #010 indicated only 3% of the falls had a post fall assessment completed.

In addition, non-compliance was identified for O.Reg. 79/10, s.8(1) related to Falls Prevention on June 8, 2015 during inspection #2015_293554_0009 and on November 15, 2016 during inspection # 2015_365194_0028.

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

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 :

(A1)
1. The licensee has failed to ensure that a drug was not administered to resident #006 unless it was prescribed.

Re: Complaint Log # 011198-16:

Resident #006 has lived in the home for a specified period of time. The resident receives off-site treatments specific to the resident's diagnosis. On a specified

date, the physician ordered a specified medication, at specified times, to correct abnormalities with the resident's metabolism specific to the resident's diagnosis.

A review of a complaint letter submitted to the home by the residents family member, approximately one month later, indicated that the off-site treatment facility was provided a current medication list for resident #006 at the resident most previous treatment. The staff at the treatment facility became aware that resident #006 was receiving this specified medication and notified the home to have this medication discontinued, due to side effects. As a result, the medication was ordered discontinued on the same day by the physician.

A review of the medical record indicated that on a specified date (the day the physician ordered the medication discontinued) the order to discontinue the drug was verified by two nurses. Review of the electronic medication administration record (eMAR) indicated the medication had not been discontinued and was administered by RPN #122 the following day after it was discontinued.

A review of a medication incident form, indicated four days later, RPN #123 had a near miss of almost administering the drug to resident #006 as medication was still on the eMAR.

In an interview, the Director of Care (DOC) indicated on a specified date, RPN #123 attempted to administer the drug to resident #006 as the order remained on the eMAR but the resident had informed RPN #123 the medication was discontinued and therefore the medication was not administered. The DOC indicated that the second nurse who verified the physician order should have ensured it was no longer on the eMAR.

A Compliance Order (CO #004) under O.Reg.79/10, s. 131(1) was issued on January 15, 2016 and then amended on April 19, 2016 with a compliance date of February 29, 2016. [s. 131. (1)]

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

Related to log # 002609-16 for resident #013:

Review of the medication incident reports indicated on a specified date, a call was received by pharmacy for resident #013, indicating an incorrect dosage calculation

had been indicated on the eMAR (and the medication label) for an electrolyte supplement. The resident was receiving a 56 % increased dose of the medication for approximately five months.

Review of the health care record for resident #013 indicated the resident was admitted on a specified date and has multiple diagnoses which included a cardiac condition. Approximately one month after admission, the physician ordered the electrolyte supplement at a specified dose. The pharmacy sent the medication but the directions had an incorrect calculation for the liquid on the bottle (more than the dose that was ordered).

Review of the progress notes for resident #013 indicated on the day the medication incident was discovered by pharmacy, the physician assessed the resident and ordered electrolyte blood work. Review of the blood work completed seven days later indicated the electrolyte was within therapeutic levels.

Therefore the resident received 56% increased dose of the specified medication for a period of approximately five months when the medication incident was discovered by pharmacy. [s. 131. (2)]

3. Related to log # 002609-16 for resident #014:

Review of Medication Incident report for resident #014 indicated on a specified date, the resident had been receiving a sleeping aide medication in the morning for three days that was to be administered at bedtime.The nurse contacted the physician and the pharmacy on the third day and had the administration time changed to bedtime.

Review of the health record for resident #014 indicated the resident was admitted three days prior to the medication incident. The progress notes indicated on the day the resident was admitted, the (BSO) staff member completed the admission assessment and indicated the resident was to receive the sleeping aide medication to assist the resident with responsive behaviours and sleep. Three days later, in the evening, the resident's SDM was visiting and staff noted the resident had not "slept for two days" and was demonstrating responsive behaviours. The SDM inquired whether the resident had been receiving the sleeping aide at bedtime and the nurse determined at that time the medication had not been given at the correct administration time. The nurse then contacted the physician to have the administration time changed to the correct time.

Therefore, the resident was admitted with a sleeping aide medication, staff documented awareness on admission that the medication was to be administered at bedtime for sleep and the medication was administered in the morning for a three day period until the medication incident was discovered by the resident's SDM.

Additional Required Actions:

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

(A2)The following order(s) have been amended:CO# 002

WN #3: 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 :

(A1)
1. The licensee has failed to ensure that when the resident had fallen, the resident had been assessed post fall, using a clinically appropriate assessment instrument that is specifically designed for falls.

Re: Critical Incident Log # 036317-15 for resident #010:

Review of the progress notes for resident #010 indicated during a six month period the resident sustained a specified number of falls. Review of the post fall assessments for resident #010 during the same time period indicated only 36 % of the falls had a post fall assessment were completed.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

(A1)
1. The licensee has failed to ensure that all areas where drugs are stored are kept locked at all times, when not in use.

On a specified date and time, on a specified unit, Inspector #571 observed Program Assistant (PA) #124 request that RPN #122 unlock the medication room door. The RPN #122 unlocked the door and left it open and returned to the medication cart in the hallway to administer medications. The medication room was observed to contain the following: two unlocked cupboards with medications including, Lactulose liquid; Tylenol pills and liquid; eye drops; Gravol and an unlocked box of discarded medication. In addition, a treatment cart was also unlocked in the medication room and contained medicated ointments. There was also a fridge in the medication room that was also unlocked and contained insulin and eye drops.

In an interview, RPN #122 indicated the RPN "opens" the medication room door for program staff and restorative staff as the resident's charts are kept in the room and the staff need to access the charts and does not remain in the room with them.

In an interview with PA #124, indicated that the medication room door is unlocked and left open by registered nursing staff when requested to access the resident's charts.

In an interview, the DOC indicated that the RPN should remain in the medication room with unregistered staff unless all medication is locked up.

Therefore, the licensee failed to ensure that the area where drugs were stored in the medication room on Cedar unit were kept locked at all times(571).

Issued on this 16 day of June 2016 (A3)

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) : LYNDA BROWN (111) - (A3)

Inspection No. / No de l'inspection : 2016_360111_0009 (A3)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 002607-16 (A3)

Type of Inspection / Genre d'inspection: Follow up

Report Date(s) / Date(s) du Rapport : Jun 08, 2016;(A3)

Licensee / Titulaire de permis : CVH (No.6) GP Inc. as general partner of CVH (No.6) LP
c/o Southbridge Care Homes Inc., 766 Hespeler Road, Suite 301, CAMBRIDGE, ON, N3H-5L8

LTC Home / Foyer de SLD : Orchard Villa
1955 VALLEY FARM ROAD, PICKERING, ON, L1V-3R6

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Trish Talabis

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To CVH (No.6) GP Inc. as general partner of CVH (No.6) LP, 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) (b)

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 :

(A1)
The licensee shall prepare, implement, and submit a corrective action plan to provide the following, and to also identify who is responsible for each action, and the completion date:
1.All residents currently in the home at moderate to high risk for falls will be reassessed, and interventions that have been considered and determined to not be effective, will have their plan of care reviewed and revised, to ensure other interventions are considered, where possible.
2. The Registered Nursing staff will review the home s Falls Prevention and Management policy to ensure they are aware of their responsibilities, specifically related to post fall assessments, reporting requirements to physicians, and review of care plans to ensure other interventions are considered when the interventions used to prevent falls and or injury have been demonstrated as ineffective,
3. The Falls Prevention and Management committee will review the "Orchard Villa Fall Prevention and Management Committee Terms of Reference" to ensure awareness of roles and responsibilities, specifically related to analyzing contributing factors to all falls, and proposing interventions to minimize the risk of resident falls and or injury; Establish a process to monitor compliance to established policies and procedures, especially when new interventions are being tried,
4. Develop and implement a monitoring process to ensure all current residents identified as moderate to high risk for falls, have been reassessed, and other interventions have been considered when interventions used have been determined to be ineffective.

This plan is to be submitted by May 26, 2016 to Lynda Brown, LTC Inspector, via email to OttawaSAO.MOH@ontario.ca

Grounds / Motifs :

(A1)
1. The licensee has failed to ensure that the "Falls Prevention and Management Program" policy was complied with.

Under O.Reg. 79 10, s.48 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:1.A falls prevention and management program to reduce the incidence of falls and the risk of injury.

Re: Critical Incident Log # 036317-15 for resident #010:

Review of the home s policy "Falls Prevention and Management Program" (RESI-10-02-01) revised April 2013, indicated:
-the Interdisciplinary team: review the resident s falls risk assessment in order to establish an individualized care plan and communicate the care plan to all staff. Interventions must address the risk factors identified through the assessment process. Ensure that a Falls Prevention and Management Program is reviewed at the committee level.
-the registered staff: when a resident falls, complete a post fall assessment and update the care plan.

Review of the "Orchard Villa Fall Prevention and Management Committee Terms of Reference" (dated July 30, 2015) indicated the committee will identify high risk residents, analyze contributing factors to all falls, and propose interventions to minimize the risk of resident falls, injury, or transfer to acute care.

A critical incident report (CIR# 2693-9999966-15) was received by the Director on December 29, 2015 for an unexpected death. The CIR indicated on December 25, 2015 at 06:15, staff found resident #010 on the floor in room. The resident was transferred to hospital and returned from hospital the same day with a fractured nose, swelling to bilateral eyes, bruise to arm, skin tear to one finger and sutures to her forehead. The following day, the resident "was not doing well", POA and MD were contacted and decision made to keep resident in the home. The resident died on December 29, 2015. The coroner indicated the cause of death was due to "blunt force trauma to the face, related to her previous fall". The CIR indicated the resident was "deemed a high falls risk and had multiple previous falls".

Review of the care plan for resident #010 indicated the resident was at high risks for falls related to immobility, dementia, responsive behaviours (will put herself on the floor usually after family visits). The following interventions were in place at the time of the falls and included:
-check every hour for safety using Hourly Falls Checklist,
-place bed in lowest position possible; ensure falls mat is placed at bedside when in bed,
-ensure sensor pad alarm is placed on wheelchair (when in wheelchair) or on her bed when in bed; check at start of shift to ensure sensor pad alarm is in place and is

working; has removed wheelchair alarm by removing clothing-staff to ensure alarm is working and attached to resident, if removed, staff to apply immediately;
-night shift to provide morning care, dress and bring to the nursing station every morning for close monitoring & seat near nursing station after meals or when not in bed for close monitoring,
-on November 13, 2015, the Falling Star Logo was added above the resident's bed to indicate falls risk.

Review of the progress notes for resident #010 during a six month period (from June 27, 2015 to December 29, 2015) indicated the resident sustained 25 falls. Twenty of the falls occurred when the resident slid out of her wheelchair and the last fall resulted in a head injury:
-on June 27, 2015 at 22:53 the "resident slid from w c 2x this shift. The first time alarm was sounding in the dining room after dinner". The resident was transferred back to wheelchair and brought to the nurse's station. Staff then went to get a co-resident out of the dining room and when staff returned to the nurse's station, the resident "was found sitting on the floor again leaning against her w c with alarm sounding". No injuries or pain noted.
-on July 5, 2015 at 17:40, the resident was found sitting on the foot rest of by the nursing station. The resident had just returned from the dining room. At the time of the fall there were no injuries but a PSW later reported bruising noted to the resident's right arm.
-on July 9, 2015 at 22:45, the resident was found sitting on the floor at the end of her bed. No injuries noted.
-on July 16, 2015 at 17:35, the resident was found sliding out of wheelchair onto the footrest in the dining room.No injury noted.
-on July 19, 2015 at 14:39, staff noted resident attempting to "get out of her chair, after her visitors left". Resident was placed at the nursing station to monitor.
-on July 23, 2015 the BSO Noted "Resident is currently in the BSO program and is been monitored on a monthly basis. Resident s follow-up was completed today and it was document that resident is still having responsive behaviors after family visits. Resident continues to put herself on the floor". Resident is now on a sleep wake study starting night of the July 23-July 26. MD to assess sleep weak study and BSO will reassess resident s interventions. The resident was discontinued from the BSO program on July 26, 2015.
-on July 25, 2015 at 10:20, a co-resident called staff to report the resident was sitting on buttocks on floor. No pain or injury was noted.
-on August 1, 2015 at 14:42, the resident "was noted slipping self out of wheel chair".

No injuries noted.
-on August 4, 2015 at 10:20, a PSW "found resident sitting on the footrests of her w c in front of the nurse s station". The chair alarm was still attached to the wheelchair and resident but did not activate. No injury or pain was noted.
-on September 8, 2015 at 14:39 staff documented a "Late Entry for Sept 7, 2015" indicating the "resident was put to bed but refused to stay in bed continued to get out repeatedly, resident was anxious and aggressive after relatives visited, left bed in low position. The call bell was observed attached but not sounding after getting out of bed as PSW observed resident lying prone on fall mat in front of bed".
-on September 11, 2015 at 21:00, PSW reported the resident was on the floor. The resident was found "kneeling on the floor, in front of her W C". No pain or injury noted. The resident was transferred to wheelchair and "is currently sitting at nurse s station for close monitoring".
-on September 22, 2015 at 22:50, the resident's "alarm was noted to be sounding at, upon checking resident was noted sitting at the edge of bed trying to get up". The resident was found with "2 skin tear to her left forearm".
-on September 27, 2015 at 16:30, the resident "had a witnessed fall by the nursing station. The resident slid out of her wheelchair". The resident had visited with son prior and was upset when son left. No injury noted. The staff indicated "chair alarm on resident but did not sound".
-on October 3, 2015 at 12:40, PSW reported the resident was on the floor in the dining room, the fall was un-witnessed. PSW reported "I heard the alarm ringing". No injury noted.
-on October 12, 2015 at 10:45, BSO staff noted "was on unit doing rounds and noted resident was very agitated and aggressive towards staff". The resident "was also attempting to put herself on the floor while yelling "I am going to throw myself on the floor and crack my skull open". The "resident would move her body to the edge of her wheelchair, staff would assisted her back into her wheelchair so resident would not have a fall and resident would continue to place herself back to the edge of her chair while striking out at staff. BSO and charge nurse monitored the resident for 1hr and 45mins until the resident was calm.
-on October 25, 2015 at 23:00, the resident was received with "increased agitation sitting in wheel chair in front of nursing station screaming out loud and attempted to slide down from wheel chair several times". At 23:15 resident did slide down from wheel chair and sat on the floor when staff while staff were attending another resident. No injury noted. 1: 1 intervention x 15 minutes and reassurances to calm resident down with good effect.
-on October 29, 2015 at 22:11, resident was in wheelchair after dinner, sitting across

from nursing station, was shouting and tearful, "once resident get into that mood she is noted to be constantly sliding herself" out of wheelchair. The resident was then witnessed falling out wheelchair by charge nurse, who was sitting at the desk. No injury noted.
-on November 1, 2015 at 15:45, PSW reported the "resident was on the floor". Resident was found sitting on foot rest of wheelchair, alarm attached to her shirt but not separated". Resident "supposedly slid herself from the wheelchair".
-on November 16, 2015 at 15:00, resident was in TV lounge participating in activity with program staff and once program was finished and everyone was dispersed, the resident became agitated and slid from her wheelchair. No injuries were noted.
-on November 21, 2015 the BSO indicated resident now palliative, "when relatives come to visit her, when they leave, she will throw herself from the wheelchair or climb out of bed onto the floor resulting into falls and skin tear".
-on December 2, 2015 physician assessed the resident and ordered "vitals only once if resident has fallen, resident is palliative".
-on December 5, 2015 at 18:40, the resident was witnessed sliding out of her wheelchair. No injuries were noted.
-on December 12, 2015 at 15:20, the resident was witnessed sliding off her wheelchair. No injuries noted. At 19:15 the resident was found on the floor and staff indicated "resident has HX of being upset and agitated post family visit and will deliberately slide herself from W C".
-on December 18, 2015 at 14:08, the resident slid from her wheelchair onto her buttocks and no injury noted. The resident was placed at nursing station desk to monitor. At 15:45, while seating at the nursing station, the resident slid down out of her wheelchair and was sitting on footrests. No injuries noted.
-on December 22, 2015 at 17:10, the resident was agitated and "noted to be shouting, and trying to slide off her chair, staff kept trying to redirect with some success". While in the dining room, the resident "had slide herself from chair and onto the floor". Staff indicated "she will hurt herself if she continues to slide herself to the floor". No injury noted.
-on December 24, 2015 at 20:00, the resident was found on the floor at bedside. "Before incident resident was lying in bed. Her call bell did not ring". The resident sustained a bruise to the nose. The resident was placed in wheelchair and taken to the nursing station.
-on December 25, 2015 the resident had remained awake most of the night and at 05:30 the resident was transferred to bed. At 0615 the alarm was heard "sounding" and the resident was found on the floor at bedside (CIR# 2693-9999966-15).

Interview of RN #107(Falls Prevention Committee Lead) indicated the committee meets monthly to discuss falls statistics, provide staff training related to falls prevention, reviews and analyzes falls and provides strategies to prevent or reduce falls or injury. RN # 107 and the DOC indicated awareness of resident #010 having ongoing falls and stated "they were due to responsive behaviours" as the resident would "throw herself to the floor from her wheelchair after the family had visited". They both indicated the resident was a high risk for falls and was on the BSO program for her responsive behaviours.

Interview of RPN #117 indicated all residents at high risk for falls are identified with a Falling Star logo at the head of the resident's bed, a list is also kept in front of the PSW s flow sheet binders and in front of nursing communication binders on each unit to indicate which residents are at high risk for falls. The RPN indicated further interventions would be identified on the resident care plan of interventions used to reduce falls injury.

Interview of OT indicated he completes "mobility equipment assessments" and "the seating and positioning includes residents who slide from wheelchairs". The OT indicated assessments are completed when "I get a referral sheet". The OT indicated "there is blank referral sheets on each unit for physio and OT" for nursing to complete. The OT indicated the last wheelchair assessment was completed for resident #010 approximately a year ago when received a referral that resident was sliding in wheelchair. The OT indicated "the issue was the cushion was not used properly or lacking air". The OT indicated no other referrals were received from nursing staff regarding the resident sliding from wheelchair.

Review of the "Falls and Restraint Committee " meeting minutes indicated the meetings occurred on October21, December 2 & 16, 2015, January 20 & March 20, 2016. The minutes indicated meetings were attended by RN s, RAI Coordinator, BSO lead, PT, Restorative care, and the Director of Quality Nursing (DQN). The meeting minutes indicated part of the meeting was to include a review of "fall statistics of the previous month by unit". There was no indication the fall statistics were analyzed for trends, especially when the monthly statistics demonstrated that two units (Birch and Pine) consistently had the highest number of falls each month. The minutes were also to include a review of "high risk residents" care plans by unit. The October 21, 2015 was the only meeting that identified one resident per unit as high risk for falls residents. Resident #010 was identified as high risk of falls and indicated the resident "often reacts to when her family leaves the building and will put

herself on the floor". There was no indication of strategies to minimize the falls or risk of injury. The meeting also indicated “a trial of weekly falls meetings” was to occur until March 2016, but there was no indication that this occurred.

There was no indication that when the resident was being reassessed, and the care set out in the plan was not effective, different approaches were considered for resident #010 or that the interventions addressed the risk factors that were identified. Staff indicated the resident s falls were triggered by responsive behaviours, and was being monitored by BSO, despite the resident being discontinued from BSO on July 26, 2015 and the resident continued to fall. The interventions of “placing the resident in front of the nursing station for close monitoring” or the use of "a chair and or bed alarm" were not effective in reducing the falls and no indication other interventions were considered. There was also no indication of referrals to other disciplines (i.e. PT or OT) was completed when 20 out of the 25 falls occurred from the resident falling out of her wheelchair.

A compliance order was issued as the severity was demonstrated in reviewing the progress notes for resident #010, during a six month period (from June 27, 2015 to December 29, 2015), the resident had sustained 25 falls. The last fall resulted in a head injury and death. Twenty out of the 25 falls occurred when the resident slid out of her wheelchair due to responsive behaviours and there was no indication that when the resident was being reassessed, and the care set out in the plan was not effective (placing the resident in front of the nursing station or the use of a chair and or bed alarm), that other interventions were considered. There was no indication of referrals to other disciplines (i.e. PT or OT) when 20 out of the 25 falls occurred from the resident falling out of her wheelchair. The scope was that although this was just one resident identified, the number of falls in the home (as demonstrated by the home s falls statistics and review of the Falls Prevention Committee Meeting minutes) indicated the committee had not reviewed the ongoing falls for resident #010, or any other residents to identify high risk residents, analyzed contributing factors to all falls, and proposed interventions to minimize the risk of resident falls, injury, or transfer to acute care, except for the month of October 2015. Review of the post fall assessments indicated only 9 out of the 25 falls had a post fall assessment completed. In addition, non-compliance was identified for O.Reg. 79 10, s.8(1) related to Falls Prevention on June 8, 2015 during inspection #2015_293554_0009 and on November 15, 2016 during inspection # 2015_365194_0028. (111)

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

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

Jun 30, 2016

Order # /
Ordre no : 002

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

Linked to Existing Order /
Lien vers ordre existant: 2015_365194_0028, CO #004;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, implement and submit a corrective action plan to ensure the following, and to include who is responsible for each action and the completion date:
1. develop and implement a monitoring process to ensure that all medications are administered to all residents in accordance with the direction for use, and as specified by the prescriber; and to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident,
2. identify actions to be taken when non-compliance is identified with same,

The plan is to be submitted by May 26, 2016 via email to Lynda Brown, LTC Inspector, at OttawaSAO.MOH@ontario.ca.

Grounds / Motifs :

(A2)
1. A Directors Referral was also issued for the Compliance Order.

The licensee has failed to ensure that a drug was not administered to resident #006 unless it was prescribed.

Re: Complaint Log # 011198-16:

Resident #006 has lived in the home for a specified period of time. The resident receives off-site treatments specific to the resident's diagnosis. On a specified date, the physician ordered a specified medication, at specified times, to correct abnormalities with the resident's metabolism specific to the resident's diagnosis.

A review of a complaint letter submitted to the home by the residents family member, approximately one month later, indicated that the off-site treatment facility was provided a current medication list for resident #006 at the resident most previous treatment. The staff at the treatment facility became aware that resident #006 was receiving this specified medication and notified the home to have this medication discontinued, due to side effects. As a result, the medication was ordered discontinued on the same day by the physician.

A review of the medical record indicated that on a specified date (the day the physician ordered the medication discontinued) the order to discontinue the drug was verified by two nurses. Review of the electronic medication administration record (eMAR) indicated the medication had not been discontinued and was administered by RPN #122 the following day after it was discontinued.

A review of a medication incident form, indicated four days later, RPN #123 had a near miss of almost administering the drug to resident #006 as medication was still on the eMAR.

In an interview, the Director of Care (DOC) indicated on a specified date, RPN #123 attempted to administer the drug to resident #006 as the order remained on the eMAR but the resident had informed RPN #123 the medication was discontinued and therefore the medication was not administered. The DOC indicated that the second nurse who verified the physician order should have ensured it was no longer on the

eMAR.

A Compliance Order (CO #004) under O.Reg.79/10, s. 131(1) was issued on January 15, 2016 and then amended on April 19, 2016 with a compliance date of February 29, 2016. [s. 131. (1)]

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

Related to log # 002609-16 for resident #013:

Review of the medication incident reports indicated on a specified date, a call was received by pharmacy for resident #013, indicating an incorrect dosage calculation had been indicated on the eMAR (and the medication label) for an electrolyte supplement. The resident was receiving a 56 % increased dose of the medication for approximately five months.

Review of the health care record for resident #013 indicated the resident was admitted on a specified date and has multiple diagnoses which included a cardiac condition. Approximately one month after admission, the physician ordered the electrolyte supplement at a specified dose. The pharmacy sent the medication but the directions had an incorrect calculation for the liquid on the bottle (more than the dose that was ordered).

Review of the progress notes for resident #013 indicated on the day the medication incident was discovered by pharmacy, the physician assessed the resident and ordered electrolyte blood work. Review of the blood work completed seven days later indicated the electrolyte was within therapeutic levels.

Therefore the resident received 56% increased dose of the specified medication for a period of approximately five months when the medication incident was discovered by pharmacy. [s. 131. (2)]

3. Related to log # 002609-16 for resident #014:

Review of Medication Incident report for resident #014 indicated on a specified date, the resident had been receiving a sleeping aide medication in the morning for three days that was to be administered at bedtime. The nurse contacted the physician and

the pharmacy on the third day and had the administration time changed to bedtime.

Review of the health record for resident #014 indicated the resident was admitted three days prior to the medication incident. The progress notes indicated on the day the resident was admitted, the (BSO) staff member completed the admission assessment and indicated the resident was to receive the sleeping aide medication to assist the resident with responsive behaviours and sleep. Three days later, in the evening, the resident's SDM was visiting and staff noted the resident had not "slept for two days" and was demonstrating responsive behaviours. The SDM inquired whether the resident had been receiving the sleeping aide at bedtime and the nurse determined at that time the medication had not been given at the correct administration time. The nurse then contacted the physician to have the administration time changed to the correct time.

Therefore, the resident was admitted with a sleeping aide medication, staff documented awareness on admission that the medication was to be administered at bedtime for sleep and the medication was administered in the morning for a three day period until the medication incident was discovered by the resident's SDM. (111)

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

May 26, 2016

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 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 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

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

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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection 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

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Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection 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

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 16 day of June 2016 (A3)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LYNDA BROWN - (A3)

Service Area Office /
Bureau régional de services : Ottawa