Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 18, 2019	2019_583117_0048	018941-19, 019924-19	Complaint

Licensee/Titulaire de permis

City of Ottawa
Community and Social Services, Long Term Care Branch 200 Island Lodge Road
OTTAWA ON K1N 5M2

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

Peter D. Clark Centre
9 Meridian Place OTTAWA ON K2G 6P8

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

LYNE DUCHESNE (117)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): October 28,29, 30 and 31, 2019 on site at the Long-Term Care Home and on October 21 as well as November 4, 2019 offsite

The following inspections were conducted:
-Log # 018941-19: a critical incident report (CIS # M609-000031-19) related to an incident of alleged abuse and or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident
-Log # 019924-19: a complaint related to medication administration, resident feeding and repositioning as well as the LTC home complaint process.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Program Manager of Resident Care Services (PMRCS), Program Manager of Personal Care Services (PMPCS), several Registered Nurses (RNs), several Registered Practical Nurses (RPNs), several Personal Support Workers (PSWs), an identified resident and a family member.

During the course of the inspection, the inspector reviewed an identified resident's health care record, observed the provision of resident care and services, reviewed electronic medication administration records (eMARs), observed video footage, reviewed a licensee internal investigation and associated correspondence, reviewed the licensee's policy # 305.02 "Safety Rounds", approved July 2017.

The following Inspection Protocols were used during this inspection:
Medication
Nutrition and Hydration
Personal Support Services
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **3 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

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

Specifically failed to comply with the following:

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

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

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 is a written plan of care for each resident that sets out, (a) the planned care for the resident, specific to physical stimulation during the provision of a meal and or snack service.

On a specified day in 2019, in the morning, PSW #121 entered resident #001's room with the resident's breakfast meal on a tray. Video footage showed that PSW #121 started to feed the resident at a specified time. PSW #121 gave some verbal cues to encourage the resident to eat. The resident did take several spoonsful of food and thickened fluids. After seven (7) minutes, the PSW finished providing the resident's meal and left the room. As per the video footage and the resident's daily food and fluid monitoring sheet, the resident consumed 25% of their meal and 50% of the offered fluids.

The resident's plan of care, in place at that time, indicates that the resident needs to be stimulated with verbal cues and to allow the resident sufficient time to eat, to feed slowly and to maintain a quiet unhurried atmosphere.

On October 28, 29 and 30, 2019, PSWs # 101, 104 as well RPN #103 were observed to

provide not only verbal cues but various physical stimulation interventions to encourage the resident to eat their meal service and consume a morning beverage. Further discussion was held with PSWs # 101 and 104, RPN # 103, RN # 110 as well as Program Managers of Resident Care and Personal Care regarding resident #001 feeding assistance interventions during meal and snack services. All indicated that resident #001 needs not only verbal cues but also physical interventions to help stimulate the resident to eat during meal and snack services. They said that physical stimulation such as rubbing the resident's arm, shoulder, cheeks and throat as well as washing the resident's face and hands with warm facecloth does help to stimulate the resident to eat and swallow offered food and fluids. They also indicated that the resident will often have their eyes closed during the meal service however, this does not indicate that the resident will not eat. They also indicated that it can take up to 20-30 minutes to assist the resident with their meal service. All indicated that these physical stimulation interventions have been in use for the past several months by regular unit staff, however these are not identified in the resident's current written plan of care.

The written plan of care for resident #001 did not include the planned care for the resident specific to the use of physical stimulation interventions during meal and snack services. [s. 6. (1) (a)]

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

On a specified day in 2019, during the morning, PSW #121 entered resident #001's room with the resident's breakfast meal on a tray. Video footage showed that PSW #121 started to feed the resident at at a specified time. PSW #121 gave some verbal cues to encourage the resident to eat. The resident did take several spoonsful of food and thickened fluids. After seven (7) minutes, the PSW finished providing the resident's meal and left the room. As per the video footage and the resident's daily food and fluid monitoring sheet, the resident consumed 25% of their meal and 50% of the offered fluids.

The resident's plan of care, in place at that time, indicates that the resident needs to be stimulated with verbal cues and to allow the resident sufficient time to eat, to feed slowly and to maintain a quiet unhurried atmosphere. As per the video, reviewed with the home's Program Manager for Personal Care, PSW #121 did not allow the resident sufficient time to eat when they provided feeding assistance, as per the resident's plan of care, on a specified day in 2019. [s. 6. (7)]

3. The licensee has failed to ensure that the care set out in the plan of care provided to the resident as specified in the plan, specifically regarding the use of bed rails, hourly safety checks and the repositioning of resident #001.

Inspector #117 reviewed video footage of two specified dates in 2019 whereby resident #001 was observed to be provided evening care. PSW # 113 and #114 provided evening care to the resident and positioning them in bed for the night. PSW #114 was observed to lower one bed rail at the start of the provision of care and then to lower the other bed rail at the end of the care. Both PSW #113 and #114 then left the resident room. Both bed rails were in the lowered position. At the start of the night shift, PSWs # 115 and #116 were noted to enter the resident's room and do a night time visual check on the resident. Neither PSW verified the status of the bed rails. Both left the room with the bed rails still in the lowered position.

Inspector #117 reviewed video footage of two specified dates, 9 and 10 days after the above incident, whereby resident #001 was observed to be provided evening care. PSW # 113 and #119 provided evening care to the resident and positioned them in bed for the night. At the start of the care, both bed rails were observed to be in the up/engaged position. The left bed rail was lowered at the start of care by PSW #119. After resident care was completed and the resident settled in bed, PSW #119 then lowered the right bed rail. Both PSWs then left the resident room.

As per the resident #001's plan of care, since a specified date in 2019, full bed rails are to be in the up / engaged position when the resident is in bed.
As such, the resident's care was not provided to the resident as per the plan of care on the for specified dates when PSW staff did not engage the bed rails when the resident was in bed. [s. 6. (7)]

4. Inspector # 117 reviewed video footage for 4 specified consecutive days in 2019 whereby resident #001 was observed to be provided evening and night time care.

On a specified day in 2019, PSWs # 106 and #117 provided evening care to the resident. The resident was positioned in their bed to be lying on their left side. PSW staff repositioned the resident to resident's right side. PSW #112 was noted to do an hourly safety check at a specified time, approximately 50 minutes later.

No hourly safety checks were noted between 2328 hours and 0203 hours when night

staff, RPN # 111 and PSW # 112 came to reposition the resident to the left side.

No hourly safety checks were noted between 0205 hour and 0445 hours, when night staff, RPN # 111 and PSW # 112 came to reposition the resident to the right side.

No hourly safety checks were noted between 0448 hour and 0700 hours.
As per resident #001's plan of care, unit nursing staff are to conduct hourly resident safety checks. As per video footage, nursing staff did not conduct hourly safety checks as per the plan of care.

On two specified dated in 2019, video footage shows that resident #001 was repositioned at 2240 hours, at 0203 hours and 0445 hours. A 3:20 hours and 2:45 hour interval between resident repositioning. As per the resident's plan of care, the resident is to be repositioned every two (2) hours when in bed.

On specified day in 2019, at 2050 hours, PSWs #113 and #119 provided evening care to the resident. The resident was position in their bed to be lying on their left side. At 2331 hours, PSW # 112 entered the resident room, conducted a safety check of the resident and left the resident room. At 0103 hours, PSW #112 entered the resident room, conducted a safety check and left the resident room. At 0207 hours PSW #112 and RPN # 111 entered the resident's room. Both proceeded to reposition the resident to the resident's right side and then leave the room.

As per video footage, resident #001 was not repositioned between 2050 hours and 0207 hours, a 4:20 hour interval between repositioning. It is also noted, as per video footage, that there was no hourly safety check conducted between 2050 hours and 2331 hours on a specified day in 2019.

As such, resident #001 was not provided the care as specified in the plan of care when resident #001 was not repositioned every two (2) hours, nor were hourly safety checks conducted during four specified days in 2019. [s. 6. (7)]

5. The licensee has failed to ensure that the resident reassessed and the plan of care reviewed and revised at least every six months and at any other time when care set out in the plan has not been effective.

Inspector #117 reviewed video footage of a specified date in 2019, whereby resident

#001 was provided evening care in bed, which included washing and dressing change. PSW # 106 and #107 were observed to provide verbal cues and explanations as to the care they were providing to the resident. On two instances, resident #001 verbally expressed pain and discomfort when the resident was being turned during the provision of care. The PSWs provided expressions of comfort to the resident, care continued to be provided and no further action related to the resident's pain and discomfort was taken. A review of the resident's health care record was conducted with RN # 110. The RN reported that registered nursing staff were not informed of the resident's pain and discomfort during the provision of care.

The Administrator and Program Manager for Personal Care were provided with and reviewed the same video footage. Both indicated that the PSW staff should have reported the resident's pain and discomfort to registered staff so that the resident could be assessed, and the care plan related to pain management could be reviewed when the care set out in the plan was not effective.

It is noted that a compliance CO #001 for LTCHA s. 6 (10) c) was issued September 9, 2019, for the same identified concerns under inspection # 2019_617148_0024 with a compliance due date of December 9, 2019. [s. 6. (10) (c)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written plan of care for each resident that sets out, (a) the planned care for the resident (LTCHA s.6 (1) a), to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

s. 131. (3) Subject to subsections (4) and (5), the licensee shall ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse. O. Reg. 79/10, s. 131 (3).

Findings/Faits saillants :

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

On a specified day in 2019, RPN #109 had prepared resident #001's 0800 hours medication. The resident is ordered to receive eight (8) prescribed medications plus a nutritional supplement. This includes a specified medication that is identified as being an administration time sensitive medication. The medications were prepared as per medical orders and mixed into the prescribed nutritional supplement.

Inspector #117 reviewed video footage dated for the specified date. The video does not show any registered nursing staff going into the resident's room to give the resident their morning medication. At 0930 hours, PSW #108 is observed to enter resident #001's room and to provide the resident with their breakfast meal service as well as a glass of the identified nutritional supplement. It is noted that PSW #108 did explain to the resident that they were providing the nutritional supplement when assisting the resident with the consumption of the supplement. Video footage showed that the resident did take all of the nutritional supplement.

During discussions held with RPN #109, the RPN informed inspector #117 that they were late in preparing resident #001's medication. When RPN #109 came to administer the resident their prescribed 0800 hours medication, PSW # 108 was entering the resident room to assist the resident with their morning breakfast meal service. PSW #108 offered to give the nutritional supplement to the resident. RPN #109 gave the supplement to PSW #108. PSW #108 proceeded to give the nutritional supplement to the resident. As per the RPN this was at approximately 0930 hours. RPN #109 said they had forgotten

that the resident's medication had been mixed into the nutritional supplement.

Program Manager for Resident Care (PM RC) was informed of the medication administration incident and conducted an internal investigation. The PM RC confirmed that the medication was administered by PSW #108 later than at the prescribed administration time. The PM RC also indicated that a specified medication should have been administered as prescribed, prior to the resident's breakfast as it is an administration time sensitive medication and has an impact on the resident's ability to eat and on the provision of their morning care routine.

As such, on a specified day in 2019, resident #001's 0800 hour medications were not administered in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

2. The licensee has failed to ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse.

On a specified day in 2019, RPN #109 prepared resident #001's 0800 hours medication. The resident is ordered to receive eight (8) prescribed medications plus a nutritional dietary supplement. These were prepared as per medical orders and mixed into the prescribed nutritional supplement.

RPN #109 came to the give resident #001 their morning medication; PSW # 108 was entering the resident room to assist the resident with their morning breakfast meal service. PSW #108 offered to give the nutritional supplement to the resident. RPN #109 gave the nutritional supplement to PSW #108. PSW #108 proceeded to give the nutritional dietary supplement to the resident.

During discussions held with RPN #109, the RPN informed inspector #117 that they had forgotten that the resident's medication had been mixed into the nutritional supplement. The RPN had not informed PSW #108 that the supplement contained the resident's medication when they gave to PSW #108 the nutritional supplement during the breakfast meal service.

Program Manager for Resident Care (PM RC) was informed of the medication administration incident and conducted an internal investigation. The PM RC confirmed

that the medication was administered by PSW #108.

As such, on a specified day in 2019, resident #001's 0800 hour medication were administered by PSW #108, who is not a physician, a dentist, a registered nurse or a registered practical nurse. [s. 131. (3)]

Additional Required Actions:

CO # - 002, 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 19th day of November, 2019

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

Ministère de la Santé et des Soins de longue durée

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

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LYNE DUCHESNE (117)
Inspection No. / No de l'inspection :	2019_583117_0048
Log No. / No de registre :	018941-19, 019924-19
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Nov 18, 2019
Licensee / Titulaire de permis :	City of Ottawa Community and Social Services, Long Term Care Branch, 200 Island Lodge Road, OTTAWA, ON, K1N-5M2
LTC Home / Foyer de SLD :	Peter D. Clark Centre 9 Meridian Place, OTTAWA, ON, K2G-6P8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Shelley Kuiack

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

To City of Ottawa, 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

Ministère de la Santé et des Soins de longue durée

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

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) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

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

Specifically, the licensee shall ensure that:

• Resident #001 is repositioned every two (2) hours when in bed, as specified in the plan of care.

• That bed rails are in the engaged/ up position when resident #001 is in bed, as specified in the plan of care.

• That hourly safety checks are completed when resident #001 is in bed, as specified in the plan of care.

• Nursing staff who provide direct care to resident #001during the evening and night shift must review the contents of the resident's plan of care at the start of their shift.

• Repositioning, hourly safety checks and application of bed rails for resident #001, when in bed, must be documented immediately following the provision of care and validated as being provided by the registered nursing staff in charge of the resident home area before the end of the evening and night shifts, as specified in the plan of care.

Grounds / Motifs :

1. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

On a specified day in 2019, during the morning, PSW #121 entered resident #001's room with the resident's breakfast meal on a tray. Video footage showed that PSW #121 started to feed the resident at at a specified time. PSW #121 gave some verbal cues to encourage the resident to eat. The resident did take several spoonsful of food and thickened fluids. After seven (7) minutes, the PSW finished providing the resident's meal and left the room. As per the video footage and the resident's daily food and fluid monitoring sheet, the resident consumed 25% of their meal and 50% of the offered fluids.

The resident's plan of care, in place at that time, indicates that the resident needs to be stimulated with verbal cues and to allow the resident sufficient time to eat, to feed slowly and to maintain a quiet unhurried atmosphere. As per the video, reviewed with the home's Program Manager for Personal Care, PSW #121 did not allow the resident sufficient time to eat when they provided feeding assistance, as per the resident's plan of care, on a specified day in 2019 (117)

2. The licensee has failed to ensure that the care set out in the plan of care provided to the resident as specified in the plan, specifically regarding the use of bed rails, hourly safety checks and the repositioning of resident #001.

Inspector #117 reviewed video footage of two specified dates in 2019 whereby resident #001 was observed to be provided evening care. PSW # 113 and #114 provided evening care to the resident and positioning them in bed for the night. PSW #114 was observed to lower one bed rail at the start of the provision of care and then to lower the other bed rail at the end of the care. Both PSW #113 and #114 then left the resident room. Both bed rails were in the lowered position. At the start of the night shift, PSWs # 115 and #116 were noted to enter the resident's room and do a night time visual check on the resident. Neither PSW verified the status of the bed rails. Both left the room with the bed rails still in the lowered position.

Inspector #117 reviewed video footage of two specified dates, 9 and 10 days after the above incident, whereby resident #001 was observed to be provided evening care. PSW # 113 and #119 provided evening care to the resident and positioned them in bed for the night. At the start of the care, both bed rails were observed to be in the up/engaged position. The left bed rail was lowered at the

start of care by PSW #119. After resident care was completed and the resident settled in bed, PSW #119 then lowered the right bed rail. Both PSWs then left the resident room.

As per the resident #001's plan of care, since a specified date in 2019, full bed rails are to be in the up / engaged position when the resident is in bed.

As such, the resident's care was not provided to the resident as per the plan of care on the for specified dates when PSW staff did not engage the bed rails when the resident was in bed.

(117)

3. Inspector # 117 reviewed video footage for 4 specified consecutive days in 2019 whereby resident #001 was observed to be provided evening and night time care.

On a specified day in 2019, PSWs # 106 and #117 provided evening care to the resident. The resident was positioned in their bed to be lying on their left side. PSW staff repositioned the resident to resident's right side. PSW #112 was noted to do an hourly safety check at a specified time, approximately 50 minutes later.

No hourly safety checks were noted between 2328 hours and 0203 hours when night staff, RPN # 111 and PSW # 112 came to reposition the resident to the left side.

No hourly safety checks were noted between 0205 hour and 0445 hours, when night staff, RPN # 111 and PSW # 112 came to reposition the resident to the right side.

No hourly safety checks were noted between 0448 hour and 0700 hours.

As per resident #001's plan of care, unit nursing staff are to conduct hourly resident safety checks. As per video footage, nursing staff did not conduct hourly safety checks as per the plan of care.

On two specified dated in 2019, video footage shows that resident #001 was repositioned at 2240 hours, at 0203 hours and 0445 hours. A 3:20 hours and 2:45 hour interval between resident repositioning. As per the resident's plan of care, the resident is to be repositioned every two (2) hours when in bed.

On specified day in 2019, at 2050 hours, PSWs #113 and #119 provided evening care to the resident. The resident was position in their bed to be lying on their left side. At 2331 hours, PSW # 112 entered the resident room, conducted a safety check of the resident and left the resident room. At 0103 hours, PSW #112 entered the resident room, conducted a safety check and left the resident room. At 0207 hours PSW #112 and RPN # 111 entered the resident's room. Both proceeded to reposition the resident to the resident's right side and then leave the room.

As per video footage, resident #001 was not repositioned between 2050 hours and 0207 hours, a 4:20 hour interval between repositioning. It is also noted, as per video footage, that there was no hourly safety check conducted between 2050 hours and 2331 hours on a specified day in 2019.

As such, resident #001 was not provided the care as specified in the plan of care when resident #001 was not repositioned every two (2) hours, nor were hourly safety checks conducted during four specified days in 2019.

The severity of this issue was determined to be minimal risk. The scope is isolated. The home has a compliance history, with non-compliance being issued to the same subsection.

• LTCHA s.6 (7) was issued as a VPC under inspection # 2019_617148_0024, September 9, 2019
• LTCHA s.6 (7) was issued as a VPC under inspection # 2018_730593_0015, November 18, 2018
• LTCHA s.6 (7) was issued as a CO under inspection # 2018_583117_0002, May 23, 2018
• LTCHA s.6 (7) was issued as a WN under inspection # 2017_708548_0027,

February 5, 2018
• LTCHA s.6 (7) was issued as a VPC under inspection # 2017_617148_0028, November 21, 2017
• LTCHA s.6 (7) was issued as a VPC under inspection # 2017_582548_0015, August 25, 2017
• LTCHA s.6 (7) was issued as a VPC under inspection # 2017_584161_0004, March 28, 2017
• LTCHA s.6 (7) was issued as a VPC under inspection # 2016_582548_0031, March 15, 2017

(117)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 09, 2019

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (3) Subject to subsections (4) and (5), the licensee shall ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse. O. Reg. 79/10, s. 131 (3).

Order / Ordre :

The licensee must be compliant with O. Reg 79/10, s.131 (3).

Specifically, the licensee shall ensure that that no person administers a drug to a resident#001, and any other resident, in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse.

Grounds / Motifs :

1. The licensee has failed to ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse.

On a specified day in 2019, RPN #109 prepared resident #001's 0800 hours medication. The resident is ordered to receive eight (8) prescribed medications plus a nutritional dietary supplement. These were prepared as per medical orders and mixed into the prescribed nutritional supplement.

RPN #109 came to the give resident #001 their morning medication; PSW # 108 was entering the resident room to assist the resident with their morning breakfast meal service. PSW #108 offered to give the nutritional supplement to the resident. RPN #109 gave the nutritional supplement to PSW #108. PSW #108 proceeded to give the nutritional dietary supplement to the resident.

During discussions held with RPN #109, the RPN informed inspector #117 that they had forgotten that the resident's medication had been mixed into the nutritional supplement. The RPN had not informed PSW #108 that the supplement contained the resident's medication when they gave to PSW #108

the nutritional supplement during the breakfast meal service.

Program Manager for Resident Care (PM RC) was informed of the medication administration incident and conducted an internal investigation. The PM RC confirmed that the medication was administered by PSW #108.

As such, on a specified day in 2019, resident #001's 0800 hour medication were administered by PSW #108, who is not a physician, a dentist, a registered nurse or a registered practical nurse.

The severity of this issue was determined to be a risk of harm. Medications are identified as being a key risk indicator. The scope is an isolated incident. The home has a compliance history, with previous non-compliance being issued to the same subsection

• O.Reg. 79/10 s. 131(2) was issued as a VPC under inspection # 2019_617148_0024, September 9, 2019
• O.Reg. 79/10 s. 131(2) was issued as a VPC under inspection # 2018_505103_0020, August 1, 2018
• O.Reg. 79/10 s. 131(2) was issued as a VPC under inspection # 2018_583117_0002, May 23, 2018
• O.Reg. 79/10 s. 131(2) was issued as a VPC under inspection # 2017_617148_0028, November 21, 2017
• O.Reg. 79/10 s. 131(2) was issued as a VPC under inspection # 2017_582548_0015, September 20, 2017
• O.Reg. 79/10 s. 131(2) was issued as a WN under inspection # 2017_584161_0010, June 9, 2017

(117)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Dec 09, 2019

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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 O. Reg 79/10, s.131 (2).

Specifically, the licensee shall ensure that drugs are administered to resident #001, and any other resident, in accordance with the directions for use specified by the prescriber.

Grounds / Motifs :

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

On a specified day in 2019, RPN #109 had prepared resident #001's 0800 hours medication. The resident is ordered to receive eight (8) prescribed medications plus a nutritional supplement. This includes a specified medication that is identified as being an administration time sensitive medication. The medications were prepared as per medical orders and mixed into the prescribed nutritional supplement.

Inspector #117 reviewed video footage dated for the specified date. The video does not show any registered nursing staff going into the resident's room to give the resident their morning medication. At 0930 hours, PSW #108 is observed to enter resident #001's room and to provide the resident with their breakfast meal service as well as a glass of the identified nutritional supplement. It is noted that PSW #108 did explain to the resident that they were providing the nutritional supplement when assisting the resident with the consumption of the supplement. Video footage showed that the resident did take all of the nutritional supplement.

During discussions held with RPN #109, the RPN informed inspector #117 that they were late in preparing resident #001's medication. When RPN #109 came to administer the resident their prescribed 0800 hours medication, PSW # 108 was entering the resident room to assist the resident with their morning breakfast meal service. PSW #108 offered to give the nutritional supplement to the resident. RPN #109 gave the supplement to PSW #108. PSW #108 proceeded to give the nutritional supplement to the resident. As per the RPN this was at approximately 0930 hours. RPN #109 said they had forgotten that the resident's medication had been mixed into the nutritional supplement.

Program Manager for Resident Care (PM RC) was informed of the medication administration incident and conducted an internal investigation. The PM RC confirmed that the medication was administered by PSW #108 later than at the prescribed administration time. The PM RC also indicated that a specified medication should have been administered as prescribed, prior to the resident's breakfast as it is an administration time sensitive medication and has an impact on the resident's ability to eat and on the provision of their morning care routine.

As such, on a specified day in 2019, resident #001's 0800 hour medications were not administered in accordance with the directions for use specified by the prescriber.

The severity of this issue was determined to be a minimal risk of harm. Medications are identified as being a key risk indicator. The scope is an isolated incident. The home has a compliance history, with previous non-compliance being issued to the same subsection

• O.Reg. 79/10 s. 131(2) was issued as a VPC under inspection # 2019_617148_0024, September 9, 2019
• O.Reg. 79/10 s. 131(2) was issued as a VPC under inspection # 2018_505103_0020, August 1, 2018
• O.Reg. 79/10 s. 131(2) was issued as a VPC under inspection # 2018_583117_0002, May 23, 2018

• O.Reg. 79/10 s. 131(2) was issued as a VPC under inspection # 2017_617148_0028, November 21, 2017
• O.Reg. 79/10 s. 131(2) was issued as a VPC under inspection # 2017_582548_0015, September 20, 2017
• O.Reg. 79/10 s. 131(2) was issued as a WN under inspection # 2017_584161_0010, June 9, 2017

(117)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 09, 2019

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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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 18th day of November, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LYNE DUCHESNE

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