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

Division de la responsabilisation et de la performance du système de santé
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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
Mar 2, 2016	2016_236622_0004	002438-16	Resident Quality Inspection

Licensee/Titulaire de permis

MANORCARE PARTNERS II
6257 Main Street Stouffville ON L4A 4J3

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

FRIENDLY MANOR NURSING HOME
9756 County Road, #2 P.O. Box 305 DESERONTO ON K0K 1X0

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

HEATH HEFFERNAN (622), AMBER MOASE (541), JESSICA PATTISON (197), SUSAN DONNAN (531), WENDY BROWN (602)

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 10 – 12, 16 – 19 and the 22 - 26, 2016

The following critical incident and complaint inspections were also completed with the RQI:
015011-15 - complaint related to care of a resident
001039-16 - complaint related to a medication error
001616-16 - complaint related to resident to resident abuse
012508-15 - complaint related to staffing shortages
005257-16 – complaint related to bed rails and falls prevention
016941-15 – CI #0934-000010-15 related to staff to resident abuse during a resident transfer
000697-16 – CI # 0934-000002-16 related to staff to resident improper care

During the course of the inspection, the inspector(s) spoke with the Administrator, the Maintenance Supervisor, the Director of Nursing (DON), the Dietary Supervisor, the Life Enrichment Supervisor, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Health Care Aides (HCA), Laundry Aide, Housekeeper, Family members, and residents.
The inspectors conducted a tour of the home, made dining room and resident care observations, observed medication administration and practices, reviewed resident health care records, interviewed staff, residents and family, observed and reviewed infection control practices, resident and family council minutes, applicable home policies, the home's staffing schedules for the nursing department, and water temperature logs.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
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
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

- **9 WN(s)**
- **5 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with 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. (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).

Findings/Faits saillants :

1. The following findings are related to log 015011-15:

The licensee has failed to comply with LTHCA 2007, s. 6(1)(c) in that the plan of care for a resident does not set out clear directions to staff and others who provide direct care to the resident.

Resident #028 is currently assessed at moderate risk for falls and has fallen out of his/her bed on four occasions during a specified period.
Review of resident #028's MDS (Minimum Data Set) assessments in a specified period indicate that the resident has had falls, but states it will not be care planned. Review of the resident's most recent care plan shows no interventions in place for the resident to prevent falls.
On a specified date, resident #028 was observed in bed asleep at 1045 hours. A fall mat was in place on one side of the bed and a posey alarm was in place and attached to the resident. The bed was not in the lowest position. PSW's #118 and #119 entered the room and were asked by the Inspector about interventions in place to prevent falls for the resident. Both indicated that the posey alarm and fall mat were used, the fall mat being put in place recently. They also stated that the bed should be in the lowest position. Inspector pointed out that it currently was not and they agreed.
When asked how staff would know what interventions are in place to prevent falls for this resident, staff indicated they just know.
Resident #028 was observed later on a specified date and time and at this time the bed was noted to be in the lowest position with fall mat and posey alarm in place.
Evening PSW #111 was interviewed about how falls are prevented for resident #028 and

he stated that the resident's bed is put in the lowest position; he/she has a posey alarm in place and frequent checks when the resident is in bed. A fall mat was not mentioned. Both the day RPN #105 and the evening RN #126 were interviewed on a specified date and were unable to say if a fall mat was used for the resident, but both indicated that his/her bed should be put in the lowest position when he/she is in bed. As such the resident's care plan does not set out clear direction to staff in regards to use of fall mat, bed position and tab alarms as fall prevention interventions. [s. 6. (1) (c)]

2. The plan of care does not set out clear directions to staff on how often resident #028 is supposed to be repositioned.
Resident #028 has a history of impaired skin integrity and currently has a pressure ulcer according to his/her care plan dated a specified date. The resident is dependent on staff for repositioning when in bed and has a therapeutic mattress in place to promote healing. The resident's current care plan does not indicate how often the resident should be repositioned when in bed. During an interview with RN #107 she indicated that the PSW's do not document how often they reposition residents during a shift, but that the expectation would be every two hours when the resident is in bed.
The home's policy #NM-T67 titled Turning and Repositioning also indicates that all residents who are unable to reposition themselves in bed, will be turned approximately every 2 hours, or more frequently if required and placed in proper alignment.
PSW #111 indicated that resident #028 is repositioned every two hours when in bed on the evening shift.
RN #123, who works nights, was interviewed on a specified date when her shift was ending by Inspector #531. She indicated that the resident had been turned and repositioned at 0130, 0430 and then again at 0630. She indicated that there is no written plan for turning and positioning resident #028.
Upon review of the progress notes, it was noted that since the specified date there are thirteen progress notes indicating that the resident was repositioned two times on the night shift and two progress notes that indicate the resident was repositioned 3 times on the night shift. [s. 6. (1) (c)]

3. The licensee has failed to comply with LTCHA 2007, s. 6(7) in that resident's plans of care were not followed with respect to resident's sleep patterns and preferences.
A concern was brought forward to Inspector #197 that residents were being woken up before their preferred wake-up times.
Inspector #531 arrived in the home at 0630 hours on February 26, 2016. At this time it was observed that approximately fourteen residents were already up and in the hallway. During an interview with PSW #121, RN #123 and PSW #125, they indicated to inspector

#531 that staff come in at 0600 hours and work with the night PSWs to start getting residents up and dressed.
Three of the fourteen residents up at 0630 hours were residents #027, #028 and #041. Residents #028 and #041 were observed sleeping and waiting outside the tub room, along with one other resident to have a bath. Resident #027 was observed in the hallway to be fully dressed and sleeping in his/her chair in the dark.
The "Getting to Know You Admission Assessment" for resident #027, dated on a specified date indicates that the resident's usual wake up time is 0730-0800 hours. The current care plan for resident #027 dated a specified date does not indicate that this preference has changed.
The "Getting to Know You Admission Assessment" for resident #028, not dated, indicates that the resident's usual wake up time is 0800 hours. The current care plan for resident #028 dated a specified date does not indicate that this preference has changed.
The "Getting to Know You Admission Assessment" for resident #041, dated a specified date indicates that the resident likes to sleep in until 0900 hours. The current care plan for resident #041 dated a specified date does not indicate that this preference has changed.
Inspector #531 interviewed the Director of Care who indicated that resident's preferences with respect wake up time should be respected by staff and only those who wish to have their care early should be awakened by staff. [s. 6. (7)]

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 in ensuring the plan of care for a resident sets out clear directions to staff and others who provide direct care to the resident, the resident's plan of care is followed with respect to the residents sleep patterns and preferences, to be implemented voluntarily.

WN #2: 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 comply with LTCHA 2007, s. 15(2)(c) in that the home, furnishings and equipment have not been maintained in a safe condition and in a good state of repair.

The following observations were made by inspectors from February 10-16, 2016:
Room 201 - Paint on lower one foot of the door is scraped (622)
Room 202 - the kick panels on both the door to the room and the washroom door has one corner peeling off. The toilet is sitting on a crooked angle in the washroom allowing the left side of the toilet tank to be approximately two and a half inches from the wall. The faucet is noted to have grey scaling/corrosion around both the hot and cold water taps. (622)
Room 204 - Just inside the doorway to the left wall a metal wall grate is noted approximately one and a half feet up from the floor. This metal plate is noted to have an electrical plug in it, is noted to be loose and sticking out from the wall about half an inch on the door side end. This metal cover/plate could be caught by something passing by. Ceiling tile above bed has a round hole cut in it. The frame work for this tile is damaged allowing gaps around the tile. Bottom outer edge of the door is chipped away. (622)
Room 205 - The faucet in the washroom is noted to be corroded around the base (622)
Room 210 - Faucet in the bathroom is corroded and rusted at the base (622)
Room 212 - Rusty/corroded privacy curtain tracks for bed two (622)
Room 214 - Side of closet in bedroom has large hole (197)
Room 217 - Bathroom door and door frame have large chips out of paint and faucet in the bathroom is corroded (197)
Room 221 - Linoleum flooring coming away from the wall in the bathroom (197)
Room 222 - Door knob does not fit the hole on the bathroom door leaving an open space (197)

Room 229 - Floor tiles in shared bathroom are coming apart leaving large gaps between tiles, chunk of floor/baseboard missing by baseboard heater underneath window in resident's room (197)
Room 232 - Corners of floor tile missing in center of bedroom, metal electric heater cover bent to right side, portions of linoleum tile missing in bathroom at corners, wood/paint chips in bathroom door (602)
Room 233 - Drywall and paint chipping in bathroom close to floor, linoleum not sealed at bathroom doorway corners, paint chipped near electric heater at the window, corner metal drywall and plastic trim not sealed at bathroom hallway near bedroom door area (602)
Room 235 - Paint chipping and drywall damage to lower bedroom walls near bathroom, paint chips in metal door frame around bathroom door (602)
Room 236 - Paint chipping and dry wall damage on lower bathroom door and in bedroom and bathroom, paint chips in metal door frame (602)
Room 238 - Paint chipping and dry wall damage in room, lower green border painted mid-wall and not finished, paint chips in metal door frame (602)
Room 240 - Paint chips in metal door frame (602)
Room 243 - Paint chipping and gouges out of drywall on lower wall in bedroom, paint chips in metal door frame in bathroom and bedroom (602)
During the initial tour of the home on February 10, 2016, Inspector #197 noted the following:
- the wood finish is worn off the legs and edges of some dining room tables
- resident bath tub has finish worn off by handles and are filled with caulking and there is another spot on the bottom of the tub where the finish is worn off
Non-intact and unfinished surfaces cannot be thoroughly cleaned, placing residents at increased risk for spread of infection. [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 in ensuring furnishings and equipment have been maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).**

**s. 73. (2) The licensee shall ensure that,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and O. Reg. 79/10, s. 73 (2).**

**s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).**

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 73 (1)8 that meals were not served course by course to residents during two lunch meals.
Lunch meals were observed in the home on February 10th and 19th, 2016.

On February 10th, 2016, Inspector #197 observed that all (three) residents at a specified table were served their entree before the residents had been assisted with their soup. In addition, five specified tables were all served dessert before the residents at each table were done their main course.
Many of these residents received ice cream as their dessert option, which would melt quickly once served and therefore negatively affecting the quality of the dessert.
On February 19th, 2016, Inspector #197 observed that the residents at two specified tables, who all required assistance with eating, received their soup and entree at the same time. Desserts were left for all residents at three specified tables, while all residents (except for one) were still eating with their entree and/or soup.
On February 19, 2016, Inspector #541 observed that residents # 19, 26, 29, 38 and 51 were all given their entree while they were still eating their soup.
On February 24, 2016, Inspector #197 spoke to the Food Service Supervisor who

indicated that course by course service is something the home needs to work on and that they are often rushed in the dining room due to the late arrival of nursing staff.
During an interview with the Food Service Supervisor on February 25, 2016, she indicated that they do not currently have any residents in the home who have been assessed as not requiring course by course service. [s. 73. (1) 8.]

2. The licensee has failed to comply with O. Reg. 79/10, s. 73 (2)(a) in that a staff member assisted three residents at the same time who require total assistance with eating or drinking.
On February 10, 2016 during the lunch meal, Inspector #197 observed RPN #105 providing feeding assistance to residents #028, 052 and 053 at the same time. A PSW later came to assist resident #028 so that RPN #105 did not have to assist all three residents though the entire meal.
The plans of care were reviewed for all three residents and all indicated that these residents require total assistance of staff for feeding from start to finish. [s. 73. (2) (a)]

3. The licensee has failed to comply with O. Reg. 79/10, s. 73 (2)(b) in that residents who require assistance with eating or drinking were served their meal before someone was available to provide assistance.
On February 10, 2016, Inspector #197 observed that resident #028 received soup at 1258 hours. At 1304 hours, RPN #105 began assisting the resident with his/her soup. The current care plan for resident #028 indicates that he/she requires total feeding assistance by staff.
On February 19, 2016, Inspector #197 observed that soup and entree were delivered to residents #053 and #054 at 1253 hours. At 1257 hours, staff began to provide assistance to resident #053. At 1304 hours, staff began to provide assistance to resident #054. The staff assisting resident #054 started feeding the resident the main course before the soup and when the soup was offered, it was not reheated. Resident #054 appeared not to enjoy his/her meal as staff was feeding him/her and only ate 1-2 spoonfuls of soup, one bite of pureed sandwhich and one bite of dessert.
The current care plans for residents #053 and #054 indicate that they both require assistance with their meals.
On February 19, 2016, Inspector #541 observed that at approximately 1300 hours, resident #040 was receiving assistance from staff member #102. At 1305 hours, staff member#102 left the table and was observed talking on the phone at the dining servery. Resident #102 was observed to be staring at his/her meal at this time while no staff was present to provide assistance. Staff #102 returned to the table to assist resident #040 at 1311 hours and left again at 1323 hours. Inspector #541 noted that resident #040 had a

full serving of salad untouched on the table when staff #102 left him/her.
The current plan of care for resident #040 states the following:
- Resident requires set up in the dining room, cut up meat, spread jam, etc. Also needs frequent reminders to eat, due to confusion, will forget to eat.; Resident is seated at a feeder table in the dining room, requiring constant assistance throughout the meal [s. 73. (2) (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 in ensuring meals are served course by course to residents at all meals, no person simultaneously assists more than two residents who need total assistance with eating or drinking, no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 90(2)(g) in that the temperature of the water serving all bathtubs, showers and hand basins used by residents has exceeded 49 degrees Celsius.

During the initial tour of the home on February 10, 2016, a PSW indicated to the inspector that the home has been having issues with their water being too hot. It was also noted by the inspector that there were signs posted above resident sinks indicating that the water is extremely hot.
Maintenance staff indicated during an interview that the home had been having trouble maintaining the water temperature at or below 49 degrees Celsius and provided a log of temperatures that the nursing staff have been taking daily. A copy of the log was provided to the inspector that covered the time period of January 14 to February 19, 2016. This daily temperature log showed that at least once per day during this time period, the water temperature servicing either a tub or sink exceeded 49 degrees Celsius, with the highest temperature recorded as 59.6 degrees Celsius.
Maintenance staff stated that action has been taken to regulate water temperatures in that a new mixing valve was installed in December 2015 and a separate holding tank/bladder was installed in January 2016. He indicated that these actions have helped but have not totally solved the problem as nursing staff continue to record temperatures above 49 degrees Celsius, with the highest temperatures occurring around 0400-0500 hours. Nursing staff are monitoring temperatures every two hours and before each bath to ensure resident safety.
The home continues to work with a plumbing company towards a permanent solution to regulate their water temperatures. [s. 90. (2) (g)]

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 in ensuring the temperature of the water serving all bathtubs, showers and hand basins used by residents has not exceeded 49 degrees Celsius, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participate in the implementation of the in the infection and control program.
On February 22, 2016, during, a lunch time, medication administration observation, Registered Nurse (RN #109) and Registered Nurse (#108) observed preparing and administering medications (oral) side by side to three residents without performing hand hygiene before or after resident and or resident environment contact; during this same observation RN #109 and RN #108 were seen touching the medication cart, the electronic eMAR (electronic medication administration record) monitor.(all completed without hand hygiene performed before or after contact with the above).
Registered Nurse (RN #108) and #109 indicated (to the inspector) hand hygiene was to be performed before and after resident and or resident environment, which includes before and after medication administration.
Registered Nurse #108 indicated (to the inspector) that she does wash her hands but she just forgot.
Registered Nurse (RN #109) indicated (to inspector #622) that his mind was on an incident that occurred prior to the noon medication pass.
The Home's "Hand Hygiene " policy # ICP H-4 states:
Policy:
Hand hygiene is the responsibility of all individuals involved in health care. All health care providers are expected to comply with hand hygiene.
• There may be several hand hygiene indications in a single care sequence or activity.
Examples of hand hygiene indications for health care providers when providing care are:
• Before initial contact with a resident or items in their environment
• Before putting on gloves when performing an invasive/aseptic procedure
• Before preparing, handling or serving food or medications to a resident
• Before moving to another activity
The DOC indicated (to the inspector) it is an expectation that hand hygiene is performed consistently by all staff; DOC indicated that all staff have had annual education regarding infection control practices and such includes hand hygiene (and the hand hygiene policy # ICP H-4) and the importance of the same. [s. 229. (4)] [s. 229. (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 in ensuring staff participate in the implementation of the infection and control program by staff performing hand hygiene, 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 every resident has 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.

During dining observation on February 19, 2016 there was noted to be a Resident Diet List posted on the bulletin board inside dining room beside the servery. This dining list contains each resident's name as well as if they have diabetes and any medication the resident takes related to diabetes.
This information can be viewed by any person entering the dining room, therefore the resident's personal health information with respect to medications prescribed to manage their diabetes, is not kept confidential. [s. 3. (1) 11. iv.]

WN #7: 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 the home's medication incident policy and procedure were complied with.
In reference to Log # 001039-16
On a specified date during the morning medication pass Registered Practical Nurse (RPN) #124 prepared and administered medication to resident #41 that were not prescribed for the resident.
The home's policy, "Medication error" (Policy #NM-M63) states:
Policy: All medication errors are reported and acted upon immediately.

Procedure:
#3. Assess the resident closely for 24 hours noting the resident's mental and physical status and behavioural changes. All assessments must be thoroughly documented in the resident's multidisciplinary progress notes. (This procedure must be adjusted depending on the severity of the error and the physician's orders)
#6. When a medication error occurs, consult with the pharmacist for management interventions.
Review of resident #41's multidisciplinary progress notes and internal incident report for a specified date indicate:
Internal medication incident report indicates the following:
Category: incident
Incident type: incorrect resident
Description: administered the wrong medication to resident #41
Physician notified: 0840 hours
Review of resident #41's multidisciplinary progress notes indicated there was no documentation of the medication incident or monitoring of resident noted until a specified date and time, twelve hours after the medication incident.
On February 24, 2016 Registered Practical Nurse (RPN) # 105, (RPN stated to the inspector) that the physician was notified @ 0840 hours and orders received to hold a specified medication and monitor the resident #41. RPN #105 told the inspector that she was not aware of the "medication error policy" or that she was to document in the resident's multidisciplinary progress notes. RPN #105 indicated that she did not notify or consult with the home pharmacist for management interventions.
Registered Practical Nurse #124 was interviewed and indicated that RPN #105 was assisting by notifying the physician and initiating the internal medication incident report. RPN #124 indicated that she did not recall how the resident was being monitored or if she documented the assessments as per policy.
Interview with the Administrator and the Director of Care both indicate the "medication error" policy was not complied with. [s. 8. (1) (b)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The following finding is related to logs 015011-15, 012508-15 and 005257-16:

The licensee has failed to comply with O. Reg. 79/10, s. 31(3) in that the home's written staffing plan does not include a back-up plan for nursing and personal care staffing that addresses situations when staff cannot come to work.

Staffing issues noted during the inspection period included:
-WN #1 related to staff waking residents up before their preferred wake times in order to get everyone up and ready for the day
-WN #3 related to one staff simultaneously feeding three residents who require feeding assistance and also residents not receiving assistance with their meal once it was delivered.

On February 25, 2016, the home's written staffing plan was reviewed. It was noted that the staffing plan provided did not include a back-up plan that addresses situations when staff cannot come to work.

The Director of Care was interviewed and she indicated that they follow their call-in procedure, which she did provide to the inspector. This call-in procedure did not explain what is done when staff are unable to come to work. [s. 31. (3)]

WN #9: 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).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10 s. 131 (1) whereby resident #41 consumed drugs not prescribed for the resident:
Reference to Log # 001039-16
Interview with Registered Practical Nurse #124 (RPN) and RPN #105 and review of the internal incident report confirm that RPN #124 administered medication to resident #41 that were not prescribed for the resident.
Review of resident #41's physician orders confirms that resident #41 consumed medication not prescribed for the resident. [s. 131. (1)]

Issued on this 2nd day of March, 2016

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

Original report signed by the inspector.