Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 27, 2020	2020_772691_0015	004622-20, 006711-20, 012036-20	Critical Incident System

Licensee/Titulaire de permis

IOOF Seniors Homes Inc.
20 Brooks Street BARRIE ON L4N 7X2

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

JENNIFER NICHOLLS (691)

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): August 10-14, 2020. Offsite Inspection activities were conducted from August 17-21, 2020.

The following intakes were inspected upon during the Critical Incident Inspection:
-One intake submitted to the Director regarding a fall with fracture;
-One intake submitted to the Director regarding missing and unaccounted narcotic;
-One intake submitted to the Director regarding a missing resident under three hours.

A Complaint Inspection (2020_772691_14) was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), Director of Resident Care (DRC), Nurse Manager(s), Director of Facilities and Environment, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Worker (PSW) and residents.

The Inspector also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions and resident to resident interactions, reviewed relevant health records, complaint logs, as well as licensee policies, medication management program, as well as procedures and programs.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Responsive Behaviours
Safe and Secure Home

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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 where the Act or the Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

In accordance with O.Reg 79/10, s. 114(2), the licensee was required to ensure that written policies, and protocols were developed for the medication management system to ensure that accurate acquisition, dispending, receipt, storage, administration and destruction and disposal of all drugs used in the home.

A) Specifically, staff did not comply with the licensee's policy #07-10-08 titled "Resident Care, Narcotic and controlled drugs", last revised June 1, 2017, which was a part of the licensee's medication management program. This policy indicated that narcotic patches when removed [were] folded into themselves and placed in the secure narcotic drawer until they [could] be wasted. All narcotic wastage, including used narcotic patches, [were to] be double witnessed and signed by two nurses. This [was to] be witnessed by two nurses and the wastage [was to] be recorded on the individual resident's narcotic and controlled drug count sheet.

A Critical Incident System (CIS) report was submitted to the Director on an identified date for a missing or unaccounted for controlled substance. The CIS report identified at the end of the evening shift during the narcotic count, RN #114 and RPN #110 identified that resident #002's used controlled substance patch was missing.

Inspector #691 reviewed the licensee's internal investigation notes related to the missing or unaccounted for controlled substance for resident #002 and noted the new controlled substance patch was signed for as given and the used medication patch wasted by RPN

#110 on the administration sheet.The Inspector also noted that there was no signature in the “checked by incoming”, only a crossed out line.

Further review of the homes internal investigation notes identified that RPN #110 indicated in a written statement that they removed resident #002's used controlled medication patch and reapplied the new one as ordered. RPN #110 further indicated that they could not locate the used controlled medication patch at the time of the narcotic count with RN #114.

In an interview with Inspector, RPN #110 indicated that they removed resident #002’s used controlled medication patch, reapplied the new one, and indicated they were unsure of where they put the used medication patch and were unable to locate it at the end of their shift. RPN #110 further indicated that they were aware of the home’s policy to ensure that the used medication patch was a controlled substance and they were to be put in a secure narcotic drawer until they were wasted with another registered staff.

In separate interviews with RPN #107, RPN #108, and RN #109 they each indicated to the Inspector, that they were aware of the home's policy for administering a controlled substance. They also indicated that if any of the controlled substance was to be wasted; the nurse would need to have that medication in a locked drawer in the medication cart until the second nurse can witness and sign off on the waste.

In an interview with the DRC, they indicated that during the course of the investigation into the missing or unaccounted for controlled substance, it was noted that on the identified date, RPN #110 had signed off as having wasted resident #002’s medication, but was not able to locate the used medication patch at the end of the evening shift for the second nurse to sign off. The DRC indicated that RPN #110 could not recall the location of the used medication and they did not secure the used controlled substance in a locked bin, until they could obtain a signature of another registered staff, therefore, RPN #110 did not comply with the home’s policy related to medication administration and the wastage of controlled substances. [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 the policies related to medication administration, specifically, the administration and waste of controlled substances, are complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to stairways and to the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,

A Critical Incident System (CIS) report was submitted on an identified date, to the Director, for a missing resident who had eloped from the home. The CIS report identified that resident #003 was seen outside the home by Personal Support Worker (PSW)#104. It was further identified that resident #003 had eloped from the home down the identified stairwell.

Inspector #691 reviewed resident #003's health care records, in which the care plan identified a focus of an elopement risk and had wandering behaviors since admission.

A further review of resident #003's progress notes by Inspector #691, identified that on an identified date, Registered Practical Nurse (RPN)#113 documented that "[they were] able to exit on the identified [wing] of the floor as one of the doors was not secure and not alarming."

In a review of the homes policy, titled "Safe and Secure Home", policy #CQI-01-00-09 effective March 23, 2000, last updated March 17, 2017, indicated the home was to provide a an environment that gives or assures safety which includes freedom from doubt, anxiety or fear which includes the use of devices such as locks or other access control systems on doors or windows to deter or prevent unauthorized access or egress.

In interview with Inspector #691, the Director of Facilities and Environment #111, they stated to Inspector #691 that on the identified date, there was a mechanical failure to the identified door, and further identified that the upper metal door latch on the door was not striking or sensing properly allowing the door to not secure correctly. During the investigation, the maintenance staff conducted multiple attempts to open and secure the door, it was identified that not every time the door was shut, was it secured to the magnetic locks. They further identified the upper metal door latch screws became loose, not allowing the door to strike consistently when it was engaged, therefore the door malfunctioned, allowing resident to exit the home.

In an interview with Inspector #691, the Director of Resident Care (DRC) identified that during their investigation, resident #003 eloped from the home, down the identified stairs and subsequently exited the home. They further identified that resident #003 eloped due to a mechanical failure to the door lock system through the identified door, and therefore the home did not provide a safe and secure environment and should have. [s. 9. (1) 1.1.]

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 ensure that all doors leading to stairway and to the outside of the home must be kept closed and locked, to be implemented voluntarily.

Issued on this 8th day of September, 2020

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

Original report signed by the inspector.