Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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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
Dec 13, 2017	2017_630589_0017	024895-17	Resident Quality Inspection

Licensee/Titulaire de permis

ROYAL CANADIAN LEGION DISTRICT 'D' CARE CENTRES
59 Lawson Rd TORONTO ON M1C 2J1

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

TONY STACEY CENTRE FOR VETERANS' CARE
59 Lawson Road TORONTO ON M1C 2J1

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

JOANNE ZAHUR (589), BABITHA SHANMUGANANDAPALA (673), JOVAIRIA AWAN (648)

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): November 2, 3, 6, 7, 8, 9, 10, 14, 15, and 16, 2017.

The following two intakes were inspected concurrently with the Resident Quality Inspection (RQI):
-log #030730-16/Critical Incident Report (CIS) #C542-000032-16 related to a medication administration error, and
-log #002524-17 related to CO #001 under s. 19 (1) which had been issued in report #2016_353589_0011.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Environmental Manager (EM), Food Services Supervisor (FSS), Registered Dietitian (RD), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), Housekeeping aide (HSK), Consulting Pharmacist (CP), Student RPN, Nurse Manager (NM), and President of the Residents' Council.

During the course of the inspection, the inspector(s) conducted a tour of the home, observations of the medication administration system, staff and resident interactions and the provision of care, record review of health records, staff training records, meeting minutes for Residents' Council and relevant policies and procedures.

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

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

- **9 WN(s)**
- **6 VPC(s)**
- **1 CO(s)**
- **0 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
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2016_353589_0011	673

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. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

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:
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed
(b) corrective action is taken as necessary, and
(c) a written record is kept of everything required under clauses (a) and (b).

As a result of non compliances noted during the completion of the Medication Inspection Protocol, O. Reg. 79/10, under r. 135 was inspected.

As per the Long Term Care Homes Act, a medication incident is defined as a preventable event associated with the prescribing, ordering, dispensing, storing, labeling, administering or distributing of a drug, or the transcribing of a prescription, and includes an act of omission or commission, whether or not it results in harm, injury or death to a resident.

Record review of the home's medication management binder revealed a letter written by

staff #107 stating, that a medication week-end audit for missing initials on the medication administration records (MARs) and treatment administration records (TARs) is enormous, unacceptable and not in compliance according to the College of Nursing and Ministry of Health requirement.

In an interview, staff #107 stated that in 2016, he/she handed out approximately five of the above mentioned letters to staff who were not documenting care provided in residents MARs and TARs. Staff #107 confirmed that he/she had not kept copies or a record of which staff members these letters had been sent to, or completed medication incident reports for these incidents as per the home's expectations. [s. 135. (2)]

2. The licensee has failed to ensure 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.

As part of the RQI, the Medication Inspection Protocol was completed as a mandatory task.

Review of the medication incidents and adverse drug reaction documentation provided by the home revealed two medication incidents had occurred in 2016.

The first incident occurred on an identified date in October 2016, when staff #118 administered another resident's medications to resident #010 resulting in resident #010 experiencing adverse reactions. The second incident occurred on an identified date in December 2016, when staff #119 administered the wrong medications to resident #030 resulting in resident #030 being sent to hospital for further investigation.

Review of the home's policy titled: Drug Incident, dated September 2016, stated that all drug errors must be reviewed quarterly to evaluate success of changes implemented.

Record review of the quarterly medication management system reviews (MMSR) for October 2016, November 2016, and March 2017, revealed that no medication errors or interactions had been reported.

In an interview, staff #120 stated that medication incidents and how to better prepare for them are discussed during the quarterly reviews of the medication management system. Staff #120 was able to recall that there were two incidents that occurred in 2016.

In an interview, staff #107 stated that the home's process for addressing adverse drug reactions and medication incidents included discussing them at the quarterly reviews of the medication management system to determine how to reduce and prevent recurrence in the future. Staff #107 confirmed that the above mentioned medication incidents had not been included in any of the quarterly reviews of the medication management system.

The scope of this non-compliance includes resident's #010 and resident #030. The severity of harm involved residents' #010 and #030 experiencing actual harm where resident #010 experienced adverse reactions affecting their health status and resident #030 was transferred to hospital for further investigation related to both residents being administered medications that had not been prescribed to them, respectively. The previous compliance history included a written notice under O. Reg. 79/10, r. 135 (3) issued in RQI 2015_302600_0012 which at the time of this inspection had been closed, however, with recurrent non-compliance with this legislation, and actual harm experienced by two residents, a compliance order is warranted. [s. 135. (3)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

As part of the RQI, the Medication Inspection Protocol was completed as a mandatory task.

As per O.Reg 79/10, s.114 (3) (a), the licensee shall ensure that the written policies and protocols are implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Record review of the narcotic count sheets on first floor on an identified date in November 2017 at 1300 hours revealed only one signature on the narcotic count sheet for 0700 hours, and that staff #101 had not signed the narcotic count sheet at 0700 hrs with the outgoing registered staff.When the inspector brought this to the attention of staff #101, he/she immediately signed the count sheet without actually completing the narcotic count stating that he/she had forgotten to sign off earlier.

Further record review of narcotic count sheets on second floor on an identified date in November 2017, at 0845 hours revealed only one signature on the narcotic count sheet for 0700 hours, and that staff #113 had not signed the narcotic count sheet at 0700 hours with the outgoing registered staff.When the inspector brought this to the attention of staff #113, he/she stated that he/she had completed the narcotic count with the outgoing staff member but had forgotten to sign off.

During observations of shift change on first floor north and south, the inspector did not observe staff #117 complete the narcotic and controlled substances count with oncoming staff #110 who had arrived at 1445 hours and staff #111 who arrived at 1505 hours, respectively before leaving the unit.

Observations conducted on the second floor by the inspector on an identified date in November 2017, at 1500hours, revealed staff #114 leaving the unit without completing the narcotic and controlled substances count with the oncoming evening registered staff.

Review of the home's policy titled: Narcotic Controlled Medication, Document No. 4, dated October 23, 2017, stated that the registered staff must document on the individual Resident's Record form each time a medication is administered and for counting verification on the change of shift count. It further stated that at the change of shift, the oncoming and outgoing registered staff persons jointly count all controlled Narcotics medication and other medication such as Ativan. The shift to shift Narcotic Count Verification form must be signed by both the outgoing and oncoming registered staff at

each change of shift and at other times indicated on the sheet. The count must be verified by two registered staff before leaving at the end of the shift.

In interviews, staff #101, staff #113, staff #110, staff #111, and staff #117 stated that the home's expectation related to narcotics and controlled substances is for oncoming and outgoing to complete the narcotic and controlled substances counts together at the change of shift and to sign the individual and shift count sheets at this time, and that they had not followed this policy. After the interview, staff #110 proceeded to count the narcotics and controlled substances on his/her own until the inspector questioned whether he/she should be counting with another registered staff like he/she had previously stated.

In interviews, staff #122 and staff #107 confirmed that the above mentioned staff had failed to comply with the home's policy narcotics and controlled substances. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #3: 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).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds been assessed by a registered dietitian who is a member of the staff of the home.

As a result of non compliances related to O. Reg. 79/10, s. 50 for residents #003 and #007, the scope of this inspection was increased to include resident #022.

Review of resident #022's health record revealed he/she had been admitted to the home in 2017. Further review revealed a physician's order identified altered skin integrity to an identified body area of resident #022. The order included dressing orders, every two hours (q2h) turning and repositioning and for the resident to be assessed by the Nurse Practitioner (NP). The physician order sheet also revealed the NP had identified the staging of the altered skin integrity and recommended new dressing orders to be implemented. Further review of the health record revealed that a registered dietitian

assessment related to resident #022's altered skin integrity had not been completed.

Review of the home's internal monthly wound report for October 2017, revealed that resident had an area of altered skin integrity.

In an interview, staff #112 stated he/she was not aware that resident #022 had altered skin integrity as he/she had not received a referral to complete an assessment. Staff #112 further stated the only referral that had been completed was on resident #022's admission date and at that time resident #022 was not exhibiting any altered skin integrity.

In an interview, staff #106 who is also the wound care lead in the home stated that a referral to the RD should have been completed when resident #022 was initially exhibiting altered skin integrity.

In an interview, staff #112 acknowledged that when resident #022 was exhibiting altered skin integrity, an assessment was not completed by a registered dietitian as per legislative requirements. [s. 50. (2) (b) (iii)]

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, been reassessed at least weekly by a member of the registered staff.

As a result of non compliances related to O. Reg. 79/10, s. 50 for residents #003 and #007, the scope of this inspection was increased to include resident #022.

Review of resident #022's health record revealed he/she had been admitted to the home on an identified date in 2017. Further review revealed a physician's order had identified altered skin integrity to an identified body area of resident #022. The order included dressing orders, every two hours (q2h) turning and repositioning for the resident to be assessed by the Nurse Practitioner (NP). The physician order sheet also revealed the NP had recommended new dressing orders to be implemented.

In an interview, staff #106 stated that as per the home's process, weekly wound assessments should have been completed for resident #022 using the weekly ulcer/wound assessment record kept in the TAR binder. Staff #106 further stated that weekly wound assessments are indicated on the TAR to be completed every Wednesday for resident #022.

Review of the resident #022's TAR failed to reveal that any weekly wound assessments had been completed to date, indicating a total of seven weekly wound assessments had not been completed.

In interviews, staff #106 and staff #107 acknowledged that the home's registered staff had failed to completed weekly wound assessments. [s. 50. (2) (b) (iv)]

3. Resident #003 triggered from stage one for skin and wound from a staff interview.

Review of resident #003's written plan of care in place at time of this inspection under the skin focus revealed he/she had two areas of altered skin.

In an interview, staff #106 who is also the skin and wound care lead in the home, stated that weekly wound assessments are to be completed for resident #003 by registered staff working on the resident home area. Staff #106 further stated that weekly wound assessments are usually completed every Wednesday using the weekly ulcer/wound assessment record.

Review of the weekly ulcer/wound assessment record revealed that for the past quarter, 14 weekly wound assessments had not been completed for altered skin integrity for resident #003.

In an interview, staff #111 stated that he/she had not completed any weekly wound assessments for resident #003 as he/she thought the wound care lead in the home had been completing them.

In an interview, staff #107 acknowledged that registered staff in the home had failed to complete weekly wound assessments. [s. 50. (2) (b) (iv)]

4. Resident #007 triggered from stage one for skin and wound from a staff interview and census record review.

Review of resident #007's health record revealed he/she had been admitted to the home with an area of altered skin integrity. Further review revealed resident #007 had been assessed by an ET nurse, was having dressing changes completed twice a week, had an identified therapeutic surface in place, and was to be turned and repositioned every two hours.

Review of the home's weekly ulcer/wound assessment record for the past three months, revealed that weekly wound assessments were to be completed every Thursday by the registered staff. Further review revealed that for eight weeks over the past three months weekly wound assessments had not been completed.

In an interview, staff #113 stated that he/she was aware that weekly wound assessments were to be completed however, he/she acknowledged that he/she was not always completing them and that when he/she gets busy, he/she forgets.

Review of the weekly ulcer/wound assessment record revealed the next weekly wound assessment for resident #007 was due on an identified date in November 2017.

Observations conducted by the inspector on the above mentioned identified date revealed that staff #113 completed the dressing change for resident #007's altered skin integrity however he/she failed to complete the weekly wound assessment.

In interviews, staff #106 and staff #107 acknowledged that the home had failed to ensure that the altered skin integrity for resident #007 had been reassessed at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

5. The licensee has failed to ensure that the resident who is dependent on staff for repositioning, was repositioned every two hours.

Resident #003 triggered from stage one for skin and wound from a staff interview.

Review of resident #003's written plan of care in place at the time of this inspection under the skin focus revealed he/she had two areas of altered skin integrity and that resident #003 was to be turned and repositioned every two hours (q2h). The written plan of care in place at the time of this inspection further revealed that resident #003 was dependent on two staff for bed mobility and repositioning related to a previous health condition. Review of the kardex report revealed that resident #003 was to be turned and repositioned every two hours related to skin care.

Review of the most recently completed Braden Scale for Predicting Pressure Sore Risk revealed revealed that resident #003 was mostly bedfast and that his/her mobility was very limited.

On two identified dates in November 2017, observations conducted by the inspector revealed resident #003 lying in bed positioned on his/her back for most of each day.

Review of resident #003's repositioning schedule for the month of September, and October and up to an identified date in November 2017, revealed that for 41 days the documentation showed that resident #003 had not been consistently turned and repositioned q2h.

In an interview, staff #116 stated that resident #003 required to be turned and repositioned every two hours and that he/she had failed to turn and reposition resident #003 on two of the 41 days identified.

In interviews, staff #106 and staff #107 acknowledged that staff had failed to ensure that resident #003 who was dependent on staff, had been turned and repositioned every two hours. [s. 50. (2) (d)]

6. Resident #007 triggered from stage one for skin and wound from a staff interview and census record review.

Review of resident #007's health record revealed he/she was admitted with an area of altered skin integrity. Further review revealed the use of a therapeutic bed surface, assessments completed by an enterostomal nurse (ET) with dressing orders, and turning and repositioning every two hours.

On two identified dates in November 2017, observations conducted by the inspector revealed resident #007 lying in bed positioned on his/her back for most of each day.

Review of resident #007's repositioning schedule for the month of September, and October and up to an identified date in November 2017, revealed that for 49 days the documentation showed that resident #007 had not been consistently turned and repositioned q2h.

In an interview, staff #113 stated that he/she was not sure of how often resident #007 required to be repositioned and was also not aware that as a registered staff, he/she was required to monitor the repositioning schedule every shift to ensure resident #007 had been turned and repositioned every two hours.

In an interview, staff #115 stated that he/she was pretty sure he/she had turned and

repositioned resident #007 every two hours on the two shifts noted in November 2017, where he/she had been assigned the care of resident #007. Staff #115 further stated that he/she had been very busy and had missed turning and repositioning resident #007.

In an interview, staff #107 acknowledged that the home had failed to ensure that resident #007 who is dependent on staff for repositioning, had not been turned and repositioned every two hours as required. [s. 50. (2) (d)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, been reassessed at least weekly by a member of the registered staff, and that the resident who is dependent on staff for repositioning, is repositioned every two hours, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures are developed and implemented for addressing incidents of lingering offensive odours.

Resident #006 triggered from stage one for room odour. On multiple occasions, a lingering, offensive odour was noted in resident #006's bathroom, shared by four residents, as follows:
- November 2, 2017, at 1219 hours,
- November 6, 2017 at 1240 hours,

- November 7, 2017 at 0800 hours, (room just cleaned by staff #121)
- November 7, 2017, at 1330 hours observed bathroom with staff #102, and
- November 15, 2017 at 1000 hours.

On an identified date in November 2017, at 0800 hours, staff #121was observed to have finished cleaning resident #006's washroom. When asked if the washroom still had an odour, staff #121confirmed there was an odour and stated that the room has had this odour for one year. Staff #121 stated that he/she had informed staff #102 about this issue two months ago, and he/she had been instructed by staff #102 to take extra time in this room to soak and clean with Urine Off; however, the issue did not resolve and he/she did not follow up with staff #102 and staff #102 had not followed up with him/her.

In an interview, staff #102 stated that the home's process in addressing lingering offensive odours in the home is for staff to report the issue to him/her so that an assessment of the odour can be completed and interventions could be implemented, and if the issue persisted, staff are expected to report the issue again. Staff #102 further stated that he/she was aware that resident #006's washroom had a sporadic issue of a lingering offensive odour in the past, and he/she had instructed housekeeping staff to clean it more often, and he/she had also buffed the floor, wiped the walls and completed a deep clean of the washroom. Staff #102 stated he had not kept any documentation of the past interventions completed to address the odour in this washroom. Staff #102 further stated that he/she was not aware that the odour was currently an issue again as he/she had not been informed of this by staff. Staff #102 accompanied the inspector on an identified date in November 2017, to resident #006's bathroom for an observation, and confirmed the presence of a lingering offensive odour.

On an identified date in November 2017, resident #012, who shares the bathroom with resident #006 told the inspector that there was a lingering offensive odour in the bathroom, which does not resolve even after housekeeping staff clean the washroom.

In an interview, staff #107 acknowledged that the home's procedure was not implemented for addressing the incidence of the lingering offensive odour in resident #006's bathroom as the odour persisted even after daily cleaning. [s. 87. (2) (d)]

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 procedures are developed and implemented for addressing incidents of lingering offensive odours, to be implemented voluntarily.

WN #5: 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 has failed to ensure that 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.

An observation conducted by the inspector during the RQI on the first floor revealed a blister pack of a specific drug in a resident's individual medication box located in the single locked drawer of the medication cart. Further observations of a medication cart on the second floor revealed controlled substances were stored in blister packs in their respective resident's individual medication boxes located in the single locked drawer of the medication cart. The above noted controlled substances that were prescribed to be

given as needed (PRN) were observed to be double locked in the narcotic bin of the medication cart.

A controlled substance within the meaning of the Controlled Drugs and Substances Act (Canada) means a substance included in Schedule I, II, III, IV or V, and the above noted drugs are listed as Schedule IV drugs.

In an interview, staff #113 stated that controlled substances are drugs that only designated people have access to, and such medications included one of the above noted drugs. Staff #113 further stated that controlled medications should be locked with the other narcotics; however, the pharmacy sends them in individual blister packs and they are stored inside the medication cart in the resident's individual medication boxes, which are not double locked.

In an interview, staff #117 stated that the home's practice was to store regularly scheduled controlled substances in resident's individual medication box. Staff #117 further stated that this would mean they are only single locked.

In an interview, staff #122 stated that controlled substances include regularly scheduled medications but not PRN medications. When asked for clarification about what a controlled substance was, he/she stated that he/she did not know how to answer the question. Staff #122 further stated that the home's policy was to keep controlled substances and narcotics safely double locked. When asked if the home was following that policy, staff #122 stated that he/she could not answer that question.

In interviews, staff #107 and staff #120 confirmed that only the PRN drugs were being double locked, and the regularly scheduled drugs of this kind were kept with the rest of the regularly scheduled medications.

In an interview, staff #120 stated that a controlled substance is defined according to the Controlled Drugs and Substances Act. Staff #120 confirmed that drugs such as the above noted drugs are Schedule IV drugs as per the Controlled Drugs and Substances Act and should be kept double locked. [s. 129. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that 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, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that a monthly audit is undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies, and that immediate action is taken if any discrepancies are discovered.

As a result of non compliances related to the mandatory Medication Inspection Protocol, under O. Reg. 79/10, r. 130. 3. was included in the inspection.

Record review of the narcotic count sheets on first floor revealed only one signature on the narcotic count sheet for 0700 hours, and that staff #101 had not signed the narcotic count sheet at 0700 hours with the outgoing registered staff.

Further record review of narcotic count sheets on the second floor on an identified date in November 2017, at 0845 hours, revealed only one signature on the narcotic count sheet for 0700 hours, and that staff #113 had not signed the narcotic count sheet at 0700 hours with the outgoing registered staff.

Observations conducted on the second floor by the inspector on an identified date in November 2017, at 1500 hours, revealed staff #114 leaving the unit without completing the narcotic and controlled substances count with the oncoming evening registered staff.

Observation on an identified date in November 2017, at 1500 hours by the inspector revealed staff #114 leaving the unit without completing the narcotic and controlled substances count with the oncoming evening staff.

Record review of the medication management binder provided by the home did not reveal monthly audits of the daily count sheets of controlled substances had occurred.

In an interview, staff #107 stated that there is no current procedure in the home for auditing the daily count sheets of controlled substances to determine if there are any discrepancies, and take immediate action if any discrepancies are discovered. He/she stated that the home had started working on developing such a procedure only two weeks ago. [s. 130. 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 a monthly audit is undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies, and that immediate action is taken if any discrepancies are discovered, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee has failed to ensure that at least quarterly, there is a documented reassessment of each resident's drug regime.

During the RQI, resident #011 was selected to complete a medication administration observation. As a result of non compliances under O. Reg. 79/10, r. 134, the scope of this inspection was increased to include residents #013 and #014.

Record review revealed that resident #011's most recent quarterly medication review obtained from his/her chart was dated for an identified date in June 2017, which indicated that the next quarterly review was two months late.

Review of resident #011's previous quarterly medication reviews revealed that they had been completed on the following dates:
- on an identified date in June 2016,
- on an identified date in October 2016, (completed one month late),
- on an identified date in February 2017, (completed one month late), and
- on an identified date in June 2017, (completed one month late).

Review of resident #013's quarterly medication reviews revealed that they had been completed on the following dates:
-on an identified date in September 2016,
-on an identified date in January 2017, (completed one month late),
-on an identified date in March 2017,
-on an identified date in May 2017, and,
-on an identified date in October 2017, (completed two months late).

Review of resident #014's quarterly medication reviews revealed that they had been completed on the following dates:
-on an identified date in March 2017, and,
-on an identified date in October 2017, (completed four months late).

In an interview, staff #101, staff #113, and staff #122 stated that the home's process for completing quarterly medication reviews included the physician and nurses reviewing all medications and making necessary changes every three months. Staff #101, staff #113, and staff #122 confirmed that resident #013's quarterly medication review had not been completed on time. Staff #101 stated that the home's regular physician had been away and the physician who covered his/her absence do not complete quarterly medication reviews. Staff #122 acknowledged that there should have been a medication review completed in September 2017 for resident #013.

In an interview, staff #107 confirmed that resident's medications are reviewed every three months and that resident #011, resident #013 and resident #014's quarterly medication reviews had not been completed every three months as per the home's expectations. [s. 134. (c)]

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 at least quarterly, there is a documented reassessment of each resident's drug regime, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

Review of the Residents' Council meeting minutes revealed concerns had been brought forward at the July 2017, and September 2017, meetings. Further review of the meeting minutes revealed that staff #107 responded on an identified date in July 2017, 14 days later and on an identified date in September 2017, 15 days later, respectively.

In an interview, staff #107 acknowledged that he/she had failed to respond within 10 days of receiving Residents' Council advice related to concerns and recommendations. [s. 57. (2)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (1) Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations. 2007, c. 8, s. 79. (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations. 2007, c. 8, s. 79. (1).

During the initial home tour of the long term care home on an identified date in October 2017, the inspector identified the home had posted the licensee copy of a RQI report at the entrance for public review. The complimentary public report was not posted at the time of this observation.

Interview and review of posted reports with the home's Administrator acknowledged the public copy of the RQI report had not been posted as per legislative requirements. [s. 79. (1)]

Issued on this 2nd day of January, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JOANNE ZAHUR (589), BABITHA SHANMUGANANDAPALA (673), JOVAIRIA AWAN (648)
Inspection No. / No de l'inspection :	2017_630589_0017
Log No. / No de registre :	024895-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Dec 13, 2017
Licensee / Titulaire de permis :	ROYAL CANADIAN LEGION DISTRICT 'D' CARE CENTRES 59 Lawson Rd, TORONTO, ON, M1C-2J1
LTC Home / Foyer de SLD :	TONY STACEY CENTRE FOR VETERANS' CARE 59 Lawson Road, TORONTO, ON, M1C-2J1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Catherine Hilge

To ROYAL CANADIAN LEGION DISTRICT 'D' CARE CENTRES, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
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

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
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

Order # /
Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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;
(b) any changes and improvements identified in the review are implemented; and

(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Order / Ordre :

The licensee shall prepare and submit a plan to ensure 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. O. Reg. 79/10, s. 135 (3).

The plan will include, at a minimum, the following elements:
-a system in place to ensure all medication incidents and/or adverse drug reaction are documented, reviewed and analyzed,
-a system in place to ensure quarterly reviews are undertaken for all medication incidents and adverse drug reactions, and
-develop an auditing system to ensure there is a written record kept all medication incidents and/or adverse drug reactions, that includes the documentation of the actual incident, the review and analysis and any required corrective action that was taken to prevent recurrence.

The compliance plan is to be submitted to: joanne.zahur@ontario.ca no later than December 22, 2017.

Grounds / Motifs :

1. The licensee has failed to ensure 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.

As part of the RQI, the Medication Inspection Protocol was completed as a mandatory task.

Review of the medication incidents and adverse drug reaction documentation provided by the home revealed two medication incidents had occurred in 2016.

The first incident occurred on an identified date in October 2016, when staff #118 administered another resident's medications to resident #010 resulting in resident #010 experiencing adverse reactions. The second incident occurred on an identified date in December 2016, when staff #119 administered the wrong medications to resident #030 resulting in resident #030 being sent to hospital for further investigation.

Review of the home's policy titled: Drug Incident, dated September 2016, stated that all drug errors must be reviewed quarterly to evaluate success of changes implemented.

Record review of the quarterly medication management system reviews (MMSR) for October 2016, November 2016, and March 2017, revealed that no medication errors or interactions had been reported.

In an interview, staff #120 stated that medication incidents and how to better prepare for them are discussed during the quarterly reviews of the medication management system. Staff #120 was able to recall that there were two incidents that occurred in 2016.

In an interview, staff #107 stated that the home's process for addressing adverse drug reactions and medication incidents included discussing them at the quarterly reviews of the medication management system to determine how to reduce and prevent recurrence in the future. Staff #107 confirmed that the above mentioned medication incidents had not been included in any of the quarterly reviews of the medication management system. (673)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 26, 2018

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 13th day of December, 2017

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
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

Name of Inspector / Nom de l'inspecteur : Joanne Zahur

Service Area Office / Bureau régional de services : Toronto Service Area Office