Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 4, 2018	2018_577611_0009	007392-18	Resident Quality Inspection

Licensee/Titulaire de permis

Maryban Holdings Ltd.
3700 Billings Court BURLINGTON ON L7N 3N6

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

Oakwood Park Lodge
6747 Oakwood Drive NIAGARA FALLS ON L2G 0J3

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

KELLY CHUCKRY (611), AILEEN GRABA (682), THERESA MCMILLAN (526)

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): April 16, 18, 19, 20, 23, 24, 25, 26, and 27, 2018.

The following Critical Incident intakes were completed during this RQI inspection: #008563-17 and Log #002653-17, both pertaining to financial abuse, Log #027541-17 pertaining to falls prevention, Log #000198-18 pertaining to hospitalization and change in condition, Log #000798-18 and Log #005071-18 both pertaining to medication management, Log #002803-18, Log #008428-18, Log #006252-17, and Log #005964-18 all pertaining to prevention of abuse and neglect.

The following complaint intakes were completed during this RQI inspection: Log #009772-17 pertaining to nutrition hydration, and personal support services, Log #013769-17 and Log #023595-17, both pertaining to personal support services, Log #000905-18 pertaining to the prevention of abuse/neglect, and Log #004686-18 pertaining to nutrition hydration, continence care and bowel management, and personal support services.

The following follow up intake was completed during this RQI inspection: Log # 0003875-18 pertained to plan of care, specifically concerning toileting.

The following inquiry intakes were completed during this RQI inspection: Log #029712-17 and Log #028029-17, both pertaining to continence care and bowel management, the prevention of abuse/neglect, and personal support services, Log #016376-17 pertaining to falls prevention and personal support services, Log #002458-18, Log #025732-17, and Log #016600-17, all pertaining to falls prevention, Log #005960-18 pertaining to hospitalization and change in condition, Log #025212-17 pertaining to infection prevention and control, Log #004475-18 pertaining to falls prevention, and personal support services, Log #023763-17 pertaining to financial abuse, Log #018227-17 pertaining to skin and wound management, and Log #017461-17 pertaining to safe and secure home.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Director of Therapeutic Recreation Services, Registered Dietician (RD), Registered staff, Personal Support Workers (PSW), housekeeping staff, residents and families.

During the course of this inspection inspector(s) conducted a tour of the home, observed the provision of resident care, observed medication administration, reviewed medication incidents, applicable clinical health records, policies, procedures, practices, meeting minutes, education material, and investigation notes.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **8 WN(s)**
- **4 VPC(s)**
- **2 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. 6. (7)	CO #001	2017_542511_0013	611

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. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A) A clinical record review indicated that resident #023 was prescribed a medication, and staff were directed to conduct a particular intervention with this medication. According to a critical incident system (CIS) 2661-000011-18 submitted by the home, and clinical records, registered staff had signed for this intervention on an evening shift in March 2018. Registered staff #136 went to administer the medication on an identified date in March 2018, and a signature was missing for the intervention from the previous night. On a specific date in March 2018, it was identified that this resident had gone without the medication for an unknown period of time, therefore resident #023 had not received the medication as prescribed.

PLEASE NOTE: This non compliance was identified during a critical incident system (CIS) inspection, log #005071-18 conducted concurrently during this RQI.

B) According to the home's medication incident documentation system and resident #041's clinical record, they were prescribed a particular medication. During an interview in April 2018, the DOC confirmed that resident #041 did not receive their medication as prescribed on an identified date in March 2018.

C) According to the home's medication incident documentation system and resident #043's clinical record, they were prescribed a particular medication. This medication was scheduled to be administered on an identified date in December 2017. This medication was not administered, as prescribed on the identified date. During an interview in April 2018, the DOC stated that resident #043 had not received the medication as prescribed.

D) According to the home's medication incident documentation system and resident #033's clinical record, they were prescribed a medication to be administered on an identified date in September 2017. On an identified date in October 2017, registered staff #136 discovered that the medication order was not processed and resident #033 continued to receive an old dosage of the medication from a previous order. During an interview in April 2018, the DOC stated that resident #033 had been administered a dosage of medication that had not been prescribed to them between September 2017 and October 2017.

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 failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

In accordance with O. Reg. 79/10 s.114 (3) (a), the licensee was required to ensure that written policies are developed, implemented, evaluated and updated in accordance with evidence- based practices and, if there are none, in accordance with prevailing practices.

Specifically, staff did not comply with the licensee's policy regarding Administration of Medication CN-M-01-1, dated April 2016, which is part of the licensee's Medication Management System that directs registered staff to administer oral medication.
6. Administer oral medication and remain with resident while he/she takes the medication (never leave a drug with a resident).

During an observation in April 2018, resident #040's oral medications were placed in a medicine cup and left in front of the resident on their dining table. Three co-residents were seated at the same dining table. Resident #040 was observed to take their medications unattended approximately six minutes later. Registered staff #115 did not witness resident #040 swallow their medications. Resident #041's medications were also observed to have been placed in a medicine cup and left on the dining table in front of them by registered staff #115. Resident #033's medication were also placed in a medicine cup and left on the dining table in front of them by registered staff #114. Both residents were observed to have swallowed their medication unsupervised while registered staff continued to dispense medications to other residents in the dining room. During an interview in April 2018, the DOC stated that the staff did not comply with the administration of medication policy which is part of the licensee's medication system.

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

According to resident #027's plan of care for an identified date in January 2018, they had a history of demonstrating responsive behaviours towards co-residents. According to critical incident reports on identified dates in March 2018 and April 2018, resident #027 exhibited these responsive behaviours in the form of abuse toward resident #028.

A) The Critical Incident Report 2661-0000013-18, on an identified date, reported that resident #027 had exhibited responsive behaviours in the form of abuse towards resident #028 in the hallway and the incident was observed by resident #030.

During the inspection, resident #030 was interviewed regarding the reported incident. Resident #030 confirmed that they witnessed the incident and stated that resident #027 stopped as soon they saw resident #030 looking at them and that resident #028 did not appear to be in distress. Resident #030 stated that they immediately reported what they saw to an unidentified staff in the home.

During an interview in April 2018, the DOC confirmed that resident #028 was not protected from abuse by resident #027 on an identified date.

B) According to interview with the Administrator in April 2018, an intervention to decrease episodes of responsive behaviours in the form of abuse were initiated for resident #027 in March 2018. During interviews conducted in April 2018, PSW #142, #128, #118, and #134 all described their role with this intervention.

According to Critical Incident Report 2661-0000018-18 and an interview with the DOC in April 2018, resident #027 was exhibiting responsive behaviour in the form of abuse towards resident #028 in the hallway on an identified date. This incident was observed by Personal Support Worker #127.

According to the home's investigation, as reported by the Administrator, the specified intervention to decrease these episodes of responsive behaviours in the form of abuse was not in place during this incident.

During interview in April 2018, PSW #127 reported that on an identified date, they observed resident #027 walking in the hallway and exhibiting responsive behaviours in the form of abuse towards resident #028 who was also in the hallway; resident #027 stopped as soon as PSW #127 yelled from down the hall for them to stop; resident #028 did not appear to be in distress.

During review of the home's investigative notes and interview with the Administrator in April 2018, it was confirmed that the home failed to protect resident #028 from abuse by resident #027 on two identified dates.

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 residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home, to be implemented voluntarily.

WN #4: 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 were stored in an area that was secure and locked.

In April 2018, 42 prescription topical medications were observed not in a secured storage area, located at three nursing stations. During interviews registered staff #136, #141, and #108 and PSWs #103, and #127 reported that the topical medications were stored in this manner for PSW accessibility. During interview with the ADOC it was confirmed that topical medications were not stored in a secured and locked location and that the medications were accessible to residents. [s. 129. (1) (a)]

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 stored in an area that is secure and locked, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

According to the plan of care for resident #035 in April 2018, they required a specific intervention for transferring.

Staff #129 was providing care to resident #035. During this observation, resident #035 was transferred from their bed, to their wheelchair. Resident #035 was also transferred from their wheelchair, to the toilet. Staff #129 did not utilize the specific intervention for transferring resident #035 for either identified transfer.

PSW staff #127, #132, and #134, interviewed in April 2018 acknowledged that at the time of the identified transfers, the specified intervention was not utilized.

During an interview with the DOC in April 2018, it was confirmed that the intervention should have been in place when assisting resident #035 with the identified transfers. Staff #129 did not use safe transferring and positioning techniques when assisting resident #035 with transferring.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #6: 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 when a resident exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A) A clinical record review indicated that resident #016 had two areas of altered skin integrity that were identified in skin assessments eight (8) times in January 2018. The skin assessments were not fully completed and did not include wound staging or measurements of the wounds. One of the areas of altered skin integrity had four (4) additional assessments completed in January and February 2018, however the measurements were omitted from the assessments. During an interview with the ADOC, it was stated that wound staging and measurements should be included in the weekly skin assessments and it was identified that the resident exhibited altered skin. The resident did not have weekly skin assessments completed in their entirety by a member of the registered nursing staff using a clinically appropriate assessment instrument. (682).

B) During this inspection, a review of resident #018's clinical health record took place for a 13 week period of time in 2018. During this time, resident #018 had two areas of altered skin integrity. During the clinical record review, it was noted that both areas of altered skin integrity were resolved in February 2018. During an identified period of time between January and February 2018 , there were no weekly skin assessments completed for these areas of altered skin integrity.

It was also documented in the clinical health record of resident #018 that they had an area of altered skin integrity. During an identified period of time between January and April 2018, weekly skin assessments were not completed a total of six (6) times,

Upon review of the weekly skin assessments for both of these areas of altered skin integrity with staff #113, it was confirmed that weekly skin assessments were not completed for this residents identified areas of altered skin integrity.

An interview was conducted with the DOC and it was further confirmed that weekly skin assessments were not consistently completed for resident #018.

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 when a resident exhibits altered skin integrity, including skin breakdown, pressure ulcers, skin tears, or wounds, has been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

Resident #017 was observed to be sitting in a chair tilted 45 degrees on an identified date in April 2018. The clinical record did not reflect any setting or positioning requirements to include tilting the chair to promote proper positioning for resident #017. During an interview on April 18, 2018, registered staff #105, staff #103 and staff #104 reported that resident #017 was tilted at times in their chair for positioning and comfort.

Registered staff #105 stated that the frequency and degree of tilting was not included in the plan of care and the written plan of care did not set out the planned care for resident #017.

2. The licensee failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

Resident #018 was observed to be sitting in a chair tilted 90 degrees on an identified date in April 2018, another identified date in April 2018. The clinical record did not include tilting the chair for resident #018. During an interview on April 18, 2018, registered staff #108 reported that resident #018 was tilted at times in their chair. Registered staff #108 stated that the frequency and degree of tilting was not included in the plan of care and the written plan of care did not set out the planned care for resident #018.

3. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed, or the care set out in the plan was no longer necessary.

A review of resident #035's plan of care took place in April 2018. According to the plan of care, resident #035 required specific interventions in place for all aspects of toileting and transferring.

In an interview conducted in April 2018 with registered staff #132 it was acknowledged that resident #035 had an improvement in their care needs, and this intervention for toileting and transferring was no longer necessary. It was further acknowledged that this resident was not reassessed when this improvement occurred.

The Administrator, and the DOC stated that resident #035 required a reassessment, and the plan of care for resident was not reviewed and revised when their care needs changed. On an identified date in April 2018, resident #035 was reassessed, and the plan of care was updated to reflect this residents current care needs as it related to toileting and transferring.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee failed to ensure that actions were taken and outcomes evaluated when residents had a weight change of five per cent (5%) of body weight, or more, over one month.

According to health records, resident #016's nutrition and hydration plan of care was changed by the Registered Dietitian (RD) in August 2017, and discontinued an intervention. At the same time, a new intervention was implemented.

Review of health records identified that resident #016 experienced a five (5) percent drop in weight between August and September 2017, and between March and April 2018. A review of the dietary plan of care indicated that the resident was to receive an intervention that was to have started on an identified date in August 2017. A review of the medication administration records and an interview with the ADOC and registered staff #105, indicated that resident #016 had not been receiving the identified intervention.

During interview, the RD stated the identified intervention was to be initiated as per the plan of care starting in August 2017, and could not confirm that this intervention was administered as part of their review of resident #016's weight loss.

The RD stated that the intervention as an action to address resident #016's weight loss had not been provided and had not been evaluated.

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

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Issued on this 12th day of June, 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) :	KELLY CHUCKRY (611), AILEEN GRABA (682), THERESA MCMILLAN (526)
Inspection No. / No de l'inspection :	2018_577611_0009
Log No. / No de registre :	007392-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 4, 2018
Licensee / Titulaire de permis :	Maryban Holdings Ltd. 3700 Billings Court, BURLINGTON, ON, L7N-3N6
LTC Home / Foyer de SLD :	Oakwood Park Lodge 6747 Oakwood Drive, NIAGARA FALLS, ON, L2G-0J3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Stephen Moran

To Maryban Holdings Ltd., you are hereby required to comply with the following order (s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 131(2) of Ontario Regulation 79/10.

Specifically the licensee must:
a) Ensure residents #023, #033, #041, #43 and any other residents, are administered drugs in accordance with the directions for use specified by the prescriber.

Grounds / Motifs :

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

A) A clinical record review indicated that resident #023 was prescribed a medication, and staff were directed to conduct a particular intervention with this medication. According to a critical incident system (CIS) 2661-000011-18 submitted by the home, and clinical records, registered staff had signed for this intervention on an evening shift in March 2018. Registered staff #136 went to administer the medication on an identified date in March 2018, and a signature was missing for the intervention from the previous night. On a specific date in March 2018, it was identified that this resident had gone without the medication for an unknown period of time, therefore resident #023 had not received the medication as prescribed.

PLEASE NOTE: This non compliance was identified during a critical incident system (CIS) inspection, log #005071-18 conducted concurrently during this RQI.

B) According to the home's medication incident documentation system and

resident #041's clinical record, they were prescribed a particular medication. During an interview in April 2018, the DOC confirmed that resident #041 did not receive their medication as prescribed on an identified date in March 2018.

C) According to the home's medication incident documentation system and resident #043's clinical record, they were prescribed a particular medication. This medication was scheduled to be administered on an identified date in December 2017. This medication was not administered, as prescribed on the identified date. During an interview in April 2018, the DOC stated that resident #043 had not received the medication as prescribed.

D) According to the home's medication incident documentation system and resident #033's clinical record, they were prescribed a medication to be administered on an identified date in September 2017. On an identified date in October 2017, registered staff #136 discovered that the medication order was not processed and resident #033 continued to receive an old dosage of the medication from a previous order. During an interview in April 2018, the DOC stated that resident #033 had been administered a dosage of medication that had not been prescribed to them between September 2017 and October 2017.

The severity of this issue was determined to be a level 2 as there was potential for actual harm/risk to the residents. The scope of the issue was a level 3 as it related to four of five residents reviewed. The home had a level 3 compliance history as they had previous non-compliance in a similar area that included:

~ s. 115. (1) written notification (WN) issued January 12, 2018 (2017_558123_0014);
~ s. 135. (1) written notification (WN) issued January 12, 2018 (2017_558123_0014);
~ s. 136. (3) (a) written notification (WN) issued January 12, 2018 (2017_558123_0014);
~ s. 135 (1) written notification (WN) issued May 31,2017 (2017_575214_0006);
~ s. 130. (1) voluntary plan of correction (VPC) issued July 27, 2015 (2015_323130_0007);
~ s. 130. (2) voluntary plan of correction (VPC) issued July 27, 2015 (2015_323130_0007);
~ s. 8 (1) (b) written notification (WN) issued July 27, 2015 (2015_323130_0007). (682)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 15, 2018

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10 s.8(1)

Specifically, the licensee must:

a) Provide training to registered staff #114 and #115 regarding the home's policy on administration of medication. A written record must be kept of this training.

b)The licensee will develop, implement and document a plan for monitoring compliance with the directions contained in the policy for administration of medication particularly,
"6. Administer oral medication and remain with resident while he/she takes the medication (never leave a drug with a resident)."

Grounds / Motifs :

1. The licensee failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

The licensee failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

In accordance with O. Reg. 79/10 s.114 (3) (a), the licensee was required to

ensure that written policies are developed, implemented, evaluated and updated in accordance with evidence- based practices and, if there are none, in accordance with prevailing practices.

Specifically, staff did not comply with the licensee's policy regarding Administration of Medication CN-M-01-1, dated April 2016, which is part of the licensee's Medication Management System that directs registered staff to administer oral medication.
6. Administer oral medication and remain with resident while he/she takes the medication (never leave a drug with a resident).

During an observation in April 2018, resident #040's oral medications were placed in a medicine cup and left in front of the resident on their dining table. Three co-residents were seated at the same dining table. Resident #040 was observed to take their medications unattended approximately six minutes later. Registered staff #115 did not witness resident #040 swallow their medications. Resident #041's medications were also observed to have been placed in a medicine cup and left on the dining table in front of them by registered staff #115. Resident #033's medication were also placed in a medicine cup and left on the dining table in front of them by registered staff #114. Both residents were observed to have swallowed their medication unsupervised while registered staff continued to dispense medications to other residents in the dining room. During an interview in April 2018, the DOC stated that the staff did not comply with the administration of medication policy which is part of the licensee's medication system.

The severity of this issue was determined to be a level 2 as there was potential for actual harm/risk to the residents. The scope of the issue was a level 3 as it related to three out of three residents reviewed. The home had a level 3 compliance history as they had previous non-compliance in a similar area that included:

~ s. 115. (1) written notification (WN) issued January 12, 2018 (2017_558123_0014);
~ s. 135. (1) written notification (WN) issued January 12, 2018 (2017_558123_0014);
~ s. 136. (3) (a) written notification (WN) issued January 12, 2018 (2017_558123_0014);

~ s. 135 (1) written notification (WN) issued May 31,2017 (2017_575214_0006);
~ s. 130. (1) voluntary plan of correction (VPC) issued July 27, 2015 (2015_323130_0007);
~ s. 130. (2) voluntary plan of correction (VPC) issued July 27, 2015 (2015_323130_0007);
~ s. 8 (1) (b) written notification (WN) issued July 27, 2015 (2015_323130_0007). (682)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 29, 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 4th day of June, 2018

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Kelly Chuckry

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