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 19, 2017	2017_606563_0008	008392-17	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

MELANIE NORTHEY (563), ALICIA MARLATT (590), AMIE GIBBS-WARD (630), DONNA TIERNEY (569), NATALIE MORONEY (610), NEIL KIKUTA (658)

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 2, 3, 4, 5, 8, 9 and 11, 2017

The following intakes were completed within the RQI:
032945-16- Complaint related to improper transfer
031718-16- Critical Incident related to falls
015912-16- Critical Incident related to suspected staff to resident abuse
035100-16- Critical Incident related to suspected improper care
020518-16- Critical Incident related to suspected resident to resident abuse
031525-16- Critical Incident related to falls
030090-16- Complaint related to suspected staff to resident abuse and medications
006111-17- Follow Up related to plan of care
003759-17- Critical Incident related to suspected staff to resident abuse
002835-17- Critical Incident related to falls
006197-17- Complaint related to care concerns and falls

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Executive Director of Nursing, the Director of Resident Care, the Director of Resident Quality Outcomes, the Director of Recreation, the acting Director of Resident Care, the Nursing Staff Coordinator, the Maintenance Supervisor, the Environmental Supervisor, a Corporate Representative, the Clinical Pharmacy Consultant, the Housekeeping and Laundry Supervisor, Housekeeping Aides, the Social Service Worker, the Nutrition Manager, the Registered Dietitian, a Dietary Aide, Registered Nurses, Registered Practical Nurses, Personal Support Workers, family members and residents.

The inspector(s) also conducted a tour of the home and made observations of residents, activities and care. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed. Inspector(s) observed meal and snack service, medication administration and drug storage areas, resident/staff interactions, infection prevention and control practices, the posting of Ministry information and inspection reports and the general maintenance, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
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.

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident regarding the monitoring of medication patches.

A resident was prescribed a medication to be checked at specific intervals and was to be removed on specific days.

Further review of the electronic Medication Administration Record (eMAR) for the resident showed the resident was to have the medication checked at the times outlined in the plan of care.

The Executive Director of Nursing (EDON) shared there was no physician order for the medication to be checked at a specific time and that the nursing staff initiated the checks as a nursing measure after an incident had occurred. The EDON further explained that the eMAR checks for the medication should have been changed to match the checks

completed and that this had not been done.

The licensee failed to ensure that the plan of care for the resident provided 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 there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident regarding the use of an assistive device.

Two residents were observed with an assistive device in use.

A Personal Support Worker (PSW) said that the residents used an assistive device when not in bed for comfort and positioning. The PSW said that the residents were not capable of getting out of the assistive device and the device was not restraining the residents. The PSW said that if they wanted to know the care requirements of a resident they would look in the kardex and in Point of Care (POC). The PSW said that staff would also know they could use the assistive device if there was a pink sticker observed on the device.

A Registered Practical Nurse (RPN) said that no restraints were used for residents in a particular home area. The RPN said that the residents had an assistive device for comfort and positioning. The RPN said that if a staff member needed to know the care requirements of a resident they would look in the electronic plan of care.

Two residents were observed with an assistive device in use and there was no pink sticker observed on the device.

The clinical record for the two residents showed:
- An Assessment for the use of an assistive device stated that the residents used an assistive device and this had been consented to by the family.
- The Point of Care (POC) task list showed that the assistive device had been used one to three times per day on specific dates.
- The electronic plan of care and kardex did not include any reference to the use of a assistive device and no direction for staff regarding the purpose or use of the assistive device.

The acting Director of Resident Care (aDRC) and the Director of Resident Care (DRC) said that the specific tasks in POC were considered part of the plan of care for the resident. They acknowledged that the POC task did not provide other direction for staff

regarding why, when and how to apply the assistive device. The Inspector reviewed the plan of care and kardex with the aDRC and the DRC and they acknowledged that the plan of care did not provide clear direction for staff regarding the assistive device.

The licensee failed to ensure that the plan of care for the two residents provided clear directions to staff and others who provided direct care to the residents.

The severity was determined to be a level 2 as there was minimal harm or potential actual harm/risk to this resident. The scope of this issue was a pattern during the course of this inspection. There was a compliance history of this legislation being issued in the home on June 16, 2016 as a Written Notification (WN) in Resident Quality Inspection # 2016_271532_0011. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

Critical Incident System report submitted to the Ministry of Health and Long Term Care reported that a resident sustained an injury.

In an interview with a RPN, they shared that residents who have any signs of a specific injury were to have a specific assessment initiated and completed by the registered staff as outlined by the home's policy.

Review of the homes "Head Injury" policy, reference number 005200.00, stated, "Any resident who potentially may have an injury to the head (abrasion, cut, swelling, bump or sudden onset of vomiting) following a fall or impact with an object, will be promptly assessed and have head injury routine initiated." The policy furthers stated, "As an unwitnessed head injury or neurological insult of unknown origin may cause changes in a resident's level of consciousness or responsiveness, all unwitnessed resident falls will be assessed for a potential head injury."

The policy directs registered staff to "Document assessments as indicated on Head Injury Routine form. Assess as per times on the form and all interventions taken on the progress notes and the vital sign recordings on 009010.22(a) Head Injury Routine Monitoring Record and place in the resident's chart upon completion."

Review of the Head Injury Routine form showed that neurological checks and vital signs were to be recorded every 15 minutes for one hour, every 30 minutes for two hours,

every hour for three hours, every two hours for two and a half hours, every four hours for 12 hours and then every shift for three shifts. In summary, a total of 22 entries/checks should be documented. Review of the resident's documentation showed that documentation was missing for eight of the 22 checks.

The Executive Director of Nursing (EDON) shared that the injury observed on the resident would require a specific assessment routine to be initiated. They shared that the resident's injury routine documentation had not been completed as outlined per the homes policy. The EDON could not confirm that these assessments were completed or documented as required.

The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

The severity was determined to be a level 2 as there was minimal harm or potential actual harm/risk to this resident. The scope of this issue was a pattern during the course of this inspection. There was no compliance history of this legislation being issued in the home. [s. 6. (9) 1.]

4. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident’s care needs changed.

A Personal Support Worker (PSW) shared that the resident had a particular meal in their room at a particular time of the day and required assistance. The PSW said they would look in the kardex to identify the care requirements of a resident.

The resident was observed in their room during a meal service. At the end of the dining room meal service, the resident was observed to receive assistance from one staff member while in their room.

A PSW said that the resident stayed in in their room regularly during a specific meal at their family's request. The PSW said they provided a tray at the end of the dining room meal service and provided assistance. The PSW said if they needed to know about the care for a resident they would ask their colleagues and would also look on the kardex in the computer.

Review of the clinical record for the resident showed the following:
- The most recent Resident Assessment Instrument Minimum Data Set (RAI-MDS)

assessment stated the resident required assistance with a particular activity of daily living. No further assessment of resident's ability was observed in the chart after this assessment.
- The plan of care and the kardex did not provide direction regarding the routine required during a specific meal.

The Registered Dietitian (RD) said they had not received notification that the resident had a particular routine implemented. The RD said it was an expectation that this would be referred to the RD and then the plan of care would be updated to reflect this change.

The acting Director of Resident Care (aDRC) said that it was the expectation in the home that the plan of care would be based on an assessment and reflect a change in a resident's needs. The aDRC reviewed the plan of care for the resident and acknowledged that this change in care needs was not reflected in the plan of care, kardex or the Point of Care (POC) tasks.

The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed. [s. 6. (10) (b)]

5. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the two residents care needs changed.

The "RAP for bladder & bowel continence" assessment in PointClickCare (PCC) for the two residents stated there was a non-triggered clinical problem for incontinence.

The Minimum Data Set (MDS) assessments completed in PCC documented there was an identified decline in continence from the previous MDS assessment.

The care plan had interventions related to the type of physical assistance the residents required and the number of staff for transferring on and off toilet. The care plan had a continence focus, but interventions related to a toileting routine to maintain an optimal level of continence were absent from the care plan for both residents.

The acting Director of Resident Care (aDRC) shared that the staff member who completed the RAP assessment for continence should have documented the change in continence and verified that there was no assessment completed related to continence as part of the RAP assessment.

A PSW shared that the PSWs rotate every month from one care area to the other. The PSW said that the resident was toileted at specific times. A PSW showed the Inspector the kardex for the two residents and verified that the kardex was where PSWs would look at to identify the care requirements of a resident. The PSW shared that the residents had a toileting focus but that there was no routine to instruct all PSW staff as to when to toilet the resident so that the resident was clean and dry. The PSW shared that the routine should be a part of the interventions for toileting.

The "Continence and Bowel Management Program" policy reference number 008010.00 stated, "A Resident Assessment Profile (RAP) assessment will take place when triggered and when there is a significant change in the bladder and bowel continence (worsening)."

The "Care Plan and Plan of Care" policy reference number 005415.00 stated, "each resident care plan and plan of care will be up to date and reflect their current care needs, goals and interventions and to be reviewed in accordance with the Long Term Care legislation."

The licensee failed to ensure that the two residents were reassessed and the plan of care reviewed and revised when the resident's continence care needs changed.

The severity was determined to be a level 2 as there was minimal harm or potential actual harm/risk to this resident. The scope of this issue was a pattern during the course of this inspection. There was a compliance history of this legislation being issued in the home on February 9, 2017 as a Compliance Order (CO) in Complaint inspection # 2017_457630_0003 with a compliance due date of April 3, 2017. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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 failed to ensure that the following rights of residents were fully respected and promoted; every resident had the right to, have his or her personal health information within the meaning of the Personal Health Information (PHI) Protection Act, 2004 kept confidential in accordance with that Act.

An observation of the medication room and medication cart was completed on a particular home area.The inspector observed a clear garbage bag attached to the medication cart with empty medication packages with resident personal health information identified on the packaging.

The Medical Pharmacies "The Medication Pass" policy 3-6 dated February 2017 stated, "Empty strip pouches can be de-identified with water to remove print information and placed into the garbage or shredded."

The EDON said that the home follows the Medical Pharmacies policies and procedures.

A Registered Practical Nurse (RPN) said that they removed the resident’s last name only from the corner of the medication packaging and both pieces were placed in the garbage and disposed of with the PHI still present on the packaging.

The EDON said that the policy and procedure in the home for removing the PHI on the individual medication packages was that staff would have a small bag that was to be placed on top of the medication cart. That staff should be adding water to the small bag with the packages to remove the PHI and then the small bags were placed in the denaturing bin in the medication room.

The home failed to ensure that that the personal health information was kept confidential according with that Act.

The severity was determined to be a level 1 as there was minimal risk to the residents. The scope of this issue was widespread during the course of this inspection. There was a compliance history of this legislation being issued in the home during the following inspections where a Written Notification (WN) was issued: Critical Incident Inspection # 2015_226192_0008, Resident Quality Inspection # 2016_271532_0011, and Complaint Inspection # 2016_258519_0004. [s. 3. (1) 11. 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 following rights of residents are 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 (PHI) Protection Act, 2004 kept confidential in accordance with that Act, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that for each resident demonstrating responsive behaviours, the behavioural triggers for the resident were identified, strategies were developed and implemented to respond to those behaviours, and actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

A resident was identified with worsening behaviour according to the most recent Minimum Data Set (MDS) assessment relative to the previous MDS assessment.

The "RAP for Mood State and Behavioural Symptoms" under the Assessment tab in PCC

demonstrated there was no documentation related to the behavioural symptoms identified in the MDS assessment. The assessment documented that no care plan was required.

The Director of Resident Care (DRC) verified that the behaviours identified in the MDS assessment were not assessed as part of the "RAP for Mood State and Behavioural Symptoms" assessment. The DRC shared that the resident had behaviours and acknowledged that there were no interventions related to this specific behaviour.

The current care plan did not include documentation related to the identified behaviour triggers or interventions implemented related to the behaviour.

The acting Director of Resident Care (aDRC) shared that behaviours identified in the Minimum Data Set (MDS) assessment were not part of the resident's care plan or in the tasks in Point of Care (POC) and that the aDRC would expect that there would be specific interventions in place related to the behaviour. The aRDC also acknowledged that the behaviours identified in the MDS assessment were not assessed as part of the "RAP for Mood State and Behavioural Symptoms" assessment and should have been.

A PSW shared that specific staff were not to provide care to the resident. The PSW showed the Inspector the POC kardex and shared that triggers were not identified, documentation was absent and there were no details regarding the behaviours as they relate to specific staff members.

The "Responsive Behaviour" policy reference number 004010.00 stated, "Adapt strategies for the individual that respond to triggers and responsive behaviours as part of the plan of care.

The licensee failed to ensure that the behavioural triggers had been identified for the resident demonstrating responsive behaviours. Strategies had not been developed and implemented to respond to the resident demonstrating these responsive behaviours, and the resident's behaviour was not reassessed.

The severity was determined to be a level 2 as there was minimal harm or potential actual harm/risk to this resident. The scope of this issue was isolated to one resident during the course of this inspection. There was a compliance history of this legislation being issued in the home on May 20, 2015 as a Written Notification (WN) in Resident Quality Inspection # 2015_325568_0011. [s. 53. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that for each resident demonstrating responsive behaviours, the behavioural triggers for the resident are identified, strategies are developed and implemented to respond to those behaviours, and actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee failed to ensure that all hazardous substances were labelled properly and kept inaccessible to residents at all times.

During the initial tour of the home:
A) A housekeeping room with keypad access was observed unlocked on the Hespeler home area. Multiple chemicals noted inside the room including "Accel RTU Surface Cleaner" with hazardous cautions for skin, eyes and ingestion, "Lime-Rid Rust" which could cause burns if absorbed through the skin and do not inhale, "Spirocidal Liquid Mod" could irritate eyes in skin and "Safety Bowl Cleaner Alpine" could burn skin and cause eye damage. The housekeeper stated the door should be locked and acknowledged that there were hazardous chemicals inside the room.

B) The elevator machine room/housekeeping with keypad access was also observed unlocked. Inside Inspectors found "Wyant Vert-2-Go" that could cause eye, skin and respiratory irritation. The housekeeper stated that the elevator machine room door should be closed and access with a code for entrance. The Executive Director (ED) stated that

residents were allowed to go to the basement as it was a resident area. The ED acknowledged the elevator machine room/housekeeping door was unlocked and expected that it should be closed with the chemicals located inside.

C) The main floor housekeeping door near the main entrance was observed unlocked and did not lock when closed. There was a container of "Alpine Safety Bowl Cleaner" with warning label that the product could cause skin burns and eye damage and there was a container of Wood Wyant Vert-2-Go" glass cleaner that could cause eye, skin and respiratory irritation. The Executive Director of Nursing verified the door should be closed and locked and acknowledged chemicals were found in the room.

The main floor housekeeping room with keypad access was observed unlocked again. Multiple residents passed this door on the way to the lobby area. There was a container of "Alpine Safety Bowl Cleaner" with a "DANGER" warning label and there was a container of Wood Wyant Vert-2-Go" glass cleaner that could cause eye, skin and respiratory irritation. The Executive Director was present and acknowledged that the housekeeping door should be locked at all times where hazardous substances were stored and accessible to residents.

The licensee failed to ensure that all hazardous substances within the housekeeping rooms were kept inaccessible to residents at all times.

The severity was determined to be a level 2 as there was minimal harm or potential actual harm/risk to this resident. The scope of this issue was a pattern during the course of this inspection. There was no compliance history of this legislation being issued in the home. [s. 91.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all hazardous substances are labelled properly and kept inaccessible to residents at all times, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 126. Every licensee of a long-term care home shall ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. O. Reg. 79/10, s. 126.

Findings/Faits saillants :

1. The licensee failed to ensure that drugs remain in the original labeled container or package provided by the pharmacy service provider until administered to the resident.

A medication administration observation was completed for a resident. Further observation of the medication packaging for the resident showed that the packaging did not have the original pharmacy label, was illegible, and did not have any resident identifying information. As a result, it was not possible to identify which resident the medication belonged too.

An observation of the same medication in a different home area medication cart also had packaging where the white sticker was illegible, damaged, and believed to only have the resident's name on the sticker as the only identifier.

The Medical Pharmacy Policy and Procedures Manual for Long Term Care Homes "How to Administer Insulin" policy 3-12 dated February 2017 stated, "Insulin pens will be clearly labeled with the person's name or other identifying information to ensure that the correct pen is used only on the correct individual."

The EDON said that the two medications in two different home areas were reviewed and they did not have identifying labels from Medical Pharmacy and that they should be labelled correctly.

The licensee failed to ensure that the labelling on the insulin pen had the person’s name or other identifying information to ensure that the correct medication was used only on the correct individual.

The severity was determined to be a level 2 as there was minimal harm or potential actual harm/risk to this resident. The scope of this issue was isolated to one resident during the course of this inspection. There was no compliance history of this legislation being issued in the home. [s. 126.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs remain in the original labeled container or package provided by the pharmacy service provider until administered to the resident, to be implemented voluntarily.

WN #6: 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).

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction was documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and reported to the resident, the resident's Substitute Decision Maker (SDM), if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

A) Medical Pharmacy completed a Medication Incident Notification Review due to a medication incident that occurred for a resident. The medication incident report showed that during a narcotic drug destruction, the resident had a transdermal medication that had been left on too long and should have been changed.

Review of the electronic Medication Administration Record (eMAR) showed that the resident was to have the transdermal medication changed on specific dates.

There was no documentation in the resident's progress notes related to the transdermal medication order being held or being reviewed by the physician or administered for pain and comfort as prescribed.

Further review of the eMAR and PointClickCare (PCC) showed that there was no further action taken to respond to the medication that was held, which was three days after the medication was to be administered.

The Executive Director of Nursing (EDON) shared that the nurses did not document the medication administration of the transdermal medication on the eMARand that the RPN had completed late documentation as to why the medication was held and had not documented if the physician was notified of holding the medication. As a result of both documentation errors, the medication was not given as prescribed and administered as ordered.

The licensee failed to ensure that appropriate actions were taken in response to the medication incident involving the resident.

B) Medication Incident Notification report was completed by Medical Pharmacies for a medication incident that occurred for a resident. The incident report showed that it was discovered that the the resident's medication package was still in the medication cart and should have been administered hours earlier.

The Medical Pharmacy Medication Incident Reporting policy 9-1 dated February 2017 stated, "Complete the Medication Pharmacies Medication Incident Reports when a medication incident or adverse drug reaction has occurred including near misses situation." "That every medication incident and adverse drug reaction involving a resident is to be report to the resident or the residents SDM, DOC, the Pharmacy and Clinical Consultant and physician should be notified." "All medication incidents are reviewed by the home."

A Pharmacy's Clinical Consultant said that the home was responsible for completing the internal investigation into the medication incidents that occurred at the home and were not related to a pharmacy error.

Further review of the Medication Incident Notification Report showed that there was no documentation that the physician or the family was notified of the omission of the medication. There was no documentation that the home followed up with an internal investigation or that immediate actions were taken to assess and maintain the resident's health, and reported to the resident or the residents Substitute Decision Maker (SDM) or that the physician was notified on the medication incident.

The resident's progress notes did not indicate that there was an omission of medication or the reason for the omission or that the SDM and the physician were notified of the medication incident.

Review of the electronic Medication Administration Record (eMAR) showed that a nurse had signed that the medications were administered.

The EDON said that the home had not completed the internal investigation related to this medication incident. That the resident's SDM and the physician were not notified of the medication omission and that although the nurse documented that the medications were administered, the medication had not been given.

The licensee failed to ensure that appropriate actions were taken in response to the medication incident involving a resident.

(C) The Medical Pharmacy Medication Incident Report showed that the resident was to receive prescribed medication at a specific time. Further review of the incident report showed that the resident received an increased dose of the medication.

The Medication Incident Report for notification of resident or family showed “no Power of Attorney (POA)” documented on the report and further review of the incident report showed that the pharmacy was not notified of the medication incident.

The progress note in PointClickCare (PCC) documented that a medication error was found that the resident received double the dose of medication. The Medical Director was notified and ordered to monitor vitals throughout night, and monitor for changes in respiratory pattern and if resident was lethargic.

A late progress note entry in PCC documented that a medication error had occurred and that the resident received at a higher dose then scheduled.

The pharmacy Clinical Consultant signed the Medication Incident Report and the EDON signed the Medication Incident Report that it was reviewed by the pharmacy.

The licensee failed to ensure that appropriate actions were taken in response to the medication incident involving the resident.

The severity was determined to be a level 2 as there was minimal harm or potential actual harm/risk to this resident. The scope of this issue was widespread for three of three residents during the course of this inspection. There was no compliance history of this legislation being issued in the home. [s. 135. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every medication incident involving a resident and every adverse drug reaction is documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider, to be implemented voluntarily.

WN #7: 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:
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).

Findings/Faits saillants :

1. The licensee failed to ensure where an incident occurred that caused an injury to a resident for which the resident was taken to a hospital, but the licensee was unable to determine within one business day whether the injury had resulted in a significant change in the resident’s health condition, the licensee 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 a description of the individuals involved in the incident, including names of any residents involved in the incident.

A Critical Incident (CI) System report related to the resident’s fall was submitted to the Director and the full name of the resident was not included in the CI submission.

Two amendments to the initial CI were submitted to the Director. The first amendment provided information on the outcome and status of the resident, the family members’ response, and long-term actions planned to prevent recurrence. The second amendment provided additional information related to the family members’ response. The full name of the resident was not included in either of the amendments.

Two requests were made by the Ministry of Health (MOH) for the home to amend the CI to include the resident’s full name.

The Director of Resident Care said that they submitted the CI for the fall incident for the resident.They also said they did not know why the full name of the resident was not included on the report to the Director.

The Executive Director of Nursing agreed that the CI report to the Director was not amended to include the resident's name.

The severity was determined to be a level 1 as there was minimal risk to this resident. The scope of this issue was isolated to one resident during the course of this inspection. There was a compliance history of this legislation being issued in the home on June 16, 2016 as a Written Notification (WN) in Resident Quality Inspection # 2016_271532_0011. [s. 107. (4) 2. i.]

Issued on this 20th day of June, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MELANIE NORTHEY (563), ALICIA MARLATT (590), AMIE GIBBS-WARD (630), DONNA TIERNEY (569), NATALIE MORONEY (610), NEIL KIKUTA (658)
Inspection No. / No de l'inspection :	2017_606563_0008
Log No. / Registre no:	008392-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 19, 2017
Licensee / Titulaire de permis :	PEOPLECARE Inc. 28 William Street North, P.O. Box 460, Tavistock, ON, N0B-2R0
LTC Home / Foyer de SLD :	peopleCare Hilltop Manor Cambridge 42 ELLIOTT STREET, CAMBRIDGE, ON, N1R-2J2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Donna Michaels

To PEOPLECARE Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2017_457630_0003, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee must achieve compliance to ensure that each resident is reassessed and the plan of care reviewed and revised at any time when the resident's care needs change.

Specifically, the licensee will ensure:
a) Resident #012 is reassessed and the plan of care reviewed and revised related to the resident's nutritional care needs,
b) Resident #006 is reassessed and the plan of care reviewed and revised related to bowel continence care needs, and
c) Resident #004 is reassessed and the plan of care reviewed and revised related to the resident's bowel continence care needs.

Grounds / Motifs :

1. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed.

A Personal Support Worker (PSW) shared that the resident had a particular meal in their room at a particular time of the day and required assistance. The PSW said they would look in the kardex to identify the care requirements of a resident.

The resident was observed in their room during a meal service. At the end of the dining room meal service, the resident was observed to receive assistance from one staff member while in their room.

A PSW said that the resident stayed in in their room regularly during a specific meal at their family's request. The PSW said they provided a tray at the end of the dining room meal service and provided assistance. The PSW said if they needed to know about the care for a resident they would ask their colleagues and would also look on the kardex in the computer.

Review of the clinical record for the resident showed the following:
- The most recent Resident Assessment Instrument Minimum Data Set (RAI-MDS) assessment stated the resident required assistance with a particular activity of daily living. No further assessment of resident's ability was observed in the chart after this assessment.
- The plan of care and the kardex did not provide direction regarding the routine required during a specific meal.

The Registered Dietitian (RD) said they had not received notification that the resident had a particular routine implemented. The RD said it was an expectation that this would be referred to the RD and then the plan of care would be updated to reflect this change.

The acting Director of Resident Care (aDRC) said that it was the expectation in the home that the plan of care would be based on an assessment and reflect a change in a resident's needs. The aDRC reviewed the plan of care for the resident and acknowledged that this change in care needs was not reflected in the plan of care, kardex or the Point of Care (POC) tasks.

The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed. [s. 6. (10) (b)]

2. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the two residents care needs changed.

The "RAP for bladder & bowel continence" assessment in PointClickCare (PCC) for the two residents stated there was a non-triggered clinical problem for

incontinence.

The Minimum Data Set (MDS) assessments completed in PCC documented there was an identified decline in continence from the previous MDS assessment.

The care plan had interventions related to the type of physical assistance the residents required and the number of staff for transferring on and off toilet. The care plan had a continence focus, but interventions related to a toileting routine to maintain an optimal level of continence were absent from the care plan for both residents.

The acting Director of Resident Care (aDRC) shared that the staff member who completed the RAP assessment for continence should have documented the change in continence and verified that there was no assessment completed related to continence as part of the RAP assessment.

A PSW shared that the PSWs rotate every month from one care area to the other. The PSW said that the resident was toileted at specific times. A PSW showed the Inspector the kardex for the two residents and verified that the kardex was where PSWs would look at to identify the care requirements of a resident. The PSW shared that the residents had a toileting focus but that there was no routine to instruct all PSW staff as to when to toilet the resident so that the resident was clean and dry. The PSW shared that the routine should be a part of the interventions for toileting.

The "Continence and Bowel Management Program" policy reference number 008010.00 stated, "A Resident Assessment Profile (RAP) assessment will take place when triggered and when there is a significant change in the bladder and bowel continence (worsening)."

The "Care Plan and Plan of Care" policy reference number 005415.00 stated, "each resident care plan and plan of care will be up to date and reflect their current care needs, goals and interventions and to be reviewed in accordance with the Long Term Care legislation."

The licensee failed to ensure that the two residents were reassessed and the plan of care reviewed and revised when the resident's continence care needs changed.

The severity was determined to be a level 2 as there was minimal harm or potential actual harm/risk to this resident. The scope of this issue was a pattern during the course of this inspection. There was a compliance history of this legislation being issued in the home on February 9, 2017 as a Compliance Order (CO) in Complaint inspection # 2017_457630_0003 with a compliance due date of April 3, 2017. [s. 6. (10) (b)] (630)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 28, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 19th day of June, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Melanie Northey

Service Area Office /
Bureau régional de services : London Service Area Office