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**


**Long-Term Care Homes Division**
**Long-Term Care Inspections Branch**

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## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Mar 22, 2018 | 2018_627138_0002 | 000071-18 | Resident Quality Inspection |

**Licensee/Titulaire de permis**

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 700 MARKHAM ON L3R 9W2

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

Extendicare Laurier Manor
1715 Montreal Road GLOUCESTER ON K1J 6N4

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

PAULA MACDONALD (138), ANANDRAJ NATARAJAN (573), LINDA HARKINS (126), MICHELLE EDWARDS (655)

## Inspection Summary/Résumé de l'inspection

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

**This inspection was conducted on the following date(s): February 1-2, 5-9, 12-16, and 20-23, 2018.**

**The following intakes were also completed:**

**Follow Up intake:**
**Log 023449-17 related to transferring and positioning.**

**Complaint intakes:**
**Log 021424-17 related to alleged inappropriate care of a resident,**
**Log 023870-17 related to alleged inappropriate care of a resident,**
**Log 000722-18 related to alleged inappropriate care of a resident,**
**Log 002826-18 related to injury of a resident, and**
**Log 003378-18 related to injury of a resident.**

**Critical Incident intakes:**
**Log 019283-17 related to abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident,**
**Log 023105-17 related to abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident,**
**Log 023106-17 related to abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident,**
**Log 023231-17 related to abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident,**
**Log 024764-17 related to abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident,**
**Log 024889-17 related to abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident,**
**Log 026385-17 related to abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident,**
**Log 027386-17 related to an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition,**
**Log 027423-17 related to an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition,**
**Log 027661-17 related to abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident,**
**Log 028567-17 related to abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident,**
**Log 029254-17 related to an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition,**
**Log 029497-17 related to abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident,**
**Log 029573-17 related to an incident that causes an injury to a resident for which**

**the resident is taken to a hospital and that results in a significant change in the resident's health condition,**
**Log 000051-18 related to an unexpected death,**
**Log 001934-18 related to abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident,**
**Log 002881-18 related to abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident and,**
**Log 003099-18 related to abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.**

**During the course of the inspection, the inspector(s) spoke with residents, family members, substitute decision makers, the Administrator, the Regional Director, the Director of Care, the Front Office/Receptionist, the Office Manager, the Resident Programs Manager, the Support Services Manager, the Food Service Supervisor, the Acting Assistant Director of Care, the Social Worker, a RAI Coordinator, the Quality Care/Risk Management, the President of the Residents' Council, the President of the Family Council, the Registered Dietitian, the Medical Director, a laundry aide, dietary aides, an activity aide, a Behavioural Supports Ontario (BSO) worker, registered nurses (RNs), registered practical nurses (RPNs), and personal support workers (PSWs).**

**The inspectors also conducted a tour of residential areas, observed the administration of medication, reviewed medication incident documentation, observed a lunch meal service, reviewed policies related to medication, reviewed resident care conference documentation, reviewed the Residents' Council meeting minutes, reviewed the Family Council meeting minutes, reviewed the Resident Admission Information Package, reviewed internal investigation documents, and reviewed resident health care records.**

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

**Accommodation Services - Housekeeping**
**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**
**Pain**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Residents' Council**
**Responsive Behaviours**
**Safe and Secure Home**
**Skin and Wound Care**
**Sufficient Staffing**
**Trust Accounts**

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

- **11 WN(s)**
- **6 VPC(s)**
- **0 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 #001 | 2017_593573_0021 | 138 |

| 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care**

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

**s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,**
**(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).**
**(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.

A Critical Incident Report (CIR) was submitted to the Director under the Long-term Care Homes Act (LTCHA), 2007, related to an allegation of resident to resident physical abuse. The CIR was related to an incident which involved resident #064 and resident #066, in which it was alleged that resident #064 pushed resident #066. In the CIR, it was indicated that there had also been several prior incidents involving the same residents, resident #064 and resident #066.

Inspector #655 reviewed the health care record belonging to resident #066.

On review of the progress notes, Inspector #655 identified three incidents (including the above-noted incident) involving resident #064 and resident #066 which occurred within a three-month period. In two out of the three incidents, resident #066 was identified as demonstrating physically aggressive behaviours in response to resident #064's wandering:

-According to a progress note, resident #064 entered resident #066's room on a specific date. In a progress note entered on the same date, it indicates that resident #066 "became violent" in response, hitting resident #064 with a piece of equipment and subsequently punching resident #064.
-According to a progress note, resident #064 again entered resident #066's room on a second date. In response, resident #066 punched resident #064. Resident #064 was not

injured.
-According to the progress notes, resident #064 again entered resident #066's room on a third date. At that time, it was alleged that resident #064 pushed resident #066, as described in the CIR referred to above.

According to a physician's order dated the same day as the first incident described above, a urine sample was to be collected for resident #066 and sent for culture and sensitivity. In the same physician's order, the clinical indicator for the physician's order was identified as "aggressive behaviour".

According to a physician's order the day after the second incident described above, a urine sample was again to be collected for culture and sensitivity. In the same physician's order, the clinical indicator for the physician's order was identified as "responsive behaviour".

On review of resident #066's health care record, Inspector #655 was unable to locate any other documentation related to the above-noted physician's orders. In resident #066's health care record, there was no indication that the urine samples had been collected or that any results had been received.

During an interview, RPN #135 was unable to speak to the results of the above-noted urine culture and sensitivity, or whether resident #066 had required any treatment related to a urinary tract infection.

During an interview, RN #106 reviewed resident #066's health care record in the presence of Inspector #655. RN #106 confirmed that on the physician and/or nurse practitioner had ordered a urine culture and sensitivity twice for resident #066. However, RN #106 was unable to locate any documentation that would demonstrate that either sample had been collected; and was unable to locate any laboratory results. At the time of the interview, RN #106 called the laboratory in order to clarify whether the above-noted urine samples had been collected and sent to the lab. According to RN #106, the lab had not received any urine samples for resident #066 associated with the dates ordered by the physician.

On February 23, 2018, the Director of Care #161 reviewed resident #066's health care record, and was also unable to locate any documentation to demonstrate that the above-noted urine samples for culture and sensitivity had been collected.

The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of resident #066, when resident #066 exhibited responsive behaviours of a physically aggressive nature, and when two orders for a urine culture and sensitivity were not actioned.
[Log 028567-17] [s. 6. (4) (a)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance related to section 6.(4)(a) of LTCHA 2007, to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other, to be implemented voluntarily.***

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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 has 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 policies, the policies were complied with.

In accordance with O. Reg. 79/10, s. 114 (2), the licensee shall ensure that written policy and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, destruction and

disposal of all drugs used in the home.

1) Specifically, staff did not comply with the licensee's policy regarding "Shift Change Monitored Drug Count" (SCMDC), Policy 6-6, dated 02/17 which is part of the medication management system. The procedure requires registered nursing staff to record the date, time, quantity of medication and sign in the appropriate spaces on the SCMDC.

On February 12, 2018, RRN #128, indicated to Inspector #126 that the narcotic count was done by self and the night nurse at the beginning of the day that morning. RPN #128 indicated that when the count is done, it is expected that the two staff record the date, time and quantity of medication and sign the appropriate spaces on the "Shift Change Monitored Medication Record Count (SCMMC)" Form.

In reviewing the SCMMC Form dated February 12, 2018, Inspector #126 noted that RPN #128 had not signed the form for that count. RPN #128 only signed the SCMMC while discussing with the inspector the policy and expectation of the narcotic count. RPN #128 indicated that there was no discrepancies this morning but did not sign the SCMMC Form at that time.

Furthermore, in reviewing the individual narcotic card, Inspector #126 noted that the morning count did not match the actual quantity in the medication card for resident #015 and resident #051. RPN #128 indicated that resident #015 was given a specific medication. The electronic Medication Administration Record (eMAR) was signed by RPN #128 but not the SCMMC Form. RPN #128 also indicated that resident #051 received a narcotic and was signed on the electronic MAR but not the SCMMC Form.

RPN #128 did not comply with the licensee policy 6-6, "Shift Change Monitored Drug Count" in that the SCMDC was not signed as per policy requirement.

2) Specifically, staff did not comply with the licensee's policy regarding "Expiry and Dating of Medications", Policy 5-1, dated 02/17 which is part of the medication management system. The procedure requires registered nursing staff to examine the expiry date of all medication on a regular basis.

On February 12, 2018, Inspector #126 reviewed the medication storage areas on the second and third floors. It was noted that on both floors the following medications had expiry dates: Novasen 325 mg (Exp: 01/18), Novogesic 500 mg (Exp: 01/18), ApoK

600mg (Exp: 12/17) and Micro K 600 mg (Exp: 11/17).

Discussion wad held with RPN #128 and RPN #139 who indicated to Inspector #126 that it is the nurse's responsibilities to check for expired medications in the medication storage areas but could not described the process of reviewing the medications for their expiration date.

Discussion held with the Director of Care #161 who indicated that there is a process and that it shall be done on a monthly basis.

The licensee failed to comply with the policy "Expiry and Dating of Medications", Policy 5-1, dated 02/17 in that expired medications were found in two medication storage areas. [s. 8. (1) (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 related to section 8.(1)(b) of O.Reg 79/10, to ensure registered nursing staff comply with the "Shift Change Monitored Drug Count" and the "Expiry and Dating Medications" policies, to be implemented voluntarily.***

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**WN #3: 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 has failed to ensure that a care conference was held within six weeks following the resident's admission and at least annually to discuss the plan of care.

1) Resident #018 was admitted to the home in early 2017, with several diagnoses.

Resident #018's Substitute Decision Maker (SDM) indicated to Inspector #126 that since the admission there was no care conference to discuss the plan of care.

Receptionist #165 indicated to Inspector #126 that coordinating the care conference for the residents is the responsibility of the receptionist. In reviewing the Resident Conference List, it was noted that resident #018 was not on the 2018 list to have the annual care conference. Resident #018's health care record was reviewed and no documentation was found related to the six weeks care conference post admission.

Resident #018 did not have the six weeks post admission nor was the annual care conference planned as of February 21, 2018.

2) Resident #021 was admitted to the home on several years ago, with several diagnoses.

Resident #021 indicated to Inspector #655 that an annual care conference "has not happened" to discuss concerns related to care and service.

Receptionist #165 indicated to Inspector #126 that in reviewing the Resident Conference List it was noted that resident #021 was not on the list to have an annual care conference in 2018. Inspector #126 reviewed resident #021's health care record and noted that the last annual care conference was in 2015.

Resident #021 has not had an annual care conference since 2015.

3) Resident #027 was admitted to the home several years, with several diagnoses.

Resident #027 indicated to Inspector #655 to have never participated in a care conference.

Inspector #126 reviewed resident #027's health care record and noted that an Interdisciplinary Team Care Conference (IDTC)-V3 was opened on January 22, 2018. This assessment tool was completed by Registered Dietitian #108 on January 22, 2018, and no other interdisciplinary team member completed the assessment.

Receptionist #165 was not aware that the annual care conference was not completed for resident #027.

Resident #027 has not had an annual care conference since 2015.

As such, the licensee has failed to ensure a six week care conference post admission and an annual care conference was held for resident #018, as well as annual care conferences were held for resident #021 and resident #027. [s. 27. (1)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance related to section 27.(1) of O.Reg 79/10, to ensure the six week care conference and the annual care conference are completed for all residents, to be implemented voluntarily.***

**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 :**

1. The licensee has failed to ensure that all areas where drugs are stored are kept locked at all times, when not in use; and, that access to these areas was restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator.

On February 1, 2018, at 1220 hours, Inspector #655 observed the nurses station door on the third floor to be opened and unlocked. Accessible from the unlocked nurses station, was an unlocked medication cart and an unlocked refrigerator. The unlocked medication cart was found by Inspector #655 to be containing prescription topicals, including antibacterial and anti-fungal creams such as fuicidin and lamisil, 1% creams. At the same time, the unlocked refrigerator was found by Inspector #655 to be fully stocked with insulin. At the time of the observation, the medication storage area was not observed to be supervised by staff. Inspector #655 continued to observe the above-described medication storage areas. At 1258 hours, the above-described medication cart and refrigerator remained unlocked.

During an interview at the same time, RN #104 indicated to Inspector #655 that the door to the third floor nurses' station was normally kept closed and locked; however, during meal times, it was left open because staff were coming and going. During the interview, RN #104 was informed of Inspector #655's observations; and, acknowledged that the fridge containing insulin had also been left unlocked during that time. At the same time,

RN #104 indicated to Inspector #655 that staff, including housekeeping aides and PSWs, have access to the third floor nurses' station at all times, including the areas where the unlocked medication cart and unlocked refrigerator had been observed.

On February 2, 2018, the third floor nurses' station door was again observed by Inspector #655 to be left open, and unlocked between the hours of 1158 and 1204. At the same time, Inspector #655 observed that both the medication cart containing prescription ointments and the fridge containing insulin were again unlocked. During the observation period, the medication storage areas were not in use. Inspector #655 observed non-registered staff (PSWs) to be entering and exiting the third floor nurses' station – the same area where the unlocked medication cart, and the unlocked refrigerator containing insulin were located. The area was not consistently supervised by staff during the observation period. At 1204 hours, Inspector #655 closed and locked the nurses' station door.

During an interview at that time, RPN #128 indicated to Inspector #655 that RPNs would not be able to access the insulin in the refrigerator if it were locked because RPNs' do not have a key to the refrigerator.

During an interview on the same day, RN #104 indicated to Inspector #655 that while the refrigerator containing insulin was equipped with a locking mechanism, the lock was not being used because neither the RNs nor the RPNs had a key. At the same time, RN #104 indicated to Inspector #655 that action would be taken to correct the issue that day. Later the same day, RN #104 indicated to Inspector #655 that the lock had been replaced on the above-noted refrigerator; and that registered nursing staff now had a key to access it so that the medication stored in this area would be secured.

On February 7, 2018, Inspector #655 conducted a follow-up observation. At that time, Inspector #655 found that the third floor nurses' station door was closed and locked. Inspector #655 was unable to access the nurses' station without a key code. At the same time, two residents seated next to the nurses' station provided the key code to Inspector #655, allowing the Inspector to access the nurses' station. At that time, Inspector #655 observed that the medication cart and the refrigerator containing insulin were locked.

During an interview on February 7, 2018, RN #104 indicated to Inspector #655 that the key code to enter the third floor nurses' station had not changed for at least two years. The key code was known by the two residents on the dates that the medication cart and the refrigerator were observed to be unlocked.

During an interview on February 9, 2018, the Director of Care #161 indicated to Inspector #655 that areas where medications are stored, including the refrigerator containing insulin on the third floor, were expected to be kept locked at all times when not in use.

On February 12, 2018, Inspector #126 observed again that the refrigerator containing insulin on the third floor nurses stated was unlocked at 1045 hours.

The licensee has failed to ensure that the above-described medication areas – the medication cart and refrigerator containing insulin - were kept locked at all times, when not in use; and, that access to these areas was restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator. [s. 130. 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 related to section 130. 2. of O.Reg 79/10, to ensure that all areas, including medication carts and refrigerators, where drugs are stored are kept locked at all times, when not in use; and, that access to these areas are restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator, to be implemented voluntarily.***

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**WN #5: 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).**

**s. 131. (3) Subject to subsections (4) and (5), the licensee shall ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse. O. Reg. 79/10, s. 131 (3).**

**Findings/Faits saillants :**

1. The licensee has failed 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.

Resident #006 was admitted in 2007 with several diagnosis. Shortly after admission, the physician ordered a specific dose of analgesic. On November 18, 2017, resident #006 was administered two doses of the specific analgesic at double the strength of the prescribed dose.

Resident #006 was administered the specific analgesic at double the dose prescribed for the resident, therefore resident #006 received a specific analgesic dosage that was not prescribed. [s. 131. (1)]

2. The licensee has failed to ensure that drugs were administered to resident #030 in accordance with the directions as specified by the prescriber.

Resident #030 was to be administered several medications at 0800 hours in the morning. on February 12, 2018, RPN #128 was observed administering those medications to resident #030 at 1030 hours that morning.

RPN #128 was late passing the medications that morning because the RPN was required to change the skin/wound care dressing for several residents.

The Director of Care #161 indicated to Inspector #126, that it is acceptable medication administration practice for registered nursing staff to administer prescribed medication up to an hour before or after the prescribed medication time.

RPN #128 administered the medications to resident #030, two and a half hours after the prescribed time. [s. 131. (2)]

3. The licensee has failed to ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse.

Discussion was held with PSW #124 who indicated to Inspector #126 that on a few occasions the PSW gave prescribed medications to resident #027. PSW #124 indicated that resident #027 did not want to receive care by a staff of the opposite sex. PSW #124 indicated that RPN #158, who is the opposite gender of resident #027, would prepare resident #027's medications and would stay within close proximity to observe while the medications were given to resident #027 by the PSW.

Discussion held with RPN #158 who indicated to Inspector #126 that on a few occasions, resident #027's medications were given by PSW #124, because resident #027 did not want to receive care by staff of the opposite sex.

Discussion held with RN #104 who indicated that in the past, RPN #158 requested that RN #104 administered resident #027's medications. RN #104 was aware that RPN #158 requested a PSW to administer medications to resident #027.

Resident #027's medications were not always administered by an RN or an RPN [s. 131. (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 related to section 131.(1) and (2) of O.Reg 79/10, 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, ensure that drugs were administered in accordance with the directions as specified by the prescriber and to ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse, to be implemented voluntarily.***

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**WN #6: 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 has failed to ensure that (a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed, (b) corrective action is taken as necessary and a written record is kept of everything required under clause (a) and (b).

On February 13, 2018, Inspector #126 reviewed the home's last quarterly medication incidents and adverse drug reactions for the period of October 2017 - January 2018. The Director of Care #161 indicated that there was no serious medication incidents or drug adverse reactions during that period.

In reviewing the incidents it was noted that the reviewing and the analysis of those incidents did not always include the following:
-Investigation notes such as who was responsible for the medication incident and the documentation of the corrective action
-Physician or Substitute Decision Maker not always notified

Discussion was held with the Director of Care regarding the incident of November 2017, when a registered nursing staff administered the wrong dosage of pain medication to a resident. In reviewing the investigation package of that incident, the Director of Care could not identify the staff that was responsible for administering the wrong dosage and there was no documentation of the corrective action. [s. 135. (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 related to section 135.(2) of O.Reg 79/10, to ensure that all medication incidents and adverse drug reactions are documented, reviewed and analyzed and that corrective action is taken as necessary and that a written record is kept, to be implemented voluntarily.***

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**WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director**

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

**s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:**
**1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
**2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
**3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).**
**4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).**
**5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm shall immediately report the suspicion and the information upon which it was based to the Director.

A Critical Incident Report was submitted to the Director under the Long-term Care Homes Act (LTCHA), 2007, indicating that on a specific date resident #044 was observed being verbally abusive toward resident #002 in the dining room at meal time. At that time, resident #002's immediate family member was visiting, got upset at resident #044, started yelling, and made an inappropriate gesture toward resident #044.

Social Worker #109 was made aware of the incident the day the incident occurred. Social Worker #109 was notified of the incident by activity aide #112 who reported the verbal altercation between resident #004 and resident #002. Social Worker #109 and RN #110 were aware the day of the incident of the verbal altercation between the two residents and that resident #002's immediate family member was verbally abusive and made an inappropriate gesture toward resident #044.

The Director of Care #161 and Inspector #126 reviewed the investigation notes and noted that the incident was not immediately reported the Director.

The licensee has failed to immediately report to the Director the incident. The Director was notified six days later.
[Log 023105-17] [s. 24. (1)]

2. Critical Incident Report was submitted to the Director under the Long-term Care Homes Act (LTCHA), 2007, related to an allegation of resident to resident physical abuse. The CIR was related to an incident which occurred on specific date, three days before the incident was reported to the Director.

According to the CIR, it was alleged that resident #064 had pushed resident #066. In the CIR it is also indicated that resident #066 sustained an injury as a result.

During an interview, RPN #166 recalled the above-noted incident. According to RPN #166 another co-resident approached the nurses' station on that day, reporting that resident #066 was on the floor in a resident room. RPN #166 indicated to Inspector #655 that at that time, it was alleged by resident #066 that resident #064 had pushed resident #066. RPN #166 recalled that resident #066 had sustained a injury. At the same time, RPN #166 indicated to Inspector #655 that the incident had been reported to RN #126 immediately.

During an interview, RN #126 recalled the above-noted incident. RN #126 indicated to Inspector #655 that the incident was not immediately reported to the Director under the LTCHA, 2007, because it was unclear at the time as to whether the incident had or had not occurred as reported. At the same time, however, RN #126 indicated to Inspector #655 that because there was a level of uncertainty – where it was possible that the incident did occur as reported, the incident should have been reported to the Director under the LTCHA (2007) immediately.

During an interview, the Director of Care #161 also indicated to Inspector #655 that based on the information that was available at the time of the alleged incident, the expectation was that the incident be reported to the Director under the LTCHA (2007) immediately. The Director of Care confirmed that the incident was not reported until three days after the alleged incident occurred.

The licensee failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone has occurred, immediately reported the suspicion and the information upon which it is based to the Director.
[Log 028567-17] [s. 24. (1)]

**WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement**

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

**s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the Personal Assistance Service Devices (PASD) used to assist resident #027 with a routine activity of living was included in the resident's plan of care.

On February 2, 2018, resident #027 was observed by Inspector #655 to be seated in a wheelchair with a front-closure lap belt in place.

Inspector #655 reviewed the health care recording belonging to resident #027, including resident #027's care plan, and was unable to locate any documentation related to the use of a front-closure lap belt for resident #027.

During an interview on February 7, 2018, resident #027 was again observed by Inspector #655 to be wearing a front-closure lap belt. At that time, resident #027 indicated to Inspector #655 that the front-closure lap belt was normally applied and removed by PSW staff. According to the resident, resident #027 was unable to undo the lap belt.

During an interview, PSW #122 indicated to Inspector #655 that resident #027 wears a front-closure lap belt for safety, so that the resident does not slide out of the wheelchair. PSW #122 indicated to Inspector #655 that the lap belt was applied by staff that morning. At the time of the interview, PSW #122 was not sure if resident #027 was able to remove the lap belt independently.

During an interview on the same day, RN #104 indicated to Inspector #655 that resident #027 wears a front-closure lap belt for positioning, to prevent the resident from sliding

down in the chair; and, that the lap belt was considered to be a PASD. At the same time, RN #104 indicated to Inspector #655 that resident #027 was unable to remove the front-closure lap belt without guidance from staff. During the same interview, RN #104 reviewed resident #027's health care record, including the care plan, and confirmed that there was no documentation related to the use of the front-closure lap belt PASD in the resident's health care record.

During an interview, Quality Care/Risk Management #111 indicated to Inspector #655 that where a resident is unable to release him or herself from a PASD, it is considered to have a restraining effect on the resident and is expected to be documented in the resident's plan of care. According to Quality Care/Risk Manager #111, where a PASD is included in a resident's plan of care, it is expected to be documented in the resident's care plan.

The licensee failed to ensure that front closure lap belt, a PASD, used to assist resident #027 with a routine activity of living and which limits resident #027's movement, was included in resident #027's plan of care. [s. 33. (3)]

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**WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 67. A licensee has a duty to consult regularly with the Residents' Council, and with the Family Council, if any, and in any case shall consult with them at least every three months. 2007, c. 8, s. 67.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the licensee consults regularly with the Family Council, and in any case, at least every three months.

On February 6, 2018, Inspector #573 spoke with the Family Council president who indicated that the licensee nor the representative from the licensee consult regularly with the Family Council.

Inspector #573 reviewed the Family Council meeting minutes and was unable to locate any documentation supporting that the licensee nor the representative from the licensee consulted regularly with the Family Council.

On February 9, 2018, during an interview with the home's Administrator #160, it was indicated to the inspector that the Administrator was designated to represent the licensee. Further, the Administrator reported to the inspector that the Family Council was not consulted on a quarterly basis. [s. 67.]

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**WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey**

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

**s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the licensee seek the advice of the Family Council in developing and carrying out of the annual satisfaction survey.

On February 6, 2018, Inspector #573 spoke with the Family Council president who indicated that the licensee did not seek any advice or input from the Family Council in developing and carrying out the home's annual satisfaction survey for 2017.

Inspector #573 reviewed the Family Council meeting minutes for 2017 and was unable to locate any documentation indicating that the licensee seek the advice of the Family Council in developing and carrying out of the home's 2017 annual satisfaction survey.

During an interview with the home's Administrator #160 on February 9, 2018, it was indicated to the inspector that the licensee did not seek the advice of the Family Council in developing and carrying out of the home's 2017 annual satisfaction survey. [s. 85. (3)]

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**WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents**

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

**s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that resident #047's Substitute Decision Maker (SDM) was immediately notified of the results of the investigation of the alleged emotional abuse of resident #047.

A Critical Incident Report was submitted to the Director for an alleged staff to resident emotional abuse. The CIR indicated that resident #006 reported a witnessed emotional abuse incident from a PSW staff to resident #047.

The Director of Care #161 indicated during an interview on February 6, 2018, with Inspector #573 that an investigation related to the allegation of emotional abuse of resident #047 was initiated immediately. The Director of Care also indicated that the investigation results failed to verify that abuse of resident #047 had occurred.

Inspector #573 reviewed the licensee's investigation documentation related to the allegation of emotional abuse of resident #047. The Inspector was unable to locate any documentation indicating that the SDM was notified of the outcome of the alleged abuse investigation.

On February 8, 2018, during an interview, the Director of Care indicated to Inspector #573 that the investigation had been completed and that the licensee failed to notify resident #047's SDM of the outcome of the alleged abuse investigation. [Log #026385 -17] [s. 97. (2)]

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**Issued on this 22nd day of March, 2018**

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

**Original report signed by the inspector.**