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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 25, 2015	2015_298557_0011	T-1726-15	Resident Quality Inspection

Licensee/Titulaire de permis

ATK CARE INC.
1386 INDIAN GROVE MISSISSAUGA ON L5H 2S6

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

RIVER GLEN HAVEN NURSING HOME
160 High Street P.O. Box 368 Sutton West ON L0E 1R0

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

VALERIE PIMENTEL (557), DIANE BROWN (110), VALERIE JOHNSTON (202)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 22, 23, 24, 27, 28, 29, 30, 31, August 4, 5, 6 and 7, 2015.

During the course of the inspection, the inspector(s) spoke with the administrator, director of care (DOC), assistant director of care (ADOC), mds rai-coordinator, registered dietitian (RD), food services manager (FSM), food service worker, recreation director (Rec D), activities director (AD), registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), laundry aide, families, volunteer and residents.

In addition the following was reviewed and or completed a tour of the home, a dining observation, record review of clinical health records, review of relevant home policies and procedures, review of other documents, Resident and Family Council meeting minutes, observations of staff and resident interactions.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Reporting and Complaints
Residents' Council
Responsive Behaviours

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

12 WN(s)
11 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

In July and August 2015, the inspector observed a resident with two half rails up on his/her bed.

Record review for the resident revealed in the kardex under the safety section that the resident uses one or two side rails while in bed and did not identify what type of side rails they were. In the plan of care under risk for falls the plan of care identified the resident was in a low bed and used one or two rails when in bed. The Minimum Data Set (MDS) assessment from June 2015, under Special Treatments and Procedures – Devices and Restraints identified full bed rails on all open sides of bed.

During an interview with an identified staff member when asked to confirm what does one over two mean in reference to side rails, the staff member indicated the resident uses one or two side rails when in bed. When further questioned about the type of rails, he/she indicated they were full rails but then said the resident had half rails on the bed now. The staff member further indicated that before the new low beds were received the residents used full length side rails and confirmed it was confusing and was not sure exactly what one over two meant. An interview with another identified staff member indicated one over two meant one or two half side rails. When questioned about the kardex and the plan of care, he/she confirmed the directions were not clear as to whether it was one or two half rails or full rails as the type of rails were not described. A review of the MDS assessment identified the use of full bed rails on all open sides of bed. The staff member confirmed this is not correct and the directions for the use of side rails were not clear.

An interview with the DOC confirmed the plan of care for the use of the side rails for the resident was not clear. [s. 6. (1) (c)]
[s. 6. (1) (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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
4. Vision. O. Reg. 79/10, s. 26 (3).

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: 4. Vision.

A review of a resident RAI-MDS assessments in November 2014, February 2015 and March 2015, indicated that the resident had impaired vision, sees large print, but not regular print in newspapers.

An interview with the resident indicated that he/she enjoys reading the newspaper daily, however, can only do so by using his/her glasses which he/she keeps in the night stand.

Interviews with identified staff members indicated that the resident has no visual difficulties and when asked if the resident wears glasses, all staff indicated that he/she does not wear glasses. A staff member revealed in an interview that the resident is able to choose between one of two choices at meal times and confirmed that the resident would have no visual limitations. Another staff member indicated in an interview that the resident enjoys reading the newspaper daily and because he/she is able to do so, indicated that the resident must not have any visual limitations.

An interview with an identified staff member indicated that registered staff are to assess residents on their ability to read small print at the time of each resident's scheduled RAI-MDS assessment. He/she further indicated that staff do not always have time to complete full assessments and confirmed the resident’s plan of care did not include an interdisciplinary assessment in respect to the resident's vision. [s. 26. (3) 4.]

2. The licensee has failed to ensure that the registered dietitian who is a member of the staff of the home assesses the resident's nutritional status, including height, weight and any risks related to nutrition care.

An identified resident had a medical condition and a BMI of 20. Record review and staff interviews revealed that the resident has had a slow gradual decrease in his/her weight. The RD assessment in July 2015, identified that the resident's weight was slowly decreasing despite 76-100% intake at all meals. There was no change to the resident's care plan.

An interview with an identified staff member revealed knowledge that the resident's medical condition could be a contributing factor to the resident's weight loss.

An interview with an identified staff member indicated that the medical condition is a risk factor to a resident's nutritional care as the condition results in a higher energy expenditure which could result in a resident losing weight.

Record review of the July 2015, nutrition assessment and interview with a staff member confirmed the resident's medical condition was not assessed in relation to resident's energy needs, intake and slow gradual weight loss and the medical condition could be contributing to resident's weight status and BMI. [s. 26. (4) (a),s. 26. (4) (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 the plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident vision, and to ensure that the registered dietitian who is a member of the staff of the home assesses the resident's nutritional status, including height, weight and any risks related to nutrition care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (1) The pain management program must, at a minimum, provide for the following:
1. Communication and assessment methods for residents who are unable to communicate their pain or who are cognitively impaired. O. Reg. 79/10, s. 52 (1).
2. Strategies to manage pain, including non-pharmacologic interventions, equipment, supplies, devices and assistive aids. O. Reg. 79/10, s. 52 (1).
3. Comfort care measures. O. Reg. 79/10, s. 52 (1).
4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies. O. Reg. 79/10, s. 52 (1).

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the pain management program must, at a minimum, provide for the following:

1.Communication and assessment methods for residents who are unable to communicate their pain or who are cognitively impaired.

A review of the home's Pain Management Policy, RCSM G-60, dated February 24, 2014, did not provide any direction to registered staff to reflect the above mentioned legislative requirements for resident's with pain.

The home's pain management program did not include reference to communication and assessment methods for residents who are unable to communicate their pain or who are cognitively impaired.

Record review identified a resident as cognitively impaired and with pain. The March 2015 quarterly pain assessment was completed using an assessment tool not designed for cognitively impaired residents. The ADOC, who was also the lead for the home's pain committee, confirmed that an incorrect pain assessment tool was used for the resident in March 2015 and that the home's pain management program does not provide direction to staff on which tool to use for cognitive impaired residents.

A record review for two different resident's documented pain and the monitoring by an identified staff member was reviewed with the ADOC. The ADOC identified that the staff are not monitoring residents with pain according to home's expectations. The ADOC confirmed that the pain program does not include specific directions to staff on the procedures related to monitoring of resident's responses to, the effectiveness of, the pain management strategies.

A review of the home's pain program and interview with the ADOC further confirmed the home's program did not include direction to staff on comfort care measures related to pain. [s. 52. (1) 1.]

2. The licensee has failed to ensure that when the resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Record review of an identified resident revealed the resident with a history of ongoing upper body joint pain, managed by regular doses of medication and medication as required.

Resident interview revealed the pain in his/her upper body is worse at night. When questioned about the level of pain in his/her upper body, the resident responded that it could reach a 10 out of 10 when the pain is at its worst. Between the December 2014

and March 2015 quarterly assessments the resident's pain changed from "pain less than daily" to "pain daily".

An interview with an identified staff member confirmed that the resident does complain of pain at night. Record review revealed that the resident received pain medication when required on 32 occasions in the month of January 2015, 34 occasions in February 2015 and 11 occasions in March 2015. An interview with an identified staff member confirmed that a pain assessment is completed for all residents quarterly.

Record review and an interview with the ADOC identified that the resident was not assessed using a clinically appropriate assessment instrument specifically designed for pain at the March 2015 quarterly assessment, when the resident's pain was still not relieved. [s. 52. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the pain management program must, at a minimum, provide for the following:
1. Communication and assessment methods for residents who are unable to communicate their pain or who are cognitively impaired and that when the resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #4: 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 ensure that a response to Residents' Council (RC) concerns or recommendations is provided in writing within 10 days of receiving the advice.

Minutes of the Residents' and Food Council (RC) meetings of February, April, May, June and July 2015, revealed resident food concerns and recommendations with no response. Resident concerns included: lettuce on the sandwiches is often too wet; resident does not like the rustic lentil soup; too much sauce on meats is being served. No responses were noted. A RC concern that sausage casings were tough to chew was noted in the February 2015, minutes with no response and again noted the May 2015 minutes. Recommendations noted in the RC minutes included more pickles added to the menu, more chocolate ice cream to the floors, and more egg salad sandwiches on the evening snack cart. No responses were noted.

An interview with the a member of the Residents' Council, confirmed, that a written response to food concerns and recommendations were not provided and that a response is usually shared at the next meeting. An interview with the RC assistant confirmed that a written response to food concerns were not provided to RC within 10 days. [s. 57. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a response to Residents' Council (RC) concerns or recommendations is provided in writing within 10 days of receiving the advice, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

**s. 72. (2) The food production system must, at a minimum, provide for,
(c) standardized recipes and production sheets for all menus; O. Reg. 79/10, s. 72 (2).**

**s. 72. (2) The food production system must, at a minimum, provide for,
(d) preparation of all menu items according to the planned menu; O. Reg. 79/10, s. 72 (2).**

**s. 72. (2) The food production system must, at a minimum, provide for,
(g) documentation on the production sheet of any menu substitutions. O. Reg. 79/10, s. 72 (2).**

**s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).**

Findings/Faits saillants :

1. The licensee failed to ensure that the food production system must provide for standardized recipes and production sheets for all menus.

In July 2015, a review of the food production system revealed no standardized recipe for pureed turkey. Further review of the home's food production system revealed the presence of food production sheets with the absence of production counts/total portions of food to prepare for all serving areas, diets, textures and menu item choices.

An interview with an identified worker revealed that he/she prepares a different quantity of food than was revealed through an interview with the FSM. The FSM, in an acting position, was unaware that total quantities of food to prepare were not included on the production sheets.

The home's policy "production sheets" #B.5 stated that detailed production sheets including the number of portions of each item required by choice, texture and service area is to be prepared and available for every meal.

An interview with the FSM confirmed the production sheets were not prepared and available with the necessary information to clearly direct staff on the quantities of food to prepare. [s. 72. (2) (c)]

2. The licensee has failed to ensure that all menu items are prepared to the planned menu.

In July 2015, at lunch, the menu items included zucchini ribbon salad and chickpea salad. The menu items were observed at lunch. A review of the corresponding recipes and interviews with an identified staff member revealed that ingredients were omitted and not substituted. The recipe changes affected the appearance, taste, texture and nutritional value of the menu items and were not prepared as planned.

An interview with the FSM confirmed staff are expected to follow recipes and he/she is to be notified of missing ingredients. The FSM confirmed that he/she was not made aware of any missing ingredients and the staff did not prepare all lunch items according to the planned menu. [s. 72. (2) (d)]

3. The licensee failed to ensure that the food production system provided documentation on the production sheet of any menu substitutions.

In July 2015, at lunch, a menu substitution was made to change cranberry loaf to poppy seed muffins. An interview with an identified worker confirmed the substitution was made and noted and another identified worker did not record the change on the "menu substitution sheet" available in the kitchen.

A review of the menu substitution sheets confirmed that there was no documentation of the substitution. An interview with the FSM stated the staff are expected to document menu substitutions on the sheet, and the substitution was not documented and she was unaware a substitution was made. [s. 72. (2) (g)]

4. The licensee has failed to ensure that all food and fluids prepared in the food production system are served using methods which preserve taste, nutritive value, appearance and food quality.

In July 2015, at lunch the pureed turkey appeared translucent and shiny, evidence of commercial thickener overuse. The item was taste tested and lacked the taste of turkey.

An interview with an identified worker who prepared the pureed turkey confirmed that when preparing pureed foods, like the turkey, that he/she would liquefy the solid to a soupy consistency and not scoopable, then add thickener to make it a pudding consistency.

A review of the recipe ingredients revealed no direction for the use of commercial thickener in pureed turkey. An interview with the FSM confirmed it is standard practice for staff to use thickener to prepare food, but stated it is a concern as the nutritional value would be affected.

An interview with the RD further confirmed commercial thickener decreases the nutritional value of the food item and should not be used unless required. The RD and FSM both confirmed the staff did not prepare pureed food using methods that preserve nutritive value. [s. 72. (3) (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 the food production system must provide for standardized recipes and production sheets for all menus, to ensure that all menu items are prepared to the planned menu, to ensure that food production system provides for documentation on the production sheet of any menu substitutions and to ensure that all food and fluids prepared and served using methods which preserve taste, nutritive value, appearance and food quality, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 126. Every licensee of a long-term care home shall ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. O. Reg. 79/10, s. 126.

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs remain in the original labeled container or package provided by the pharmacy service provider until administered to a resident.

In August 2015, the inspector observed two open unlabeled syringes containing an unidentified liquid in the top drawer of the medication cart in an identified home area.

An interview with an identified staff member confirmed these two unlabeled syringes contained an identified injectable medication and they were for an identified resident. The staff member further explained the homes practice in this situation is to pre-fill the syringes with the medication so that they do not waste the remainder of the medication, as you can get four injections out of the one ampoule.

Record review for the identified resident revealed he/she is to receive the identified medication every two hours as necessary.

The DOC confirmed the home's expectation is that the injectable medication would remain in the original labeled container provided by the pharmacy until administered. [s. 126.]

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 remain in the original labeled container or package provided by the pharmacy service provider until administered to a resident, to be implemented voluntarily.

WN #7: 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 drugs are stored in the medication cart that is used exclusively for drugs and drug-related supplies.

In August 2015, the inspector observed in the narcotic drawer of the medication cart on an identified home area, personal items belonging to two different identified resident's, as well as, a zip lock bag containing money and three unidentified rings and a second bag containing another ring.

During an interview with an identified staff member, he/she confirmed there was no place to store valuables so they lock found valuables in the narcotic drawer for safe keeping.

The identified staff member and the DOC confirmed that only drugs and drug related supplies should be stored in the medication cart. [s. 129. (1) (a)]

2. 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.

In August 2015, the inspector observed in an identified home area, in the top drawer of a medication cart two syringes containing an identified injectable medication for an identified resident. The top drawer of the medication cart cannot be double locked. The medication cart does contain a separate narcotic storage area that locks within the

locked cart.

Record review for the identified resident revealed he/she is to receive an injectable medication every two hours as necessary. The identified medication is to be kept in the locked narcotic storage area of the medication cart.

An interview with an identified staff member confirmed that he/she placed the two syringes containing the medication in the top drawer of the medication cart and that the particular drawer could not be double locked, he/she had no explanation as to why he/she did not lock the medication in the narcotic storage area. The DOC confirmed that the resident's medication should have been stored in a separate double locked area within the locked medication cart. [s. 129. (1) (b)]

3. In August 2015, the inspector observed a blister pack containing 31 tablets of a controlled substance for an identified resident sitting in a plastic container in an identified home areas medication room with a note indicating please return to pharmacy. Do not put this in the destruction box, thanks.

Interviews with identified staff members and the DOC confirmed that the medication was a controlled substance and should have been double locked in the medication cart or placed in the narcotic/controlled substance destruction bin. [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 drugs are stored in the medication cart that is used exclusively for drugs and drug-related supplies, 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, and 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 #8: 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 steps are taken to ensure the security of the drug supply, including all areas where drugs are stored shall be kept locked at all times, when not in use.

In July 2015, the inspector observed an identified resident rummaging through the treatment cart which contained prescription creams for residents within an identified home area. The resident removed a prescription cream and was holding onto it. The AD removed the prescription cream from the resident and placed it back in the drawer of the treatment cart and informed a staff member that the treatment cart was not locked and the resident had removed the prescription cream from the drawer. The staff member did not have the keys for the treatment cart and had to page an identified staff member to return to the floor from his/her break with the keys in order to lock the treatment cart.

In July 2015, the inspector observed the medication cart unlocked outside of the nursing station, in an identified home area. A staff member was present sitting at the computer in the nursing station not observing the medication cart. Another staff member was involved in a team meeting down the hall and could not see the medication cart. The inspector was able to open the medication cart, as the lock was not engaged. The inspector called to the identified staff member three times from where the medication cart was stationed and there was no response. The inspector went to the entrance of the nursing station

and said excuse me to the identified staff member before he/she acknowledged the inspector's presence. The RN then came to lock the medication cart.

The other identified staff member returned to the medication cart and confirmed he/she could not see the medication cart from where he/she was and that the cart had not been locked.

The identified staff members and the DOC confirmed the treatment cart and medication cart containing prescription medications should be kept locked at all times when not in use. [s. 130. 1.]

2. In July 2015, the inspector observed an identified staff member place prescription creams for two identified residents on the counter in the nursing station. The staff member then said, I'm going to put the coffee on and left. The nursing station was not secure as the lock on the half door to this area was taped over so that the lock would not engage, therefore, it did not keep the residents out of the nursing station. Five minutes later an identified resident entered into the nursing station and was rummaging around the desk. A staff member returned to the home area. The inspector brought to the attention of the identified staff member that the prescription creams were left on the counter unattended. The staff member confirmed the medicated creams should not be left on the counter.

An interview with the identified staff member and the DOC confirmed prescription creams are to be locked in the medication room or treatment cart when not in use and should not be left unsupervised anywhere. [s. 130. 1.]

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 steps are taken to ensure the security of the drug supply, including all areas where drugs are stored shall be kept locked at all times, when not in use, to be implemented voluntarily.

WN #9: 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 has failed to ensure that drugs are administered to the residents in accordance with the directions for use specified by the prescriber.

Record review for an identified resident revealed the following: the resident upon admission was ordered an analgesic at specific administration times during the day.

In September 2014, the resident's analgesic order was changed to a stronger dose and to be administered at different times than the original order. The identified administration times were confirmed by an identified staff member and the DOC.

The electronic medication administration records (EMAR) were reviewed from September 2014 to June 2015 and the resident continued to receive his/her analgesic at the original prescribed times and not at the new prescribed times as ordered by the physician.

An interview with an identified staff member and the DOC confirmed the resident did not receive his/her analgesic in accordance with the directions of the prescriber. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are administered to the resident in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 133. Drug record (ordering and receiving)
Every licensee of a long-term care home shall ensure that a drug record is established, maintained and kept in the home for at least two years, in which is recorded the following information, in respect of every drug that is ordered and received in the home:
1. The date the drug is ordered.
2. The signature of the person placing the order.
3. The name, strength and quantity of the drug.
4. The name of the place from which the drug is ordered.
5. The name of the resident for whom the drug is prescribed, where applicable.
6. The prescription number, where applicable.
7. The date the drug is received in the home.
8. The signature of the person acknowledging receipt of the drug on behalf of the home.
9. Where applicable, the information required under subsection 136 (4). O. Reg. 79/10, s. 133.

Findings/Faits saillants :

1. The licensee has failed to ensure that a drug record is established, maintained and kept in the home for at least two years, in which is recorded the following information, in respect of every drug that is ordered and received in the home:
The date the drug is ordered.
The signature of the person placing the order.
The date the drug is received in the home, and

The signature of the person acknowledging receipt of the drug on behalf of the home.

Record review of the Drug Record Book located in an identified home areas medication room revealed the following:

1 – On an identified page in the drug record book revealed that two different identified resident had a re-order's for a medications and the following information was missing from both re-orders: the date the drug was ordered, name of the person placing the order, the date the drug was received in the home and the signature of the person receiving the drug.

An identified resident had a new prescription ordered for a controlled substance and the following information was missing: the date this was ordered and the signature of the person placing the order. The nurse who received this order documented the required information.

2 - On a second identified page, another identified resident was ordered an analgesic when necessary, as well as, a routine analgesic to be given twice daily. A second identified resident had an order for injectable medication and a sublingual medication, the following information was missing: the date the medication was ordered and/or signature identifying that the drugs were received.

3- On a third identified page another resident had an order for injectable medication, as well as, an oral analgesic, the following information was missing: the date the medication was ordered and the signature of the person placing the order.

4 – On a fourth identified page another resident was ordered an analgesic, the following information was missing, the date and signature of nurse placing the order for the medication recorded.

Interview with an identified staff member and the DOC confirmed that the when the registered staff are ordering and receiving drugs they did not always document who placed or received the order and the date the drug was ordered or received. [s. 133.]

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 ensure that a drug record is established, maintained and kept in the home for at least two years, in which is recorded the following information, in respect of every drug that is ordered and received in the home:
1. The date the drug is ordered.
2. The signature of the person placing the order.
3. The name, strength and quantity of the drug.
4. The name of the place from which the drug is ordered.
5. The name of the resident for whom the drug is prescribed, where applicable.
6. The prescription number, where applicable.
7. The date the drug is received in the home.
8. The signature of the person acknowledging receipt of the drug on behalf of the home, to be implemented voluntarily.

WN #11: 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 when a resident is taking any drug that there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

The inspector observed in August 2015, the administration of an analgesic to an identified resident who complained of pain by an identified staff member.

Record review of the resident's EMAR revealed the identified staff member had not documented the resident's response to the effectiveness of the medication for pain control.

An interview with the DOC confirmed that there was no monitoring or documentation completed as to the resident's response and effectiveness of the medication. [s. 134. (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 when a resident is taking any drug that there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

1. The complainant shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.

During stage 1 interviews, an identified resident indicated his/her wallet and sixty dollars went missing about two months ago and reported the concern to staff at the time, however, there had been no response or wallet and money found. Interviews with identified staff members revealed that they had heard that the resident's wallet and money went missing about two to three months ago and indicated that the wallet and money was still missing. Both staff further stated that there is no specific process to follow when a resident or family reports a concern or missing item. Staff indicated that the concern is reported to the staff member working at the time and both laundry and management were notified. Staff were unaware as to whether a response is made to the resident or person who made the concern.

A review of the resident's progress notes indicated that in April 2015, a laundry aide brought the resident's wallet up to the identified home area as it had been retrieved from the dryer. The walled contained fifty five dollars, bank card, health card, birth certificate and an old age security card. The notes further indicated that the wallet would be placed in the medication cupboard on the identified home area.

In July 2015, an interview with an identified staff member indicated that when a resident reports an item missing, staff are to put a communication note on point click care, for all to see. When asked if the resident had reported a missing wallet and money, the staff member indicated that he/she had not heard of any missing wallet or money reported by the resident. When asked if the resident's wallet and money were in the medication room, the staff member indicated that it would not be there, however, searched the room. The staff member was able to find a black wallet and money in a bin in the medication room and confirmed that the wallet and money belonged to the identified resident. The staff memmber indicated that he/she was unaware that the resident's wallet and money were in the medication room and proceeded to the resident's room to notify him/her of the find.

The identified staff member indicated the resident's wallet and money should not have been left in the medication room for the past three months and the wallet and money should have been taken to the business office. He/she further confirmed no knowledge of procedures to follow in the home for dealing with verbal or written complaints.

A review of the home’s Client Service Response Form policy, dated January 15, 2009, states that a client response form is to be completed by any person receiving a complaint or concern, with no direction to staff as to when to respond to a received concern.

An interview with the DOC indicated that staff/families/residents are to fill out a concern form when an item goes missing or if they have a concern. The DOC further revealed that the concern is to be investigated and although the response time had not been included in the home’s above mentioned policy as in accordance to the legislative requirement, a response is made to be made to the complainant. The DOC further indicated that a response form had not been completed for the resident’s missing wallet and money, and confirmed that a response had not been provided to the resident. [s. 101. (1) 1.]

Issued on this 2nd day of December, 2015

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

Original report signed by the inspector.