Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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
Sep 10, 12, 2018	2018_565647_0024	019589-18	Resident Quality Inspection

Licensee/Titulaire de permis

2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

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

Owen Hill Care Community
130 Owen Street BARRIE ON L4M 3H7

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

JENNIFER BROWN (647), CHAD CAMPS (609), LOVIRIZA CALUZA (687)

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): August 7-10 and 13-17, 2018.

The following critical incidents (CIS) were completed during this inspection:
- one related to late reporting;
- one related to resident to resident abuse;
- one related to visitor/unknown person to resident abuse;
- two related to staff to resident abuse,
- three related to fall with injury;

The following complaints were completed during this inspection:
- one related to resident to resident abuse;
- one related to weight loss/eating, lack of supervision;
- one related to neglect, staff shortages;
- one related to resident abuse, continence, dining service.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Registered Dietitian (RD), Environmental Services Manager (ESM), Office Manager, Director of Care (DOC), Interim Director of Care (IDOC), Associate Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Dietary Aide (DA), Housekeeper, Residents, Family Members, and Substitute Decision Makers.

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

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Critical Incident Response
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

- **8 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

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

Resident #018 was identified as having a decline in an activity of daily living (ADL) from a Minimum Data Set (MDS) assessment.

A review of the written plan of care, indicated under the specified ADL that resident #018 had been required to be taken to a specified area at regular intervals to maintain a specific ADL with one staff assistance, however, under another focus in the same written plan of care, indicated different directions for the specified ADL.

In an interview with Inspector #647, direct care staff member #104 and Registered staff member #113, identified that resident #018 had required total care with all ADL's due to their current health condition. Both staff members acknowledged that resident #018 did not require the specified ADL, however acknowledged that the written plan of care for resident #018 indicated two different interventions for the same ADL.

In an interview with Inspector #647, the Director of Care (DOC) identified that the written plan of care did not provide clear direction to staff when the written plan of care indicated two different interventions for the specified ADL.

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

The home submitted a critical incident report (CIS) to the Director, related to an incident that caused an injury to resident #006. The resident had been taken to hospital which further resulted in a significant change in the resident's health status.

A record review of the CIS report indicated that resident #006 had been found lying on the floor after falling out of bed. The CIS report further indicated that later during the same shift, resident #006 had been transferred to hospital and diagnosed with a fracture.

The clinical chart and the plan of care indicated that resident #006 had been deemed a high fall risk, and required an identified intervention for fall prevention.

Interviews with Registered staff member #112, direct care staff member's #118 and #119, who all worked the day of the above mentioned incident, indicated that during change of shift they had walked past resident #006's room and observed them to be lying on the floor. The above mentioned staff members all acknowledged that the plan of care for resident #006 indicated the use of an identified fall prevention intervention. These staff members further confirmed that when they passed by and entered the room of resident #006, the identified fall prevention intervention had not been in place.

An interview with the DOC confirmed that the plan of care for resident #006 had not been followed when the fall prevention intervention had not been in place.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident, and to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

The O. Reg. 79/10 defines verbal abuse as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth and that was made by anyone other than a resident.

The home submitted a CIS report to the Director, which indicated that resident #002 was allegedly abused by direct care staff member #121 while resident #002 was receiving personal care.

Inspector #687 reviewed the home's policy titled "Prevention of Abuse & Neglect of a Resident" last revised January 2015, which indicated the following:

-the Executive Director (ED)/Administrator or designate initiates the investigation by requesting that anyone aware of or involved in the situation write, sign, and date a statement accurately describing the event, reiterating anonymity and protection against retaliation,
-the alleged abuser is also asked to write, sign, and date a statement of the event, and,
-if statements have been written, the ED/Administrator or designate interviews those persons completing the statements after the statement has been written.

Inspector #687 interviewed direct care staff member #112 who stated that they were with direct care staff member #121 performing personal care to resident #002 when the resident started to have responsive behaviours towards the staff. According to direct care staff member #112, direct care staff member #121 responded to the resident with the same responsive behaviour and direct care staff member #112 then reported this abuse incident to Registered staff member #122. Direct care staff member #112 verified that

they did not write any detailed statement of the abuse incident that occurred between direct care staff member #121 and resident #002. The direct care staff member further verified that they were not interviewed by any management staff at any time about the abuse incident.

In an interview with the DOC, they indicated that their designate in relation to an internal investigation of any abuse or alleged abuse would be the Administrator or any manager on duty. The DOC stated in their recollection, direct care staff member #112 was interviewed about the alleged abuse incident. The DOC acknowledged that in the internal investigation report notes, they wrote the short interview statement made by direct care staff member #112 but acknowledged that it did not indicated the date of the interview and no signature from direct care staff member #112. The DOC further acknowledged that based on the review of the home's policy, they should have asked for a written statement, signed and dated from all the staff that were identified or involved in the incident and verified the written information through follow-up interviews with the involved staff members.

2. Inspector #609 reviewed a CIS report submitted to the Director, which outlined how on an identified date, Registered staff member #129 attempted a medical intervention to resident #024 no less than five times despite the resident's negative vocalizations. On examination the resident sustained an injury to an affected area.

The O. Reg. 79/10 defines emotional abuse as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

The O. Reg. 79/10 further defines physical abuse as the use of physical force by anyone other than a resident that causes physical injury or pain.

During an interview with resident #024, they recalled the incident with Registered staff member #129 who ignored their negative vocalizations and went on to attempt a medical intervention no less than five times.

A review of the home's policy titled "Prevention of Abuse and Neglect of a Resident" current revision January 2015 outlined how all residents were to be free from abuse and neglect, whereby removal of a resident's decision-making power when the individual was able to participate would be defined as emotional abuse. The policy further defined

physical abuse as any action of physical force by anyone who understood and appreciated the consequences of their own actions that was contrary to a resident's health, safety or wellbeing that caused pain or physical harm to the resident.

During an interview with the ED, a review of the home's internal investigation was conducted. They outlined how on an identified date, Registered staff member #129 attempted a medical intervention to resident #024 five times, without the consent of the resident which caused an identified injury.

3. Inspector #609 reviewed a CIS report which outlined how on an identified date, direct care staff member #107 retaliated against resident #025 by shaking their fists at them. This occurred after the direct care staff member had learned that the resident had previously made a complaint to the home about direct care staff member #017's conduct.

The O. Reg. 79/10 defines emotional abuse as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

During an interview with resident #025, they recalled the incident with direct care staff member #107 who shook their fists at them after the direct care staff member had found out that the resident had complained about direct care staff member #107's conduct to the home. Resident #025 stated that they felt threatened by their actions.

A review of the home's policy titled "Prevention of Abuse and Neglect of a Resident" current revision January 2015, outlined how all residents were to be free from abuse and neglect, whereby threatening the security of sense of safety and wellbeing of the resident, would be defined as emotional abuse.

During an interview with the ED, a review of the home's internal investigation was conducted and verified how on an identified date, direct care staff member #107 had retaliated against resident #025 after they became aware of a complaint from the resident related to their conduct.

4. The O. Reg. 79/10 defines verbal abuse as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth

and that was made by anyone other than a resident.

The home submitted a CIS report to the Director, which indicated that resident #002 was allegedly abused by direct care staff member, while resident #002 was receiving care.

The CIS report indicated that resident #002 was expressing responsive behaviours at direct care staff members #112 and #121 while they were providing care. Direct care staff member #121 responded by expressing the same responsive behaviours back to the resident and direct care staff member #112 felt that direct care staff member #121 had abused the resident at that particular moment and reported this incident to management.

Inspector #687 reviewed the home's policy titled "Prevention of Abuse & Neglect of a Resident" last revised January 2015, which indicated that, "all residents have the right to dignity, respect, and freedom from abuse and neglect. The organization has a Zero Tolerance Policy for resident abuse and neglect. Abuse is not tolerated in any circumstance by anyone and may result in termination of employment and/or criminal charges and any deviation from this standard will not be tolerated."

In a record review of the home's internal investigation, direct care staff member #112 and #121 had provided care to resident #002. The resident was expressing responsive behaviours multiple times to both direct care staff members #112 and #121. Direct care staff member #121 denied responding to resident #002 using the same responsive behaviours.

In an interview with Inspector #687, direct care staff member #112 stated that they were with direct care staff member #121 performing personal care to resident #002 when the resident started to express responsive behaviours towards the staff. According to direct care staff member #112, direct care staff member #121 responded to the resident with the same responsive behaviour.

In an interview with the DOC, they stated that they interviewed direct care staff member #121, however, direct care staff member #121 denied the abuse allegation. The DOC further stated that based on their internal investigation reports, there was a clear indication that direct care staff member #121 abused resident #002 at that time.

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 written policy to promote zero tolerance of abuse and neglect of residents was complied with, to be implemented voluntarily.

WN #3: 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).

Findings/Faits saillants :

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

During the initial tour on August 7, 2018, and further observation completed on August 15, 2018, Inspector #647 observed that 13 resident rooms had been equipped with over the door personal protective equipment (PPE) holders. It had further been observed that five of the identified rooms had been missing the precaution signage that would direct staff and visitors what PPE they should dawn before entering the affected room.

During interviews with Registered staff members #120 and #132, direct care staff members #110 and #134, and Housekeeper #133, they all acknowledged the home had an infection control program that monitored infections throughout the home. These staff indicated that one process in the home is to hang a yellow door caddy over the resident's door that is supplied with PPE that includes gloves, hand sanitizer, gowns, masks, and door signage to indicate what precautions staff are required to take related to the individual infection.

During further interviews with the above mentioned staff, they acknowledged that the five identified rooms had been missing the precaution signage that would direct staff what

PPE they should dawn before entering the affected room.

A review of the home's "Identification of Isolation Rooms", Policy #IX-G-10.90, indicated that Registered staff are to place signage on the resident's door to indicate the type of additional precautions in place.

A review had been completed of the Provincial Infectious Diseases Advisory Committee (PIDAC), Routine Practices and Additional Precautions, In All Health Care Settings, 3rd edition, a document that was developed by the Provincial Infectious Diseases Advisory Committee on Infection Prevention and Control (PIDACIPC). PIDAC-IPC is a multidisciplinary scientific advisory body that provides evidence-based advice to the Ontario Agency for Health Protection and Promotion (Public Health Ontario) regarding multiple aspects of infectious disease identification, prevention and control. PIDAC-IPC's work is guided by the best available evidence. On page 26/113 it indicated that signage specific to the type(s) of additional precautions should be posted.

Inspector #647 interviewed the DOC and the Administrator who acknowledged that PIDAC was used in the home as a resource for policy development and infection prevention and control best practices. The DOC and the Administrator both confirmed at the time of interview that the staff still required PPE to care for the affected residents and that best practices had not been followed related to the infection prevention and control program as the above indicated rooms had not had the required signage to direct staff to the appropriate PPE.

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 staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 30. Protection from certain restraining

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff. 2007, c. 8, s. 30. (1).
2. Restrained, in any way, as a disciplinary measure. 2007, c. 8, s. 30. (1).
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that no resident was restrained by the use of a physical device, other than in accordance with section 31 (included in the resident's plan or care) or under the common law duty described in section 36.

On an identified date, resident #022 yelled out to Inspector #609 from an identified area for help as they were unable to move their mobility device, as they usually are able to do. The resident could not move because the brakes were applied and they were unable to release the brakes on their own.

A review of resident #022's plan of care failed to indicate that the resident was to have their mobility restricted.

A review of the home's policy titled "Restraint Implementation Protocols" current revision November 2015, indicated that the home practiced the philosophy of least restraint whereby residents were free from physical devices that restricted movement.

During an interview with direct care staff member #109, they verified that they had locked resident #022's brakes when they transported the resident to the identified area. A review the resident's plan of care was conducted with the direct care staff member who verified that they had restrained the resident in their mobility device without direction from the resident's plan of care.

During an interview with Registered staff member #113, they verified that resident #022 should not have had their movements restrained by direct care staff member #109.

During an interview with the Interim DOC, the observations of resident #022 by Inspector #609 were outlined. The Interim DOC verified that direct care staff member #109 should not have restrained the resident's movements by locking their mobility device.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Inspector #609 observed the mobility devices for resident #008 and #023 to be visibly soiled and/or stained with white material.

A review of health care records for resident #008 and #023 found no documentation to support that the residents' mobility aids were cleaned.

During an interview with direct care staff member #130, they outlined how an identified shift was responsible for cleaning residents' mobility devices and that this task used to be documented in Point Click Care (PCC). The direct care staff member indicated that since the home changed their electronic documentation database, there was no way to document the cleaning of the mobility devices.

During an interview with the Associate Director of Care (ADOC), they outlined that the home switched to a new PCC database and that it had not yet been updated with the mobility device cleaning task which would enable the documentation of the cleaning of residents' mobility devices.

During an interview with the ED, they verified that cleaning residents' mobility devices had not been completed.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation
Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee’s policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of the analysis undertaken of every incident of abuse or neglect of a resident at the home were considered in the evaluation.

A CIS report was submitted by the home to the Director, which outlined how direct care staff member #121 abused resident #002 while resident #002 was receiving care.

Inspector #609 reviewed the home's prevention of abuse and neglect program evaluation for an identified 12 month period of time, which failed to consider the confirmed incident of abuse on the identified date, or any other incidents of abuse and neglect of residents in the evaluation for the identified 12 month period of time.

A review of the home's policy titled "Prevention of Abuse and Neglect of a Resident" current revision January 2015, indicated that as part of the evaluation, the inter-professional team was to review all reported incidents and outcomes of abuse and neglect.

During an interview with the ED, a review of the abuse and neglect program evaluation was conducted for the identified 12 month period of time. The ED verified that all incidents of abuse and neglect of residents for the identified 12 month period of time were not considered in the evaluation and should have been.

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. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee informed the Director no later than one business day after the occurrence of the incident of:

1. Subject to subsection (3.1), an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital.

The home submitted a CIS report to the Director on a specified date, related to an incident that caused an injury to resident #006 which occurred five days prior. The resident had been taken to hospital which further resulted in a significant change in the resident's health status.

A review of the above mentioned CIS report indicated that resident #006 had been found lying on the floor after falling out of bed. The CIS report further indicated that later during the same shift, resident #006 had been transferred to hospital and diagnosed with an injury.

During an interview with the Inspector, the ED acknowledged that the CIS reporting requirements to the Director are to report within one business day for any incident that caused an injury to a resident that resulted in a significant change in the resident's health condition. The ED further acknowledged that the incident occurred on the identified date, and the Director had not been notified until five days later and therefore did not meet the time lines as required by the legislative requirements.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

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

In a review of the home's quarterly medication incident report, Inspector #687 identified:

- a medication incident was reported involving Registered staff member #140 who provided an extra dose of an identified medication in addition to the same scheduled identified medication to resident #021.

Inspector #687 conducted a record review of the home's policy titled "The Medication Pass" revised January 2018, which indicated that "All medications administered are listed on the resident's medication administration record (MAR). Each resident receives the correct medication in the correct prescribed dosage, at the correct time, and by the correct route. The right resident receives the right medication (not expired) of the right dose, at the right time, by the right route for the right reason and completed by the right documentation."

In an interview conducted by Inspector #687 with Registered staff member #113, they stated that prior to administering a medication to a resident, the registered staff must ensure that the medication would be provided to the right resident, right dose, right time, right route and right medication prescribed by the physician. The Registered staff member further stated that these rights need to be adhered at all times as indicated in the home's policy under "Medication Pass".

In an interview with the Interim DOC, they stated that all medication incident reports reported were analyzed and determined that a number of registered staff did not follow the policy for the medication pass and corrective action was in place to prevent further medication incidents for re-occurrence.

Issued on this 13th day of September, 2018

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

Original report signed by the inspector.