**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 le Loi de 2007 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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## Amended Public Copy/Copie modifiée du public de permis

| Report Date(s)/ Date(s) du Rapport | Inspection No/ No de l'inspection | Log #/ No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Aug 30, 2018; | 2018_583117_0004 (A2) | 010317-18 | Resident Quality Inspection |

**Licensee/Titulaire de permis**

CVH (No. 4) GP Inc. as general partner of CVH (No. 4) LP
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes CAMBRIDGE ON N3H 5L8

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

Manoir Marochel
949 Montreal Road OTTAWA ON K1K 0S6

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

Amended by LYNE DUCHESNE (117) - (A2)

## Amended Inspection Summary/Résumé de l’inspection modifié

**On August 27, 208 the home's administrator requested an extension for CO #4 . The Administrator requested a new compliance due date of December 31, 2018. The purpose of the extension is to allow the home time to recruit, orientate and train Registered Nurses( RN’s). This request was accepted and December 31, 2018 is the new compliance due date for CO #4.**

**Issued on this 30 day of August 2018 (A2)**

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

**Original report signed by the inspector.**

**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**

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

Amended by LYNE DUCHESNE (117) - (A2)

## Amended Inspection Summary/Résumé de l’inspection modifié

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

**This inspection was conducted on the following date(s): June 4, 5, 6, 7, 8, 11, 12, 13, 14 and 18, 2018**

**During the course of this Resident Quality Inspection, the following inspections were conducted concurrently:**

**- a Follow-Up inspection related to an Order CO#001 issued November 16, 2017 under inspection report # 2017_621547_00002 related to O.Reg. s. 48 (1) 2) Skin and Wound Care Program with a compliance due date of March 26, 2018 (log # 027124-17)**

**- a complaint inspection related to resident care and services (log # 027271-17)**

**- a critical incident report regarding an alleged incident of visitor to resident abuse (log # 025585-18)**

**- a critical incident report regarding an incident of resident injury resulting in a transfer to hospital (log # 023242-17)**

**- a critical incident report regarding an alleged incident of staff to resident neglect (log # 004831-17)**

**- a critical incident report regarding a medication incident (log # 005085-18)**

**During the course of the inspection, the inspector(s) spoke with the home's**

**Administrator, the Extendicare Assist Nursing Consultant (EANC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personnal Support Workers (PSW), the RAI Coordinator, the Food Service Supervisor, a Pharmacist from Advantage Care Pharmacy Services, the Activity Manager, an activity aide, housekeeping staff, the nursing scheduling clerk, the administrative assistant, several residents, several resident family members, the Chair of the Residents' Council and the Chair of the Family Council.**

**During the course of the inspection, the inspector(s) reviewed several resident health care records; observed provision of snacks and beverages; observed resident rooms and common use area; observed the provision of care and services; reviewed the Extendicare policy RC-23-01-02 Skin and Wound Care Program: Wound Care Management, effective February 2017; reviewed the Extendicare policy RC-23-01-02 Management of Skin Rashes, Lesions and Irritations, Appendix 6 and 9, effective February 2017; reviewed the Advantage Care Pharmacy Services policies 7-1 Admission of Residents, effective January 2017; 4-4 Ordering Medications for New Admissions, effective January 2017; 9-1 Medication Incidents and Error Reporting, effective January 2017; pharmacy services after-hours contact information; a Medication Incident / Near Miss Report; the home's nursing schedule from March 9 2018 to June 14, 2018; as well as reviewed the minutes of the Residents' Council and the Family Council.**

**The following Inspection Protocols were used during this inspection:**

**Accommodation Services - Housekeeping**

**Continence Care and Bowel Management**

**Dignity, Choice and Privacy**

**Falls Prevention**

**Family Council**

**Hospitalization and Change in Condition**

**Infection Prevention and Control**

**Medication**

**Nutrition and Hydration**

**Personal Support Services**

**Prevention of Abuse, Neglect and Retaliation**

**Reporting and Complaints**

**Residents' Council**

**Responsive Behaviours**

**Safe and Secure Home**

**Skin and Wound Care**

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

**The following previously issued Order(s) were found to be in compliance at the time of this inspection:**
**Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:**

| REQUIREMENT/ EXIGENCE | TYPE OF ACTION/ GENRE DE MESURE | INSPECTION # / NO DE L’INSPECTION | INSPECTOR ID #/ NO DE L’INSPECTEUR |
|---|---|---|---|
| O.Reg 79/10 s. 48. (1) | CO #001 | 2017_621547_0012 | 547 |

## 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

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.

Legendé

WN – Avis écrit
VPC – Plan de redressement volontaire
DR – Aiguillage au directeur
CO – Ordre de conformité
WAO – Ordres : travaux et activités

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. 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).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the care set out in the plan of care related to behaviours and falls was provided to resident #008 as specified in the plan.

Resident #008 was admitted to the home on a specified day with several medical diagnoses including dementia. Resident #008 had a fall while self-transferring to the bathroom and sustained an injury nine days post admission.

Resident #008's health care records and initial plan of care, in place at time of the incident, identified that the resident was at risk of falls due to cognitive and physical impairments. The resident was known to get up during the night to self-transfer and to go to the bathroom. Fall prevention interventions related to this night time behaviour included that the resident be put to bed only after a specified garment is removed. RN #100 provided the SDM a "getting to know me" tool to be completed about resident #008. This tool was returned to the home on three days post admission and added as part of the resident's plan of care. This tool indicated that the resident self-toilets and cannot removed specified garments independently and that it is required that the resident's s specified garments be removed at bedtime, otherwise the resident is at risk of falls during the night. The tool further indicated that resident #008 had sustained two falls prior to admission while self-transferring, with the specified garments in place, during the night.

The SDM indicated to inspector #547 on a specified day, that the resident was dressed in clothes from the previous day, with the specified garments still in place, when the SDM arrived at the home the day following the resident's fall. Registered nursing staff indicated to the SDM that the resident had refused assistance to take off their clothes and specified garments the night before at bedtime.

The resident's plan of care indicated, two days prior to the fall, that the resident had behaviours and a post-admission adjustment period to the home. Plan of care interventions identified that if the resident refused personal care, staff are to call the resident's SDM and family at any time from the resident's phone, located in the resident's room, provided by the family. On the day of the fall, the resident refused personal care at bedtime and was put to bed with clothes and specified garments on. The SDM indicated that they did not receive any calls to indicate the resident was refusing personal care as identified in the resident's plan of care at admission.

As such, resident #008's plan of care was not complied by PSW staff on the evening of a specified day. [s. 6. (7)]

***Additional Required Actions:***

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

**(A1)The following order(s) have been amended:CO# 001**

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**WN #2: 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 are administered to resident #004 in accordance with the directions for use specified by the prescriber. (log # 005085-18)

A Critical Incident System (CIS ) report was received by the Director on a specified day in 2018, related to a medication incident involving resident #004. The CIS report noted that there was a pharmacy system delivery error and the resident had not received their prescribed medications for three (3) days.

A review of the resident's health care record, CIS report and home's Medication Incident / Near Miss Report documented the following incident:

Resident # 004 was admitted to the home on a specified day. The resident is diagnosed with several medical conditions. Medical orders were received from the attending physician and faxed to the home's pharmacy provider the afternoon of the resident's admission day.

The resident had 11 prescribed medications that are to be administered at varied times of day and evening.

On the day of the resident's admission, the evening RPN #102 noted in the progress notes and unit shift report book that the resident's prescribed medications were not delivered to the home and that the resident had not received any of the prescribed medications for the evening shift. During an interview with RPN #102, the RPN said to inspector #117 that to their knowledge the admission medication orders had been faxed to the pharmacy. RPN #102 had not contacted the pharmacy provider to let them know that the medications had not been received. RPN #102 had also not notified the attending physician nor the resident's Substitute Decision Maker (SDM) to let them know that the ordered medications had not been received from the pharmacy and no medication had been administered to the resident. It is noted that there was no RN in charge that evening. RPN #102 did give information related to the medications not being delivered and the need to follow up with the pharmacy service provider to the night RN #124. Inspector #117 reviewed resident #004's progress notes that documented the monitoring of the resident's vital signs and health status by RPN #102; no adverse effects were noted.

Five (5) prescribed medications and five (5) medication doses were not administered to resident #004 on that day.

The next day, RPN #125, who worked the day shift, did not administer any medication to resident #004. It is noted that there was no day RN working that day. RPN #125 informed the evening RN #121 that the resident's medications had not been delivered by the pharmacy. At a specified time, RN #121 notified the home's then DOC of the non-delivered medications. The home's Administrator came to the home to try to assist RN #121, with the telephone assistance with the DOC, in adding resident #004's prescribed medications to the home's electronic documentation system Point Click Care and electronic Medication Administration Record (eMAR). During an interview with RN #121, the RN said that this attempt to create an eMAR was unsuccessful. RN #121 also said that at that time the DOC, Administrator and RN #121 had not contacted pharmacy provider to let them know

resident #004's medications had not been delivered to the home, had not notified the attending physician nor the resident's Substitute Decision Maker (SDM) about the resident not being administered the prescribed medications. RN #121 did give information related to the need to follow up with the pharmacy service provider on the shift report and to the night RN #126. Reviewed progress notes document that the resident had expressed some discomfort during the evening and that RN #121 had administered a prescribed medication with effect. Notes also document the monitoring of the resident's vital signs and health status during all shifts; no adverse effects were reported nursing staff on that day.

Nine (9) medications and ten (10) medication doses were not administered to resident #004 that specified day.

The second day post admission, the day RN #115 contacted the pharmacy service provider emergency contact to inform them of resident #004's medications not being delivered since admission, two days prior. The pharmacist on-call contacted the home and RN #115 faxed the admission medical orders to the pharmacy provider for processing. Documentation indicates that the resident's physician and Substitute Decision Maker (SDM) were informed that the resident had not received their prescribed medications for 3 days by the DOC. RN #115 contacted the attending physician who provided an immediate order for a specified medication to be given to the resident and therapeutic blood test to be done four (4) days later. RN #121 accessed the home's emergency drug supply and government stock medication and administered the specified medication as well as three other prescribed medications to resident #004.  Reviewed progress notes document the monitoring of the resident's vital signs and health status during all shifts; no adverse effects were reported by nursing staff on that day.

Six (6) medications and seven (7) medication doses were not administered to resident #004 that specified day.

The third day post admission, the resident's prescribed medications were delivered to the home and administered to the resident with no other medication administration delays. On a specified day, the prescribed therapeutic blood test was done, results were within therapeutic range. No adverse effect to the resident were reported by nursing staff.

As such, resident #004 was not administered eleven (11) prescribed medications with a total of 22 missed medication doses, in accordance with the directions for

use specified by the prescriber on specified days. [s. 131. (2)]

***Additional Required Actions:***

**CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".**

**(A1)The following order(s) have been amended:CO# 002**

***DR # 001 – The above written notification is also being referred to the Director for further action by the Director.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system**

**Specifically failed to comply with the following:**

**s. 114. (3) The written policies and protocols must be,**
**(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 114 (3).**
**(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).**

**Findings/Faits saillants :**

1. The licensee failed that the written policies and protocols for the medication management system must be implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

As per O.Reg. s. 121 "Every licensee of a long-term care home shall ensure that a

system is developed for notifying the pharmacy service provider within 24 hours of the admission, medical absence, psychiatric absence, discharge, and death of a resident. (log # 005085-18)

A Critical Incident System (CIS) report was received by the Director on a specified day, related to a medication incident involving the admission of resident #004. The CIS report noted that there was a pharmacy system delivery error and the resident had not received their prescribed medication for three (3) days

A review of the resident’s health care record, CIS report and home’s Medication Incident / Near Miss Report documented the following incident:

Resident # 004 was admitted to the home on a specified day. The resident is diagnosed with several medical conditions. Medical orders were received from the attending physician and faxed to the home’s pharmacy provider the afternoon of the resident’s admission day.

On the day of the resident’s admission, the evening RPN #102 noted in the progress notes and unit shift report book that the resident’s prescribed medications were not delivered to the home and that the resident had not received any of the prescribed medications for the evening shift. During an interview with RPN #102, the RPN said to inspector #117 that for all new admissions, the home faxes the admission medication orders to the pharmacy. The home has a fax with a pre-programmed direct to pharmacy fax number. To their knowledge, the admission medication orders had been faxed to the pharmacy. RPN #102 said that they had not contacted the pharmacy provider to let them know of that the resident’s medications had not been delivered to the home when they discovered that the medications had not been received. It is noted that there was no RN working that evening. RPN #102 did give information related to the non-delivered medications and the need to follow up with the pharmacy service provider to the night RN #124.

The next day, RPN staff member #125, who worked the day shift, did not administer any medication to resident #004. It is noted that there was no day RN working that day. RPN #125 noted that the medications for resident #004 had not been delivered by the pharmacy to the evening RN # #121. At specified time, RN #121 notified the home’s then DOC of the non-delivered medications. The home’s Administrator came to the home to try to assist the evening RN #121, with the telephone assistance with the DOC, in adding resident #004’s prescribed medications to the home’s electronic documentation system Point Click Care and

electronic Medication Administration Record (eMAR). During an interview with RN #121, the RN said that the DOC, Administrator and RN #121 had not contacted pharmacy provider to let them know of the non-delivered medications. RN #121 did give information related to the non-delivered medications and the need to follow up with the pharmacy service provider on the shift report and to the night RN #126.

The second day post admission, day RN #115 contacted the pharmacy service provider via the pharmacy emergency contact number at a specified time to inform them of resident #004's medications had not been delivered since admission. The pharmacist on-call contacted the home and RN #115 faxed the admission medical orders to the pharmacy provider for processing. During an interview with the pharmacist on-call, the pharmacist said to inspector #117 that they had not received any information from the home on a specified day related to the resident admission and medication orders nor had they received any calls related to the medications not being delivered on the evening of the resident admission nor at any time the next day. The first notification received by pharmacy relating to resident #004's medications was on the second day post admission. Afterwards, pharmacy received the resident's faxed admission medication orders. These were processed and delivered on the third day post admission.

The licensee failed to ensure that their pharmacy management system be implemented when the pharmacy service provider was not notified within 24 hours of the resident #004's admission. [s. 114. (3) (a)]

***Additional Required Actions:***

**CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".**

**(A1)The following order(s) have been amended:CO# 003**

**WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 8. Nursing and personal support services**

**Specifically failed to comply with the following:**

**s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that there is that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times.

Manoir Marochel is a long-term care home that has 64 licensed long-term care beds.

As per O.Reg. 79/10, s. 45 (1) The following are the exceptions to the requirement that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, as required under subsection 8 (3) of the Act:

1. For homes with a licensed bed capacity of 64 beds or fewer, i. a registered nurse (RN) who works at the home pursuant to a contract or agreement between the nurse and the licensee and who is a member of the regular nursing staff may be used, ii. in the case of an emergency where the back-up plan referred to in clause 31 (3) (d) of this Regulation fails to ensure that the requirement under subsection 8 (3) of the Act is met,

A. a registered nurse (RN) who works at the home pursuant to a contract or agreement between the licensee and an employment agency or other third party may be used if the Director of Nursing (DOC) and Personal Care or a registered nurse who is both an employee of the licensee and a member of the regular nursing staff is available by telephone, or
B. a registered practical nurse (RPN) who is a member of the regular nursing staff may be used if the Director of Nursing and Personal Care or a registered nurse who is both an employee of the licensee and a member of the regular nursing staff

is available by telephone. O. Reg. 79/10, s. 45 (1).

As per O.Reg. 79/10, s. 45. (2) In this section, “emergency” means an unforeseen situation of a serious nature that prevents a registered nurse from getting to the long-term care home.

A review of the home’s registered nursing staffing schedule from March 2018 to June 2018, was conducted. It was identified that on the following dates, and shifts, there was no RN working in the building. There is no identified RN on call and no 3rd RPN or agency staff working.

• On a specified day in March 2018 – no RN on the evening shift, only 2 RPNS working
• On a specified day in March 2018 – no RN on the day shift, 3 RPNs working
• On a specified day in March 2018 – no RN on the evening shift, only 2 RPNS working
• On a specified day in March 2018 - no RN on the evening shift, only 2 RPNS working
• On 2 specified days in March 2018 - no RN working on the day shift, Acting DOC is present in the home
• On 3 specified days in March 2018 - no RN on the evening shift, only 2 RPNS working
• On a specified day in April 2018 - no RN working on the day shift, Acting DOC is present in the home
• On 6 specified days in April 2018 - no RN on the evening shift, only 2 RPNS working
• On 2 specified days in April 2018 – No RN on the night shift, and no RPN on the night shift
• On a specified day in May 2018 - No RN on the night shift, and one RPN working the night shift
• On a specified day in June 2018 - No RN on the night shift, and one RPN working the night shift
• On 2 specified days in June 2018 - no RN on the evening shift, only 2 RPNS working

On June 14, 2018, the home’s nursing scheduling clerk staff #123, said to inspector #117 that the home has a limited number of registered nurses (RN) and currently does not have a Director of Care (DOC). Because of this, two members of the home’s registered nurses take turns being the Acting Director of Care. As such,

there are some days where they will be no designated RN working on a shift. A review of the nursing staffing schedule with nursing scheduling clerk staff #123, identified that there were no identified emergencies on the shifts where there is no RN in the building.

On June 18, 2018, RN #100 said to inspector #117 that for the past several months the home has not had a Director of Care. The position has been shared between RN #100 and RN # 115. RN #100 said that there are some days where there are no designated RN working on a shift. To their knowledge there is no RN who is designated to be on-call when this occurs.

As such, the licensee failed to ensure that there that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times. [s. 8. (3)]

***Additional Required Actions:***

**CO # - 004 will be served on the licensee. Refer to the “Order(s) of the Inspector”.**

**(A2)The following order(s) have been amended:CO# 004**

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**WN #5: 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. 1. The licensee has failed to ensure that the home's policy and procedure instituted or otherwise put in place is in compliance with and is implemented in accordance with all applicable requirements under the Act was complied with.

RN #100 provided Inspector #547 the Licensee's current policy and procedure titled Wound Care Management #RC-23-01-02 last updated February 2017.

Policy and procedure #RC-23-01-02 A9 on page 1 of 1 stated the nurse obtains orders for topical application and enter treatment orders on Treatment Administration Record (ETAR). Initiate/update resident's care plan to reflect altered skin integrity focus, including characteristics of rash/lesion/irritation, current goals and interventions.

For resident #023, the skin irritation was initially observed and assessed by RN #121 on a specified day. No ETAR was initiated or care plan updated to reflect this altered skin integrity focus as required in this policy.

On June 12, 2018 RN #121 indicated to Inspector #547 to have assessed resident #023's skin irritation after the PSW's reported this concern on the evening of the specified day. RN #121 indicated that they called the physician, however did not add this altered skin integrity focus to the resident's ETAR or careplan as required by the home's policy.

On June 10, 2018 RN #122 completed a skin assessment in the resident's progress notes regarding this altered skin irritation had ruptured with drainage. RN #122 completed a dressing to the open area however did not add this altered skin

integrity order on treatment in the resident's ETAR or initiate/update the resident's careplan to reflect this altered skin integrity focus, characteristics, goals or interventions required.

On June 12, 2018 RN #115 completed a skin assessment, added the wound to the resident's ETAR and updated the resident's care plan to reflect this altered skin integrity including focus, characteristics, goals and interventions as required.

As such, the Licensee failed to ensure that the policy and procedure titled Management of skin rashes, lesions and irritations was complied by RN #121 and RN #122. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee has failed to ensure that the home's policy and procedure instituted or otherwise put in place is in compliance with and is implemented in accordance with all applicable requirements under the Act was complied with.

RN #100 provided Inspector #547 the Licensee's current policy and procedure titled Management of Skin rashes, lesions and irritations #RC-23-01-02 A9 last updated February 2017. This policy indicated on page 1 of 1 the nurse obtains orders for topical application and enter treatment orders on Treatment Administration Record (ETAR). Initiate/update resident's care plan to reflect altered skin integrity focus, including characteristics of rash/lesion/irritation, current goals and interventions.

Inspector #547 observed resident #005's face and noted an open lesion on a specified day.

Resident #005’s health care records identified the skin irritation of reddened spots to the resident's face was initially observed and assessed by PSW staff during the bath skin observation the previous day. The skin and wound care assessment was then placed in the unit’s skin observation binder as per the Licensee's skin policies.

On June 8, 2018 Inspector #547 observed the skin lesion to the resident's nose had scabbed over.

The Extendicare Assist Nursing Consultant indicated to Inspector #547 that the registered nursing staff are supposed to review the PSW skin assessments that are completed after resident baths in order to then reassess the resident’s skin and

determine goals and intervention plan. The resident's skin was open previously, and now scabbed over, that is more than a red spot irritation, and required registered nursing staff to assess and adjust the resident's plan of care for healing and prevention. This was not completed by the registered nursing staff and no ETAR was initiated or care plan updated to reflect this altered skin integrity focus as required in this policy. [s. 8. (1) (a),s. 8. (1) (b)]

3. The licensee failed that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee is required to ensure that the policy (b) is complied with. (log # 005085-18)

As per O.Reg. s. 114. (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

As per O.Reg. 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 (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.

The home has a policy "9-1 Medication Incidents and Error Reporting", January 2017 that identifies the following:
"All medication errors, including incidents and near misses must be reported immediately to the Director of Care, the prescribing physician and the pharmacist and must be documented and reported on a Medication Incident Report form supplied by the pharmacy" (Page 2 of 18)

"Every incident involving a resident, including adverse drug reactions, must be reported to the resident, the resident's substitute decision-maker, if any, and to the Medical Director as well as the Director of Nursing Care and the pharmacist." (Page 5 of 18)

A Critical Incident System (CIS) report was received by the Director on a specified

day, related to a medication incident involving the admission of resident #004. The CIS report noted that there was a pharmacy system delivery error and the resident had not received their prescribed medication for three (3) days.

A review of the resident’s health care record, CIS report and home’s Medication Incident / Near Miss Report documented the following incident:
Resident # 004 was admitted to the home on a specified a day. Medical orders were received from the attending physician and faxed to the home’s pharmacy provider that same day.

On the day of the resident’s admission, the evening RPN #102 noted in the progress notes and unit shift report book that the resident’s prescribed medications were not delivered to the home and that the resident had not received any of the prescribed medications for the evening shift. During an interview with RPN #102, the RPN said to inspector #117 that they had not contacted the pharmacy provider to let them know of that resident #004’s medications had not been delivered to the home when they had discovered that the medications had not been received. RPN #102 also did not contact the then Director of Care, the Medical Director, the prescribing  physician nor the resident’s substitute decision maker (SDM) regarding the resident’s #004 not having been administered any of their prescribed medications nor of the non-delivery of the prescribed medications.

On the next day, RPN #125, who worked the day shift, did not administer any medication to resident #004. RPN #125 noted that resident #004’s medications had not been delivered to the evening RN #121. At a specified time, RN #121 notified the home’s then DOC of the non-delivered medications. The home’s Administrator came to the home to try to assist with the medication incident. During an interview with RN #121, the staff member said that the DOC, Administrator and RN #121 had not contacted pharmacy provider nor to the Medical Director, the prescribing physician nor the resident’s SDM to let them know of the non-delivery of the resident’s medications.

On second day post-admission, day RN #115 contacted the pharmacy service provider via the pharmacy emergency contact number to inform them of resident #004’s medications had not been delivered to the home since the resident’s admission. The pharmacist on-call contacted the home and RN #115 faxed the admission medical orders to the pharmacy provider for processing. During an interview with the pharmacist, the pharmacist said to inspector #117 that they had not received any information from the home on specified day related to resident

#004's admission and medication orders nor had they received any calls related to the non-delivery of the resident's medications on that evening of the resident admission nor at any time on the next day. The first notification received by pharmacy relating to the resident #004's non-delivered medication was on the second day post resident admission.

Documentation in the home's Medication Incident Report notes that the resident's attending physician and SDM were informed of the non-delivered medications by the DOC sometime on the second day post resident admission. It is noted that the resident's attending physician was the home's acting Medical Director at the time of the medication incident

As such, the home's policy for immediately notifying the DOC, the resident's attending physician/ acting Medical Director, resident SDM and pharmacist was not complied with as they were not informed of the non-delivery of resident #004's medications as per policy "9-1 Medication Incidents and Error Reporting", January 2017. [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 o ensure that the home's policy and procedure instituted or otherwise put in place is in compliance with and is implemented in accordance with all applicable requirements under the Act was complied with in regards to the policy and procedure under their Skin and Wound care program titled Management of Skin rashes, lesions and irritations #RC-23-01-02 A9 last updated February 2017 as well as the policy under the Medication Management System "9-1 Medication Incidents and Error Reporting", January 2017, to be implemented voluntarily.***

**Issued on this 30 day of August 2018 (A2)**

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

**Original report signed by the inspector.**

**Ministry of Health and Long-Term Care**

**Ministère de la Santé et des Soins de longue durée**

## Order(s) of the Inspector

## Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

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**

Ottawa Service Area Office
347 Preston St, Suite 420
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston, bureau 420
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670


# Amended Public Copy/Copie modifiée du public de permis

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**Name of Inspector (ID #) / Nom de l'inspecteur (No) :** Amended by LYNE DUCHESNE (117) - (A2)

**Inspection No. / No de l'inspection :** 2018_583117_0004 (A2)

**Appeal/Dir# / Appel/Dir#:**

**Log No. / No de registre :** 010317-18 (A2)

**Type of Inspection / Genre d'inspection:** Resident Quality Inspection

**Report Date(s) / Date(s) du Rapport :** Aug 30, 2018;(A2)

**Licensee / Titulaire de permis :** CVH (No. 4) GP Inc. as general partner of CVH (No. 4) LP
766 Hespeler Road, Suite 301, c/o Southbridge Care Homes, CAMBRIDGE, ON, N3H-5L8

**LTC Home / Foyer de SLD :** Manoir Marochel
949 Montreal Road, OTTAWA, ON, K1K-0S6

**Name of Administrator / Nom de l'administratrice ou de l'administrateur :** Paul Beverley

To CVH (No. 4) GP Inc. as general partner of CVH (No. 4) LP, 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)

**Pursuant to / Aux termes de :**

LTCHA, 2007, 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).

**Order / Ordre :**

The licensee must be compliant with LTCHA s. 6 (7).

The licensee shall ensure that:
- When resident #008 presents with responsive behaviours and refuses the provision of care as specified in the plan of care, staff are to contact the resident's SDM and family to assist with resident communication and management of responsive behaviours.

- That nursing staff review the contents of the resident #008' s plan of care at the start of each night shift to ensure the evening care identified in the plan of care has been provided to the resident.

- That registered staff monitor the provision of evening care to ensure that resident #008 receives the evening care set out in the plan of care and that responsive behaviours, interventions and contact with the resident's SDM / family be documented following the provision of care.

**Grounds / Motifs :**

1. The licensee has failed to ensure that the care set out in the plan of care related to behaviours and falls was provided to resident #008 as specified in the plan.

Resident #008 was admitted to the home on a specified day with several medical diagnoses including dementia. Resident #008 had a fall while self-transferring to the bathroom and sustained an injury nine days post admission.

Resident #008's health care records and initial plan of care, in place at time of the incident, identified that the resident was at risk of falls due to cognitive and physical impairments. The resident was known to get up during the night to self-transfer and to go to the bathroom. Fall prevention interventions related to this night time behaviour included that the resident be put to bed only after a specified garment is removed. RN #100 provided the SDM a "getting to know me" tool to be completed about resident #008. This tool was returned to the home on three days post admission and added as part of the resident's plan of care. This tool indicated that the resident self-toilets and cannot removed specified garments independently and that it is required that the resident's s specified garments be removed at bedtime, otherwise the resident is at risk of falls during the night. The tool further indicated that resident #008 had sustained two falls prior to admission while self-transferring, with the specified garments in place, during the night.

The SDM indicated to inspector #547 on a specified day, that the resident was dressed in clothes from the previous day, with the specified garments still in place, when the SDM arrived at the home the day following the resident's fall. Registered nursing staff indicated to the SDM that the resident had refused assistance to take off their clothes and specified garments the night before at bedtime.

The resident's plan of care indicated, two days prior to the fall, that the resident had behaviours and a post-admission adjustment period to the home. Plan of care interventions identified that if the resident refused personal care, staff are to call the resident's SDM and family at any time from the resident's phone, located in the resident's room, provided by the family. On the day of the fall, the resident refused personal care at bedtime and was put to bed with clothes and specified garments on. The SDM indicated that they did not receive any calls to indicate the resident was refusing personal care as identified in the resident's plan of care at admission.

As such, resident #008's plan of care was not complied by PSW staff on the evening of a specified day.

The risk is identified as a level 3 actual harm, as a resident sustained an injury. The

scope is a level 1 isolated incident involving only one resident. The home's compliance history is a level 4 as there has been ongoing non-compliance with a VPC or CO in the same related area.

Inspection # 2017_619550_0026 – a VPC was issued for LTCHA. s. 6(7) related to falls
Inspection # 2017_621547_0012 – a VPC was issued for LTCHA. s. 6(7) related to skin and wound
Inspection # 2017_621547_0002 – a VPC was issued for LTCHA. s. 6(7) related to falls and personal services

(547)

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

Sep 04, 2018(A1)

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**Order # / Ordre no :** 002

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

**Pursuant to / Aux termes de :**

O.Reg 79/10, 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).

**Order / Ordre :**

The licensee must be compliant with s. 131 (2) of the O.Reg. 79/10.

Specifically the licensee shall:
1. Ensure that resident #004 receives their currently prescribed medications and any new prescribed medications, in accordance with the directions for use specified by the prescriber.

2. Ensure that newly admitted residents receive their prescribed medications, in accordance with the directions for use specified by the prescriber

**Grounds / Motifs :**

1. The licensee failed to ensure that drugs are administered to resident #004 in accordance with the directions for use specified by the prescriber. (log # 005085-18)

A Critical Incident System (CIS ) report was received by the Director on a specified day, related to a medication incident involving resident #004. The CIS report noted that there was a pharmacy system delivery error and the resident had not received their prescribed medications for three (3) days.

A review of the resident’s health care record, CIS report and home’s Medication Incident / Near Miss Report documented the following incident:

Resident # 004 was admitted to the home on a specified day. The resident is diagnosed with several medical conditions. Medical orders were received from the attending physician and faxed to the home’s pharmacy provider the afternoon of the resident’s admission day.

The resident had 11 prescribed medications that are to be administered at varied times of day and evening.

On the day of the resident’s admission, the evening RPN #102 noted in the progress notes and unit shift report book that the resident’s prescribed medications were not delivered to the home and that the resident had not received any of the prescribed medications for the evening shift. During an interview with RPN #102, the RPN said to inspector #117 that to their knowledge the admission medication orders had been faxed to the pharmacy. RPN #102 had not contacted the pharmacy provider to let them know that the medications had not been received. RPN #102 had also not

notified the attending physician nor the resident's Substitute Decision Maker (SDM) to let them know that the ordered medications had not been received from the pharmacy and no medication had been administered to the resident. It is noted that there was no RN in charge that evening. RPN #102 did give information related to the medications not being delivered and the need to follow up with the pharmacy service provider to the night RN #124. Inspector #117 reviewed resident #004's progress notes that documented the monitoring of the resident's vital signs and health status by RPN #102; no adverse effects were noted.

Five (5) prescribed medications and five (5) medication doses were not administered to resident #004 on that day.

The next day, RPN #125, who worked the day shift, did not administer any medication to resident #004. It is noted that there was no day RN working that day. RPN #125 informed the evening RN #121 that the resident's medications had not been delivered by the pharmacy. At a specified time, RN #121 notified the home's then DOC of the non-delivered medications. The home's Administrator came to the home to try to assist the evening RN #121, with the telephone assistance with the DOC, in adding resident #004's prescribed medications to the home's electronic documentation system Point Click Care and electronic Medication Administration Record (eMAR). During an interview with RN #121, the RN said that this attempt to create an eMAR was unsuccessful. RN #121 also said that at that time the DOC, Administrator and RN #121 had not contacted pharmacy provider to let them know resident #004's medications had not been delivered to the home, had not notified the attending physician nor the resident's Substitute Decision Maker (SDM) about the resident not being administered the prescribed medications. RN #121 did give information related to the need to follow up with the pharmacy service provider on the shift report and to the night RN #126. Reviewed progress notes document that the resident had expressed some discomfort during the evening and that the evening RN #121 had administered a prescribed medication with effect. Notes also document the monitoring of the resident's vital signs and health status during all shifts; no adverse effects were reported nursing staff on that day.

Nine (9) medications and ten (10) medication doses were not administered to resident #004 that specified day.

The second day post admission, the day RN #115 contacted the pharmacy service provider emergency contact to inform them of resident #004's medications not being

delivered since admission, two days prior. The pharmacist on-call contacted the home and RN #115 faxed the admission medical orders to the pharmacy provider for processing. Documentation indicates that the resident's physician and Substitute Decision Maker (SDM) were informed that the resident had not received their prescribed medications for 3 days by the DOC. RN #115 contacted the attending physician who provided an immediate order for a specified medication to be given to the resident and therapeutic blood test to be done four (4) days later. Evening RN #121 accessed the home's emergency drug supply and government stock medication and administered the specified medication as well as three other prescribed medications to resident #004. Reviewed progress notes document the monitoring of the resident's vital signs and health status during all shifts; no adverse effects were reported by nursing staff on that day.

Six (6) medications and seven (7) medication doses were not administered to resident #004 that specified day.

The third day post admission, the resident's prescribed medications were delivered to the home and administered to the resident with no other medication administration delays. On a specified day, the prescribed therapeutic blood test was done, results were within therapeutic range. No adverse effect to the resident were reported by nursing staff.

As such, resident #004 was not administered eleven (11) prescribed medications with a total of 22 missed medication doses, in accordance with the directions for use specified by the prescriber on specified days.

The risk is identified as a level 3 potential risk of harm, as a resident did not receive their prescrbed medications on 3 consecutive days. The scope is a level 1 isolated incident involving only one resident. The home's compliance history is a level 3 where there has been one or more related issues of non-compliance areas in the past 36 months.

Inspection # 2015_286547_0025 - a VPC was issued for O.Reg. s. 131 (2)

(117)

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

Sep 04, 2018(A1)

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**Order # / Ordre no :** 003

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

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

**Order / Ordre :**

The licensee must comply with s. 114 (3) b) of the O.Reg. 79/10.

Specifically, the licensee must:

- Ensure that a process is implemented and documented to verify that the pharmacy service provider has received the residents' admission medication orders.

- Review and revise their policy regarding the notification of the pharmacy service provider to ensure that the verification process noted above is included in the policy.

**Grounds / Motifs :**

1. The licensee failed that the written policies and protocols for the medication management system must be implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

As per O.Reg. s. 121 "Every licensee of a long-term care home shall ensure that a system is developed for notifying the pharmacy service provider within 24 hours of the admission, medical absence, psychiatric absence, discharge, and death of a resident. (log # 005085-18)

A Critical Incident System (CIS) report was received by the Director on a specified day, related to a medication incident involving the admission of resident #004. The CIS report noted that there was a pharmacy system delivery error and the resident had not received their prescribed medication for three (3) days
A review of the resident's health care record, CIS report and home's Medication Incident / Near Miss Report documented the following incident:

Resident # 004 was admitted to the home on a specified day. The resident is diagnosed with several medical conditions. Medical orders were received from the attending physician and faxed to the home's pharmacy provider the afternoon of the resident's admission day.

On the day of the resident's admission, the evening RPN #102 noted in the progress notes and unit shift report book that the resident's prescribed medications were not delivered to the home and that the resident had not received any of the prescribed

medications for the evening shift. During an interview with RPN #102, the RPN said to inspector #117 that for all new admissions, the home faxes the admission medication orders to the pharmacy. The home has a fax with a pre-programmed direct to pharmacy fax number. To their knowledge, the admission medication orders had been faxed to the pharmacy. RPN #102 said that they had not contacted the pharmacy provider to let them know of that the resident's medications had not been delivered to the home when they discovered that the medications had not been received. It is noted that there was no RN working that evening.  RPN #102 did give information related to the non-delivered medications and the need to follow up with the pharmacy service provider to the night RN #124.

The next day, RPN staff member #125, who worked the day shift, did not administer any medication to resident #004. It is noted that there was no day RN working that day.  RPN #125 noted that the medications for resident #004 had not been delivered by the pharmacy to the evening RN # #121. At a specified time, RN #121 notified the home's then DOC of the non-delivered medications. The home's Administrator came to the home to try to assist the evening RN #121, with the telephone assistance with the DOC, in adding resident #004's prescribed medications to the home's electronic documentation system Point Click Care and electronic Medication Administration Record (eMAR). During an interview with RN #121, the RN said that the DOC, Administrator and RN #121 had not contacted pharmacy provider to let them know of the non-delivered medications. RN #121 did give information related to the non-delivered medications and the need to follow up with the pharmacy service provider on the shift report and to the night RN #126.

The second day post admission, day RN #115 contacted the pharmacy service provider  via the pharmacy emergency contact number at a specified time to inform them of resident #004's medications had not been delivered since admission. The pharmacist on-call contacted the home and RN #115 faxed the admission medical orders to the pharmacy provider for processing. During an interview with the pharmacist on-call, the pharmacist said to inspector #117 that they had not received any information from the home on a specified day related to the resident admission and medication orders nor had they received any calls related to the medications not being delivered on the evening of the resident admission nor at any time the next day. The first notification received by pharmacy relating to resident #004's medications was on the second day post admission. Afterwards, pharmacy received the resident's faxed admission medication orders. These were processed and delivered on the third day post admission.

The licensee failed to ensure that their pharmacy management system be implemented when the pharmacy service provider was not notified within 24 hours of the resident #004's admission

The risk is identified as a level 3 potential risk of harm, as the pharmacy was not informed of a resident admission and the resident did not receive their prescribed medications on 3 consecutive days. The scope is a level 1 isolated incident involving only one resident. The home’s compliance history is a level 2 where there has been one or more non-related issues of non-compliance areas in the past 36 months.

Inspection # 2015_286547_0025 - a VPC was issued for O.Reg. s. 131 (2)

(117)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d’ici le :**

Sep 04, 2018(A1)

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**Order # /**
**Ordre no :** 004

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

**Pursuant to / Aux termes de :**

LTCHA, 2007, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

**Order / Ordre :**

The licensee must be compliant with s.8 (3) of the LTCHA.

- Specifically, the licensee must ensure that at least one registered nurse who is an employee of the licensee or works at the home pursuant to a contract with the licensee and is a member of the regular nursing staff of the home is on duty and present at all times.

- In addition, until compliance is achieved, the licensee is required to ensure that for each shift where there is no RN in the building, there is an identified RN who is on-call for the identified time period, that this information is communicated to staff working during that time period and that this information be documented and accessible to working staff.

- Further more, the licensee is to implement a monitoring process on every shift where there is no RN in the building, to ensure that risks associated with the delivery of nursing care, such as medication administration and any other high risk care areas, are mitigated and corrective actions, if required, are implemented immediately.

- The results of the monitoring process is to be reported to the manager on-call at the end of each of these shifts.

All steps of this process must be documented as they are being implemented.

**Grounds / Motifs :**

1. The licensee failed to ensure that there is that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times.

Manoir Marochel is a long-term care home that has 64 licensed long-term care beds.

As per O.Reg. 79/10, s. 45 (1) The following are the exceptions to the requirement

that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, as required under subsection 8 (3) of the Act:

1. For homes with a licensed bed capacity of 64 beds or fewer, i. a registered nurse (RN) who works at the home pursuant to a contract or agreement between the nurse and the licensee and who is a member of the regular nursing staff may be used, ii. in the case of an emergency where the back-up plan referred to in clause 31 (3) (d) of this Regulation fails to ensure that the requirement under subsection 8 (3) of the Act is met,

A. a registered nurse (RN) who works at the home pursuant to a contract or agreement between the licensee and an employment agency or other third party may be used if the Director of Nursing (DOC) and Personal Care or a registered nurse who is both an employee of the licensee and a member of the regular nursing staff is available by telephone, or

B. a registered practical nurse (RPN) who is a member of the regular nursing staff may be used if the Director of Nursing and Personal Care or a registered nurse who is both an employee of the licensee and a member of the regular nursing staff is available by telephone. O. Reg. 79/10, s. 45 (1).

As per O.Reg. 79/10, s. 45. (2) In this section, “emergency” means an unforeseen situation of a serious nature that prevents a registered nurse from getting to the long-term care home.

A review of the home’s registered nursing staffing schedule from March 2018 to June 2018, was conducted. It was identified that on the following dates, and shifts, there was no RN working in the building. There is no identified RN on call and no 3rd RPN or agency staff working.

• On a specified day in March 2018 – no RN on the evening shift, only 2 RPNS working
• On a specified day in March  2018 – no RN on the day shift, 3 RPNs working
• On a specified day in March 2018 – no RN on the evening shift, only 2 RPNS working
• On a specified day in March 2018 - no RN on the evening shift, only 2 RPNS working

• On 2 specified days in March 2018 - no RN working on the day shift, Acting DOC is present in the home
• On 3 specified days in March 2018 - no RN on the evening shift, only 2 RPNS working
• On a specified day in April 2018 - no RN working on the day shift, Acting DOC is present in the home
• On 6 specified days in April 2018 - no RN on the evening shift, only 2 RPNS working
• On 2 specified days in April 2018 – No RN on the night shift, and no RPN on the night shift
• On a specified day in May 2018 - No RN on the night shift, and one RPN working the night shift
• On a specified day in June 2018 - No RN on the night shift, and one RPN working the night shift
• On 2 specified days in June 2018 - no RN on the evening shift, only 2 RPNS working

On June 14, 2018, the home's nursing scheduling clerk staff #123, said to inspector #117 that the home has a limited number of registered nurses (RN) and currently does not have a Director of Care (DOC). Because of this, two members of the home's registered nurses take turns being the Acting Director of Care. As such, there are some days where they will be no designated RN working on a shift. A review of the nursing staffing schedule with nursing scheduling clerk staff #123, identified that there were no identified emergencies on the shifts where there is no RN in the building.

On June 18, 2018, RN #100 said to inspector #117 that for the past several months the home has not had a Director of Care. The position has been shared between RN #100 and RN # 115. RN #100 said that there are some days where there are no designated RN working on a shift. To their knowledge there is no RN who is designated to be on-call when this occurs.

As such, the licensee failed to ensure that there that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times.

The risk is identified as a level 3 potential risk of harm, as a resident did not receive

their medication when there was no RN in the building for 2 shifts, on 2 consecutive days. The scope is a level 2 pattern regarding the availability of 24 hours nursing staff in the building for 2 shifts on 2 consecutive days. The home’s compliance history is a level 3 where there has been one or more related issues of non-compliance areas in the past 36 months.

Inspection # 2015_286547_0025 - a CO #001 was issued for LTCHA s. 8(3) issued December 14, 2015 found to be in compliance July 5, 2016
(117)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d’ici le :**

Dec 31, 2018(A2)

## 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, commercial courier 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON  M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON  M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON  M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

**Issued on this 30 day of August 2018 (A2)**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** Amended by LYNE DUCHESNE - (A2)

**Service Area Office / Bureau régional de services :** Ottawa