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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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
Jul 13, 2017	2017_582548_0008	005952-17	Resident Quality Inspection

Licensee/Titulaire de permis

Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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

GARDEN TERRACE
100 Aird Place KANATA ON K2L 4H8

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

RUZICA SUBOTIC-HOWELL (548), MICHELLE JONES (655), PAULA MACDONALD (138)

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): On May 8,9,10,11,12,15,16,17,18 and 19, 2017

The following critical incident inspections were conducted concurrently as a part of the Resident Quality Inspection:

Log 031509-16 and Log 035092-16 related to medication incident
Log 002281-1 injury resulting in significant change in health status
Log 003941-17 fall incident
Log 008641-17 resident to resident alleged physical abuse

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Cares (#113 and #132), Registered Nurses, Registered Practical Nurses, Personal Support Workers (PSWs), RAI Coordinator, Clinical Care Coordinator, Co-Chair of Family Council, Nutrition Care Workers (NCW), Nutrition Care Manager, Life Enrichment Worker, Resident member of Resident Council, Assistant Nutrition Care Manager, Registered Dietitian, Physiotherapist, Pharmacist and Environmental Services Manager, residents and Family members.

During the course of the inspection, the inspector(s) completed a tour of resident areas, observed medication administration and storage areas, observed resident care, observed meal services, reviewed medication incident documentation, reviewed Resident's Councils meeting minutes, reviewed Family Council meeting minutes, reviewed resident health records, reviewed food temperature logs, wheelchair cleaning documentation, reviewed home specific policies, protocol and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

- **11 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee failed to comply with section 68. (2) (b) of the Regulation in that the licensee failed to ensure that the nutrition care and dietary services and hydration programs include the identification of any risks related to nutrition care and dietary services and hydration.

Inspector #138 observed the lunch service on on a specified unit and day during the inspection. During the course of the lunch service the inspector reviewed the meal temperature log of the temperatures that were recorded by Nutrition Care Worker (NCW) #101 prior to the lunch service. It was noted by the inspector that some of the temperatures including the soup were recorded above 90 degrees Celsius (°C). The inspector spoke with NCW #101 about acceptable temperatures for serving meals to residents and the NCW stated that hot food temperatures must be above the temperature danger zone (above 60 °C) but the NCW was unable to identify a maximum or ideal temperature to serve to residents to minimize the risks of burns. The NCW did state that the soups can be hot at times and staff will portion the soup in a bowl and leave it to cool off a few minutes before serving. The inspector noted that this had been done during the lunch service however the soup temperature had not been rechecked

prior to service to residents to ensure it was safe.

At that same lunch service, resident #053 was provided a coffee along with other beverages. Resident #053 stated loudly after drinking some of the coffee that the coffee was too hot and that the resident's tongue had been burnt. The resident left the dining room, returned several minutes later and reported to RPN #100 that the resident's tongue had been burnt on the coffee, that the coffee was too hot. The Inspector observed the resident's coffee and noted that there was rolling steam coming from the coffee cup indicating that the coffee was very hot.

Inspector #138 reviewed some of the available meal temperature logs for May 2017. The inspector noted several temperatures recorded above 90 °C and recorded as high as 97 °C, close to the temperature of boiling water.

Inspector #138 spoke with the Nutritional Care Manager regarding the serving temperatures of food and fluid to residents. The Nutritional Care Manager stated that hot foods are required to be above the temperature danger zone (above 60 °C) and acknowledged that there was no practice or policy in the home that outlined a maximum or ideal temperature to serve hot food and fluids to residents to minimize the risks of burns.

As such, the licensee has not identified within the dietary services program the risk of hot food and fluid temperatures to residents. [s. 68. (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 to ensure the home identifies within the dietary services program the risks of hot foods and fluids served to residents, to be implemented voluntarily.

WN #2: 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 has failed to ensure that every medication incident involving a resident is documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and that every medication incident involving a resident is 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.

On May 15, 2017, DOC #113 provided Inspector #655 with copies of seventeen medication incident reports, each report outlining a medication incident occurring in the home between the period of January 2017 and May 2017.

Inspector #655 reviewed the medication incident reports and identified five incidents that affected a resident and/or involved a high-risk medication.

i. A medication incident occurred on a specified day in January 2017. According to the medication incident report, an error occurred at the level of order entry and/or transcription; but did not reach the resident. According to the medication incident report, RPN#143 observed that on a specified day in December 2016, a medication had been discontinued on the resident’s Medication Administration Record (MAR) without an order. The intervention, as recorded on the medication incident report, was to put the medication on the MAR and administer it. However, in an entry made by pharmacy on the same medication incident report, it is indicated that on a specified day in December 2016, an order was received for another medcation that was a duplicate therapy; and that for this reason, the initial medication had been stopped. On the medication incident report, it is further indicated that neither the residents’ family nor the physician were notified of the medication incident. In addition, there was no record of the immediate actions taken to assess and maintain the resident’s health together with the medication incident report.

During an interview on May 18, 2017, Inspector #655 reviewed the medication incident with DOC #113 and the Licensee’s Pharmacist. During the interview, DOC #113 indicated to Inspector #655 that when the nurse had identified that the first medication was removed from the residents’ MAR without an order, the physician was contacted by the nurse for clarification. The DOC #113 indicated to Inspector #655 that the medication was discontinued as required, before it was administered to the resident. DOC #113 indicated to Inspector #655 that the resident had not been affected by the error.

Inspector #655 reviewed the MAR belonging to the resident involved in the medication incident. According to the resident’s MAR, the resident received both medications for two days.

During interviews on May 18 and May 19, 2017, RPN #143 and DOC #132 confirmed, after reviewing the residents' MAR, that the resident involved received both medications

for two days. DOC #132 further indicated to Inspector #655 that she was not aware of the incident as described in the report and DOC #113 also indicated to Inspector #655 that she was not familiar with the medication incident.

Prior to the inspection, neither DOC was aware that the resident had received duplicate therapies.

ii. A medication incident occurred on a specified day in March 2017. According to the medication incident report it was related to an error that occurred at the level of administration. A resident was administered a medication from a bottle which was inappropriately labeled. According to the incident report, the medication was supplied by the resident's substitute decision-maker with a label on which there was no patient name, no medication name, no route of administration, and no expiry date. According to the medication incident report, the resident received the medication from the unlabelled bottled for two consecutive days. Over the course of the inspection, it was determined through discussion with DOC #132 that the admitting nurse administered the medication from the inappropriately labeled container to the resident for two days, before another nurse identified that the inappropriately labeled container was being used and brought it forward to DOC #132. On the incident report, there was no record of the immediate actions taken to assess and maintain the resident's health.

iii. There was a group of medication incidents that occurred on a specified day in April 2017 related to an error at the level of medication administration – specifically, an error related to the administration of insulin. According to the medication incident reports, an agency nurse was unfamiliar with the insulin pens being used to administer the following medications to three separate residents. According to each of the medication incident reports, the agency nurse did not put a needle onto the insulin syringe before administering the insulin. On review of each of the incident reports, it was indicated that neither the residents' family nor the physician had been notified of any of the three related medication incidents. Over the course of the inspection, it was determined through discussion with the DOCs that because the error was discovered late at night, a resident's family or SDM would not have been notified at the time of the incident; but may have been notified the following day.

Over the course of the inspection, both DOC #113 and DOC #132 indicated to Inspector #655 that the Medical Director is not necessarily made aware of every medication incident involving a resident.

During an interview on May 18, 2017, DOC #113 and the Licensees' Pharmacist indicated to Inspector #655 that medication incidents are reviewed at PAC meetings, which take place on a quarterly basis. At the same time, it was indicated to Inspector #655 that the Medical Director attends the PAC meetings. It was further indicated to Inspector #655 that the last PAC meeting was held on December 1, 2016 and involved a review of medication incidents occurring between June and August, 2016. No documentation was provided to demonstrate the Medical Director had been notified of any medication incident occurring after August, 2016.

The licensee has failed to ensure that every medication incident involving a resident is documented together with a record of the immediate actions taken to assess and maintain the resident's health.

The licensee failed to ensure that every medication incident involving a resident is reported to the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the resident's attending physician, and the Medical Director. [s. 135. (1)]

2. The licensee has failed to ensure that all medication incidents are reviewed and analyzed.

Over the course of the inspection, the process for medication incident reporting was reviewed by Inspector #655 with DOC #113 and DOC #132.

According to DOC #132, all medication incident reports are first submitted by registered nursing staff (as a medication incident notification) to DOC #113 through an electronic reporting system. DOC #132 explained that DOC #113 is responsible for responding to medication incidents that occur involving any resident on two floors and she is responsible for medication incident followup on the remaining floors upon notification.

During an interview on May 17, 2017, Inspector #655 reviewed several medication incident reports including with DOC #132 – both incidents having occurred on her responsible floor. According to each of the medication incident reports, both incidents involved an error that reached the resident. DOC #132 was unable to speak to either medication incident. At the same time, DOC #132 indicated to Inspector #655 that she had not received a medication incident notification or report for either incident; and had not done any follow-up.

Neither of the two medication incidents were reviewed or analyzed by the DOC #132.

Inspector #655 also reviewed another medication incident with DOC #132 upon identifying that the incident affected a resident on the floor of her responsibility.

As described in part one of the finding as related to an incident that occurred on specified day in January 2017. According to the medication incident report, RPN #143 observed that on a specified day in December 2016 a medication had been discontinued on the resident's Medication Administration Record (MAR) without an order. The intervention, as recorded on the medication incident report, was to put the medication on the MAR and administer it. However, in an entry made by pharmacy on the same medication incident report, it was indicated that an order was received for another medication that was a duplicate therapy; and that for that reason, the original medication was to be stopped.

During an interview on May 18, 2017, DOC #132 reviewed the MAR belonging to the resident involved in the incident with Inspector #655 present. On review of the residents' MAR, DOC #132 acknowledged that the resident had received both medications which for two days. At the time of the interview, DOC #132 indicated to Inspector #655 that prior to the interview, she was not aware of the incident and had not received or reviewed the medication incident notification or final report provided by pharmacy.

On May 19, 2017, DOC #113 also indicated that she was not familiar with medication incident and had not been reviewed or analyzed by either DOC #113 or DOC #132.

DOC #132 explained that as a result of a change in the medication incident reporting system, she had not received any medication incident notifications or reports for some time.

During an interview on May 19, 2017, DOC #132 indicated to Inspector #655 that with the current processes in place, it is possible that a medication incident is missed when one of the DOCs is away.

The licensee failed to ensure that all medication incidents are reviewed and analyzed. [s. 135. (2)]

3. The licensee has failed to ensure that a quarterly review is undertaken of all medication incidents that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents.

During an interview on May 15, 2017, DOC #113 was unable to speak to a process for ensuring that a quarterly review of all medication incidents that have occurred in the home since the time of the last review was undertaken. During the same interview, DOC #113 indicated to Inspector #655 that medication incidents may be discussed in PAC meetings as needed, but that there was no process in place for this.

Following the initial interview, however, DOC #113 indicated to Inspector #655 that a quarterly review of medication incidents actually does occur; and that pharmacy prepares a quarterly report which is discussed at PAC meetings, which are expected to take place every three months.

Inspector #655 was provided with a copy of the “Clinical Consultant Pharmacist Quarterly Report" (quarterly report) dated December 1, 2016.

Inspector #655 reviewed the quarterly report during an interview with DOC #113 and the Pharmacist on May 18, 2017. During the interview, the Pharmacist indicated to Inspector #655 that for the purpose of the December 1, 2016 quarterly report, medication incidents occurring between the period of June and August, 2016, would have been the focus of the report and the PAC meeting at which the report would have been reviewed. At the same time, the Pharmacist indicated to Inspector #655 that December 1, 2016, was also the date of the PAC meeting. The Pharmacist indicated to Inspector #655 that because the meeting was held in December, and the report only contained incidents that occurred between June and August, 2016; there would have been verbal discussions related to more recent incidents at the time of the December, 2016, PAC meeting as well. However, neither the Pharmacist nor the DOC #113 were able to demonstrate any documentation to indicate that any medication incidents occurring after August, 2016, had been reviewed.

During the interview on May 18, 2017, DOC #113 indicated to Inspector #655 that the December 1, 2016, PAC meeting was the most recent PAC meeting. DOC #113 explained that the March, 2017, PAC meeting had been cancelled; and the next PAC meeting would take place on June 8, 2017.

There was no record to indicate that any medication incident occurring in the home after August, 2016, had been reviewed as part of a quarterly review process. [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 that every medication incident involving a resident is documented, together with a record of the immediate actions taken to assess and maintain the resident's health, to be implemented voluntarily.

WN #3: 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. (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 licensee has failed to ensure that the care set out in the plan of care was provided to resident #012 as specified in the plan.

On a specified day in May 2017, Inspector #655 observed the bed system belonging to resident #012 to have two 1/4 length bed rails (assist rails) to be in the up position. At the same time, from the foot of the bed, Inspector #655 observed that there was a larger space between the left bed rail and mattress when compared to the right side. A family member of resident #012 was present at the time of the observation and indicated to Inspector #655 that the residents' mattress had recently been changed.

Inspector #655 reviewed the health care record belonging to resident #012, who has multiple diagnoses, was known to be a wanderer and had both a morning and afternoon nap.

In the resident's current care plan it was indicated that resident #012 uses assist bed rails when in bed for safety and mobility. In an update made to the same care plan on April 17, 2017, it was indicated that resident #012's bed system had failed a bed entrapment assessment that had been conducted by an outside service provider. According to the care plan, security checks were to be conducted every 30 minutes for

resident #012 until the resident's bed system was given a passing grade. In the care plan, it further specified that the security checks were to be done on paper.

During an interview on May 12, 2017, PSW #136 indicated to Inspector #655 that resident #012 uses bed rails for mobility and for transfers. At the same time, PSW #136 accompanied Inspector #655 to resident #012s' room in order to observe the positioning of the bed rails. Two 1/4 length bed rails remained in the up position. According to PSW #136, this was the way the bed rails were normally positioned for resident #012. During an interview on the same day, PSW #136 indicated to Inspector #655 that resident #012s' typical routine included going back to bed in the morning and afternoon. At the time of the interview, PSW #136 indicated to Inspector #655 that resident #012 required monitoring due to a tendency to wander (not entrapment risk); but was unable to speak to whether or not every 30 minute security checks were expected to be documented for resident #012.

During an interview on May 12, 2017, RPN #144 indicated to Inspector #655 that she was not sure if resident #012 was being monitored every 30 minutes while in bed due to safety concerns related to the bed system.

During an interview on May 12, 2017, RN #134 indicated to Inspector #655 that security checks are in place for resident #012 and that the resident is expected to be monitored every 30 minutes at night, and whenever the resident is in bed during the day. DOC #132 confirmed the same.

During an interview on May 15, 2017, the Clinical Care Coordinator (CCC) #137 indicated to Inspector #655 that if a bed system which had previously failed the entrapment testing had since been given a passing grade, it would be noted in the residents' care plan and progress notes. According to CCC #137, if a passing grade has not been identified in the residents care plan or progress notes, the security checks intervention is expected to remain in place. CCC #137 demonstrated to Inspector #655 that the security checks are expected to be documented on the "30 Minute Security Check Flow Sheet" every 30 minutes.

Over the course of the inspection, Inspector #655 was unable to locate any documentation that would indicate that resident #012s' bed system had been given a passing grade at the time of the inspection.

Inspector #655 observed the security checks documentation for resident #012 (the "30

Minute Security Check Flow Sheet") for the a specified period of time. Security checks were documented from 2300-0600, every 30 minutes, on all dates between a specified period of time. It was noted, however, that there were no day time security checks documented for several days.

On May 16, 2017, Inspector #655 observed the resident to be sleeping in bed for one hour in the morning. The Inspector #655 remained in close proximity to resident #012s' room – the room remained in the Inspectors sight. For the duration of the observation period (1 hour), Inspector #655 did not observe any staff member perform a security check on resident #012. At the same time, Inspector #655 observed that both 1/4 length bed rails remained in the up position for the duration of the observation period.

During an interview on a specified day in May 2017, PSW #136 indicated to Inspector #655 that between the hours of the Inspector's observation on that day she was on the other side of the unit – and was not on resident #012s' home area. PSW #136 further indicated to Inspector #655 that she would have checked on resident #012 before leaving the home area but would not have checked on resident #012 again herself until one hour later. PSW #136 indicated to Inspector #655 that there was no PSW staff on resident #012s' home area while she was away. PSW #136 was unable to confirm whether another staff member had conducted any security checks for resident #012 during that time. According to PSW #136, she is often called upon to assist with the care of residents on the other side of the unit during the day shift; and for this reason, security checks – including those in place for resident #012 – are not always completed every 30 minutes.

The licensee failed to ensure that the care set out in the plan of care related to security checks was provided to resident #012 as specified in the plan. [s. 6. (7)]

WN #4: 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 failed to ensure that the policy titled "Shift Change Monitored Drug Count", dated January, 2014, was complied with, as per Ontario Regulation 79/10, s. 114 (3) (a): The written policies and protocols must be developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

On a specified day a critical incident report (CIR) was submitted to the Director under the Long-Term Care Homes Act (LTCHA), 2007, related to a controlled substance that was missing or unaccounted for.

According to the CIR, during the evening medication pass (at 2000 hours) on a specified day in December 2016, an evening registered nurse noticed that two tablets of a barbiturate, belonging to resident #031, were missing from resident #031s' blister pack. The two missing tablets would have been for the morning dose of specified day in December 2016. Two nurses had completed a Shift Change Monitored Medication Count at 1500 hours on that day; had not noticed that any tablets were missing. The missing barbiturate tablets were never accounted for.

On a specified day in May 2017, Inspector #655 observed the 0800 hours medication pass for resident #031. At the time of the observation, RPN #104 was observed to administer two 30 mg tablets of the barbiturate to resident #031. Immediately following the administration RPN #104 was observed to record the balance of barbiturate tablets remaining in resident #031s' blister pack on the residents' individual Monitored Medication Record. On observation, there was no indication that RPN#104 had counted the individual tablets remaining in resident #031s' blister pack. During an interview at the same time, RPN #104 indicated to Inspector #655 that because the initial quantity of

barbiturate tablets was recorded at the top of the blister pack, she could determine the remaining balance by subtracting two, rather than by counting each individual tablet.

On a specified day in May 2017, Inspector #655 spoke to RPN #142 who was identified in the CIR as being one of the registered nurses who conducted the Shift Change Monitored Medication Count at 1500 hours on the specified day in December 2016 – the day the CIR was submitted to the Director.

During the interview, RPN #142 also indicated to Inspector #655 that he was one of two registered nurses who completed the Shift Change Monitored Medication Count at 1500 hours on the day the CIR was submitted to the Director.

During the same interview, RPN #142 indicated to Inspector #655 that when he performed a count of the remaining barbiturate tablets in resident #031s' blister pack as part of the shift change medication count he did not notice if two tablets were missing. According to RPN #142, at the time of the incident, the individual and shift change counts for controlled substances were being done by counting the number of "blisters" (or doses) remaining in the resident's blister pack – the practice was not to count each individual tablet remaining in the blister pack. RPN #142 indicated to Inspector #655 he would not have counted the individual tablets of in resident #031s' blister pack when completing the individual Medication Monitoring Record for resident #031; nor when completing the Shift Change Monitored Medication Count.

Inspector #655 reviewed resident #031s' health care record. According to the health care record, resident #031 was to receive four times daily. At the time of the incident, all four doses were stored in the same blister pack. Each individual blister would have contained one to three tablets. The count would not be expected to decrease by an increment of one each time, if the total quantity of tablets were counted.

Inspector #655 reviewed resident #031s' individual Monitored Medication Record for the day of the medication incident. On the individual Monitored Medication Record, the balance of barbiturate tablets is recorded for the four administration times.

Inspector #655 also reviewed the Shift Change Monitored Medication Count sheet for the day of the incident. Neither the Individual Monitored Medication Record nor the Shift Change Monitored Medication Count for the specified day of the incident reflected the actual quantity of tablets administered to resident #031 each time; nor the actual quantity of tablets remaining after each administration.

During an interview on May 18, 2017, DOC #132 indicated to Inspector #655 that registered nursing staff are expected to count each individual remaining tablet in a residents' blister pack when counting a controlled substance. DOC #132 confirmed that when the Shift Change Monitored Medication Count sheets were reviewed in response to the incident it was identified that nursing staff were counting doses rather than individual tablets. DOC #132 further indicated that prior to the incident involving resident #031 and two missing tablets of medication she was not aware that the nursing staff were counting total doses remaining as opposed to the total quantity of individual tablets remaining when counting a controlled substance.

Inspector #655 reviewed the licensees' policy titled "Shift Change Monitored Drug Count", dated January, 2014. In the policy, it is stated that two registered nursing staff are expected to conduct the shift change count together; and to do so by counting the actual quantity of medications remaining.

The licensee failed to ensure that the policy "Shift Change Monitored Drug Count" was complied with. [s. 8. (1) (b)]

WN #5: 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 resident equipment, including walkers and wheelchairs, are kept clean and sanitary.

On a specified day in May 2017, the wheelchair belonging to resident #021 was observed by Inspector #138 to be unclean. Three days later, Inspector #655 also observed the wheelchair belonging to resident #021 to be unclean, with white stains and dried debris on both armrests and on the seat cushion.

On two days in May 2017 the walker belonging to resident #003 was observed by Inspector #655 to be unclean with white stains on the walker seat.

During an interview on a specified day in May 2017, PSW #125 indicated to Inspector #655 that it is the responsibility of night-staff (PSWs) to clean resident equipment including wheelchairs and walkers, in accordance with an established cleaning schedule. PSW #125 indicated, however, that when a walker or wheelchair is observed to be soiled during the day shift, it is the responsibility of day staff to ensure that the equipment is wiped clean in the interim. In that case, PSW #125 indicated to Inspector #655, that the evening and subsequently the night staff would then be made aware of the need to clean the residents' equipment before the scheduled cleaning.

Inspector #655 reviewed the "Night Shift Cleaning Duties" schedule for the month of May, 2017, for each residents' home area. According to the cleaning schedule, the wheelchair belonging to resident #021 was scheduled to be cleaned once weekly on specific dates and according to the cleaning schedule, the walker belonging to resident #003 was scheduled to be cleaned once weekly on specific dates.

On review of the cleaning schedules, Inspector #655 was unable to locate any documentation to indicate that either resident #021s' wheelchair or resident #003s' walker had been cleaned at any time in the month of the observation.

Over the course of the inspection, PSW #100 and RPN #120 indicated to Inspector #655 that staff are expected to initial directly below the date on the Night Shift Cleaning Duties once a residents walker or wheelchair had been cleaned.

During an interview on May 15, 2017, PSW #120 indicated to Inspector #655 that she could not determine that the walker belonging to resident #003 had been cleaned based on the documentation on the cleaning schedule.

During an interview on May 18, 2017, RPN #100 indicated to Inspector #655 that, based on the lack of documentation on the cleaning schedule she could not determine whether or not resident #021s' wheelchair had been cleaned as scheduled.

On May 15, 2017, Inspector #655 observed the wheelchair belonging to resident #021, and the walker belonging to resident #003 still to be unclean.

The licensee failed to ensure that the walker belonging to resident #003, and wheelchair belonging to resident #021 was kept clean and sanitary. [s. 15. (2) (a)]

WN #6: 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 failed to 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.

A CIR was submitted was submitted to the Director under the Long-Term Care Homes Act (LTCHA), 2007 of resident's #045 unwitnessed fall incidents.

According to the CIR, resident #045 was found on the floor between the bed and closet in the resident's room. The resident sustained an injury. A few days later the resident was found lying on the floor in their room between the bed and closet.

On May 12, 2017 during an interview with Inspector #548 the Clinical Care Coordinator (CCC) indicated that after every fall incident a resident is to be assessed using the electronic tool "Fall Investigation Tool/Fall assessment". She further explained that the tool is used to record an analysis and the precipitating factors relate to the fall incident. She further explained the "Fall Investigation Tool/Fall assessment" tool is a clinically appropriate assessment tool specifically designed for post fall assessments.

The Inspector #548 reviewed the resident's #045 health care record and could not locate the electronic post fall assessment for a specified date in February 2017.

During an interview with Inspector #548, May 12, 2017, the DOC indicated that each fall incident is assessed using the fall assessment tool however, from her review of the resident's #045 health care record the assessment was not conducted as required for the fall incident.

As such, the Licensee failed to ensure a post fall assessment was conducted for Resident #045. [s. 49. (2)]

WN #7: 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 failed to comply with section 85. (3). of the Act in that the licensee failed to ensure that the licensee shall seek out 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.

Inspector #138 spoke with the Co-Chair of the Family Council regarding the satisfaction survey that is required by the licensee to be conducted each year to measure resident and family satisfaction with the home and the care, services, programs and goods provided at the home. The Co-Chair of the Family Council stated that the satisfaction survey had been conducted for this year and the results are expected to be communicated to the Family Council in the near future. When asked by the inspector if the Family Council had been given an opportunity to provide advice into the development and carrying out of this recent satisfaction survey, the Co-Chair of the Family Council responded by stating that there had not been such an opportunity.

Inspector #138 spoke with the Life Enrichment Coordinator, who is assigned to assist the Family Council, regarding the development and carrying out of this year's satisfaction survey. The Life Enrichment Coordinator stated that she did not have any knowledge of this as it pertained to the Family Council and directed the inspector to speak with the Administrator.

Inspector #138 did speak with the Administrator regarding an opportunity for the Family Council to provide advice on the developing and carrying out of this year's satisfaction survey. The Administrator stated that she had not been aware of this requirement and so no such opportunity had been provided to the Family Council.

As such, the licensee failed to seek out the advice of the Family Council in developing and carrying out the satisfaction survey. [s. 85. (3)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to comply with section 87. (2) (d) of the Regulation in that the licensee failed to ensure that procedures are implemented and developed for addressing incidents of lingering offensive odours.

Inspector #138 observed throughout the course of the inspection that there was a strong urine like odour on one of the floors. It was observed by the inspector that the window in the lounge was consistently opened with a breeze blowing into the lounge and that, despite this breeze, the urine like odour was still strong.

Inspector #138 spoke with the Director of Care #113 regarding the strong urine like odour. The Director of Care stated that the odour is caused from a resident who urinates on the radiator in this lounge. The Director of Care described interventions trialed and/or in place with this resident to try to prevent this behaviour from happening. The Director of Care was unable to outline the specific details of the procedures implemented to address the strong urine odour but did state that she was aware that Environmental Services used charcoal bags and a specific cleaning product.

Inspector #138 also spoke with the Environmental Service Manager regarding the strong urine smell in the front lounge on the east side of the first floor. The Environmental Services Manager was aware that the odour is caused from a resident who urinates on the heating radiator in this lounge. The Environmental Services Manager stated that cleaning the radiator is difficult because it is a heat source but added that the home uses two bags of charcoal that are changed every 60 days in an attempt to absorb the odour. The Environmental Services Manager also stated that physical barriers were tried with this resident but they were determined to be ineffective. The Environmental Service Manager was not able to outline any further procedures that were developed and implemented to address the strong urine smell in the lounge. [s. 87. (2) (d)]

WN #9: 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 report a medication incident of which a resident is taken to hospital.

A CIR was submitted to the Director under the Long-Term Care Homes Act (LTCHA), 2007 on a specified day related to a medication incident of which resident #047 was taken to hospital.

Resident #047`s care plan nutritional requirements specified low potassium interventions for all meals and snacks and, cardiac interventions specified that medications are to be administered as ordered and that staff are to ensure the maintenance of the resident`s fluid and electrolyte balance. Resident #047 has multiple diagnoses.

On a specified day in October 2017 on the Physician Order Form an antibiotic is ordered related to a medical diagnosis for resident #047. The following day,the physician ordered blood Potassium levels be checked the following week due to antibiotic medication

interaction.

Refer to WN #10.

Review of 'Medication Incident Report' conducted by the DOC #132 on a specified day in October 2016 indicated that the resident did not receive the medication as ordered due to processing issues between the home and pharmacy provider.

Upon review of the Physician Order Form for a specified day Inspector #548 noted that the two nursing signatures acknowledging that the order was processed were missing.

On May 19, 2017 during an interview with Inspector #548, DOC #132 indicated she had completed the review of the medication incident and became aware on a specified day in October that a stat (immediate) order to administer a medication was administered however, there was a 24 hour delay in the administration of two additional medication that the resident required for fluid and electrolyte balance for three days. She added that the delay in the administration of the medications produced increased blood levels resulting in the required hospitalization for resident #047. She further indicated that she was not aware of the requirement to report the incident no later than one business day after the occurrence of a medication incident of which a resident is taken to hospital.

As such, the Licensee failed to report the medication incident no later than one business day after the occurrence of the incident where resident #047 required hospitalization due to the omission of prescribed medication. [s. 107. (3)]

WN #10: 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 failed to ensure that drugs are administered to resident #047 in accordance with the directions for use specified by the prescriber.

A CIR was submitted to the Director under the Long-Term Care Homes Act (LTCHA), 2007 on a specified day in October 2016 related to a medication incident of which resident #047 was taken to hospital.

On a specified day in October 2017 on the Physician Order Form an antibiotic is ordered related to a medical diagnosis for resident #047. The following day,the physician ordered blood Potassium levels be checked the following week due to antibiotic medication interaction.

On a specified day in October 2016 the home was notified by the laboratory that the resident's #047 blood electrolyte was abnormal.

A physician order on a specified day in October 2017 via telephone was obtained at the afternoon for a stat medication to be administered to the resident #047. In addition two other medications were ordered to be administered for three days and blood electrolyte levels were to be collected a few days later.

Blood levels were collected on a specified day in October 2016 and the home was notified that electrolyte levels were abnormal.

The resident #047 was sent to hospital on a specified day.

Review of 'Medication Incident Report' conducted by the DOC #132 on a specified day in October 2016 indicated that the resident did not receive the medication as ordered due to processing issues between the home and pharmacy provider.

Upon review of the Physician Order Form on the specified day, Inspector #548 noted that the two nursing signatures acknowledging that the order was processed were missing.

Refer to WN #9

As such, the Licensee failed to ensure the prescribed medications required for fluid and electrolyte balance were administered to resident #047 in accordance with the directions as specified by the prescriber. [s. 131. (2)]

WN #11: 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 failed to ensure that staff participate in the implementation of the infection prevention and control program.

On a specified day in May 2017, Inspector #655 observed in resident's #004 two catheter drainage bags and its tubing to be hanging on the grab bars in a shared bathroom. Both tubes were uncapped; one uncapped tube end was lying on the floor of the bathroom. Neither bag was labelled with a resident's name.

On a specified day in May 2017, Inspector #548 observed two catheter drainage bags and their tubing to be hanging on the towel bars in the bathroom. Both tubes were uncapped. Neither bag was labelled with a resident's name.

The health records were reviewed for resident #004 and #052. The Minimum Data Set dated indicated that Resident #052 uses an indwelling catheter. According to the resident's current care plan, resident #052 uses two types of catheter drainage bags: a leg bag during the day and a drainage bag during the night.

On a specified day in May 2017, during an interview with Inspector #548 PSW #115 indicated that the resident's #052 drainage bag is changed from a night bag to a leg bag each morning. PSW #115 indicated that PSW staff are to clean all catheter drainage bags daily with a vinegar solution and the caps are to be replaced once cleaned. She further indicated that there are several residents who use an indwelling catheter on the unit and the drainage bags are to be identified with the resident's name. During the interview Inspector #548 observed two unlabelled catheter drainage bags and their tubing to be hanging on two separate towel bars in the shared bathroom. One catheter bag had remnants of clear yellow fluid remaining in its tube, the uncapped tip of the tube was attached to the bag. The other unlabelled catheter drainage bag had clear fluid in

the tubing and the tubing, uncapped, was attached to the bag. A closed system had not been maintained. PSW #115 discarded the drainage bag with the yellow fluid in its tube in the presence of the inspector.

On a specified day in May 2017, during an interview with the Inspector #548 RAI Coordinator explained that PSWs are responsible to clean the catheter drainage bags as mentioned by PSW #115. She added that the resident's care plan should specify the procedure and the drainage bag must remain a closed system when not in use by capping the tip of the tube.

During an interview on a specified day in May 2017, the Director of Care #113 indicated to Inspector #548 that the catheter drainage bags are expected to be capped and stored away in the resident's bathroom and are not to be hung on the towel grab bars.

The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program as it relates to catheter care for residents #052. [s. 229. (4)]

Issued on this 13th day of July, 2017

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

Original report signed by the inspector.