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
Apr 13, 22, 2015	2015_266527_0005	H-002017-15	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 MISSISSAUGA
855 JOHN WATT BOULEVARD MISSISSAUGA ON L5W 1G2

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

KATHLEEN MILLAR (527), CATHIE ROBITAILLE (536), MICHELLE WARRENER (107)

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): February 24, 25, 26 and March 3, 4, 9, 10 and 11, 2015.

The following complaints, critical incidents and follow-up inspections were completed concurrently with this Resident Quality Inspection (RQI):
Complaints - H-000823-14, H-001089-14, H-001695-14;
Critical Incidents - H-001286-14, H-001656-14, H-001660-14; and
Follow-ups - H-000558-14, H-000559-14.

During the course of the inspection, the inspector(s) spoke with residents, families, Residents' and Family Council members, the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), the Office Manager, the Social Worker, the Program Manager, the Maintenance Supervisor, the Food Service Manager (FSM), the Registered Dietitician (RD), the Physiotherapist (PT), the Resident Assessment Instrument-Minimum Data Set Coordinator (RAI MDS), activities staff, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), dietary and housekeeping aides.

The Long Term Care (LTC) Inspectors toured the home, observed the provision of care and services, reviewed the home's documents including: policies and procedures, menus, production sheets, maintenance schedules, staffing schedules, audit reports, meeting minutes, log reports, and clinical records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
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
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

- **7 WN(s)**
- **5 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. 15. (1)	CO #001	2014_210169_0007	527
LTCHA, 2007 S.O. 2007, c.8 s. 6. (1)	CO #002	2014_210169_0007	107

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

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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 has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

In November 2014, resident #102 had a fall and was hospitalized after sustaining a significant injury. When the resident returned to the home, the physician ordered a physiotherapy (PT) reassessment. The PT assessed the resident, and recommended that the resident was to be transferred using a full mechanical lift with the sling placed under both legs (hammock style). The resident could be up in the wheelchair for meals. The interventions on the care plan and kardex (the name staff use for the document that directs care to the resident) was incorrectly transcribed. The interventions identified the resident was to be transferred and sitting in the wheelchair at lunch and dinner and back to bed in the afternoon and after supper. On a specific date in November 2014, the resident was placed in the wheelchair before breakfast and was not returned to bed until lunch time when the resident's POA insisted. The PSWs were interviewed and stated that the resident was to be up for four hours then back to bed. The RPN and PSWs reviewed the PT recommendations and stated that the interventions on the care plan and kardex were confusing and were not clear. The registered staff, the PSWs and the DOC confirmed the plan of care did not provide clear directions to staff and others that provide direct care to the resident. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other, (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.

A) The different aspects of resident #046's plan of care were not consistent and did not complement each other.

i) The care plan (the name staff use for the document that directs care to the resident) for resident #046 identified the resident was to receive a specific amount of high energy high protein pudding at the morning and evening snack pass and receive a sandwich at the afternoon snack pass. Documentation on the food and fluid intake records (where staff recorded the resident's intake) reflected the specific amount of high energy high protein pudding at the morning and afternoon snack and no snack for the evening snack pass. The two documents were not consistent in identifying the snacks the resident

required.

The Nutrition Manager confirmed that food was being prepared according to their computer system, which indicated a pudding in the morning and evening, and a sandwich in the afternoon (consistent with the care plan). Documentation on the February and March 2015 flow sheets was incomplete under "pudding" identified for the afternoon snack and no special snacks were recorded for the evening. It was unclear if resident #046 was actually taking the items identified on their plan of care. The resident was not able to be interviewed (poor historian).

ii) Information on the resident's care plan and flow sheets was not consistent in relation to the required special snacks.

B) The different aspects of resident #022's plan of care were not consistent and did not complement each other.

i) A printed paper in the PSW binder directed staff to provide a fluid restriction for resident #022. The kardex that PSWs refer to for direction about care (also in the PSW binder)did not identify a fluid restriction, nor did the diet list used for meal service. The physician's order for a fluid restriction had been discontinued in June, 2013. The computerized plan of care for resident #022 identified a specific hydration goal. The fluid goal identified on the food and fluid intake records was different. Direction for staff providing care to resident #022 was inconsistent related to hydration targets between the computerized care plan, PSW binder, and food and fluid intake records. Interviews with the PSWs, RPN, and ADOC confirmed the information was not consistent between the various areas of the resident's plan of care. [s. 6. (4) (b)]

3. The licensee has failed to ensure that the Substitute Decision Maker (SDM) had been provided the opportunity to participate fully in the development and implementation of the plan of care.

In February 2015, due to a decline in resident #024's ability to be able to transfer safely on and off toilet, the home made the decision to no longer transfer the resident on the toilet, and instead they would use a bedpan for continence care. This change was communicated to the direct care staff. The home left a voicemail message for the SDM to arrange for a care conference in three days. The SDM visited the home in the evening, and was informed by the staff of the changes made to resident #024's plan of care. The SDM was not provided with the opportunity to participate in the development and

implementation of the plan of care. [s. 6. (5)]

4. The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

A) The plan of care for resident #102 identified that the resident was to be up in the wheelchair for meals and then returned to bed. On a specific date in November 2014, and as well as other days as identified by the PSWs, the resident was up for breakfast and was not transferred back to bed until after lunch. Based on the Physiotherapist recommendations, and direction to staff, when the resident returned from the hospital, the resident should have been returned to bed after each meal. In review of the clinical record it was identified that the recommendations from the PT were not transcribed to the care plan and kardex (the name staff use for the document that directs care to the resident) correctly. The RPN was interviewed and confirmed the misinterpretation of the PT recommendations, and didn't clarify with the PT, therefore the care to resident #102 was not provided as specified in the plan resulting in the resident being up in the wheelchair for longer periods of time, and the resident was uncomfortable.

B) In November 2014, the physician ordered that staff were to complete pain assessments for resident #102 at least every shift, and pre and one hour post daily and breakthrough doses of pain medication. There was no pain assessment conducted for a number of days in November and December 2014. The registered staff confirmed in an interview that they were expected to complete pain assessments for the resident upon admission, when there was a change in condition and when needed. The registered staff were not aware of the physician's order for pain assessments. The care set out in the plan of care for resident #102 was not provided to the resident as specified in the plan.

The clinical documentation was reviewed and confirmed that staff did not provide the care as ordered by the physician, and based on the recommendations of the PT. The registered staff, PSWs, and the DOC were interviewed several times in March 2015, and confirmed that care was not provided as specified in the plan. [s. 6. (7)]

5. The licensee failed to ensure that the staff and others who provided direct care to resident #054 had convenient and immediate access to the plan of care.

A) Registered staff and PSWs confirmed that direct care staff referred to the printed kardex and did not have access to the computerized care plan (both documents were derived from the resident's plan of care and were used by staff to direct care). The

second page of resident #054's kardex was not printed and accessible to direct care staff. Staff confirmed the second page of the kardex had not been printed and was missing since February, 2015, when the forms were printed. The missing information had not been reported to the charge nurse.

B) Resident #054 required oral hygiene four times daily (as per Registered staff interview) and this information was not available for staff providing care. The kardex (the name PSWs use for the document that directs care to the resident) did not provide direction related to the four times daily oral hygiene. The RPN confirmed that information should have been available for staff providing direct care to the resident. [s. 6. (8)] (107) [s. 6. (8)]

6. The licensee failed to ensure that the following was documented: 1. The provision of the care set out in the plan of care.

A) Resident #102 was at high risk for falls as identified in the RAI-MDS Assessment in October 2014 and November 2014. The plan of care directed staff to monitor the resident's pain, monitor for restlessness, and monitor the bed and chair alarms.

The PSWs were expected to document on the Daily Care Record if the resident complained of pain or not, and report to the registered staff if the resident was in pain. The PSWs would identify if the resident was in pain based on the resident's facial expressions and behaviour. There was no documentation related to the resident's response to pain for approximately ten days in November 2014.

B) The PSWs were expected to document in the Daily Care Record if the resident was restless or not, and report to the registered staff. The PSWs would identify if the resident was restless if the resident was fidgeting, attempting to get out of the wheelchair, or trying to climb out of bed. There was no documentation for 75% of the shifts over a period of 17 days in November and December 2014.

C) The PSWs were expected to document the bed and seat alarm monitoring on the Alarm Monitoring Checklist for each shift. There was no documentation for approximately 50% of the shifts for approximately 12 days in November 2014.

The PSWs, registered staff, DOC and Administrator confirmed that the PSWs were expected to document the provision of care for resident #102 as directed in the plan for each shift, and the documentation was not consistent.

D) The Registered Dietitian (RD) initiated special snacks for resident #045 (initiated July 2014) consisting of high energy high protein pudding at the morning snack and a sandwich at the afternoon snack. The RD confirmed the special snacks were to be documented on the food and fluid intake records. The food and fluid intake records for resident #045 for the month of February 2015, did not include the special snacks, and staff recorded only fluids at the morning snack pass for the entire month of February 2015.

The food and fluid intake records for the month of March 2015, identified a sandwich was required at the afternoon snack for resident #045; however, did not include the high energy pudding at the morning snack. Only fluids were recorded for 7/10 days at the morning snack pass in March 2015. Staff confirmed pudding would not be recorded as a "fluid".

The morning snack cart was observed on a specific date in March 2015, and the labeled pudding was available on the cart and provided to resident #045. The resident was offered both the pudding and a beverage. The afternoon snack pass was observed on a subsequent date in March 2015, and the sandwich was available on the cart and provided to resident #045 in addition to a beverage.

Interview with the RD and PSWs reflected the labeled snacks were not being documented consistently. (107) [s. 6. (9) 1.]

7. The licensee has failed to ensure that the plan of care for resident #048 was revised when the resident's care needs changed in relation to level of assistance required for eating.

The care plan (the name staff use for the document that directs care to the resident)for resident #048 identified the resident required supervision for eating.

A) The RAI-MDS assessment, completed in August 2014, identified the resident required supervision with eating. The RAI-MDS assessment, completed November 2014, identified the resident required limited assistance with eating (increased assistance). The RAI-MDS assessment, completed in February 2015, identified the resident required extensive assistance with eating (increased assistance). The RN indicated that the resident frequently required physical assistance with eating.

B) The noon meal service was observed on a specific date in March 2015, and the resident was observed to require staff to place items in their hand and provide encouragement to begin the eating process.

The RN confirmed the care plan had not been updated to reflect the increasing assistance that resident #048 required with eating that was identified through the RAI-MDS assessments. [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 there is a written plan of care for each resident that sets out, (a) the planned care for the resident; (b) the goals the care is intended to achieve; and (c) clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was:(b) complied with.

The home's "Pain Management" policy, number RESI-10-03-01, and revised August 2013, was not complied with. The policy directs registered staff to complete a pain assessment when the resident was taking an increased dose, and/or if the frequency of pain medication increased, and when the family indicated pain was present.

A) In November 2014, the POA indicated that resident #102 was in pain and uncomfortable. There was no documented pain assessment conducted by the registered staff as directed by the home's policy.

B) In December 2014, the physician changed the dose and route of the resident's daily and breakthrough pain medications. The registered staff did not conduct a pain assessment for the increased dose of pain medication as directed by the home's policy.

The registered staff, DOC and a review of the clinical record confirmed that staff were not complying with the "Pain Management" policy of the home as they did not complete the pain assessments as directed by their policy when resident #102 was taking an increased dose and/or increased frequency of pain medication, and when the family indicated that pain was present. [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 to ensure 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, (b) is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

During the initial tour of the home in February and March 2015, the LTC Inspector observed the following:

A) The corridor walls outside all of the resident rooms and the door frames to all resident rooms were significantly scratched and/or chipped especially the lower quarter of the walls, and the lower part of the door frames in the Cherry Hill House, Meadowvale House, Applewood House, Credit Waters House, Gooderham House, and Heritage House.

B) The shower spa and tub room in Cherry Hill House had three large orange stains on the floor, there were missing tiles at the bottom of the wall, and the wooden panel at the entrance of the room had the lacquer worn off and the wood was significantly chipped causing ragged edges.

C) Across from a resident's room in Cherry Hill House in the resident bathroom there were three areas of drywall that were damaged with holes, and the resident grab bar was missing.

D) In the Meadowvale House, a specific room had chipped linoleum tiles entering the room, which was a potential trip hazard for residents.

E) In the Applewood House spa room there were tiles broken off at the doorway between the bathtub and shower. The wooden panel between the entrance door and the bathtub

had the lacquer worn off and significantly chipped causing ragged edges.

F) In the spa room in Gooderham House, there were many pieces of non-skid flooring loose or broken off. In addition, there were two long strips approximately 14 to 16 inches long and 4 inches wide beside the tub/shower that were peeled off. The flooring at the seam in the spa room had a large split and the baseboard weld edges were pulling apart.

G) In the shower side of the spa room in Heritage House there were broken tiles and the baseboard was torn at the door frame.

The Maintenance Supervisor confirmed there were no work orders to repair the areas of disrepair identified during the observations by the LTC Inspectors. The Maintenance Supervisor and the Administrator confirmed that the home's equipment and furnishings were not maintained in a good state of repair, and in safe condition. [s. 15. (2) (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 that, (c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that all food was prepared and served using methods that preserved taste, nutritive value, appearance and food quality.

A) At the observed lunch meal on a specific date in February 2015, the pureed food for a resident receiving tray service was identified as being runny with items running into each other on the plate. The pureed ham salad sandwich and pureed vinaigrette coleslaw were running into each other on the plate. The PSWs and RN who were feeding residents in the dining room identified that the pureed food was runny and not cohesive. (527)

B) At a subsequent lunch meal in March 2015, the LTC Inspector observed that the pureed foods were noted to be runny (not cohesive) and items were running into each other on the plate, resulting in reduced nutritive value (too much fluid added) and appearance of the meal. The pureed bread, pureed hamburger, and pureed vegetables were running into each other. The Dietary Aide also confirmed the pureed cold vegetables and pureed fruit were a bit runny. [s. 72. (3) (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 to ensure that all food and fluids in the food production system are prepared, stored, and served using methods to, (a) preserve taste, nutritive value, appearance and food quality, to be implemented voluntarily.

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. (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 has failed to ensure that drugs are administered to the resident in accordance with the directions for use specified by the prescriber.

Resident #102 returned from the hospital in November 2014 with a significant injury. The Nurse Practitioner (NP) attended the home as arranged by the hospital, and to ensure continuity in the transition of care. The NP assessed the resident, and reviewed the medications from the hospital with the home staff. The NP advised the registered staff to contact the physician to review the hospital medication regimen and obtain orders to continue with the same medication regimen as it was effective for the resident. On that same day the physician ordered the pain medications for the resident.

A) In November 2014 the resident did not receive one of the daily doses of pain medication every six hours according to the physicians order. Also, the resident did not receive another daily does of pain medication every eight hours, instead the first dose was not administered until bedtime, which was eleven hours after the resident returned from the hospital. The registered staff and the DOC confirmed that both medications were available in the home, the staff were busy the day the resident returned from the hospital, and the medications were not administered as they were missed.

B) Resident #102 was ordered by the physician daily doses of pain medication three times per day, and it was not administered to the resident on a specific date in November 2014 until later in the afternoon. The registered staff confirmed the dose was missed being administered, and were unsure why.

C) Later in the month of November 2014, the physician revised the pain medication orders as resident #102 was not comfortable and continued to experience pain. The type and frequency of pain medication was changed. The pain assessment in the morning identified the resident had increased pain intensity. The medication was not administered until the middle of the day; therefore, the resident did not receive the pain medication every four hours as specified by the physician. The registered staff and DOC confirmed the medication was not administered and were unsure why it was missed.

The registered staff, the DOC and the clinical documentation confirmed that the pain medications were not administered to the resident in accordance with the directions for use specified by the physician. [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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents' personal Health Information was kept confidential.

In March 2015, during the observation of the medication pass on one of the resident units, the LTC Inspector identified that the medication pouches, which identified the resident's name and medications, where being disposed of in the regular garbage. This was confirmed by the RN. During an observation of other medication rooms in resident units it was identified by the LTC Inspector that the medication pouches were in the regular garbage. [s. 3. (1) 11. iv.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and a Registered Dietitian who is a member of the home.

In March 2015, the LTC Inspector interviewed the DOC and reviewed the Annual Evaluation for Medication Management. The annual review was completed in December 2014. The DOC confirmed that the RD had not been involved in the Annual Evaluation for Medication Management, and was not previously included in the annual program review for Medication Management. [s. 116. (1)]

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

Issued on this 6th day of May, 2015

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

Original report signed by the inspector.