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

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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
Jun 16, 2016	2016_271532_0011	012652-16	Resident Quality Inspection

Licensee/Titulaire de permis

PEOPLECARE Inc.
28 William Street North P.O. Box 460 Tavistock ON N0B 2R0

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

peopleCare Hilltop Manor Cambridge
42 ELLIOTT STREET CAMBRIDGE ON N1R 2J2

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

NUZHAT UDDIN (532), AMIE GIBBS-WARD (630), CHRISTINE MCCARTHY (588), SHERRI COOK (633), SHERRI GROULX (519)

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): May 3, 4, 5, 6, 9, 10, 11,12,13,16,17,18,19, 2016

The following CIS and Complaints were inspected concurrently with this inspection:
Complaint log # 032356-15, IL-41488-LO related to a fall,
Critical Incident log # 001433-16 CI # 2606-000004-16 related to staff to resident

abuse,
Critical Incident log # 027943-15 CI # 2606-000016-15 related to staff to resident abuse,
Critical Incident log # 005953-16 CI # 2606-000009-16 related to staff to resident neglect,
Critical Incident log # 030560-15- CI # 2606-000020-15 related to resident abuse/neglect,
Critical Incident log # 009023-16 CI # 2606-000015-16 related to staff to resident abuse,
Critical Incident log # 001395-16 CI # 2606-000023-15 related to fall,
Critical Incident log # 008922-16 CI # 2606-000014-16 related to responsive behaviours,
Critical Incident log # 009906-14 No CI # related to leave of absence,
Critical Incident log # 016757-15 No CI # related to unexpected death ,
Critical Incident log # 026275-15 CI # 2606-000014-15 resident to resident abuse,
Critical Incident log # 013968-16 CI # 2606-000018-16 related to abuse,
Critical Incident log # 013752-16 CI: 2606-000017-16 related to abuse.

During the course of the inspection, the inspector(s) spoke with the three Executive Director(s), one Corporate Director of Policy, one Corporate Director of Care, one Corporate Executive Director, one Executive Director of Resident Care (EDOC), two Director of Care(s), one Director of Environmental Service, one Environmental Service Supervisor, one Dietitian, one Director of Program Services, one Director of Food Services, one Dietary Supervisor, two Director of Resident Quality Outcomes , one Behaviour Support Ontario Staff (BSO)staff, two Registered Nurses (RN), 16 Registered Practical Nurses (RPN), 12 Personal Support Workers (PSW) , Family and Residents' Council Representatives, Residents and Family members.
Inspector also toured the resident home areas and common areas, medication rooms, spa rooms, observed resident care provision, resident/staff interaction, dining services, medication administration, medication storage areas, reviewed relevant residents clinical records, posting of required information, relevant policies and procedures, as well as meeting minutes pertaining to the inspection, and observed general maintenance and cleaning of the home.

The following Inspection Protocols were used during this inspection:

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

During the course of this inspection, Non-Compliances were issued.
- **11 WN(s)**
- **7 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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

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

A) The plan of care and kardex indicated the resident wore an incontinent product and the tasks indicated the resident did not wear an incontinent product, rather the resident was on a toileting plan.

Registered Nurse (RN), in an interview stated that the details in the care plan and kardex were not the same as the detail listed in the Tasks. RN confirmed that the expectation of the home was to have clear direction for the staff based on the plan of care. (588)

B) Behavioural Symptoms tool/Assessment indicated that the identified resident was admitted with a fall and since the admission the identified resident had multiple falls resulting in injuries. It further indicated that the identified resident was a fall risk.

Room observation revealed that there was an orange leaf posted on the wall indicating that the identified resident was a high risk for falls.

Fall risk assessment indicated that the identified resident was at moderate risk of falls.

Review of the care plan under falls indicated "increased monitoring- see prevention strategy task for details."

Task reviewed with the Director of Care (DOC) who shared that the resident was not a "high" risk for falls however; the DOC had left the leaf posted on the wall to indicate that the resident was a "risk of falls" as per policy only high risk fallers were identified by an orange leaf and not moderate. She further checked the Kardex with the Inspector and confirmed that falls were not included in the Kardex and interventions related to falls were not identified in the task as indicated in the plan of care.

DOC stated that the plan of care did not set out clear directions to staff and others who provided direct care to the resident. (532)

C) An identified resident was admitted to the home with an assistive device. It was removed and re-inserted again.

The initial care plan stated that the identified resident was frequently incontinent of bladder. The care plan was not updated to reflect the changes when the assistive device was removed and re-inserted back. The Director of Resident Quality Outcomes confirmed that the identified resident was now continent with the assistive device in place.

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. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

According to the plan of care an identified resident was an extensive assistance with Activities of Daily Living (ADL). The resident was at high risk for falls.

Record review stated that the identified resident fell in the bathroom after they were escorted by one staff that left the resident unattended on the toilet. The identified resident had a fall; however, there were no injuries.

An identified staff member acknowledged that they did not follow the plan of care.

The Director of Resident Quality Outcomes (DRQO) and the Executive Director of Resident Care (EDRC) stated that the PSW did not follow the plan of care for the identified resident. [s. 6. (7)]

3. The licensee has failed to ensure that the resident reassessed and the plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

Record review for an identified resident stated that they had altered skin integrity.

An initial skin integrity assessment indicated that a dressing was applied.

Record review stated that the altered skin integrity for the identified resident was assessed by the Physician.

The care plan was reviewed and the altered skin integrity was not listed in the care plan in order to provide resident information to the Personal Support Workers (PSWs) to review before giving direct care.

Upon interview with Registered Practical Nurse it was confirmed that the altered skin integrity was not in the plan of care; however, it should have been. She further stated that she would add the information in the plan of care immediately.

The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months when the altered skin integrity was noted and the care plan was not updated. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident, to ensure that the care set out in the plan of care is provided to the resident as specified in the plan and to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A) During Stage 1 of the Resident Quality Inspection it was noted that 23 out of 40 or 57. 5 percent of the resident sample had their height done in 2014.

Review of the policy on monitoring of resident's weight and height, indicated under height that after admission heights were required to be taken annually by the health care staff.

It was confirmed with the EDRC that the heights were to be taken annually and it was not

done.(532)

The licensee has failed to ensure that the programs include, a body mass index and height upon admission and annually thereafter.

B) An identified resident was admitted with an assistive device, which was removed and then re-inserted.

There was no assessment done when the assistive device was removed for the second time with a change in continence status.

The home's policy titled, "Continence Care", stated under Assessment that "continence assessments are completed on admission to the LTC home as part of the 24 hour Care Plan. Thereafter, the RAI-MDS 2.0 which includes assessment of urinary/bowel function and continence is completed within 14 days of the resident's admission, on a quarterly with worsening bladder incontinence, and on an annual basis if worsening bladder incontinence, or on significant change of health status (i.e. change in continence care level)".

Upon interview with the Director of Resident Quality Outcomes, it was confirmed that an updated continence assessment for bladder was not done when identified resident had a change in continence status. (519)

C) Interviews during Stage 1 of the Resident Quality Inspection (RQI) revealed that identified residents, shared numerous concerns related to response times to call bells ranging from five to 60 minutes.

Record review of the call bell response logs, on identified home area, stated that call bell response times registered from five to 43.47 minutes, and that 55/117 or 47 percent of the time the response time was longer than ten minutes for an identified Resident.

Record review of the call bell response logs, on a identified home area stated that call bell response times registered from five to 28.28 minutes, and that 26/82 or 32 percent of the time the response time was longer than ten minutes for identified resident.

Record review of the call bell response logs identified on a identified home area that call bell response times registered from five to 22.24 minutes, and that 10/32 or 31 percent of

the time the response time was longer than ten minutes for an identified resident.

Record review of the People Care Policy, called "Call Bell Response" stated "Procedure: All staff will: 1 Respond to all call bells promptly." "4. Turn the call bell off at source only after going to the source of the call and addressing the request."

Interview with the Director of Policy and Legislation stated that the word "promptly" in reference to the home's policy, would mean "as soon as possible". Staff confirmed that the home's expectation was that staff responding to a call bell up to 30 minutes after it had been activated was not responding promptly, as per the policy and that the staff should be responding sooner than that. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that plan, policy, protocol, procedure, strategy or system related Program, Bladder and Bowel Continence Assessment and Call Bell Response is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
1. Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks. O. Reg. 79/10, s. 24 (2).

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
6. Known health conditions, including allergies and other conditions of which the licensee should be aware upon admission, including interventions. O. Reg. 79/10, s. 24 (2).

Findings/Faits saillants :

1. The licensee of has failed to ensure that the 24-hour admission care plan developed for each resident included any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks.

Record review of the document revealed that identified resident had an identified number falls in the last 90 days.

Record review of the document, revealed that an identified resident had sustained a fall while walking to the bathroom unassisted.

Record review of the 24 hour care plan completed by the home, indicated that the resident had fallen in the past 30 days and 31-180 days however, did not include interventions to mitigate risk for falls.

Record review of the home's policy titled Care Plan and Plan of Care revealed that the 24 hour care plan must identify risks that the resident may pose to himself/herself, including falling and interventions to mitigate the risk.

Interview with the Director of Resident Quality Outcomes confirmed that the identified resident was at high falls risk on admission to the home and interventions to mitigate risk of falls were not included on the 24 hour Care Plan.

The licensee of has failed to ensure that the 24-hour admission care plan that was developed for the identified resident included interventions to mitigate falls risks. [s. 24. (2) 1.]

2. The licensee has failed to ensure that a 24-hour admission care plan was developed for each resident and communicated to direct care staff within 24 hours of the resident's admission to the home including known health conditions, and other conditions of which the licensee should be aware upon admission, including interventions.

Record review of the document revealed that an identified resident required a treatment at all times. The identified resident's treatment was known to fluctuate and the documents indicated that the identified resident demonstrated behaviours of non-compliance.

Record review of the 24 hour care plan completed by the home, revealed that the identified resident's required treatment and interventions were not included in the care plan.

Interview with the Director of Resident Quality Outcomes confirmed that the identified resident had a health condition and they required the treatment which was not identified and interventions to mitigate risk were not included on the 24 hour Care Plan.

The licensee has failed to ensure that the 24-hour admission care plan developed for each resident and communicated to direct care staff within 24 hours of the resident's admission to the home included known health conditions and other conditions of which the licensee should be aware upon admission, including interventions. [s. 24. (2) 6.]

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 24-hour admission care plan developed for each resident including any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks and to ensure that a 24-hour admission care plan is developed for each resident and communicates to direct care staff within 24 hours of the resident's admission to the home including known health conditions, and other conditions of which the licensee should be aware upon admission, including interventions, to be implemented voluntarily.

WN #4: 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:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the responsive behaviour plan of care based on an interdisciplinary assessment of the resident included any mood and behaviour patterns; including wandering, any identified responsive behaviours, and any potential behavioural triggers and variations in resident functioning at different times of the day.

An identified resident insisted in helping another identified resident was pushed and sustained a fall with injury.

Director of Resident Care explained that the resident demonstrated responsive behaviours by wandering into large crowds and setting off other residents which triggered altercations.

Record review of the plan of care indicated that there was no plan of care related to behaviour patterns, including wandering; and potential behavioural triggers.

The DOC stated that the plan of care related to behaviours including wandering was closed, however, the identified resident continued to have the behaviours. The DOC confirmed that the behaviour patterns including wandering were not included in the plan of care and then added them to the plan of care. (532)

B) An identified resident had responsive behaviours identified.

The progress note outlined how the identified resident had responsive behaviours and the Power of Attorney (POA) requested for a treatment to be done to rule out an infection. The treatment was done and the resident was subsequently diagnosed by the Physician and started on an antibiotic.

Upon interview with Personal Support Worker it was stated when the behaviours escalated for the identified resident then they knew that the resident had an infection.

Upon interview with Registered Practical Nurse (RPN) it was stated that the identified resident had responsive behaviours when they had an infection.

Inspector reviewed the plan of care for the identified resident and it was noted that the triggers for the responsive behaviours were not included in the care plan.

Upon interview with the Director of Resident Quality Outcomes it was confirmed that the infection trigger for responsive behaviours was not included in the care plan and on the point of care "tasks" for the PSWs to refer to when caring for the resident. [s. 26. (3) 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 the responsive behaviour plan of care is based on an interdisciplinary assessment of the resident including any mood and behaviour patterns; including wandering, any identified responsive behaviours, and any potential behavioural triggers and variations in resident functioning at different times of the day, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A) An altered skin integrity assessment indicated that an identified resident had altered skin integrity and that it had healed.

However, documentation review indicated that there was no weekly wound assessment completed during the time frame the resident had the altered skin integrity..

An RPN checked the altered skin assessment under the assessment tab and confirmed that the altered skin assessment should have been reassessed weekly by a member of the registered nursing staff and this was not done. (532)

B) An identified resident was admitted to the home with altered skin integrity. An altered skin integrity assessment was not done until five weeks later and the next reassessment was was not completed for another 14 days.

When reviewing the documentation on weekly wound assessments with the Registered Practical Nurse, it was stated that the altered skin integrity had not yet healed and several weekly wound assessments had been missed.

The altered skin integrity was reassessed and the altered skin integrity had worsened as noted on the reassessment. As per the progress notes, the skin assessment was not done due to time constraints, and was not assessed again until three weeks later when it was determined to be healed.

The licensee failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

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 resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, 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 drugs were stored in an area or a medication cart, that was secure and locked.

During Stage 1 of the Resident Quality Inspection (RQI) it was observed by Inspector that a treatment cream was sitting by an identified resident's bedside.

Inspector observed another identified resident had an identified cream sitting inside the bathroom by the sink.

PSW confirmed that the creams were in the resident's room and explained that they should be kept in a locked area.

It was noted that on the third floor home area there was a drug sitting on top of the medication cart unattended. The medication cart was parked in the hallway across from the nurses station and residents were sitting all around the medication cart. Registered staff were not observed in the hallway or around the medication cart. Inspector waited for the registered staff for over five minutes.

Approximately five minutes later, the registered staff was observed coming down the hall. The RPN confirmed that she had left the drug sitting on top of the medication cart; however, she stated that she should have locked the drug when it was not in use.

The licensee has failed to ensure that drugs were stored in an area or a medication cart that was secure and locked. [s. 129. (1) (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 the drugs were stored in an area or a medication cart, that was secure and locked, to be implemented voluntarily.

WN #7: 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. (4) A member of the registered nursing staff may permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical, if,
(a) the staff member has been trained by a member of the registered nursing staff in the administration of topicals; O. Reg. 79/10, s. 131 (4).
(b) the member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and O. Reg. 79/10, s. 131 (4).
(c) the staff member who administers the topical does so under the supervision of the member of the registered nursing staff. O. Reg. 79/10, s. 131 (4).

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).

s. 131. (7) The licensee shall ensure that no resident who is permitted to administer a drug to himself or herself under subsection (5) keeps the drug on his or her person or in his or her room except,
(a) as authorized by a physician, registered nurse in the extended class or other prescriber who attends the resident; and O. Reg. 79/10, s. 131 (7).
(b) in accordance with any conditions that are imposed by the physician, the registered nurse in the extended class or other prescriber. O. Reg. 79/10, s. 131 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug was used by or administered to a resident in the home unless the drug was prescribed for the resident.

During Stage 1 of the Resident Quality Inspection (RQI), it was observed that there were medications inside a dosette (drug container) sitting on the bedside table in an identified resident's room.

The medications were again observed sitting inside the resident's personal drug container on the bed side table and the observations were confirmed with the identified resident.

In an interview the identified resident reported that in the past the staff were able to get the medication for a headache etc. for themselves at the home but this was not the practice anymore. The identified resident confirmed that they kept the medication for the staff and provided it to them when the staff needed it for their headache.

Record review revealed that the drug was not prescribed for the resident.

Interview with the Registered Practical Nurse revealed that they were not aware of the medication in the room and the drug was not prescribed for the identified resident to be used by or administered to others.

The licensee has failed to ensure that no drug was used by or administered to a resident in the home unless the drug was prescribed for the resident. [s. 131. (1)]

2. The license has failed to ensure that a member of the registered nursing staff permit a staff member who was not otherwise permitted to administer a drug to a resident to administer a topical only if:
(a) The staff member has been trained by a member of the registered nursing staff in the administration of topicals
(b) The member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and
(c) The staff member who administers the topical does so under the supervision of the member of the registered nursing staff.

During Stage 1 of Resident Quality Inspection (RQI) Inspector observed treatment creams at the identified resident's bedside.

Inspector observed another identified resident having a treatment cream sitting inside their bathroom.

PSW confirmed that the treatment creams were in the identified resident's room and explained that they should be kept in a locked area.

RPN took the creams from the Inspector and confirmed that they should not have been sitting in the bathroom as staff were to apply the creams and bring it back to the Registered staff.

PSW also reported that PSW staff were permitted to apply the topical creams as they were trained, however, they were to bring the topical cream back to the registered staff after they were done.

The Corporate Director of Policy and Legislation confirmed that PSW staff were not to apply the topical creams on the resident as that was not the home's policy or the direction from the Directors of Care meetings. She shared that she was not aware that the staff were administering topical creams as they were not trained nor had any education on how to administer topical creams.

The EDRC confirmed that the PSW staff were not permitted to administer topical creams to residents at the home. [s. 131. (4)]

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

Observation revealed that a drug was sitting on the side table, in an identified resident's room. The resident confirmed that they administer the drugs to themselves and kept it by their bed side.

Record review revealed that there were no orders for the resident to self-administer the drug as the administration was not approved.

Inspector informed RPN and it was noted that the staff did receive an order for one of the drugs to self-administer. However, the other drug was still not ordered for self-administration and the drug was still sitting in the room where resident was able to self-administer.

RPN acknowledged that the both of the drugs were kept in the room as the resident was able to self-administer, however, she confirmed that self-administration should be approved by the physician and there should be an order and this was not done.

The licensee has failed to ensure that no resident administers a drug to himself or herself

unless the administration was approved by the prescriber in consultation with the resident. [s. 131. (5)]

4. The licensee has failed to ensure that no resident who was permitted to administer a drug to himself or herself keeps the drug on his or her person or in his or her room except, as authorized by a physician, registered nurse in the extended class or other prescriber who attends the resident.

During Stage 1 of Resident Quality Inspection (RQI) observation of the resident rooms revealed that there were drugs sitting inside the identified residents’ room.

The identified residents confirmed that they kept the drugs by the bedside.

Record review revealed that there were no orders to keep the drug in the room.

RPN checked the Physician's orders for the resident and confirmed that resident were not authorized to keep the drugs in their room as there were no orders to do so.

The licensee has failed to ensure that no resident was permitted to administer a drug to himself or herself keeps the drug on his or her person or in his or her room except, as authorized by a physician. [s. 131. (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 to ensure that no drug is used by or administered to a resident in the home unless the drug is prescribed for the resident and to ensure that a member of the registered nursing staff permits a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical only if:
(a) The staff member has been trained by a member of the registered nursing staff in the administration of topicals
(b) The member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and
(c) The staff member who administers the topical does so under the supervision of the member of the registered nursing staff
and to ensure that no resident administers a drug to himself or herself unless the administration is approved by the prescriber in consultation with the resident and to ensure that no resident who is permitted to administer a drug to himself or herself keeps the drug on his or her person or in his or her room except, as authorized by a physician, registered nurse in the extended class or other prescriber who attends the resident, to be implemented voluntarily.

WN #8: 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 the following rights of residents were fully respected and promoted: Every resident has the right to 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).

During medication observation an identified RPN was administering drugs to resident's from a plastic individual strip. The strips were noted to have resident's name, date and time and drug information. The RPN was observed throwing the individual strips in the regular garbage bag.

The RPN was interviewed and she confirmed that the individual medication strips with the resident personal health information was to go into a separate plastic bag and after the medication administration was completed, the staff member would soak the strips in the water to take the information off, however, she did not do that during this drug administration and confirmed that the expectation was resident's personal health information was kept confidential.

The licensee has failed to ensure that any personal health information within the meaning of the Personal Health Information Protection Act, 2004 was kept confidential in accordance with that Act. [s. 3. (1) 11.]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a PASD described in subsection (1) was used to assist a resident with a routine activity of living only if the use of the PASD was included in the resident's plan of care.

On May 4, 2016, during Stage one of the Resident Quality Inspection (RQI), an identified resident was observed using a Personal Assisitve Service Device (PASD)

On another date the same resident was observed using a PASD.

In an interview the resident stated that they used the PASD for comfort.

In an interview a Registered Practical Nurse (RPN) reported that the identified resident used a PASD which supported the resident in their breathing due to identified resident's health condition.

The identified RPN and Inspector reviewed the plan of care and noted that there was no documentation related to the PASD. RPN confirmed that there was no assessment, consent, alternatives and or plan of care documented.

The Executive Director of Care (EDC) stated that the expectation was to have the use of the PASD documented in the plan of care. [s. 33. (3)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids cleaned as required.

An identified resident was observed on two different occasions sitting in a wheel chair that was dirty with old food stains and crumbs on the right side of the wheel chair.

PSW confirmed that the wheelchair was dirty with stains and dirt built up on the right side of the chair with food sitting on the chair from lunch time. The PSW cleaned the vegetables off the wheelchair and informed the Inspector that the wheelchair was cleaned on night shift on resident's bath days and it was documented in Point of Care (POC).

Record review of POC confirmed that there was no documentation related to wheelchair cleaning in Point of Care for the identified resident.

Executive Director of Care was interviewed and after reviewing the documentation, she confirmed that there was no task under POC for the cleaning of wheelchair for the identified resident. She further acknowledged that the wheelchair had not been cleaned since the first time it was received.

The licensee has failed to ensure that the personal items, including personal aids such as dentures, glasses and hearing aids, cleaned as required. [s. 37. (1) (b)]

WN #11: 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. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
O. Reg. 79/10, s. 107 (4).
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).
5. The name and title of the person who made the initial report to the Director under subsection (1) or (3), the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident: 1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.

An identified Administrator called the Ministry of Health and Long-Term Care after hour's pager to inform the Director of an incident in the home and stated a critical incident report was to follow.

Inspector reviewed the Ministry of Health and Long-Term Care website and noted that there was no Critical Incident System (CIS) report submitted.

Interview with the Administrator who called the Ministry of Health and Long-Term Care after hours pager confirmed that a CIS report was not completed for the identified incident.

Interview with Executive Director of Care confirmed that a CIS report was not completed and the expectation would be that a written CIS report would be completed by the home and submitted to the Director when an identified critical incident occurred.

The licensee has failed to inform the Director in writing within 10 days of becoming aware of the critical incident. [s. 107. (4)]

Issued on this 17th day of June, 2016

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

Original report signed by the inspector.