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 prévue 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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**Public Copy/Copie du public**

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Dec 20, 2018 | 2018_745690_0017 | 018068-18, 027383-18, 028698-18, 029429-18, 029455-18, 029573-18 | Critical Incident System |

## Licensee/Titulaire de permis

IOOF Seniors Homes Inc.
20 Brooks Street BARRIE ON L4N 5L3

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

IOOF Seniors Home
10 Brooks Street BARRIE ON L4N 5L3

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

TRACY MUCHMAKER (690)

## Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): December 11 -14, 2018**

**The following intakes were inspected during this Critical Incident Inspection:**
**-One log which was a critical incident the home submitted to the Director related to falls prevention;**
**-Three logs which were critical incidents the home submitted to the Director related to missing/unaccounted for controlled substances; and**
**-Two logs which were critical incidents the home submitted to the Director related to alleged resident to resident abuse.**

**Follow up Inspection #2018_745690_0016 was conducted concurrently with this inspection.**

**During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), the Director of Resident Care (DORC), the Assistant Director of Resident Care (ADORC), the Resident Care Nurse Manager, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), family members and residents.**

**During the course of the inspection, the inspector(s) conducted observations in resident home areas, observation of care delivery processes, review of the home's policies and procedures, and residents' health records.**

**The following Inspection Protocols were used during this inspection:**
**Falls Prevention**
**Medication**
**Prevention of Abuse, Neglect and Retaliation**
**Responsive Behaviours**

**During the course of this inspection, Non-Compliances were issued.**
- **1 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. (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. (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).**

**Findings/Faits saillants :**

1. 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.

A Critical Incident (CI) report was submitted to the Director for a missing/unaccounted for medication. The CI report indicated that staff were unable to locate resident #006's medication at a specified time.

A review of resident #006's electronic medication administration record (emar) indicated that resident #006 was prescribed an identified trans-dermal patch medication. A task on the emar indicated that staff were to check the location of the medication at specified times.

The documentation on the emar by Registered Practical Nurse (RPN) #105 on an identified date at a specified time, indicated that the medication was present. The documentation two hours and six hours after the initial documentation by RPN #105 indicated that there would be a progress note documented.

The progress note documented on the day of the incident indicated that RPN #105 did not check the location of the medication at a specified time as they were too busy. The progress note further indicated that staff were unable to locate the medication four hours later.

In an interview with Inspector #690, RPN #105 indicated that they had not completed the check for resident #006's medication at a specified time as they were too busy and that they were made aware that the medication was missing four hours later. RPN #105 indicated that the expectation was that the check for the medication was to be completed

as per the schedule on the emar and that they did not complete the check for the medication at a specified time on the day that the medication went missing.

In an interview with Inspector #690, the Director of Resident Care (DORC) indicated that Registered staff were to check to ensure the medication for resident #006 was present as per the schedule on the emar and that the check was not completed at a specified time . [s. 6. (7)]

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

A Critical Incident (CI) report was submitted to the Director for a missing/unaccounted for medication that was prescribed to resident #006. Please see WN #1, finding 1 for more information.

A review of resident #006's emar for a two month period, indicated that staff were to check to ensure that the resident's medication was present at specified times with two Registered Staff. Staff were to complete the check together and sign the emar at specified times. Inspector #690 noted that there was missing documentation in 26 out of the 180 emar tasks for the first month. A review of resident #006's emar for the second month, revealed that there was no documentation for the check of the medication 14 times.

In an interview with Inspector #690, RPN #105 indicated that two Registered staff were to go together at specified times and check that resident #006's medication was present. RPN #105 further indicated that both Registered staff were then to document on the emar that the check of the medication was completed. Together Inspector #690 and RPN #105 reviewed the documentation on resident #006's emar and RPN #006 indicated that there were several missing signatures during the two month period for the check of the medication and that there should not have been any missing signatures.

In an interview with Inspector #690, the DORC indicated that a task was implemented on resident #006's emar to direct two Registered staff to go at specifed times to ensure that resident #006's medication was present. The DORC further indicated that both Registered staff were to document on the emar to indicate that the check had been done. Together Inspector #690 and the DORC reviewed resident #006's emar documentation for the check of the medication and the DORC indicated that there were several missing signatures during the two month period to indicate that two Registered staff had

completed the check and that there should not be any missing documentation. [s. 6. (9) 1.]

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**Issued on this 21st day of December, 2018**

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

**Original report signed by the inspector.**