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**

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

## Amended Public Copy/Copie modifiée du public de permis

| Report Date(s)/ Date(s) du Rapport | Inspection No/ No de l'inspection | Log #/ Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jan 03, 2017; | 2016_555506_0028 (A1) | 030721-16 | Resident Quality Inspection |

### Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

DOVER CLIFFS
501 St George Street P.O. BOX 430 Port Dover ON N0A 1N0

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

Ontario

**Ministry of Health and Long-Term Care**

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**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**

LESLEY EDWARDS (506) - (A1)

## Amended Inspection Summary/Résumé de l'inspection modifié

**The change was to give the home an extension on the compliance date from January 6, 2017 until January 31, 2017.**

**Issued on this 3 day of January 2017 (A1)**

**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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501 St George Street P.O. BOX 430 Port Dover ON N0A 1N0

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

LESLEY EDWARDS (506) - (A1)

## Amended Inspection Summary/Résumé de l’inspection modifié

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

**This inspection was conducted on the following date(s): November 15, 16, 17, 18, 21, 22, 23 and 25, 2016.**

**During this inspection the inspections listed below were conducted concurrently:**

**Critical Incident Reports**

**034142-15- related to medication administration.**

**010288-16- related to abuse and neglect.**

**020447-16- related to abuse and neglect.**

**023573-16- related to medication administration.**

**During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Associate Director of Care/Resident Assessment Instrument Co-ordinator (ADOC/RAI), Office Manager/Resident Service Co-ordinator, Staff Educator/Nursing Assistant, Environmental Supervisor Manager (ESM), Food Service Manager (FSM), Registered Dietitian (RD), Registered Nurses (RN's), Registered Practical Nurses (RPN'S) personal support workers (PSW's),**

**Pharmacist, Human Resources for Health Care Agency, Former Director of Care, (DOC), Regional Manager of Clinical Services, Agency staff, residents and families.**

**During the course of the inspection the inspectors toured the home, observed the provision of care and services, reviewed relevant records including meeting minutes, policies and procedures and resident health records and conducted interviews.**

**The following Inspection Protocols were used during this inspection:**

**Continence Care and Bowel Management**

**Dignity, Choice and Privacy**

**Family Council**

**Infection Prevention and Control**

**Medication**

**Minimizing of Restraining**

**Nutrition and Hydration**

**Personal Support Services**

**Prevention of Abuse, Neglect and Retaliation**

**Residents' Council**

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

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.<br><br>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. 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 :**

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

A) Resident #021 was involved in a medication incident, which was suspected to have occurred on an identified date in December 2015, when they had a change in condition, were transferred to the hospital and were identified to have a classification of drug in their blood stream that was not ordered for them. This incident was reported to the Director as required. On the Critical Incident (CI) report the DOC identified that it was suspected that the incident occurred when resident #021 received, in error, resident #026's medications. The CI indicated that the home had an identification bracelet program in place, in addition to photographs on the Medication Administration Records (MAR) and that resident #021 had removed their bracelet. Corrective action was identified to include, but not limited to, an audit of all residents for compliance with wearing identified bracelets and those who were non-complaint would be identified in their plans of care along with an alternative method of positive identification. Resident #021 was observed during the course of the inspection to not be wearing an identification bracelet. The resident and the RAI co-ordinator confirmed no identification bracelet was worn. A review of the plan of care, did not include this intervention in identifying the resident nor an alternate method of identification. Interview with the former DOC identified that they had made a request of the former ADOC to audit residents and amend their plans of care as needed but did not follow up to ensure completion. Interview with the current ADOC verified that they were unaware of this expectation and did not capture this need in resident plans of care when relevant.
B) Resident #021 had a medication incident in November 2015, when staff failed to process medication orders for approximately one week resulting in a delay in the initiation of a medication and a change in dose for a medication. A review of the documentation available in the home regarding the incident did not include a record that the error was reviewed or analyzed or the specific action which was taken. Interview with the former DOC identified that they completed all of the required steps for the medication incident; however, this may be documented in a number of areas including but not limited to a personal notebook. When asked for the notebooks for review it was identified that they had been destroyed when the former DOC left the home. A written record was not maintained as required.
C) Resident #050 had a medication incident on an identified date in January 2016.

The medication incident was related to a transcription error. The prescription was supposed to be used whenever necessary but was transcribed to be used twice a day. Interview with the former DOC confirmed that medication incident was not reviewed and analyzed for contributing factors and corrective actions nor was there any follow-up completed. [s. 135. (2)]

***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**

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

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee failed to ensure that 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 complied

with.

The home had a procedure "Medication Administration, CARE13-010.01, effective date August 31, 2016" as part of the written policies and protocols developed for the medication management system required under Regulation 114 (2), which identified that all "medications administered, refused, or omitted will be documented immediately after administration on the MAR/TAR or eMAR/eTAR using the proper codes by the administering nurses".

A) A specified Registered Practical Nurse (RPN) #117 worked at the home on an identified date in November 2015. Interview with the RPN identified that they had not received orientation to the home prior to the time of this shift and did not have an individualized or a confidential user name and password or access to the home's electronic documentation system and electronic Medication Administration Records (eMARs). The RPN indicated that during the shift they documented on the eMARs, for each resident which they administered medications to, using the user name and password given to them by the DOC, which was the DOC's user name and password. A review of the eMARs for residents #030, #008 and #001 included the initials of the DOC on an identified date in November 2015, as the person who administered medications on the specified date. Interview with the now former DOC verified that there had been occasions when they did give out their user name and password to new staff to use to complete documentation. Direction was also provided to record a note in each resident's record to identify who actually completed the documentation, although this direction may not have been provided to RPN #117.
The procedure "Medication Administration" was not complied with when the staff who administered the medication did not sign that they administered the medications as required.
B) Resident #034 had a physician's order for an analgesic to be administered as needed. A review of the Narcotic and Controlled Substance Administration Record identified that this medication was given at a specified time on an identified date in July 2016; however, the administration of this medication was not recorded on the eMAR as required, as confirmed during an interview with the ED.
The staff who administered the medication did not comply with the home's procedure for Medication Administration. [s. 8. (1) (b)]

2. The home had a procedure "Narcotics and Controlled Drugs Management-ON, CARE13-020.02, effective date August 31, 2016" as part of the written polices and protocols developed for medication management system required under

Regulation 114 (2), which identified that "narcotic and controlled drug(s) are also documented on the individual Resident's Narcotic and Controlled Drug Count sheet, located in a separate binder and/or on the Medication Administration Record (MAR) binder, which will be stored in the medication room when not in use".

A) Medication Incident Report was completed for resident #031, who had a physician's order for a medication to be administered as per physician's orders. According to the eMAR and the narcotic count, the resident received the medication as ordered at a specified time, on an identified date in July 2016, by RN #122; however, the staff member failed to record the administration of the drug on the Narcotic and Controlled Substance Administration Record as identified during the internal investigation by the ED and Regional Manager of Clinical Services.
B) A Medication Incident Report was completed for resident #033, who had a physician's order for an analgesic to be administered as per physician's orders. According to the eMAR and the narcotic count, the resident received the medication as ordered at a specified time, on an identified date in July 2016, by RN #122; however, the staff member failed to record the administration of the drug on the Narcotic and Controlled Substance Administration Record as identified during the internal investigation by the ED and Regional Manager of Clinical Services.
RN #122 did not comply with the expectation of the home to document the administration of all controlled substances and narcotics in the Narcotic and Controlled Substance Administration Record as verified by the ED. [s. 8. (1) (b)]

3. The licensee has failed to ensure that the home's weight change policy was complied with.

The home's policy "Weight Management" (policy number LTC-G-60, last revised date August 2012) as required under the nutrition and hydration program Regulation 68 (2) (a), directed staff to review the home's weight records monthly, and for a nutrition referral to the RD to be completed and the information documented in the interdisciplinary progress notes for the following weight variances:

i. Weight loss or gain of greater than or equal to 5% of the total body weight over one month;
ii. Weight loss or gain of greater than or equal to 7.5% of the total body weight over three months;
iii. Weight loss or gain of greater than or equal to 10% of the total body weight over six months;

iv. Any other weight changes that compromises the resident's health status.

A) Review of resident #001's weight record, revealed that the resident experienced a significant weight loss of five percent in one month. There was no evidence in the clinical record that a referral was sent to the FSM or RD regarding the resident's weight loss as per the home's policy. Interview with the FSM on an identified date in November 2016, confirmed that the referral was not completed.
B) Review of resident #001's weight record, revealed that the resident experienced a significant weight loss of five percent in one month. There was no evidence in the clinical record that a referral was sent to the FSM or RD regarding the resident's weight loss as per the home's policy. Interview with the FSM on an identified date in November 2016, confirmed that the referral was not completed.
C) Resident #003 was identified to have a weight change of five percent over one month, which required a referral to the RD as identified in the home's policy. A review of the progress notes identified that the RD assessed the resident, as part of their quarterly review, for the weight change in August 2016 and completed an Oral/Nutritional Status Resident Assessment Protocol (RAP) in the same month for the identified need. A review of the clinical record did not include a referral to the dietary department for the weight change. Interview with the FSM verified that the referral was not submitted as required. (Inspector #168) [s. 8. (1) (b)]

***Additional Required Actions:***

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

**(A1)The following order(s) have been amended:CO# 002**

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure policies and procedures are followed for medication administration and resident weight changes, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care**
**Specifically failed to comply with the following:**

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

**s. 6. (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 the care set out in the plan of care was provided to the resident as specified in the plan.

Resident #027 was observed on an identified date in November 2016, to be administered their morning medications which included a supplement, by RN #115, directed in the electronic Medication Administration Record (eMAR). A review of the physician's orders identified that the supplemented was ordered on an identified date in September 2016. A Quarterly Medication Review, which discontinued all previous orders, was completed on an identified date in October 2016. The orders received on an identified date in October 2016, did not include the order for the supplement, as verified by registered staff #114 and #115. RN #115 verified that the supplement was administered to the resident as observed. The resident was not provided care as per the plan of care, when the supplement was not reordered on an identified date in October 2016 and staff continued to administer it according to the eMar. [s. 6. (7)]

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.

Resident #003 was previously on nutritional interventions to promote bowel functioning. A progress note created in August 2016, identified that the registered dietitian discontinued the use of bowel interventions as the resident had consistent bowel movements. A review of the plan of care in November 2016, identified that the resident was to have an intervention daily at breakfast and the dining room servery sheet indicated the need for the intervention each morning at breakfast. Interview with the FSM verified that the resident no longer received the interventions and that the plan of care and servery sheet had not been revised when the interventions were no longer necessary. [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 to ensure that the resident's plan of care is followed and that when the resident's care needs change the plan of care is reviewed and revised, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care**
**Specifically failed to comply with the following:**

**s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:**
**19. Safety risks. O. Reg. 79/10, s. 26 (3).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the plan of care was based on an interdisciplinary assessment with respect to the resident safety risks.

A) Observation of resident #003's bed system identified that they had a mattress on their bed with raised sides. Interview with the ED verified that the resident had a mattress with raised sides and that although the home had a significant number of these mattresses they were not the only style available for use. A review of the plan of care included the use of the mattress on the Point of Care (POC) documentation; however, it did not identify if the surface supported the resident with an activity of daily living, restricted their movement out of bed or any other safety risks associated with the use of the device. The clinical record did not include an assessment of the resident with respect to the use of the mattress, as supported during an interview with the ADOC and ED. The ED identified that the home did not complete a specific assessment of the resident for the use of the mattress, other than with the Fall Risk Assessment Tool (FRAT), nor was the plan of care based on an assessment of the resident's safety risks.
B) Observation of resident #006's bed system identified that they had a mattress on their bed with raised sides. Interview with the ED verified that the resident had a mattress with raised sides and that although the home had a significant number of these mattresses they were not the only style available for use. A review of the plan of care did not include the use of the mattress; nor did the clinical record include an assessment of the resident with respect to the use of the mattress, as supported during an interview with the ADOC and ED. [s. 26. (3) 19.]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care is based on an interdisciplinary assessment with respect to the residents safety risks, to be implemented voluntarily.***

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

**Specifically failed to comply with the following:**

**s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

According to a Critical Incident that was submitted to the Director on an identified date in July 2016, resident #010 was involved in an incident with co-resident #012. A review of resident #010's and resident #012's clinical record did not include any documentation of the incident, any actions taken nor the resident's responses to the incident. This was confirmed with the ED on an identified date in November 2016. [s. 30. (2)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.***

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**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours**

**Specifically failed to comply with the following:**

**s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,**
**(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).**
**(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).**
**(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that, for each resident who demonstrated responsive behaviours, actions taken to respond to the needs of the resident, including assessments, reassessments and interventions and the resident's responses to interventions were documented

Resident #007 identified that there was an incident on a shift in October 2016, between themselves and a PSW. Staff and witness interviews identified that the incident resulted in an escalation of the resident's responsive behaviours and others feeling were troubled by the resident's actions. The resident was immediately re-instructed by RN #113 and according to the ED they were notified of the situation, responded by arriving on site and speaking with the resident immediately following the incident and again the following day regarding the situation. A review of the resident's clinical record included a progress note that the resident was upset on the identified date, regarding the actions of the co-resident. There was no documentation of the behaviours identified by the resident, immediate actions taken to respond to the behaviour, nor the residents responses. The ED and PSW #105 identified that the following day a discussion was held with resident #007, which was mildly efffective in an effort to resolve the issue. A review of the clinical record did not include documentation of this intervention nor the response of the resident. Interview with the ED verified that the documentation of the resident did not consistently include the behaviours of the resident, the actions taken nor the resident's response regarding the identified incident. [s. 53. (4) (c)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure residents who demonstrate responsive behaviours, actions taken to respond to the needs of the resident, including assessments, reassessments and interventions and the resident's responses to interventions are documented, to be implemented voluntarily.***

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**WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 115. Quarterly evaluation**

**Specifically failed to comply with the following:**

**s. 115. (3) The quarterly evaluation of the medication management system must include at least,**
**(a) reviewing drug utilization trends and drug utilization patterns in the home, including the use of any drug or combination of drugs, including psychotropic drugs, that could potentially place residents at risk; O. Reg. 79/10, s. 115 (3).**
**(b) reviewing reports of any medication incidents and adverse drug reactions referred to in subsections 135 (2) and (3) and all instances of the restraining of residents by the administration of a drug when immediate action is necessary to prevent serious bodily harm to a resident or to others pursuant to the common law duty referred to in section 36 of the Act; and O. Reg. 79/10, s. 115 (3).**
**(c) identifying changes to improve the system in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 115 (3).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the quarterly evaluation of the medication management system included a review of reports of any medication incidents and adverse drug reactions referred to in subsections 135 (2) and (3).

The home had a Professional Advisory Committee (PAC), an interdisciplinary team, which was comprised of members of the management staff at the home and the pharmacist. The PAC held meetings on a quarterly basis according to the ED, former DOC and pharmacist. It was identified by the former DOC, pharmacist and Regional Manager of Clinical Services that during these PAC meetings the team reviewed reports of any medication incidents and adverse drug reactions referred to in sections 135 (2) and (3). A review of the PAC meeting minutes held following two medication incidents which occurred in November 2015, and a second incident suspected to have occurred on an identified date in December 2015, did not include a review of the medication incidents as required. During interview with the former DOC, who was in attendance at the meeting and recorded the minutes, the meeting minutes of the identified meeting were reviewed and verified that the incidents were not reviewed or discussed at the meeting. The quarterly evaluation did not include a review of reports of all medication incidents and adverse drug reactions as required. [s. 115. (3)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that quarterly evaluation of the medication system must include a review of reports of any medication incidents and adverse drug reactions, to be implemented voluntarily.***

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**WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs**

**Specifically failed to comply with the following:**

**s. 131. (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 :**

1. The licensee failed to ensure that no drug was used by or administered to a resident in the home unless the drug has been prescribed for the resident.

Resident #021 had a change in condition on an identified shift in 2015. RN #113 assessed the resident, noted the change in condition and transferred the resident to the hospital. While at the hospital it was determined that the resident had an identified medication in their bloodstream, which they were not prescribed and may have accounted for the change in their condition. The home conducted an internal investigation into the incident. Staff at the home suspected that the resident had received another resident's medication in error, which was identified by the former DOC. The licensee did not ensure that no drug was used by or administered to the resident unless it was prescribed for the resident. [s. 131. (1)]

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

A. Resident #031 had a physician's order in place for a medication to be administered daily. According to a report the resident did not receive their medication as ordered on an identified date in July 2016. Interview with the ED verified that the medication was not administered as ordered, as the tablet was still in the pouch, as dispensed by the pharmacy for the identified date in July 2016, the incident was first identified the same day, by RN #121.
B. Resident #021 had orders written by the physician on an identified date in November 2015, to direct staff in the frequency of assessments and for a change in dosage of a medication and the initiation of a medication. A progress note on an identified date in November 2015, by RN #113, identified that physician's orders were found, on the resident's chart, which were not processed, that the resident sustained no ill effects and that the orders had since been processed and communicated to pharmacy. A review of the eMAR for November 2015, verified that the medication changes were not processed until a later date in November 2015. Interview with the former DOC verified that the incident had occurred and an incident report was completed.
Drugs were not administered to the residents in accordance with the directions for use as specified by the prescriber. [s. 131. (2)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that no drug is administered to a resident in the home unless the drug has been prescribed and to ensure that drugs administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.***

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**WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 222. Exemptions, training**

**Specifically failed to comply with the following:**

**s. 222. (2) The licensee shall ensure that the persons described in clauses (1) (a) to (c) are provided with information about the items listed in paragraphs 1, 3, 4, 5, 7, 8 and 9 of subsection 76 (2) of the Act before providing their services. O. Reg. 79/10, s. 222 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the persons described in clauses (1) (a) to (c) were provided with information about the items listed in paragraphs 1, 3, 4, 5, 7, 8 and 9 of subsection 76 (2) of the Act before providing their services.

RPN #117 worked at the long term care home, as arranged by their employer, an employment agency who held a contract with the home, to provide professional nursing services on request.
RPN #117 was identified as "staff" according to the interpretation of "staff" in the LTCHA, 2007, as a person who worked at the home, pursuant to a contract or agreement between the, licensee and an employment agency or other third party.

LTCHA, 2007, section 76(2) identified that training must be provided to staff, as defined in the Act, before providing their services in the areas of:
1. Residents' Bill of Rights,
3. Policy to promote zero tolerance of abuse and neglect of residents,
4. Duty to make mandatory reports under section 24,
5. Whistle-blower protections under section 26,
7. Fire prevention and safety
8. Emergency and evacuation procedures
9. Infection prevention and control

RPN #117 received electronic communication from their employer, on an identified date in November 2015 to work at the home on the following day on the day shift.
When interviewed the RPN identified that the shift worked on the identified date in November 2015, was their first shift at the home, during which time they worked as a RPN, provided direct care to residents and was responsible to administer medications and monitor approximately half of the residents at the home.
A review of the Narcotic and Controlled Substance Administration Record for resident #030 included the nurses hand writing and initials for administering medications, as prescribed for the resident, on the identified shift during the identified hours.
The RPN identified that they did not receive any orientation or formalized training at the home prior to their shift on in November 2015.
Orientation and training records provided by the home and interview with RPN #117 identified that orientation and training was provided in required areas after they preformed their duties as a RPN on the identified date in November 2015.
Orientation and training was provided on Residents' Bill of Rights, policy to promote zero tolerance of abuse and neglect of residents, duty to make mandatory reports under section 24, whistle-blower protections under section 26, fire prevention and safety, emergency and evacuation procedures and infection prevention and control three days later.
The licensee failed to ensure that training was provided as required. [s. 222. (2)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all persons described in clauses (1) (a) to (c) are trained according to the act before providing their services, to be implemented voluntarily.***

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

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee failed to ensure that a care conference of the interdisciplinary team who provide the resident's care is held within six weeks following the resident's admission to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker.

Interview with resident #002's substitute decision-maker (SDM) confirmed that they were not invited to the resident's six week initial care conference. A review of the resident's progress notes, in the clinical record, identified that the initial six week care conference was not completed and this was confirmed by the ED. [s. 27. (1) (a)]

**Issued on this 3 day of January 2017 (A1)**

**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**

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255


## Amended Public Copy/Copie modifiée du public de permis

**Name of Inspector (ID #) / Nom de l'inspecteur (No) :** LESLEY EDWARDS (506) - (A1)

**Inspection No. / No de l'inspection :** 2016_555506_0028 (A1)

**Appeal/Dir# / Appel/Dir#:**

**Log No. / Registre no. :** 030721-16 (A1)

**Type of Inspection / Genre d'inspection:** Resident Quality Inspection

**Report Date(s) / Date(s) du Rapport :** Jan 03, 2017;(A1)

**Licensee / Titulaire de permis :**
REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR,
MISSISSAUGA, ON, L5R-4B2

**LTC Home / Foyer de SLD :**
DOVER CLIFFS
501 St George Street, P.O. BOX 430, Port Dover, ON, N0A-1N0

**Name of Administrator / Nom de l'administratrice ou de l'administrateur :** Pauline Robinson

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

To REVERA LONG TERM CARE INC., 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. 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).

**Order / Ordre :**

The licensee shall ensure that all medication incidents and adverse drug reactions are:

1. Documented and according to the long term care home's policy and pharmacy expectations.
2. Reviewed and analyzed for trends and corrective action taken as necessary.
3. A written record of the review and analysis is maintained.

**Grounds / Motifs :**

1. Judgement Matrix:
Severity: Minimal Harm/Risk or Potential for Actual Harm/Risk
Scope: Pattern
Compliance History: Previous WN (Similar Area)

The licensee failed to ensure that all medication incidents and adverse drug

reactions were documented, reviewed and analyzed and corrective action was taken as necessary, and a written record was kept of everything required under clauses (a) and (b).

A) Resident #021 was involved in a medication incident, which was suspected to have occurred on an identified date in December 2015, when they had a change in condition, were transferred to the hospital and were identified to have a classification of drug in their blood stream that was not ordered for them. This incident was reported to the Director as required. On the Critical Incident (CI) report the DOC identified that it was suspected that the incident occurred when resident #021 received, in error, resident #026's medications. The CI indicated that the home had an identification bracelet program in place, in addition to photographs on the Medication Administration Records (MAR) and that resident #021 had removed their bracelet. Corrective action was identified to include, but not limited to, an audit of all residents for compliance with wearing identified bracelets and those who were non-complaint would be identified in their plans of care along with an alternative method of positive identification. Resident #021 was observed during the course of the inspection to not be wearing an identification bracelet. The resident and the RAI co-ordinator confirmed no identification bracelet was worn. A review of the plan of care, did not include this intervention in identifying the resident nor an alternate method of identification. Interview with the former DOC identified that they had made a request of the former ADOC to audit residents and amend their plans of care as needed but did not follow up to ensure completion. Interview with the current ADOC verified that they were unaware of this expectation and did not capture this need in resident plans of care when relevant.

B) Resident #021 had a medication incident in November 2015, when staff failed to process medication orders for approximately one week resulting in a delay in the initiation of a medication and a change in dose for a medication. A review of the documentation available in the home regarding the incident did not include a record that the error was reviewed or analyzed or the specific action which was taken. Interview with the former DOC identified that they completed all of the required steps for the medication incident; however, this may be documented in a number of areas including but not limited to a personal notebook. When asked for the notebooks for review it was identified that they had been destroyed when the former DOC left the home. A written record was not maintained as required.

C) Resident #050 had a medication incident on an identified date in January 2016. The medication incident was related to a transcription error. The prescription was supposed to be used whenever necessary but was transcribed to be used twice a

day. Interview with the former DOC confirmed that medication incident was not reviewed and analyzed for contributing factors and corrective actions nor was there any follow-up completed. [s. 135. (2)] (168)

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

Jan 31, 2017(A1)

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**Order # /**
**Ordre no :** 002

**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 shall ensure that the home's policy and procedure for Medication Administration will be followed:

1. To ensure that all employees and agency staff that are working at the home have an individualized or a confidential user name and password to access the home's electronic documentation system and electronic Medication Administration Records.

2. To ensure that all employees and agency staff do not share their individualized or confidential user name and password to access the home's electronic documentation system and electronic Medication Administration Records.

**Grounds / Motifs :**

1. Judgement Matrix:
Severity: Minimal Harm/Risk or Potential for Actual Harm/Risk
Scope: Pattern
Compliance history: Previously issued as a VPC on November 10, 2015.

The licensee failed to ensure that 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 complied with.

The home had a procedure "Medication Administration, CARE13-010.01, effective date August 31, 2016" as part of the written policies and protocols developed for the medication management system required under Regulation 114 (2), which identified that all "medications administered, refused, or omitted will be documented immediately after administration on the MAR/TAR or eMAR/eTAR using the proper codes by the administering nurses".

A) A specified Registered Practical Nurse (RPN) #117 worked at the home on an identified date in November 2015. Interview with the RPN identified that they had not received orientation to the home prior to the time of this shift and did not have an individualized or a confidential user name and password or access to the home's

electronic documentation system and electronic Medication Administration Records (eMARs). The RPN indicated that during the shift they documented on the eMARs, for each resident which they administered medications to, using the user name and password given to them by the DOC, which was the DOC's user name and password. A review of the eMARs for residents #030, #008 and #001 included the initials of the DOC on an identified date in November 2015, as the person who administered medications on the specified date. Interview with the now former DOC verified that there had been occasions when they did give out their user name and password to new staff to use to complete documentation. Direction was also provided to record a note in each resident's record to identify who actually completed the documentation, although this direction may not have been provided to RPN #117.

The procedure "Medication Administration" was not complied with when the staff who administered the medication did not sign that they administered the medications as required.

B) Resident #034 had a physician's order for an analgesic to be administered as needed. A review of the Narcotic and Controlled Substance Administration Record identified that this medication was given at a specified time on an identified date in July 2016; however, the administration of this medication was not recorded on the eMAR as required, as confirmed during an interview with the ED.

The staff who administered the medication did not comply with the home's procedure for Medication Administration. [s. 8. (1) (b)]

(168)

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

Jan 31, 2017(A1)

## 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

## 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

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 3 day of January 2017 (A1)**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** LESLEY EDWARDS - (A1)

**Service Area Office /**
**Bureau régional de services :** Hamilton