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 # / Registre no	Type of Inspection / Genre d'inspection
Jul 6, 2017	2017_532590_0010	009045-17	Resident Quality Inspection

Licensee/Titulaire de permis

SHARON FARMS & ENTERPRISES LIMITED
1340 HURON STREET LONDON ON N5V 3R3

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

SAUGEEN VALLEY NURSING CENTER
465 DUBLIN STREET MOUNT FOREST ON N0G 2L3

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

ALICIA MARLATT (590), DONNA TIERNEY (569), NEIL KIKUTA (658), SHARON PERRY (155)

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): May 15, 16, 17, 18, 19, 23, 24, 25, 26, 29 and 30, 2017.

The following Critical Incidents were inspected concurrently:
LSAO Log #002906-17/CIS #1002-000002-17 was related to falls prevention.
LSAO Log #004980-17/CIS #1002-000005-17 was related to infection prevention and control.
LSAO Log #003646-17/CIS #1002-000004-17 was related to prevention of abuse and neglect.
LSAO Log #026945-16/CIS #1002-000009-16 was related to responsive behaviours.

The following complaints were inspected concurrently:
LSAO Log #022180-16/IL-45737-LO was related to continence care and responsive behaviours.
LSAO Log #028167-16/IL-46822-LO was related to continence care and responsive behaviours.

Follow up to compliance orders left during a Resident Quality Inspection, inspection #2016_258519_0008, on October 4, 2016.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), the Director of Dietary and Facility Services, the Director of Recreation, a Recreation Aide, a Physiotherapy Assistant, a Housekeeper, an Occupational Therapist, five Registered Nurses (RN), six Registered Practical Nurses (RPN), 15 Personal Support Services (PSW), a representative of the Family Council, a representative of the Resident`s Council, four Family members and 40+ Residents.

During the course of the inspection, the inspector(s) reviewed the Family Council meeting minutes, the Resident`s Council meeting minutes, relevant policies and procedures, Critical Incident reports and Infoline reports.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
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.
- **9 WN(s)**
- **5 VPC(s)**
- **0 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
O.Reg 79/10 s. 130.	CO #006	2016_258519_0008	658
O.Reg 79/10 s. 134.	CO #007	2016_258519_0008	658
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #002	2016_258519_0008	590
O.Reg 79/10 s. 51. (2)	CO #004	2016_258519_0008	569
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2016_258519_0008	569
O.Reg 79/10 s. 71. (3)	CO #005	2016_258519_0008	590
O.Reg 79/10 s. 8. (1)	CO #003	2016_258519_0008	590

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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan, policy, protocol, procedure, strategy or system, is complied with.

Ontario Regulation 79/10 s. 48(1) states that the licensee shall ensure that a falls prevention and management program to reduce the incidence of falls and the risk of injury is developed and implemented.

The licensee reported to the Director through Critical Incident (CI) #1001-000002-17 that an identified resident suffered a fall that resulted in an injury.

The home's policy "Fall Prevention and Management" NUM-B-820, said that a head injury routine assessment was to be initiated if the fall was not witnessed.

Review of Point Click Care (PCC) clinical record for a four and a half month time period, showed that the resident had nine falls. Of the nine falls, there were three falls that were unwitnessed falls. No head injury routine was found for these falls on the resident's hard copy clinical chart.

An interview was conducted with a RPN. They said that all unwitnessed falls require a head injury routine to be completed in hard copy format and filed in the resident's chart. The RPN reviewed the identified unwitnessed falls and acknowledged that a head injury routine was not completed for those falls and should have been.

During an interview with the ADOC, they said that every unwitnessed fall required a head injury routine to be completed as per policy and that they were not completed for this resident's falls on three occasions.

The licensee failed to ensure that the home's Fall Prevention and Management policy related to head injury routine completion for the three identified unwitnessed falls for an identified resident was complied with.

The severity was determined to be a level two as there was minimal harm or potential for harm. The scope of this issue was identified as a pattern throughout the inspection. The home has a history of unrelated non-compliance. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

The licensee reported to the Director through the CI System #1001-000002-17 that an identified resident suffered a fall that resulted in an injury. Review of the resident's clinical record on PCC for a four and a half month time period, showed that this resident had nine falls.

Review of this resident's progress notes documented that the resident sustained an unwitnessed fall. No post-fall assessment was found related to that fall.

In an interview with a RPN, they said that the resident had a fall on a specified date, but did not have a post falls assessment completed for that fall.

The home's policy "Fall Prevention and Management" NUM-B-820, says that registered

staff will complete a post-fall assessment that includes the level of consciousness, evidence of seizure activity, vital signs, assessment of injury, shock, hemorrhage, and pain.

During an interview with the ADOC, they said that every fall required a post-falls assessment and that one was not completed for this resident's fall on the specified date.

The licensee failed to ensure that a post-fall assessment was completed as directed the homes policy for this resident fall on a specified date. [s. 49. (2)]

2. The licensee has failed to ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

CI #1002-000009-16 was related to an identified resident who was outside when they had fallen and injured themselves.

Review of the assessments tab on PCC showed there was no post fall assessment for the fall on the specified date.

The home's policy "Fall Prevention and Management" NUM-B-820, says that registered staff will complete a post-fall assessment that includes the level of consciousness, evidence of seizure activity, vital signs, assessment of injury, shock, hemorrhage, and pain.

During an interview with ADOC, they said that every fall required a post-fall assessment and that one was not completed for this resident's fall on the identified date.

The licensee failed to ensure that a post-fall assessment was completed as directed by the homes policy after this resident suffered a fall that resulted in an injury.

The severity was determined to be a level two as there was minimal harm or potential for harm. The scope of this issue was identified as a pattern throughout the inspection. The home has a history of unrelated non-compliance. [s. 49. (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 when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the documentation included all assessment, reassessment and monitoring, including the resident's response.

An identified resident was observed utilizing a positioning device during the inspection.

In an interview with a RPN, they shared that this resident used the device as a Personal Assistance Services Device (PASD) for positioning purposes. They shared that all PASD's are to be monitored by a registered staff member at least every shift and the monitoring should be documented on the electronic Medication Administration Record (eMAR). The RPN and Inspector #590 reviewed this resident's eMAR together and found that registered staff had not been documenting safety checks every shift for the use of the PASD.

The home's policy titled "Personal Assistance Service Devices (PASDs)", policy number NUM-B-1461 with an effective date of February 2015, stated that registered staff will:

"1. Review the use of the PASD each shift to ensure that it is being used as outlined on the Care Plan.
2. Monitor the use of the PASD regularly, according to the review dates and goals on the Care Plan. Evaluate if the Care Plan goals are being worked on and if they have been achieved. Update the Care Plan as required.
3. All staff will monitor resident satisfaction (i.e. emotional, cognitive, and physical responses) regularly."

In an interview with the Administrator, they shared that it was the home's expectation that all PASD's were monitored by a registered staff member each shift and that their safety checks were documented.

The licensee failed to ensure that safety checks every shift for PASD's were completed and documented.

The severity was determined to be a level two as there was minimum harm or potential for harm. The scope was identified to be a pattern throughout the inspection. The home has a history of unrelated non-compliance. [s. 110. (7) 6.]

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 documentation includes all assessments, reassessments and monitoring, including the resident's responses, to be implemented voluntarily.

WN #4: 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 remained 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.

On a specific date, Inspector #658 was completing the initial tour of the home when they observed a RPN administering medications during a medication pass. Inspector #658 observed the RPN crushing medications, pouring the medications into medication cups, and then placing them back into the medication cart. When approached, the RPN explained that sometimes the resident is taken down in the elevator for meals before they can administer the medications, and the registered staff has to put the medication back into the resident's container on the medication cart.

Inspector #658 asked the RPN to open up the medication cart, and the inspector observed several resident containers with medications located in clear medication cups, outside of their original labelled package provided by the pharmacy service provider. Inspector #658 identified two residents who had their medications already crushed and poured into clear medication cups. The RPN stated that they do not normally pre-crush the medications.

Inspector #658 had the DOC complete an observation of this RPN's medication cart. When the medication cart was opened, Inspector #658 and the DOC counted six resident containers with medications poured into clear medication cups outside of their original labelled container or package provided by the pharmacy service provider. This count did not include the two residents with crushed medications as they were already administered to the residents.

The DOC stated that medications were supposed to be in their original labelled package, and not sitting in medication cups.

The licensee failed to ensure that medications were kept in their original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed.

The severity was determined to be a level two as there was minimal harm or potential for harm. The scope was identified as an isolated incident. The home has a history of unrelated non-compliance. [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 labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

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

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident, the resident's substitute decision maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

Record review of three medication incident reports with dates ranging over a three week period, showed that the registered staff who discovered the incidents all notified the DOC. All three incident reports did not indicate that the physician or family was notified, as these sections were left blank with no documentation.

Record review of a chart titled "Saugeen Valley Nursing Center Medication Error Tracking" showed that:

- In a specific month, the home had 14 medication errors. The tracking sheet showed the Power of Attorney (POA) was informed in two of the 14 incidents, and the physician was informed in three of the 14 incidents.
- In a specific month, the home had seven medication errors. The tracking sheet showed the POA was informed in one of the seven incidents, and the physician or nurse practitioner was informed in two of the seven incidents.
- In a specific month, the home had three medication errors. The tracking sheet showed that the POA's and physician were not informed of any of the three incidents.

A RPN explained that they were not directed to notify family or the physician, but would notify them if it was a "very bad" incident that led to hospitalization. The RPN said that they would not notify the family or physician of any "minor incidents."

The Administrator explained that it was the responsibility of the staff member who discovered the incident to notify the POA, resident, physician, and pharmacy. The Administrator acknowledged that the physician and POA's were not documented as notified on the three examples of medication incident reports reviewed during the inspection.

The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident, the resident's substitute decision maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. [s. 135. (1)]

2. The licensee has failed to ensure that corrective action was taken as necessary for all medication incidents and adverse drug reactions.

A medication incident report on a specified date, stated that a registered staff member had discovered an extra controlled substance medication in the resident's medication

card. The registered staff member stated that it was "unknown when the missed dose happened," and then notified the DOC the same day. The DOC did not document in the "manager's response" box, and wrote in the "action taken to prevent reoccurrence" box for "staff to ensure the 8 rights are followed." The report did not capture which staff member was involved or who would have to ensure the eight rights were followed.

A medication incident report on a specified date, stated that a registered staff member had identified a medication error. The DOC documented in the "manager's response" box the reason for the medication error, but did not document in the "action taken to prevent reoccurrence" box, and there was no documentation as to what corrective action was taken in response to the medication incident.

The Administrator stated that the DOC was required to follow up with the residents and staff of each medication incident report, and to document any corrective action. The Administrator acknowledged that the two medication incident reports did not capture any documentation as to what the DOC did to address the medication incidents.

The licensee has failed to ensure that corrective action was taken as necessary for all medication incidents and adverse drug reactions. [s. 135. (2)]

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

Record review of the home's most recent Professional Advisory Committee (PAC) meeting notes, showed that the home reviewed medication errors that occurred in a three month time period. PAC notes documented that there were 22 medication errors in the identified time period. Documentation for these errors grouped liked errors together; administration errors, documentation errors, transcription errors, prescribing errors, and pharmacy errors.

PAC notes documented what had happened in each respective error group, but no strategies were identified to reduce and prevent medication incidents and adverse drug reactions. The Administrator acknowledged that improvements and corrections were not documented in the PAC report.

The licensee has failed to ensure that a quarterly review was undertaken of all

medication incidents and adverse drug reactions that had occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions.

The severity was determined to be a level two as there was minimal harm or potential for harm. The scope of this issue was identified as widespread throughout this inspection. The home has a history of unrelated non-compliance. [s. 135. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every medication incident involving a resident and every adverse drug reaction is reported to the resident, the resident's substitute decision maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider; to ensure that corrective action is taken as necessary for all medication incidents and adverse drug reactions; to ensure that a quarterly review is undertaken of all medication incidents and adverse drug reactions that had occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure a written complaint concerning the care of a resident or the operation of the long-term care home was immediately forwarded to the Director.

A family member had shared that they were not satisfied with how the home managed their concerns.

During review of this specific complaint, it was observed that the home had received a written complaint letter in the form of an email on a specific date, and that a written response was provided via email by the home two days later.

Review of the home's policy titled Concern/Complaint Procedure, policy number ADM-C-4 dated December 28, 2012, states that:

The Administrator will: Advise the MOHLTC Centralized Intake, Assessment and Triage Team verbally or by email of any written or serious verbal complaint that is NOT an incident of abuse or neglect. In the case of abuse or neglect follow the CI reporting procedure for mandatory reporting.

In an interview with the Administrator, they shared that they thought they had sent the complaint letter to the Ministry of Health and Long Term Care (MOHLTC) at the time of the complaint, but when they reviewed their emails, shared that they could not locate an email sent to the MOHLTC forwarding the complaint letter to the Director.

The licensee has failed to ensure a written complaint concerning the care of a resident or the operation of the long-term care home was immediately forwarded to the Director.

The severity was determined to be a level one as there was minimal risk for harm. The scope of this issue was isolated. The home has a history of unrelated non-compliance. [s. 22. (1)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a PASD described in subsection (1) that is used to assist a resident with a routine activity of living included in the residents' plan of care.

An identified resident was observed during the inspection, to be utilizing a positioning device.

Review of this resident's clinical record showed that the use of the positioning device was not included in the plan of care. There were no documented directions found as to when to apply the device or why the resident used the device.

Review of the home's policy titled "Personal Assistance Service Devices (PASD's)", policy number NUM-B-1461 with an effective date of February 2015, was completed and it stated that:

"7. A PASD focus on the Care Plan has been created outlining the following;
i. Goals for use of PASD and specific instructions for use (i.e. how, when, and why the device will be used),
ii. Frequency and duration of PASD use,
iii. Date of discontinuation of PASD, or date of next review.
iv. Observation schedule for safety checks/positioning"

In an interview with a RPN, they shared that this resident used the device as a PASD for positioning purposes. They shared that all PASD's are to be included in the residents plan of care and that this resident's PASD was not included in their care plan. They shared that the purpose of the PASD and the directions for when to use the PASD should be included in the plan of care to communicate with staff the care needs of the resident.

In an interview with the Administrator they shared that it was the home's expectation that all PASD's were included in the resident's plan of care.

The licensee has failed to ensure that a PASD described in subsection (1) that is used to assist a resident with a routine activity of living included was in the residents' plan of care.

The severity was determined to be a level two as there was minimal harm or potential for harm. The scope of this issue was isolated. The home has a history of unrelated non-compliance. [s. 33. (3)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was immediately informed, in as much detail as was possible in the circumstances of an outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.

CI System report #1002-000005-17 was first submitted to the MOHLTC on February 27, 2017. The report stated that Public Health had declared an enteric outbreak in the home on February 21, 2017, and the predominant symptoms were nausea, vomiting, and diarrhea. The report showed that the Director was notified six days later.

A review of the enteric outbreak line listing #2266-2017-054 showed that Public Health was first notified on February 20, 2017, and symptoms were documented on February 21, 2017. The line listing forms were completed to track case identification, symptoms, lab tests and results, and the outcome for the resident.

On May 24, 2017, Administrator #116 acknowledged that the enteric outbreak was reported late to the Director, and that they expected outbreaks to be reported immediately.

The licensee has failed to ensure that the Director was immediately informed, in as much detail as was possible in the circumstances of an outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.

The severity was determined to be a level one as there was minimal risk for harm. The scope of this issue was isolated. The home has a history of this legislation being issued in the home on July 5, 2016, as a Voluntary Plan of Correction (VPC) in a Resident Quality Inspection #2016_258519_0008. [s. 107. (1) 5.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 117. Medical directives and orders — drugs
Every licensee of a long-term care home shall ensure that,
(a) all medical directives or orders for the administration of a drug to a resident are reviewed at any time when the resident's condition is assessed or reassessed in developing or revising the resident's plan of care as required under section 6 of the Act; and
(b) no medical directive or order for the administration of a drug to a resident is used unless it is individualized to the resident's condition and needs. O. Reg. 79/10, s. 117.

Findings/Faits saillants :

1. The licensee has failed to ensure that all medical directives or orders for the administration of a drug to a resident are reviewed at any time when the resident's condition is assessed or reassessed in developing or revising the resident's plan of care as required under section 6 of the Act.

A complaint was received by the MOHLTC about the amount of time taken to process a physician's order in the home.

An identified resident had an appointment with a consulting specialist on a specific date, and returned to the home the same day with a prescription from the consulting physician.

The prescription had a specific date, and ordered the following: To taper down the dose of a specific medication the resident was already receiving and to start a new medication.

Review of this resident's eMAR for the the identified month, showed that the first day the new dosage of the medication was administered and the initiation of the new medication was five days after the resident's appointment.

Record review showed a document titled Physician's Fax Order Sheet with a specific date. This sheet was faxed to the attending physician the day after the resident's appointment from the nursing staff, with the new orders and a response was sent to the

home three days later, from the homes physician, approving the consulting physician's orders.

Review of the homes policy titled Ordering and Receiving Medications, policy number 4-5, stated "For residents returning to the home with prescriptions from other physicians or specialists: the registered nursing staff need to verify the order with the facility doctor and either transcribe it onto the Physician's Order Form, or attach the prescription from the outside doctor onto the Physician's Order Form and have the facility doctor sign below the prescription when he is in the facility for the next visit." The policy further stated that "For all New Physician's Orders, the change will always start from the following day, unless otherwise noted on the order."

In an interview with a RPN, they shared that the home's attending physician has to approve all orders before the staff can implement them. They shared that they would fax the attending physician the new orders and the physician would fax them back with a response. The RPN further shared that if a fax is sent to the attending physician on a Friday, they would normally not receive a response from the physician until the next Monday.They shared that if the order was related to changes of a high risk medication, like the identified medication, they would have called the physician's office for orders that day to have to the order processed in a more timely manner.

In an interview with the DOC, they shared that the home's process regarding medication orders, was that the home's physician has to approve all orders written from outside physician's. They shared that the process can take some time. Staff were to fax the physician the orders and wait for a response before implementing the orders. They further shared that if a fax was sent to the attending physician on a Friday, it was normal that the home would not receive a response until the following Monday.

In an interview with the Administrator, they also shared the same process, that the homes physician has to approve all other physician's orders before being implemented. The Administrator denied concerns with the length of time it took to process the medication order.

The licensee has failed to ensure that all medical directives or orders for the administration of a drug to a resident are reviewed at any time when the resident's condition is assessed or reassessed in developing or revising the resident's plan of care as required under section 6 of the Act.

The severity was determined to be a level two as there was minimal harm or potential for harm. The scope was identified as isolated. The home has a history of unrelated non-compliance. [s. 117. (a)]

Issued on this 6th day of July, 2017

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

Original report signed by the inspector.