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 # / No de registre	Type of Inspection / Genre d'inspection
Nov 3, 6, 2017	2017_525596_0017	024113-17	Resident Quality Inspection

Licensee/Titulaire de permis

LABDARA FOUNDATION
5 Resurrection Road TORONTO ON M9A 5G1

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

LABDARA LITHUANIAN NURSING HOME
5 Resurrection Road TORONTO ON M9A 5G1

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

THERESA BERDOE-YOUNG (596), JOY IERACI (665)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): October 18, 19, 20, 23, 24, 25, 2017.

The following complaint inspections were conducted concurrently with the Resident Quality Inspection (RQI): log #009936-15 and #033162-15 related to care issues.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Medical Director, Attending Physician, Pharmacist, registered nurse (RN), registered practical nurse (RPN), personal support worker (PSW), Residents' Council President, residents and family members.

During the course of the inspection, the inspectors toured the home, observed resident care, observed staff to resident interaction, reviewed resident health records, meeting minutes, schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Residents' Council

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program.

During a medication administration observation on a specified date in October 2017, on an identified resident home area, registered practical nurse (RPN) #104 administered medications to residents #005, #006 and #007 without performing hand hygiene in between residents.

Interview with RPN #104 indicated he/she would perform hand hygiene in between residents during medication administration when he/she administered a particular type of medication or if residents were sick and had respiratory symptoms. The RPN later approached inspector and stated after review of the home's infection prevention and control policies and discussion with the Director of Care (DOC), he/she acknowledged he/she should have performed hand hygiene in between residents during the medication administration pass.

Interview with the DOC revealed that hand hygiene is to be performed between residents during medication administration. The DOC acknowledged the RPN did not participate in

implementing the home’s infection prevention and control program. [s. 229. (4)]

2. The licensee has failed to ensure that each resident admitted to the home was screened for tuberculosis within 14 days of admission, unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.

Record review of resident #016's clinical record included a signed consent for treatment dated a specified date in April 2017, for a diagnostic test related to a particular type of screening. The clinical record indicated that the resident was admitted to the home in April 2017.

Record review of resident #016's clinical record did not include documentation regarding the above mentioned particular type of screening. The resident's community care access centre (CCAC) application indicated that the screening was not completed and there was no further information available regarding the resident's screening status.

Interview with registered nurse (RN) #102 revealed that the particular type of screening had not been completed for resident #016 who was over 65 years of age, and admitted to the home in April 2017. RN #102 confirmed that the resident's substitute decision maker (SDM) had signed the consent in April 2017, and he/she could not find any diagnostic test results or physician's order for the resident after checking the clinical record. The RN stated that he/she was not sure how it was missed, and that the resident's attending physician had been notified and ordered the diagnostic test to be done as soon as possible, to determine the resident's screening status.

Interview with the DOC revealed the home's process for the particular type of screening mentioned is that all newly admitted residents over 65 years of age should be screened via a particular type of diagnostic test, and resident #016 who was admitted to the home in April 2017 had not been screened. [s. 229. (10) 1.]

3. The licensee has failed to ensure that residents were offered immunizations against pneumoccocus in accordance with the publicly funded immunization schedules posted on the Ministry website.

Record review of resident #017's clinical record included a signed consent for treatment dated a specified date in June 2017, for the administration of a particular type of vaccine. The clinical record indicated that the resident was admitted to the home in June

2017.

Record review of the home's policy titled Vaccines, date revised March 2011, indicated that the vaccine will be given when there is no documented evidence of previous vaccination. The vaccine will be given at the time of the annual flu shot, in November, for all existing residents and upon admission for all new residents.

Interview with RPN #112 revealed that the consent for the particular type of vaccine administration was signed by the resident's SDM in June 2017 when the resident was admitted to the home. The RPN reported upon review of the resident's clinical record including the electronic medication administration records (eMAR) from June 2017 to present, there was no documented evidence that the above mentioned vaccine had been administered to the resident prior to admission or since admission to the home. The RPN stated that the home's expectation was that the vaccine should have been administered to the resident since the consent had been signed upon admission in June 2017. After contacting resident #017's attending physician, the RPN informed the inspector that the resident had not previously received the vaccine and it would be offered to the resident as soon as possible.

According to the DOC, in the absence of evidence of previous vaccination, the above mentioned particular type of vaccine should have been administered to resident #017 upon admission in June 2017, as the consent for treatment had been signed. [s. 229. (10) 3.]

4. Record review of resident #016's clinical record included a signed consent for treatment dated a specified date in April 2017, for the administration of a particular type of vaccine. The clinical record indicated that the resident was admitted to the home in April 2017.

Interview with RN #102 revealed that the consent for the vaccine administration was signed by the resident's SDM in April 2017 when the resident was admitted to the home. Upon review of the resident's clinical record the RN reported there was no documented evidence that the vaccine had been administered to the resident prior to admission or since admission to the home. The RN stated that the home will now try to obtain the resident's medical records from his/her previous physician to determine if the resident had received the vaccine in the past.

Record review of the resident's MARs from April to October 2017 did not include sign off

for administration of the above mentioned vaccine.

Resident #016's daughter who was caregiver for the resident prior to admission to the long term care home told the inspector that to the best of his/her knowledge the resident had not received the vaccine prior to admission to the home. He/she confirmed signing consent for administration of the vaccine to her mother after he/she was admitted to the home.

According to the DOC, in the absence of evidence of previous vaccination, the particular type of vaccine should have been administered to resident #016 upon admission in April 2017, as the consent for treatment had been signed by the SDM. [s. 229. (10) 3.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff participate in the implementation of the infection prevention and control program, that each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee, and that residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website, 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.

According to O.Reg 79/10, s.136 (1), Every licensee of a long-term care home shall ensure as part of the medication management system, that a written policy is developed in the home that provides for the ongoing identification, destruction and disposal of, (a) all expired drugs.

The home used Medical Pharmacies medication management policies and procedures. Medical Pharmacies' policy #5-1, titled, Expiry and Dating of Medications dated February 2017, indicated under procedure number one, "Examine the expiry date of all medications on a regular monthly basis. Be especially careful to check all storage areas including monitored medication (narcotic and controlled)."

During the mandatory drug storage observation for narcotics and controlled substances on a specified date in October 2017, on an identified resident home area with RPN #104, two expired narcotic cards of a particular narcotic medication was observed in the narcotic drawer of the medication cart belonging to resident #008.

Review of the narcotic cards found 28 tablets on on card and 21 tablets on the other card, of the particualr medication.

Interview with RPN #104 indicated expired narcotics were to be removed from the narcotic drawer upon discovery and given to the DOC or the Associate Director of Care (ADOC) if the DOC is not available. The RPN indicated the pharmacy was called on October 3, 2017, and confirmed the particular narcotic medication had expired; the

expired medication should have been removed from the narcotic drawer of the medication cart.

Interview with the DOC revealed expired narcotics were to be promptly removed from the medication cart and forwarded to him/her or the ADOC if he/she was unavailable. The DOC indicated that the night registered staff should check all the medication carts, including the narcotic drawers and medication cupboards for expired medications on a monthly basis. The night nurse did not have a set schedule when the check was to be completed during the month, and there was no form for the nurse to sign to confirm completion. The DOC stated he/she received resident #008's expired particular narcotic medication on October 20, 2017, after it was brought to the home's attention by the inspector on the same day. The DOC acknowledged resident #008's expired narcotic medication should have been removed from the narcotic drawer upon discovery and brought to his/her office until drug destruction occurred with the pharmacist.

2. According to O.Reg 79/10, s.136 (2) 2, The drug destruction and disposal policy must also provide for the following: (2) That any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs.

Medical Pharmacies' policy #5-4, titled, Drug Destruction and Disposal, dated February 2017, indicated under monitored medication, removal and storage, "Retain the medications in a double-locked wooden box, in a locked medication room, separate from those medications available for administration to a resident. Only the DOC will hold the keys to the wooden box, however the box is only accessed with the DOC (or designate) and the pharmacist or physician. Only active narcotic and controlled orders are to be stored in the cart narcotic bin."

During the drug storage observation for narcotics and controlled substances on a specified date in October 2017, on an identified resident home area with RN #102, the inspector observed two tablets of a particular discontinued medication, belonging to resident #010, in the narcotic drawer of the medication cart. Review of the package of the particular medication revealed it was discontinued on October 18, 2017.

Interview with RN #102 indicated it was the home's process that discontinued controlled substances are promptly given to the DOC or to the ADOC if the DOC is not available. The RN acknowledged the above mentioned discontinued particular medication for

resident #010 should have been removed from the narcotic drawer and given to the DOC on the day it was discontinued or the following day.

Interview with the DOC indicated it was the home's expectation for registered staff to remove discontinued controlled substances from the narcotic drawer in the medication cart and forward the medication to him/her, or to the ADOC if he/she is not available, on the day the medication is discontinued or the following day. The DOC stated he/she received the above mentioned discontinued medication for resident #010 on October 20, 2017, after it was brought to the home's attention by the inspector. The DOC acknowledged staff did not follow home's expectation regarding the storage of discontinued controlled substances. [s. 8. (1) (b)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 59. Family Council

Specifically failed to comply with the following:

s. 59. (7) If there is no Family Council, the licensee shall,
(a) on an ongoing basis advise residents' families and persons of importance to residents of the right to establish a Family Council; and 2007, c. 8, s. 59. (7).
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council. 2007, c. 8, s. 59. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that if there was no Family Council, the licensee shall convene semi-annual meetings to advise residents' families and persons of importance to residents of the right to establish a Family Council.

Interview with the home's Administrator confirmed that the home did not have an established Family Council in 2016, and did not convene semi-annual meetings to advise residents' families and persons of importance to residents of their right to establish a Family Council in 2016. The home was unable to provide any supporting documentation of the same. [s. 59. (7) (b)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

During the drug storage observation for narcotics and controlled substances on a specified date in October 2017, on an identified resident home area with RPN #103, the inspector observed the count for a particular medication for resident #009 was incorrect. Resident #009's narcotic card had 13 tablets and the individual monitored medication record (IMMR) count indicated 12 tablets. The IMMR revealed RPN #103 had signed off for administering the above mentioned medication at 0910 hours.

Record review of resident #009's physician orders and eMAR revealed the physician ordered the particular medication, one tablet by mouth twice daily.

Interview with RPN #103 indicated he/she did not realize that he/she did not administer the medication to resident #009 until the inspector conducted the drug storage observation. The RPN indicated he/she was distracted during the morning medication pass and forgot to administer it. RPN #103 acknowledged that he/she did not administer the above mentioned particular medication to resident #009 as specified by the prescriber.

Interview with the DOC indicated it is the home's expectation for medications to be administered as ordered by the physician. The DOC acknowledged RPN #103 did not administer resident #009's morning dose of the particular medication as specified by the prescriber. [s. 131. (2)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident was 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.

A review of the home's 2017 medication incidents revealed three of the five medication incidents involving residents #011, #012 and #013 were not reported to the resident or the residents' SDM.

Review of the three medication incident reports revealed on a specified date in March

2017, the pharmacy technician from Medical Pharmacies during his/her audits found the following expired medications in the unit's medication cart:
1) A particular type of medication was to be discarded on a specified date in February 2017, for resident #011
2) A particular type of medication was to be discarded on a specified date in December 2016, for resident #012
3) A particular type of medication was to be discarded on a specified date in March 2017, for resident #013.

Review of the above medication incident reports did not indicate if the resident or SDM were notified of the medication incidents.

Review of the progress notes for the three residents mentioned above did not locate documentation that the residents/SDMs were notified of the medication incidents.

Interviews with RPNs #103 and #104 indicated it was the home's process for the resident or their SDM be notified when a medication incident occurs.

Interview with the DOC indicated it is the home's expectation for the resident or the resident's SDM to be notified when a medication incident occurs. The DOC reviewed the medication incident reports for residents #011, #012 and #013 and acknowledged the SDMs for the residents were not notified of the medication incidents as per home's expectation. [s. 135. (1)]

2. The licensee has failed to ensure that any changes and improvements identified in the review were implemented.

Record review of the home's quarterly medication incident analysis for the period of January to March 2017, revealed there were three medication incidents in March 10, 2017, where a particular type of expired medications were found in the medication cart belonging to residents #011, #012 and #013. The quarterly medication incident analysis indicated an action plan for the night nurse to check the medication cart monthly for expired drugs.

Interview with the DOC indicated that the action plan for monthly checks of expired drugs had not been implemented since the analysis was completed in March 2017. The DOC indicated he/she was currently working on implementing the process. The DOC stated it is the home's process to implement any improvements identified immediately when an

action plan is developed. The DOC acknowledged the quarterly medication incident analysis action plan was not implemented as per the home's process [s. 135. (3)]

Issued on this 27th day of November, 2017

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

Original report signed by the inspector.