Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 5, 2015	2015_292553_0001	O-001409-14	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

EAGLE TERRACE
329 EAGLE STREET NEWMARKET ON L3Y 1K3

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

MATTHEW STICCA (553), GWEN COLES (555), JESSICA PATTISON (197), MARIA FRANCIS-ALLEN (552)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 12-16 and 19-23, 2015

In addition to the Resident Quality Inspection process, two additional logs were inspected upon. Log # T-1507-14 and T-1017-14 were inspected upon. Any non-compliance generated from those Logs will be identified in this report.

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Director of Care (DOC), Environmental Service Manager (ESM), Program Manager, Staff Educator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Registered Dietitian (RD), Laundry Aide, Residents' Council President, Residents, Family Council Representative and a Physician.

In addition to speaking to those identified above, during the inspection the inspectors did the following: reviewed clinical health records of Residents requiring, observed meal services, observed medication passes, observed staff to Resident interactions, Resident to Resident interactions, Resident activities and reviewed relevant policies as required related to the inspection process.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Recreation and Social Activities
Residents' Council
Skin and Wound Care
Training and Orientation

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

Related to Log # T-1017-14 in which a critical incident report was submitted:

On specified date, Resident #43 was being prepared for transfer into the tub bath via ceiling lift when the ceiling lift bar was let down by PSW #113 and struck Resident #43 in the forehead, resulting in an abrasion. The staff member was manoeuvring the mechanical lift without the assistance of another staff member. The Resident was treated; the Substitute Decision Maker and Physician were contacted; and the Resident was not transferred to hospital. The employee was immediately placed on leave pending investigation, then subsequently terminated.
Interview on January 20, 2015 with Resident #43 who remembers being hit in head with the ceiling bar and was sitting in locomotive aid at that time awaiting transfer to tub, resulting in a laceration to the head. Resident #43 reports only one staff member was present at that time but always has two staff present now when being bathed and transferred. A transfer logo was observed at the time of the interview over Resident #43's bed indicating mechanical transfer.
An interview was conducted on January 20, 2015 with the Director of Care (DOC), who reported that residents are to have a Safety in Ambulating Lifting and Transferring Program (SALT) assessment completed to indicate the resident specific transfer level and logo. PSW #105 reports Resident #43 is a mechanical lift for all transfers and requires two persons at all times.
Review of policy entitled "Safety in Ambulating Lifting and Transferring Program" date June 2012 HS16-O-12 indicates:
"Staff and resident will follow SALT policy and procedures in order to mitigate the risk of injury during mechanical transfers. Any employee in default of this operating procedure will be subject to discipline ranging from a suspension up to and including termination of employment depending on all the circumstances."
" Staff will use a mechanical lifting/transferring device for every resident who cannot weight bear or exhibits high risk characteristics as concluded by the lift and transfer assessment form (HS16-T-20)."
" Two staff will always be present during the operation of the mechanical device."
Review of clinical records at that time indicated that Resident #43 required two person physical assist and uses a mechanical lift for transfer into the tub; and requires support for all transfers via mechanical lift, two person required, using floor lift or ceiling lift.

Interview conducted with the Executive Director on January 20, 2015 who reported PSW #113 did receive training on the SALT policy and indicated that PSW #113 did not follow safe transferring techniques as per the policy and was terminated.

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 that shall ensure that staff use safe transferring techniques when assisting residents, to be implemented voluntarily.

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. (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 :

The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber r. 131. (2)

Related to Log #T-1507-14 in which a critical incident report was submitted:

On a specified date Resident #47 reported to a registered staff member that he/she had not received her medications that morning. The staff member identified that an Agency Registered Staff member had failed to administer multiple medications to various residents. The incident was reported to management and the Agency Registered staff member was removed from duty.

Interview conducted with RPN #112 on January 21, 2015, who reported on a specified date at a specified time Resident #47 approached her and stated "I hadn't got any medications today". RPN #112 was aware that Resident #47 was ordered medications for the morning and at noon, and reports that Resident #47 was capable of indicating receipt of said medications. RPN #112 followed up with the Agency Registered Staff member and found that said medications had been given to Resident #47 through review of the discarded empty medication pouches.

Interview conducted with RPN #112 on January 21, 2015, who reported on a specified date and at a specified time, all resident medication drawers in the medication cart for that unit were reviewed and all 0800, 1100, and 1200 scheduled medication pouches that still contained medications were collected and given to RN #115 who was the Acting DOC (ADOC) with a report of the incident. RPN #112 stated that the ADOC advised the Agency Registered Staff member not to give any more medications and for RPN #112 to assume control of the medications cart and keys, and to monitor the residents on that floor. RPN #112 reported that the ADOC contacted families and the Physicians involved.

Review of unopened Medication Packages containing medications from the specified date, which were provided by the ED, indicated:

Resident #44 @ 0800: 2 Stool softeners, 1 Calcium Channel Blocker, 1 ACE Inhibitor, 2 vitamin and minerals, 1 cholinesterase inhibitor; 1 hormone replacement ; 1 proton pump inhibitor.

Resident # 28 @0800: 1- anti-inflammatory ; 1- vitamin supplement ; 1-anti-coagulant ; 1- proton pump inhibitor; 1 ACE inhibitor.
Resident #45 @0800: 1- analgesic; 1 stool softener; 1 diuretic ; 1 hormone replacement; 2 anti-spastic; 1 vitamin;
@1200 2 anti-spastic;

Resident #24 @0800: 1 Calcium Channel blocker; 1 diuretic;

Resident #46 @1200: 1 mineral; 1- anti-hypertension agent;

Resident #32 @1200: 1- Iron supplement ; 1- mineral; 1- antidepressant; 1- mutlivitamin;

Resident #5 @1200: analgesia; 2-anti-epileptic;

Resident #29 @0800: 1 anti-inflammatory ; 1- mineral; 1- anti-arrhythmia ; 1- anticonvulsant; 1-anti-depressant; 1-proton pump inhibitor; 1-hormone replacement; 1-beta-blocker; 1-Vitamin

Resident #48 @1100: 1- anticonvulsant,
@1200 – 2- anti-epileptic , 2- antiemetic

Review of Resident #47 medications @ 0800: 1-diuretic; and @1200 1- anticoagulant; 1-proton pump inhibitor; 1- anti-epileptic.

The medication pouches that were reviewed were cross referenced with Physician orders for the above identified Residents. The Physician orders indicated that each Resident identified were to receive the listed medications.

Review of the clinical documentation indicates that Residents #44, 28, 45, 24, 29 did not receive above noted medications at 0800; Residents #46, 32, 5, 48 did not receive the above noted medications at 1200; and Resident #48 did not receive the above noted medications at 1100. Resident #29 was given the prescribed anti-arrhythmia later on the same specified day as per the Physicians order received as a result of the Physician's review of the missed medications.

Review of the policy entitled Medication Administration LTC-F-20 dated August 2012 indicates "scheduled medications will be administered according to standard medication administration times. Medications should be given within the recommended time frame, 60 minutes prior to and 60 minutes after the scheduled administration time"; and "all medication administered, refused or omitted will be documented immediately after administration on the MAR/TAR using the proper codes by the administering nurse."

Interview conducted on January 21, 2015 with RN #115 who was the Acting DOC (ADOC) indicated that the Agency registered staff was directed to stop giving any more medications. The ADOC verified clinical documentation to the unopened medications pouches with RPN #112 and identified the residents who missed a medication dose. The ADOC reported that no adverse effects were noted for any residents affected or any other residents on the unit related to the alleged medication incident.

Interview conducted on January 21, 2015 with the Physician indicated they did not feel any resident needed to be transferred to hospital for treatment and was not informed of any residents experiencing any adverse effects.

Interview conducted on January 22, 2015 with the ED and the DOC who both indicated that the above noted residents did not receive their medications as per the scheduled time. The ED and DOC report that the expectation for the role of agency staff to perform the complete registered staff member's duties including medication administration as per the policy.

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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 126. Every licensee of a long-term care home shall ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. O. Reg. 79/10, s. 126.

Findings/Faits saillants :

The licensee failed to ensure that drugs remained in the package provided by the pharmacy service provider until the drugs are administered to a resident or destroyed.

It was observed on January 15, 2015 at 1040hrs that there were three medication cups in the top drawer of the medication cart. One of the cups had crushed medications in it mixed with apple sauce, another medication had two pills and a third cup was empty. When asked why those medication cups were there, RN #100 indicated to Inspector #553 that Resident #41 had refused medication this morning in the dining room and RN #100 was going to re-approach Resident #41 to attempt to administer the medications that were already poured and sitting in the apple sauce. At the time of this conversation the medications would have been sitting in the apple sauce for over 2 hours.

The other medication cup with the two pills in it, was medication that was due to be discarded as the resident had refused the medications as well. RN #100 then proceeded to discard the medications in front of Inspector #553.

When asked, RN #100 indicated the expectation is to not keep medications prepared for administration in the medication cart unlabelled and not in the package provided by the pharmacy service provider.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The Licensee failed to ensure that medications stored in a medication cart were secured and locked.

It was observed by Inspector #553 on January 15, 2015 at 1040hrs outside of the 1st floor nurses station that the medication cart was left unlocked and unattended. Inspector #553 was able to access the drawers of the medication cart with ease. Multiple non-registered staff members and at least three Residents, walked by the cart while Inspector #553 waited for the registered staff to return. Approximately 2 minutes later, RN #100 came out a room where they were helping with care. When asked what the expectation was regarding an unattended medication cart, RN #100 stated to Inspector #553 that the cart should have been locked and should have been within eyesight. RN #100 stated that the home is working short staffed and they are "very busy today"

In an interview on January 15, 2015 at 13:47hrs, RN #100 and the DOC indicated that the pharmacy service provider had been called in to fix and or replace the locks on the medication cart located on the first floor.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program by reducing the risk of transmission of disease as indicated by:

The following was observed during Stage 1 of RQI January 12-14, 2015.

-Room 101-Unlabelled toothbrush in Resident's shared washroom. This washroom is shared by 3 Residents.
-Room 102-Unlabelled used toothbrush on shelf in Resident's shared washroom. This washroom is shared by 2 Residents.
-Room 201-2 Unlabelled combs, 1 unlabelled cup with bar soap in a shared washroom. This washroom is shared by 4 Residents.
-Room 202-Unlabelled denture cup in Resident's shared washroom. This washroom is shared by 4 Residents.
-Room 203-Unlabelled electric shaver on counter in Resident's shared washroom. This washroom is shared by 3 Residents.
-Room 205-Unlabelled urinal in shared washroom. This washroom is shared by 2 Residents.
-Room 207-Unlabelled urinal in shared washroom. This washroom is shared by 2 Residents.

Interview with Staff indicated that the expectation is that items such as urinals are to be labelled to indicate which Resident the urinal belongs to.

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Issued on this 5th day of February, 2015

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

Original report signed by the inspector.