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

Division des foyers de soins de longue durée
Inspection de soins de longue durée

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 6, 2017	2017_363659_0006	004224-17	Resident Quality Inspection

Licensee/Titulaire de permis

FAIRVIEW MENNONITE HOME
515 Langs Drive CAMBRIDGE ON N3H 5E4

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

FAIRVIEW MENNONITE HOME
515 LANGS DRIVE CAMBRIDGE ON N3H 5E4

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

JANETM EVANS (659), DONNA TIERNEY (569), INA REYNOLDS (524), TRACY RICHARDSON (680)

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): March 8, 9, 10, 13, 14, 15, 16, 17, 20 and 21, 2017.

The following follow up and intakes were completed at the time of the RQI:
001416-17 - F/U to Compliance Order # 001, Inspection # 2016_262523_0034, Log # 027448-16 related to home and furnishings not kept clean and sanitary.
024465-16 - C524-000014-16 Critical incident related to resident behaviours; possible chemical restraint; possible resident to staff abuse/neglect.
025437-16 - C524-000015-16 Critical incident related to staff physically restraining/confining resident to his room; chemically restraining resident to manage behaviours.
019173-16 - C524-000010-16 Critical incident related to resident to resident altercation.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Medical Director, the Clinical Coordinator, Environmental Services Supervisor, acting Program Manager, the Dietitian, Behavioural Support Nurse (BSO), Registered Nurses, Registered Practical Nurses,Personal Care Providers, Physical Therapy Aid, Dietary Aides, Maintenance staff, Pharmacist, Residents, Family members and Family Council Representative.

The inspector(s) conducted a tour of the home, and reviewed clinical records and plans of care for relevant residents, pertinent policies and procedures, Residents' and Family Council minutes. Observations were also made of general maintenance, cleanliness, and condition of the home, infection prevention and control practices, provision of care, staff to resident interactions, medication administration and storage areas, and required Ministry of Health and Long-Term Care postings.

The following Inspection Protocols were used during this inspection:

Accommodation Services -
Housekeeping Accommodation Services
- Maintenance Continence Care and
Bowel Management Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **13 WN(s)**
- **10 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
LTCHA, 2007 S.O. 2007, c.8 s. 15. (2)	CO #001	2016_262523_0034	569

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).

Findings/Faits saillants :

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

Observation of a resident's bed system showed that the identified resident had an assistive device in place.

Review of the identified resident's plan of care and kardex showed an absence of interventions documented related to the use of the assistive device.

Upon interview with a Registered Practical Nurse it was stated that interventions for the use of the assistive device should have been included in resident's plan of care to set out clear directions to staff and it was not. [s. 6. (1) (c)]

2. Review of the clinical record for an identified resident showed the resident was assessed to be at risk for falls on Fall Risk Assessment Tool (FRAT). According to the home's Fall Program a resident with a moderate risk for falls would be identified with a specified colour leaf logo.

The identified resident's care plan documented an intervention related to the fall risk.

Observations completed at the time of the inspection showed that the intervention documented for the identified resident in their plan of care was not in place.

In interviews a Personal Support Worker (PSW) stated the intervention for the identified resident indicated that the resident was a high risk for falls. A Registered Nurse (RN) stated the resident was a moderate risk for falls. The RN acknowledged that the intervention in place for the identified resident was incorrect.

Director of Care (DOC) stated interventions in a resident's plan of care were to be updated by staff at the time they complete a Fall Risk Assessment. The DOC acknowledged that the intervention for the identified resident had not been updated. [s. 6. (1) (c)]

3. During stage one of the home's Resident Quality Inspection (RQI), a decline in the resident's Activities of Daily Living (ADL's) status was documented from the time of their admission to three months post admission from their Minimum Data Set (MDS)

Assessment for a resident.

During an interview with the resident, they shared that they used to be independent with their ADL's but lately they required full assistance from staff.

During an interview with a Personal Support Worker (PSW), they said the resident's health and functional ability had declined. The resident used to be independent with ADL's but now required assistance.

Observation of the resident's bathroom showed documentation which identified the resident as independent . Review of the home's electronic chart system showed the resident was documented as independent in one area for ADL's and another section that read "Resident requires limited assistance".

During an interview with a Registered Practical Nurse (RPN), they agreed there were two different task directions provided related to the identified resident's ADL needs.

The Director of Care (DOC) acknowledged that there were two different and conflicting tasks identified on PCC related to the resident's ADL needs, as well as the printed and posted Kardex report related to the level of ADL assistance required for the identified resident and therefore that they did not provide clear direction to staff. [s. 6. (1) (c)]

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

Observation of an identified resident's bed system during stage one of the Resident Quality Inspection, showed that assistive devices were in use for the identifed resident.

Review of the resident's plan of care and kardex showed an absence of interventions documented related to the use of the assistive device in the identified resident's plan of care.

Record review of the resident's Minimum Data Set (MDS) Quarterly assessment showed the resident required the assistive devices to aid in transfers.

During an interview with the Registered Practical Nurse it was stated that the resident used the assistive devices and this should have been included in resident plan of care to set out clear directions to staff and it was not.

The severity of the issue was determined to be minimal risk of harm. The scope was isolated. The home had a history of non compliance. A voluntary plan of correction was issued on August 10, 2015 and January 28, 2014. [s. 6. (1) (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 with ensuring that the plan of care for residents set out clear directions to staff and others who provide care to the residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
14. Hydration status and any risks relating to hydration. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on, at a minimum, interdisciplinary assessment of the resident's hydration status and any risks relating to hydration.

Record review of an identified resident's plan of care indicated a goal related to the resident's fluid and hydration intake.

Record review of documentation completed by the home's Registered Dietitian indicated the identified resident was not meeting their fluid goals and was not able to access fluids on their own. The Dehydration Resident Assessment Protocol (RAP) triggered due to insufficient fluid intake and indicated the dehydration problem would be addressed in the resident's care plan and the RAP indicated an intervention to be implemented.

A review of the identified resident's plan of care indicated that dehydration/fluid maintenance including strategies and interventions were not included in the plan of care.

The Registered Dietitian acknowledged the absence of interventions related to the resident's dehydration needs in the plan of care and that there should be.

The severity of the issue was minimal risk of harm. The scope was isolated. The home had a history of unrelated non compliance. [s. 26. (3) 14.]

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 with ensuring that the plan of care will be based on, at a minimum, an interdisciplinary assessment of the resident's hydration status and any risks relating to hydration, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident has fallen, the resident has been assessed and, if required, a post-fall assessment has been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Review of the clinical record for an identified resident showed the resident was assessed as at risk for falls on a Fall Risk Assessment Tool (FRAT).

A review of the progress note documentation on an identified date for the identified resident showed the resident had a fall in the past quarter. There was no documented evidence of a post fall assessment being completed by registered staff for this fall.

The licensee's Falls Program, Reference No. 8-FP-02 last reviewed February 2017, indicated that a Fall Risk Assessment Tool (FRAT) "will be done after each fall, (unless frequent high risk faller as per policy) and interventions implemented to reduce risk whenever possible".

During interviews the Registered Nurse (RN) stated residents were reassessed quarterly or if they had a fall and no FRAT was done within a month then a FRAT would be completed.

The Director of Care (DOC) stated that a FRAT was to be completed immediately after fall, admission, change of status, quarterly if triggered if it had not already been completed within the last 7 days. The DOC said they would not have expected the FRAT to be completed again for the resident as a FRAT had been completed two days earlier.

The licensee failed to ensure that the resident had a post-fall assessment conducted using a clinically appropriate assessment instrument that was specifically designed for

falls. [s. 49. (2)]

2. An identified resident sustained an unwitnessed fall on an identified date. The identified resident's plan of care stated under the falls focus that the resident was in the fall prevention program and directed staff to "complete fall risk assessment after each fall". Record review indicated there was no documented evidence that a post-fall risk assessment was completed by registered staff.

Review of the home's Falls Program, Reference No. 8-FP-02 last reviewed February 2017, stated the Fall Risk Assessment Tool (FRAT) "will be done after each fall and interventions implemented to reduce risk whenever possible".

The Clinical Coordinator acknowledged that the post Fall Risk Assessment Tool was not completed and should have been done within 24 hours after the resident's fall.

The severity of the issue was potential risk of harm. The scope was isolated. The home had a history of non compliance. It was issued as a voluntary plan of correction on August 10, 2015. [s. 49. (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 when a resident has fallen, the resident is assessed and, if required, a post-fall assessment has been conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that, each resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident required, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

An identified resident was assessed as continent of bladder upon admission to the home. A significant change in status Minimum Data Set assessment indicated the resident had a decline in bladder function and was occasionally incontinent of urine.

There was no documented evidence of a continence assessment being completed for this resident.

The RPN acknowledged that a continence assessment had not been completed and further said that a continence assessment would be completed at admission and with a change in continence status.

The home's policy titled, "Continence Care Bladder and Bowel", Reference No. 8-CC-01, review date March 2017, stated under procedure that each resident's bowel and bladder functioning, including individual routines and the resident's level of continence shall be reassessed when there was any change in the resident's health status that affects continence.

Upon interview with the Clinical Coordinator it was acknowledged that the resident did not have a continence assessment completed when there was a change in continence level and an assessment should have been completed.

The severity of the issue was potential for harm. The scope was isolated. The home had a history of of related non compliance. A voluntary plan of correction was issued on September 20, 2016. A compliance order was complied on September 28, 2016. [s. 51. (2) (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 residents who are incontinent receive an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstance of the resident required, an assessment is conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O. `Reg. 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.) O. Reg. 79/10, s. 110 (2).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff release a resident from the physical device and reposition the resident at least once every two hours.

The care plan for an identified resident documented registered staff were to assess resident safety and restraint requirements each shift and record on the eMAR.
The tasks assigned to Personal Support Workers (PSW) included release, reposition and reapply restraint every two hours.

During a two hour timeframe of observations the identified resident was seen to use two physical devices that restrained them for safety reasons. The resident's physical devices were not removed, the resident was not repositioned and the physical devices were not reapplied.

In interviews a Personal Support Worker stated that they reposition the resident every two hours and check their physical device every hour. The PSW stated they were not certain if the resident had been repositioned or the physical device removed within the last two hours.

A review of the documentation from the follow up questions on Point of Care (POC) showed the PSW had documented a safety check and the release, repositioning and reapplication of the physical device for the identified resident during the time of the inspector's observations.

In an interview the Clinical Coordinator acknowledged documentation for restraint safety checks should be completed once staff had completed the task.

The severity of the issue was potential for harm. The scope was isolated. The home had a history of related non compliance. A voluntary plan of correction was issued on September 20, 2016. A compliance order was complied on September 28, 2016. [s. 110. (2) 4.]

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 residents who are restrained will have the physical device removed, the resident will be repositioned and the physical device will be reapplied at least once every two hours. Documentation will include every release of the device and repositioning of the residents, to be implemented voluntarily.

WN #6: 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 :

1. The licensee has failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

In an interview the Pharmacist stated a regular dose of a medication was placed in the strip packages for a specified resident. The Pharmacist acknowledged that the medication was a controlled substance and that when in the strip packaging for regular dosing to a resident it would not be double locked. The Pharmacist stated that "as needed" (PRN) medication should be counted each shift and treated as a narcotic.

Interview with the Director of Care (DOC), they stated that identified medication was in the daily strip packaging for specified residents given on a daily basis would not be double locked. The DOC stated that because regular dose medication was not counted as they would not expect the as needed (PRN) medication be counted and therefore counting every shift of this medication is not done.

In interviews with Registered Practical Nurses (RPN) they stated that the PRN identified medication was not counted each shift.

The licensee has failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

The severity of the issue was determined to be potential for actual harm. The scope of the issue was isolated. The home had history of unrelated non compliance. [s. 129. (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 that drugs are stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies and that is secure and locked and that controlled substances will be stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart, to be implemented voluntarily.

WN #7: 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 where the drugs are stored it is restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator.

During observations of the storage room where medication and treatment carts are kept, it was observed that medications had been left unsecured.

On March 10, 2017 the inspector observed the maintenance person opening the door and entering the room to empty the garbage.

In an interview the Registered Practical Nurse, acknowledged that all staff have access to enter this room using a code. The Director of Care (DOC) stated that the medication storage area observed was not considered the medication room and that anyone who had the code for that keypad can enter that room.

The licensee has failed to ensure that where the drugs are stored it is restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator.

The severity of the issue was determined to be potential for actual harm. The scope of the issue was isolated. The home had a history of unrelated non compliance. [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 to ensure that the area where drugs are stored are restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that an identified resident was administered drugs in accordance with the directions for use specified by the prescriber.

Review of the clinical record for an identified resident showed a Physician's order included a scheduled specified medication be given two times a day for responsive behaviours. An order was also left for an as needed (PRN) dose of the specified medication for responsive behaviours - may administer once a day.

A review of the identified resident's Medication Administration Record (MAR) showed that an as needed (PRN) medication was administered to the resident twice in one day on an identified date to manage the identified resident's behaviours.

In interviews, the Registered Practical Nurse (RPN) acknowledged administering the PRN medication despite that it had already been given earlier in the day. The RPN acknowledged that the physician should have been contacted for an order if additional sedation was required.

The Director of Care (DOC) acknowledged that the PRN medication order was for the medication to be administered once a day as needed and that it had been given twice on one day.

2. The licensee has failed to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident.

On two specified dates, two identified residents were observed to have medications left

by their plates in the dining room during the meal.
Both residents were seated at tables with other residents in attendance.

During observations on one of the dates, the Registered Practical Nurse (RPN) did not remain in the dining room to observe the residents take the medication. The RPN remained in the dining room but was taking orders from resident's for their meal preference.

Review of the Physician order and Medication Administration Record (MAR) for these residents did not show evidence of a physician order related to a resident administering a drug to him or herself.

Review of the plan of care for the identified residents did not show evidence of documentation related to the resident's preferences related to medication administration or self-administration of medications.

During interviews the Registered Practical Nurses (RPN) stated that it was the resident's wishes to take their medication with their meal. One RPN stated I know you are supposed to make sure the resident takes their medications.

The Director of Care (DOC) they stated it would not be an expectation that the RPN observe the resident take their medications as the residents are competent and capable of ensuring their table mates do not take their medications. The DOC also stated the dietary aide and/ or Personal Support Worker (PSW) assisting to porter residents out of the dining room would alert the nurse should a pill be left.

The licensee has failed to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident.

The severity of the issue was determined to be potential for harm. The scope of the issue was isolated. The home had a history of unrelated non compliance [s. 131. (5)]

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 medication is administered to all residents in accordance with the directions for use specified by the prescriber. In addition to this the licensee will ensure that all residents who self-administer medications will have approval by the prescriber to self-administer the medications, to be implemented voluntarily.

WN #9: 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. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

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).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction was:
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and
(b) reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending

physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

Review of clinical records and incident reports for a three month period showed:
Eleven incidents reports had no documented evidence to support that the resident and/or family had not been notified of the medication incident.
Nine incident reports had no documented evidence to support that the doctor had been notified.
Two of the incident reports the staff recorded the incident had an impact to the resident and there is no progress note or documentation to support that an assessment had been done to ensure the residents wellbeing.

The Director of Care (DOC) acknowledged that the doctor and family notifications were not always completed and stated they could find no evidence that these notifications had occurred.

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

Review of clinical records and Review of incident reports from a three month period showed an incident where a medication package was found to be opened and missing a medication out of the package; there were no corrective actions noted on the form and no investigation notes. The Director of Care (DOC) confirmed there were no investigation notes on this incident.

Review of incidents involving a pharmacy error showed no corrective action was noted on the incident form. The Pharmacist acknowledged that there should be a corrective action comment and that the pharmacy would have the detailed investigation and action plan in their office but not always at the home.

For incidents involving a medication error, no corrective action plan was documented.

The DOC stated during interviews that there was no written corrective action or analysis for listed incidents.

In interviews, Registered Practical Nurses (RPN's) and Registered Nurse (RN) stated they were not informed of the medication errors that they were involved in.

The licensee has failed to ensure that (a) all medication incidents and adverse drug reactions were documented, reviewed and analyzed; (b) corrective action was taken as necessary; and (c) a written record was kept of everything required under clauses (a) and (b). [s. 135. (2)]

3. The licensee has failed to ensure that (a) a quarterly review was undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; (b) any changes and improvements identified in the review were implemented; and (c) a written record is kept of everything provided for in clauses (a) and (b)

Review of the meeting minutes March 10, 2017 of the "PT&T Committee" and the "Pharmacy Report" noted the number of incidents in the home during a three month period. There was no analysis or corrective action plans written in these reports. In the report dated December 9, 2016 from the PT & T meeting trends were discussed, plan was addressed and no follow up with that implementation was recorded or reviewed at the next meeting

In an interview with the Director of Care (DOC), they stated that medication incidents are reviewed and discussion about trends are completed at the quarterly PT &T meeting but that the committee does not always those action plans into their minutes. The DOC stated there was no written corrective action plan for the last quarter of incidents.

The licensee has failed to ensure that (a) a quarterly review was undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; (b) any changes and improvements identified in the review were implemented; and (c) a written record is kept of everything provided for in clauses (a) and (b).

The severity of the issue was determined to be potential for harm. The scope of the issue was a pattern. The home had a history of non related non compliance. [s. 135. (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 with ensuring that every medication incident involving a resident and every adverse drug reaction is documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and is reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider and that (a) all medication incidents and adverse drug reactions were documented, reviewed and analyzed; (b) Corrective action was taken as necessary, and a written record was kept of everything required under clauses (a) and (b).

In addition the written plan should address how the licensee will achieve compliance related to ensuring a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; any changes and improvements identified in the review were implemented; and a written record is kept of everything provided for in the quarterly review and related to any changes and improvements identified and implemented, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O. Reg. 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all direct care staff receive the required training.

In an interview, the Director of Care (DOC) stated that for 2016 an online module had not been posted for staff to complete electronically and this module contained required programs.

The DOC stated they were not able to provide evidence that all direct care staff had been trained with respect to mental health issues, including dementia and behaviour management.

The licensee has failed to ensure that all direct care staff receive the required training as per s. 76 (7) for: Mental health issues, including care for persons with dementia; and Behaviour management.
. [s. 221. (2)]

2. The licensee has failed to ensure that all direct care staff receive the required annual training in Continence care and bowel management.

In an interview, the Director of Care (DOC) acknowledged that for 2016, the home was unable to provide documented evidence that all staff completed the training on Continence care and bowel management as one module of training for required programs had not been rolled out to staff; this module included continence care.

The severity of the issue was minimal harm. The scope of the issue was wide spread. The home had a history of non compliance. A voluntary plan of correction was issued on August 10, 2016. [s. 221. (2) 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 with ensuring that annual training for direct care staff will be provided related to Continence care and bowel management; techniques and approaches related to responsive behaviours, to be implemented voluntarily.

WN #11: 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 advice of the Residents' Council was sought in developing and carrying out the satisfaction survey, and in acting on its results.

A review of the minutes from the Resident Council meetings was completed and failed to show evidence that the Resident Council's advice was sought in developing and carrying out the satisfaction survey and in acting on its results.

The Administrator acknowledged that if it was not documented in the minutes of the meeting then input was not sought from the Resident Council for the satisfaction survey.

The severity of the issue was minimal risk. The scope of this issue was isolated. The home had a history of unrelated non compliance. [s. 85. (3)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): 3. A missing or unaccounted for controlled substance.

On an identified date an incident report regarding a resident documented that a specified medication was missing. Staff were unable to account for the missing controlled substance.

Review of the Critical Incident Reporting System (CIS) showed no Critical incident report was submitted by the home for this incident.

The Director of Care (DOC) acknowledged that no critical incidents were completed on the missing medication and that the police had not been notified of the missing medication.

In an interview with the Administrator, they stated that they would expect that mandatory reporting be done as required.

The severity of the issue was determined to be minimal risk of harm. The scope was isolated. The home had a history of unrelated non compliance. [s. 107. (3)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (3) The drugs must be destroyed by a team acting together and composed of,
(b) in every other case,
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) one other staff member appointed by the Director of Nursing and Personal Care. O. Reg. 79/10, s. 136 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a drug that is destroyed is not a controlled substance, it was done by a team acting together that was composed of:
i. one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
ii. One other staff member appointed by the Director of Nursing.

The Director of Care (DOC) stated that they were not involved in the non-narcotic destruction process and that none of the nursing staff from the home are included in this destruction process. The DOC stated the pharmacist has a technician that comes to do the destruction of non-controlled substances.

The Pharmacist stated that during non-narcotic destruction the registered staff place the medication in a bin under the sink and lock them until destruction. During destruction the registered staff unlock the door to allow access and the pharmacist destroys the medication without assistance from anyone from the home. There was not a record kept of that medication destruction system.

The licensee has failed to ensure that a drug that was destroyed was not a controlled substance, it was done by a team acting together that was composed of:
i. one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
ii. One other staff member appointed by the Director of Nursing. [s. 136. (3) (b)]

Issued on this 14th day of July, 2017

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

Original report signed by the inspector.