Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 10, 2017	2017_597655_0019	014848-17	Resident Quality Inspection

Licensee/Titulaire de permis

MAXVILLE MANOR
80 Mechanic Street MAXVILLE ON K0C 1T0

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

MAXVILLE MANOR
80 MECHANIC STREET WEST MAXVILLE ON K0C 1T0

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

MICHELLE EDWARDS (655), PAULA MACDONALD (138)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 25, 26, 27, 30, 31, 2017; and, November 1 and 2, 2017.

The following logs were conducted concurrently with this RQI:
Log #'s 003606-17, 006131-17, 030833-16, 004229-17 - all four were critical incidents; and,
Log # 006405-17 (complaint).

During the course of the inspection, the inspector(s) spoke with residents and family members, Personal Support Workers (PSWs), Registered Practical Nurses (RPNs) and Registered Nurses (RNs), the Activity Manager, Registered Dietician (RD), Maintenance Manager, RAI Coordinator, and the Acting Director of Care (ADOC).

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **6 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 O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

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. O. Reg. 79/10, s. 114 (2).

Findings/Faits saillants :

1. The licensee has failed to 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.

Inspector #655 reviewed the health care record belonging to resident #027. According to the resident's health care record, resident #027 was to receive a specified medication in accordance with specified directions, several times daily.

On review of resident #027's health care record, Inspector #655 found that the method of documentation related to the administration of resident #027's specified medication was inconsistent, and at times did not accurately reflect the amount of the drug which resident #027 actually did or did not receive.

i. On a specified date during the inspection, Inspector #655 observed RN #123 to administer medications to resident #027 during the noon medication pass. At that time, RN #123 was observed by the Inspector to have administered a dose of a specified amount, of the specified medication, to resident #027, in accordance with the directions specified.

RN #123 was subsequently observed by Inspector #655 to document the administration of the specified medication in the resident's electronic Medication Administration Record (eMAR). RN #123 was observed to enter the amount administered under the "Not Administered" or "wasted" column; and to note "other" as the reason for doing so. RN #123 indicated to Inspector #655 that it is his/her practice to document the administration of the specified medication this way so that the amount of drug that was given can be documented each time.

After the above-described observations, Inspector #655 reviewed a print-out of the eMAR belonging to resident #027 for a specified period of five days. There was an entry made on the same day and time of the above-noted observations that read "1 N" next to the specific medication that was scheduled for 1200 hours that day.

On the eMAR record that was reviewed by Inspector #655, there was also a legend. According to the legend, "N" is indicative that a medication was "not delivered"; and, "G" is indicative that a medication was "given". For each entry, there were also one to two numerals recorded. One numeral corresponded with the name of the registered staff member who made the entry (where "1" corresponded to RN #123). There was a second

numeral only where it was documented that a medication was given; and in that case, the second numeral signified the amount of the specified medication that was given. That is, according to the legend, the above-noted entry made for the 1200 hour medication pass on the day of the Inspector's observation, was made by RN #123; and was indicative that the specified medication was not given to resident #027, though it was observed by Inspector #655 to have been given at the time.

ii. During an interview on a specified date during the inspection, RPN #109 indicated to Inspector #655 that he/she had conducted the 0800 hour medication pass for resident #027 earlier that day.

According to RPN #109, on the above-noted date, at 0800 hours, resident #027 did not receive the specified medication because it was not warranted based on the results of a specified test. At the same time, RPN #109 accessed the resident's eMAR to demonstrate the documentation that was completed after the 0800 hours medication pass for resident #027. RPN #109 demonstrated to Inspector #655 that it had been documented that the specified medication was adminstered, though it was not. RPN #109 indicated that the number "2" that was also part of the entry (which the Inspector understood to be indicative of the amount of drug given), was not representative of the amount of the medication that was given (as the specified medication was actually not given).

Inspector #655 reviewed the print-out of the eMAR belonging to resident #027 for a specified period of five days. On the above-noted day, there was an entry that read "3 G2" next to the specified medication that was scheduled to be administered at 0800 hours that day, where "3" corresponded to RPN #109. According to the above-described legend on the eMAR, the entry of "3 G2" was indicative that RPN #109 had "given" a specified amount of the specified medication to resident #027 at 0800 hours on a specific day, though RPN #109 indicated to Inspector #655 that the resident had not received the same specified medication at that time.

Inspector #655 further noted that there was an entry next to the specified medication that was scheduled for 1200 hours on the same day which read "3 G2". This entry was again indicative that RPN #109 had given a specified amount of the specified medication to resident #027 during the 1200 hour medication pass on that day. However, Inspector #655 reviewed the results of a specified test in the resident's electronic health care record and noted that at that time, the results of the test did not warrant the administration of the specified medication in the amount that was documented on the

eMAR. Where RPN #109 had recorded the results of this same test, RPN #109 had also documented that that a different amount of the drug was administered (as opposed to the amount that was documented on the eMAR). The actual amount of the specified medication that was given was not accurately captured on resident #027's eMAR.

iii. Over the course of the inspection, Inspector #655 also interviewed RPN #121 and RPN #117 who reviewed the process whereby the documentation of the administration of the specified medication (or the decision not to administer it) in a resident's eMAR would be done.

According to RPN #121, the amount of the medication actually administered to a resident, when it varies depending on the results of the specified test, is to be entered when the administration is signed for. At the time of the interview, RPN #121 demonstrated that while the "amount" pre-populates as a specific number in the resident's eMAR, it can be changed for each entry.

During an interview on November 2, 2017, RPN #117 indicated to Inspector #655 that when a medication, such as the specified medication in use for resident #027, is not administered – for example, because the results of a specific test did not warrant its administration, the practice would be to document the medication as "not given" and choose the option of "other" from a drop-down menu in the eMAR. According to RPN #117, when "other" is chosen, a text box becomes available within the electronic system, allowing for the documentation of the rationale for not giving the specified medication.

During the inspection, Inspector #655 reviewed the Pharmacy Manual which contained multiple policies and procedures related to the medication management system in the home. On review of the manual, Inspector #655 was unable to locate any written policy or procedure that spoke to documentation practices related to medication administration using the electronic MAR.

During interviews on November 1 and November 2, 2017, the above-described inconsistencies in the documentation of the administration of a specified medication for resident #027 by registered nursing staff were reviewed with ADOC #115. Initially, ADOC #115 was unable to speak to the expectation related to the method of this documentation. After reviewing the differing methods outlined above, ADOC #115 indicated to Inspector #655 that the correct method of documentation would require that the staff member indicate that the specified medication was given only when it was administered; and in that case, the staff member would also be expected to document

the correct dosage that was administered each time in the space provided within the electronic system. At the same time ADOC #115 indicated that where the specified medication was not administered because the results of a specified test did not warrant it, the staff member should document that the specified medication was "not given", and document the results of the specified test within the electronic system.

On November 2, 2017, ADOC #115 indicated to Inspector #655 that registered nursing staff are interpreting the documentation procedure related to the administration of a specified type of medication within the eMAR differently, resulting in inconsistencies. At the same time, ADOC #115 indicated to Inspector #655 that there was no written policy or procedure available to registered nursing staff in the home that would provide the staff with guidance related to eMAR documentation practices.

The licensee has failed to ensure that written policies or protocols were developed for the medication management system, related to the documentation of medication administration (specifically, of a specified type of medication) in the electronic MAR, to ensure the accurate dispensing and administration of the drug in the home. [s. 114. (2)]

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 there is a policy or protocol developed for the medication management system to ensure the accurate dispensing and administration of drugs used in the home - specifically, with regards to the documentation related to the dispensing and administration of a specified type of medication, to be implemented voluntarily.

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 residents in accordance with the directions for use specified by the prescriber.

Inspector #655 was provided with copies of medication incident reports for a specified three month period. On review of the medication incident reports, Inspector #655 identified several incidents which involved high-risk medications in which the error reached the resident. Three of these incidents are described below. In each case, the resident was given a medication which was not administered in accordance with the directions for use specified by the prescriber.

i. In a medication incident report of a specified date, a medication incident involving resident #027 is described.

According to the medication incident report, resident #027 received an incorrect dose of a specified medication at a specified time on a specific date. RPN #102 is identified on the medication incident report as the registered nursing staff member who completed the report.

Inspector #655 reviewed the health care record of resident #027, including physicians' orders and electronic Medication Administration Record (eMAR).

According to the health care record, at the time of the incident, resident #027 was to receive a specified amount of a specified medication. The amount of the medication varied within a specified range, depending on the results of a specified test.

In an entry made on the eMAR on a specified date, at a specific time, it is indicated that resident #027 received the specified medication in an amount that was not warranted based on the results of a specified test.

During an interview on October 31, 2017, RPN #102 recalled the medication incident that occurred on the specified date, as described above. RPN #102 indicated to Inspector #655 that on that day, resident #027 received the incorrect dose (double the prescribed dose) of a specified medication at a specified time. According to RPN #102, resident #027 was not adversely effected as a result of the incident.

During an interview on November 2, 2017, ADOC #115 also confirmed that on the

specified date, resident #027 received the wrong dose of a specified medication.

On a specified date, resident #027 was given the incorrect dose of a specified medication; and as such, the specified medication was not administered in accordance with the directions for use specified by the prescriber on that day.

ii. In a medication incident report of a specified date, a medication incident involving resident #028 was described.

According to the medication incident, resident #028 was prescribed a specified medication at a specified dose and frequency on a specified date. According to the same medication incident report, the order was then changed the following day, so that resident #028 was then prescribed the same specified medication but of a different dose and frequency. In the medication incident report, it is indicated, however, that in resident #028's eMAR, the order was entered incorrectly, in that the the wrong frequency was entered when the dose was changed. According to the medication incident report, resident #028's total dose of the specified medication was doubled when the revised order was verified incorrectly. As indicated in the medication incident report, this error was discovered on a specified date, almost four weeks after the order was received. RPN #121 was identified on the medication incident report as the registered nursing staff member who completed the report.

Inspector #655 reviewed the health care record belonging to resident #028, including the physicians' orders and eMAR.

An order that was written on a specified date indicated that a specified amount (dose) of a specified medication was to be administered at a specified frequency. An order on the following day, indicated that the same medication was to be administered at a different dose and frequency.

Inspector #655 reviewed the eMAR for resident #028 for a specified period of four weeks. According to the eMAR, resident #028 was given a specified amount of the specified medication at a frequency which was not consistent with the revised order for a four week period, up until a specified date (when the error was discovered), at which time the order was changed to reflect the actual dosage that had been provided to the resident over the four week period.

That is, based on the documentation, resident #028 received the specified medication at

a frequency that was not consistent with the order for a period of four weeks.

During an interview on November 1, 2017, RPN #121 recalled the medication incident involving resident #028 as it was described in the medication incident report. RPN #121 was present when the error was discovered. According to RPN #121, resident #028 had received the specified medication at the incorrect frequency regularly over a four week period. RPN #121 indicated to Inspector #655 that there were no adverse effects to the resident. RPN #121 recalled that the physician was notified of the error on a specified date, at which time the physician ordered that the resident continue to receive the specified medication at the dose and frequency that was being provided over the four week period.

During an interview on November 2, 2017, ADOC #115 also confirmed that resident #028 had received a specified medication at a frequency that was not ordered on a regular basis during the four week period; and as such, the medication was not administered to resident #028 in accordance with the directions for use specified by the prescriber for a period of our weeks.

iii. In a medication incident report of a specified date, a medication incident involving resident #029 was described.

According to the medication incident report, resident #029 received an incorrect dose of a specified medication on a specified date and time. RPN #122 is identified in the medication incident report as the staff member who discovered the incident; while RN #111 is identified in the medication incident report as the registered nursing staff member who completed the report.

Attached to the medication incident report was an additional document. According to the additional document, an incorrect dose of the specified medication was contained in the medication packaging for resident #029 at the time of the incident. According to the directions for use, also specified in the document, resident #029 was to receive a smaller dose than what was contained in the packaging, at regular intervals as required.

During an interview on October 31, 2017, RPN # 122 recalled the incident that occurred on a specified date, as described above. RPN #122 indicated to Inspector #655 that at the time of the incident, resident #029's medications were dispensed in a specified type of packaging; and each package contained the incorrect dose of the specified medication. RPN #122 indicated to Inspector #655 that as a result, resident #029 had

received the incorrect dose of the specified medication; however, RPN #122 was unsure how many incorrect doses the resident had received. According to RPN #122, there were no adverse effects to resident #029 as a result of the error.

During an interview on the same day, RN #111 confirmed the same, explaining that when the packaging was received from the pharmacy at the time of the incident, the individual packages contained the incorrect dose of the specified medication. RN #111 indicated to Inspector #655 that resident #029 received a dose of the specified medication that was not consistent with the directions for use on one occasion.

During an interview on November 2, 2017, ADOC #115 also confirmed that on a specified date, resident #029 received an incorrect dose of a specified medication; and, as such, the medication was not administered in accordance with the directions for use specified by the prescriber on that day.

The licensee failed to ensure that drugs were administered to resident #027, resident #028, and resident #029, in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

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 drugs are administered to residents, including resident #-027, resident #028, and resident # 029, in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

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

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident is documented, together with a record of the immediate actions taken to assess and maintain the resident's health.

Inspector #655 was provided with copies of medication incident reports for a three month period. On review of the medication incident reports, Inspector #655 identified several

incidents which involved high-risk medications in which the error reached the resident. Three of these incidents are described in written notification # 2. In each case, the resident was given an incorrect dose of a medication. On review of the medication incident reports for each of the three medication incidents, it was noted that in two out of the three cases, there was no record on the incident report of the immediate actions taken to assess and maintain the resident's health after the incident occurred.

Specifically, when it was discovered on a specified date, that resident #028 had been receiving a specified medication at a specified frequency in error, for a period of four weeks, the immediate actions that were taken to assess and maintain the resident's health were not documented together with the medication incident report.

When it was discovered on a specified date that resident #029 had received the incorrect dose of a specified medication, the immediate actions that were taken to assess and maintain the resident's health were not documented together with the medication incident report.

During an interview on November 1, 2017, ADOC #115 reviewed the above- noted medication incident reports, and also identified that there was no documentation on either medication incident report related to the immediate actions taken to assess and maintain the health of resident #028 and resident #029, respectively. According to ADOC #115 the registered nursing staff can also document this information in the progress notes for each resident. However, the progress notes were not attached to the medication incident reports; and were not kept or filed together with the medication incident reports.

In addition, Inspector #655 reviewed the progress notes for resident #028 and resident #029, respectively; and was unable to locate any documentation related to either of the medication incidents or any actions taken to assess and maintain the resident's health.

Over the course of the inspection, it was further noted that out of a total of 19 medication incident reports completed during a three month period, the immediate actions taken to assess and maintain the resident's health were not documented, together with the medication incident report in a total of six cases, including the two outlined above.

The licensee has failed to ensure that every medication incident involving a resident is documented, together with a record of the immediate actions taken to assess and maintain the resident's health. [s. 135. (1)]

2. The licensee has failed to ensure that a written record is kept of the review and analysis of all medication incidents.

Inspector #655 was provided with copies of medication incident reports for a specified three month period. On review of the medication incident reports, Inspector #655 identified several incidents which involved high-risk medications in which the error reached the resident. Three of these incidents are described in written notification # 2. In each case, the resident was given an incorrect dose of a medication:

i. On a specified date, resident #027 received the incorrect dose of a specified medication. (Medication Incident Report (MIR) i)

ii. Over a four week period, resident #028 regularly received a specified medication at the incorrect frequency. (MIR ii)

iii. On a specified date, resident #025 received the incorrect dose of a specified medication. (MIR iii)

On review of the medication incident reports for each of the three above-noted medication incidents, it was noted that in all three cases, there was no documentation to demonstrate that any of the three medication incidents had been reviewed or analyzed.

MIR i was completed on a form which was titled "Medication Incident/Discrepancy Report". On MIR i, "part B" was titled "Review of incident". In part B, there was a guidance statement that read: "to be completed by the Director of Nursing". This section was left blank, containing no documentation related to a review or analysis of the incident by the Director of Nursing (DOC or ADOC). "Part D", titled "Review of Incident by Pharmacy" was also left blank, containing no documentation related to the review or analysis of the incident by pharmacy. At the bottom of the form were signatures of the nurse who prepared the report, the nurse supervisor, the ADOC and the Pharmacy Manager.

MIR ii and MIR iii were both completed using a different form which was titled "Medication Incident".

On both MIR ii and MIR iii the sections titled "Investigation Details" were blank, containing no documentation related to the review or analysis of the medication incident

by anyone. At the bottom of the forms in both cases were the signatures of the nurse making the report, the Medical Director, the staff member involved, and the ADOC.

During an interview on November 2, 2017, ADOC #115 indicated to Inspector #655 that the signatures on the bottom of each of the above-noted medication incident reports were indicative that each incident report had been reviewed and analyzed by those individuals. However, ADOC #115 also identified on review of the medication incident reports, that there was otherwise no record of that review or analysis: there was no indication as to what the analysis entailed or what the outcome was. ADOC #115 was unable to locate any other written records that would demonstrate this.

Over the course of the inspection, Inspector #655 also noted that of the 19 medication incident reports that were completed over a three month period, there was no documentation related to the analysis or review of ten of the medication incidents, including the above-noted three incidents.

The licensee has failed to ensure that a written record is kept of the review and analysis of all medication incidents. [s. 135. (2)]

3. The licensee has failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions.

As previously indicated, Inspector #655 was provided with copies of the medication incident reports for all medication incidents that occurred during a specified three month period – a total of 19 medication incident reports.

Over the course of the inspection, Inspector #655 reviewed the process in place for ensuring that a quarterly review was undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions.

According to ADOC #115, a medication incident report is completed for each medication incident; and each medication incident report is filed in a medication incident binder, where the incidents are sorted by month. According to ADOC #115, the DOC maintained a list of medication incidents for each month; and for each quarter (3 month period), the list was used to facilitate the quarterly review of all medication incidents during

Professional Advisory Committee (PAC) meetings. ADOC #115 indicated to Inspector #655 that he/she was the designate in the DOC's absence.

Inspector #655 reviewed the PAC meeting minutes of a specified date. On review of the meeting minutes, Inspector #655 found no record of a quarterly review of any medication incidents that occurred since the time of the last review. Specifically, there was no documentation related to any of the nineteen medication incidents that had occurred between a specified three month period, including the three incidents which involved high-risk medications and which reached the resident as outlined in written notification #2.

During an interview on November 2, 2017, ADOC #115 indicated that at the time of the above-noted PAC meeting, he/she was not aware of the process in place for reviewing all medication incidents on a quarterly basis; and as such, the 19 medication incidents which had occurred between a specified three month period had not been reviewed when they should have been, at the PAC meeting.

The licensee has failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions. [s. 135. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all medication incidents involving a resident are documented, together with a record of the immediate actions taken to assess and maintain the resident's health; that a written record is kept related to the review and analysis of all medication incidents; and, that a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

i. When resident #024 exhibited altered skin integrity, resident #024 did not receive a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Inspector #655 reviewed the health care recording belonging to resident #024. According to a Minimum Data Set (MDS) Resident Assessment Instrument (RAI) of a specified date, resident #024 was identified as having a specific skin condition at the time of the assessment.

Inspector #655 reviewed resident #024's progress notes and was unable to determine when the specified skin condition, identified in the RAI-MDS assessment of a specified date was first identified. In a progress note entered by the Dietician on a specified date,

resident #024 was again described as having a specified type of skin condition. On review of the progress notes, Inspector #655 identified several other instances in which resident #024 was identified as having exhibited altered skin integrity over a three month period.

In resident #024's current care plan, resident #024 was identified as being at risk for alterations in skin integrity.

On review of resident #024's health care record, Inspector #655 was unable to locate any documentation that would demonstrate that resident #024 had been assessed by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, at any time - including those times when resident #024 had exhibited altered skin integrity according to the progress notes.

According to PSW #112 and RPN #102, resident #024 did not have any current alterations in skin integrity at the time of the inspection; however, resident #024 was described as being at risk for skin breakdown.

During an interview on October 31, 2017, RN # 111 indicated to Inspector #655 that resident #024 had a history of altered skin integrity. According to RN #111 there were several issues related to resident #024's skin condition in a specified month. During the interview, RN #111 identified two specific instances in which resident #024 had exhibited altered skin integrity during the specified month, and RN #111 described the alterations.

ii. When resident #014 exhibited altered skin integrity, resident #014 did not receive a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Inspector #655 reviewed the health care record belonging to resident #014. According to a Minimum Data Set (MDS) Resident Assessment Instrument (RAI) of a specified date, resident #014 had a specific skin condition. The data recorded in a previous MDS-RAI assessment , of a specific date, was indicative that resident #014 had the same skin condition which presented as an alteration in skin integrity.

In resident #014's current care plan, resident #014 was identified as being at risk for skin breakdown. In the care plan, it indicated that resident #014 had a specific skin condition

on a specific area of the body.

On review of resident #014's health care record, Inspector #655 was unable to locate any documentation that would demonstrate that resident #014 had been assessed by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, at any time (including when resident #014's skin condition was at a level in which there was evidence of altered skin integrity, as was described in a RAI-MDS assessment done at that time).

During an interview on October 31, 2017, PSW #116 indicated to Inspector #655 that resident #014 continued to exhibit a specified skin condition on a specific area of the body. According to PSW #116, resident #014 had a history of altered skin integrity. PSW #116 indicated to Inspector #655, that PSW staff observe the resident's skin regularly, and document the location of areas of altered skin integrity on a body mapping sheet in order to notify the nurse who would then conduct a skin assessment. At the same time, Inspector #655 observed that on the body mapping sheet in use for resident #014, there was a circle drawn over a specific area of the body.

During an interview on October 31, 2017, RPN #101 indicated to Inspector #655 that PSW's document the location of any identified area of altered skin integrity using a body mapping sheet for each resident as needed. RPN #101 indicated to Inspector #655 that this process serves as a mechanism of reporting, so that registered staff are informed of any skin alterations. RPN #101 indicated to Inspector #655 that the nurse would then conduct a skin assessment. However, RPN #101 was unable to speak to the use of a clinical tool, specifically designed for skin and wound assessment, that would be used by registered nursing staff to assess a resident in response to an observation made by a PSW - that is, to assess a resident who was exhibiting altered skin integrity; except for the "wound assessment/progress tool" which, according to RPN #101 would be used to assess only those resident's requiring a specified type of intervention related to the skin. However, RPN #101 did indicate to Inspector #655 that resident's would be assessed using the Braden scale on a quarterly basis.

During the same interview, RPN #101 reviewed the resident's health care record (including "second chart", electronic health care record, and a binder related to skin care); and was unable to locate any documentation that would indicate that resident # 014 had received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment at any time (including when resident #014 had exhibited an alteration

in skin integrity). According to RPN #101, there was no indication that the resident had been assessed using the Braden Scale; and no indication that the resident was assessed by registered nursing staff using the "wound assessment/progress tool".

Over the course of the inspection, Inspector #655 interviewed several other members of the registered nursing staff. None of the registered staff interviewed, including RPN #102 and RN #111, were able to speak to the use of a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment to assess resident's who exhibit altered skin integrity; except when those residents required specific interventions related to skin in which case the "wound assessment/progress tool" would be utilized.

During an interview on November 2, 2017, RAI Coordinator #114 indicated to Inspector #655 that the use of an assessment instrument, specifically designed for skin and wound assessment, is not part of the quarterly assessment process. That is, resident's – including those exhibiting altered skin integrity – are not assessed using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment on a quarterly basis.

Over the course of the Inspection, ADOC #115 was also unable to speak to the use of a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment that would be used to assess resident's exhibiting altered skin integrity, except for the use of the "wound assessment/progress tool", identified by staff to be used only to assess those resident's requiring specific interventions related to skin.

When resident #024 and resident #014 exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, the licensee failed to ensure that the resident's received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

WN #5: 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. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. The licensee failed to ensure that where an incident occurred that caused injury to a resident for which the resident was taken to hospital, and where the licensee determined that the injury resulted in a significant change in the resident's health condition or the licensee remained unable to determine whether the injury had resulted in a significant change in the resident's health condition, the licensee informed the Director of the incident no later than three business days after the occurrence of the incident.

i. Two Critical Incident Reports (CIRs) were submitted to the Director under the Long-term Care Homes Act (2007). On each of the CIRs, it is indicated that an incident occurred which caused an injury to the resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.

Both CIR's were related to the same incident involving resident #025. In both CIRs, it is indicated that resident #025 sustained a specified injury as a result of specified incident. In the CIRs, the resident is described as experiencing a change in health status.

The first of the two CIR reports was submitted over two weeks after the initial occurrence of the incident.

ii. A CIR was submitted to the Director under the Long-term Care Homes Act (2007) on a specified date. On the CIR, it is indicated that an incident occurred that caused an injury

to the resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. The incident involved resident #026.

According to the CIR, resident #026 sustained a specified injury as a result of the incident.

The CIR was submitted four weeks after the occurrence of the incident.

During an interview on October 30, 2017, ADOC #115 indicated to Inspector #655 that the above-noted CIRs were reported late. According to ADOC #115, the DOC who normally completes and submits CIRs to the Director under the Long-term Care Homes Act (2007) was not consistently available for a period of time – during which time, both critical incidents occurred. ADOC #115 explained to the Inspector that there had been no alternate process implemented in order to ensure that critical incidents were being reported as required until a specified date, at which time ADOC #115 was appointed as the designate.

The licensee failed to ensure that where the licensee determined that the above-noted incidents resulted in a significant change in the residents' health status; or, when the licensee was unable to determine whether the injury had resulted in a significant change in the resident's health condition, the licensee informed the Director of the incident no later than three business days after the occurrence of the incident. [s. 107. (3.1)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs are stored in an area or a medication cart that is secure and locked.

On October 25, 2017, Inspector #138 observed a basket of prescription, medicated creams (twelve different creams) in the tub room on a specific resident home area.

On the same day, Inspector #655 observed two prescription medications belonging to resident #014 to be left in resident #014's room. One of the specified prescribed medications was found on the resident's bed side table; and, the other on the vanity in the resident's bathroom.

On November 2, 2017, Inspector #655, observed a basket of prescription, medicated creams and other topical medications, on the counter at the nurses' substation (nursing centre 400). The nursing substation was not fully enclosed, and the gate was unlocked, allowing the Inspector to access the area behind the counter, and to access the basket of prescribed, medicated creams and topical medications. At the time of the observation, there was one resident and no staff in the area.

On the same day, Inspector #655 observed a basket of prescription, medicated creams on the counter at the nurses' substation (nursing centre 700), located on another resident home area. Inspector #655 was able to reach the medicated creams in the basket on the counter without accessing the nurses' station (i.e. going behind the counter). The nurses'

station was not enclosed; and while the gate was closed, it was not locked. At the time of the observation, there were no residents in the area; and staff were in the area on an intermittent basis.

During an interview on November 1, 2017, RPN #121 indicated to Inspector #655 that prescription medications, including prescription creams, may be kept in a resident's room under certain circumstances - if the resident is capable. According to RPN #121 the decision to leave a prescribed medication in a resident's room would be based on an assessment of the resident by the registered nursing staff. According to RPN #121, prescription creams– if not left in a residents' room under the circumstances described above, are to be kept in a basket at the nurses' station, if it is to be applied by a PSW; or, in the medication cart, if it is to be applied by a member of the registered nursing staff.

During an interview on November 1, 2017, ADOC #115 indicated to Inspector #655 that prescribed medications are not to be left in a resident's room. According to ADOC #115, prescription ointments are expected to be stored securely in a medication room; or, where PSWs are applying the ointment: in an area of the tub room or at one of the primary nurses' stations, where they would be stored securely, in a locked area. ADOC #115 indicated to Inspector #655 that the primary nurses stations' are entirely enclosed and are to be kept locked at all times. At the same time, ADOC #115 indicated to Inspector #655 that the above-noted nurses' substations are not considered secure; and that prescription ointments are not to be left unattended at these stations.

The licensee failed to ensure that all drugs, mainly prescription ointments and other topical medications, are stored in an area or a medication cart that is secure and locked. [s. 129. (1) (a)]

Issued on this 10th day of November, 2017

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

Original report signed by the inspector.