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
Apr 5, 2017	2017_644507_0002	016393-16, 016644-16, 017221-16, 018651-16, 020398-16, 022033-16, 027087-16, 029051-16, 032216-16, 033612-16, 035173-16, 002392-17	Critical Incident System

Licensee/Titulaire de permis

City of Toronto
55 JOHN STREET METRO HALL, 11th FLOOR TORONTO ON M5V 3C6

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

SEVEN OAKS
9 NEILSON ROAD SCARBOROUGH ON M1E 5E1

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

STELLA NG (507), ADAM DICKEY (643), SIMAR KAUR (654)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): February 8 - 10, 13 - 17, 21 - 24, 27 - 28 and March 1, 2017.

The following critical incident reports were inspected during this inspection:

#017221-16, #018651-16, #020398-16, #032216-16 and #033612-16, related to alleged staff to resident abuse,
#016393-16, #016644-16, #022033-16, #027087-16, #035173-16 and #002392-17 related to resident to resident abuse, and
#029051-16 related to Medication Management.

During the course of the inspection, the inspector(s) spoke with the Assistant Administrator (AA), Home Physician (HP), Director of Nursing (DON), Nurse Managers (NMs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Care Assistants (PCAs), Food Service Manager (FSM), Food Service Workers (FSWs), Building Services Manager, Heavy Duty Cleaner, Pharmacy Manager (PM), residents, substitute decision makers (SDMs) and family members of residents.

The inspectors conducted observations of staff and resident interactions, provision of care, dining and snack services, record review of resident and home records, staffing schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Snack Observation

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

8 WN(s)
6 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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

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 has failed to ensure that staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

a) Record review of a critical incident system report (CIR) revealed an incident of suspected resident to resident abuse had been observed by staff on an identified date.

Record review of resident #002's most recent plan of care on an identified date, revealed a focus for responsive behaviour was last updated 18 days prior. A goal of the behaviour problems focus was to stop resident #002 from exhibiting responsive behaviour. Interventions included counseling at an identified interval, health teaching by Behavioural Support Ontario (BSO) staff, and explaining and exploring the effects of his/her behaviour on co-residents and staff.

In interviews Personal Care Assistants (PCAs) #101, #102, #103 and #104 stated that the direct care staff have access to individual resident's plan of care in the personal care record (PCR) binders on each unit. PCA #102 further stated that direct care staff are updated on changes to resident care needs and behaviours during shift report.

In an interview, RPN #100 stated that the most current plan of care should be printed

when changes are made and placed into the PCR binder for direct care staff to access the information. When questioned if the most recent plan of care updates had been placed into the PCR for resident #002's use of as needed medication, RPN #100 stated they had not.

Record review of resident #002's plan of care located on an identified unit PCR binder revealed a focus for responsive behaviour was last updated six months prior. No problems of specific behaviour focus for resident #002 was located in the PCR binder.

b) Record review of another CIR revealed an incident of resident to resident abuse on an identified date. Resident #008 pushed resident #009.

Record review of PCR binder for resident #008 revealed a focus for behavioural problems which was last updated on an identified date. Interventions for the resident's responsive behaiours included BSO monitoring, intense monitoring, administration of medications and meals in alternate setting.

Record review of resident #008's current plan of care on an identified date, revealed a focus of behaviour problems that the resident had been transferred to another unit, discharged from intense monitoring and was discharged from the BSO program as his/her behaviour was managed by medication.

In an interview with RN #120, he/she stated that direct care staff were expected to refer to the PCR binder to review individual resident care plans. RN #120 further stated it was the expectation of the home to have the most current plan of care in the PCR binder for direct care staff to access, but this may not always get done at the time when care plans are updated.

In an interview the Director of Nurse (DON) stated that it was the expectation of the home for the most current plan of care to be printed and placed in the PCR on the units for each resident. The DON further stated it is the responsibility of the staff member who updates the plan of care to print the updated plan and put it in the PCR binder. In these cases the licensee had failed to ensure that staff and others who provide direct care to a resident were kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. [s. 6. (8)]

2. The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and when care set out in the plan is no

longer necessary.

Two Critical Incident Reports (CIR) were submitted to the Ministry of Health and Long Term Care (MOHLTC) related to responsive behaviours exhibited by resident #005.

Review of the first CIR and an interview with RPN #116 revealed that on an identified date, resident #005 was found in resident #007's room and resident #007 reported he/she was hit by resident #005 with an object.

Review of the the second CIR and an interview with FSW #121 revealed that on an identified date, resident #005 was observed kicking resident #006 in a common area. Interview with RPN #113 revealed that both residents were separated and no injuries were noted to either resident.

Review of resident #005's health record revealed that Modified Dementia Observational System (DOS) was completed for an identifed period of two weeks. Interviews with RN #114 and RPN #115 revealed that resident #005 was placed on DOS monitoring on an identified date due to his/her escalated responsive behaviours. The DOS monitoring was discontinued two weeks later when resident #005 did not exhibit the identified responsive behaviours.

Review of resident #005's most recent plan of care on an identified date revealed that one of the interventions for managing the resident's responsive behaviours was DOS monitoring.

Interviews with PCA #111 and #112 revealed that resident #005 was on DOS monitoring a few months ago, but not when at the time of this inspection.

Interviews with RN #114 and RPN #115 confirmed that the DOS monitoring for resident #005 had been discontinued a few months prior to the inspection and his/her care plan should have been updated to reflect the changes.

Interview with the DON revealed that a resident's care plan should be updated when the care needs changed and every quarter. The DON confirmed that resident #005's care plan should be updated when his/her DOS monitoring was no longer necessary. [s. 6. (10) (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 staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it, and the resident is reassessed and the plan of care reviewed and revised at least every six months and when care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Record review of a CIR revealed an allegation of staff to resident abuse was reported to the MOHLTC on an identified date. The initial report related to this allegation was an after-hours call placed to the Spills Action Center (SAC) on the same day.

Record review of resident #014's progress notes revealed that an allegation was made by the resident's family member that a PCA had hit the resident with a wet towel and roughly handled him/her while in the shower room on an identified date. These allegations were entered in to the progress notes as a late entry two days later.

Record review of the home's policy titled "Zero Tolerance of Abuse and Neglect" (policy #RC-0305-00, effective January 8, 2016) revealed that it is the responsibility of registered staff to inform the nurse manager (NM) or RN in charge (RNIC) immediately once an

allegation suspicion or witnessed incident of abuse has been made. This includes informing the on-call manager. Management level staff would then immediately notify the MOHLTC that an alleged, suspected, or witnessed incident of abuse or neglect has become known.

In an interview, RPN #126 stated that the allegation of abuse of resident #014 was received from the resident's family member on an identified date. RPN # 126 stated that he/she was informed by resident #014's family member that a PSW had hit resident #014 with a wet towel during a shower. RPN #126 stated that he/she reported this incident to NM #137 though he/she had not reported the allegation that day.

In an interview NM #137 stated that it was the expectation of registered staff to report immediately to the NM or RNIC any allegation or suspicion of abuse or neglect of a resident. NM #137 stated that he/she had immediately reported the allegations upon receiving the information from RPN #126. NM #137 further stated that RPN #126 did not follow the home's policy on zero tolerance of abuse and neglect of residents by not immediately reporting the allegations to the NM or RNIC.

In an interview with the DON he/she stated that it is the expectation of the home for staff to follow the home's policy and immediately report any allegations of abuse or neglect of a resident by anyone. The DON further stated that the allegations should have been immediately reported to the NM on the unit and be called in to the MOHLTC immediately and investigated. In this case the licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with. [s. 20. (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 the written policy to promote zero tolerance of abuse and neglect of residents was complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that, for resident #008 demonstrating responsive behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

Record review of a CIR revealed an incident of resident to resident abuse in which resident #008 pushed resident #009 on an identified date.

Record Review of resident #008's plan of care on an identified date revealed the resident exhibited responsive behaviours. Interventions in place for the responsive behaviours included distraction techniques, such as food, social interaction, and activities; and administration of medications to manage his/her behaviours.

Record review of resident #008's medication administration record (MAR) revealed that resident #008 was prescribed an identified medication PRN for uncontrolled responsive behaviours. Resident #008's MAR sheet was missing documentation for two occasions on two identified dates. The PRN medication was administered to resident #008 with no documentation of the effectiveness of the drug documented in either the MAR sheet or progress notes.

In an interview RN #120 stated that resident #008 had exhibited responsive behaviours and had been receiving medications to manage his/her responsive behaviours. RN #120 further stated that the effectiveness of a PRN medication used to manage a resident's behaviours should be documented either in the progress notes, on the back of the MAR

sheet, or both. RN #120 stated that the effectiveness would be monitored by assessing the resident level of exhibiting responsive behaviours and documenting if the medication had the effect of reducing the level of observed responsive behaviours and documenting as noted above.

In an interview, the DON stated that the expectation of the home was for registered staff to document the effectiveness of a PRN medication used to manage responsive behaviours should be documented both in the progress notes and on the back of the MAR sheet. The DON stated that for the two administrations of the identified medication on the two above mentioned dates, the registered staff had failed to document the response of resident #008 to the interventions for his/her responsive behaviours. In this case the licensee has failed to ensure that, for a resident demonstrating responsive behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented. [s. 53. (4) (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, for each resident demonstrating responsive behaviours, actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 114 (3).
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written polices and protocols for the medication management system are developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

A Critical Incident Report (CIR) was submitted to the MOHLTC related to a medication incident occurred to resident #017.

Review of the home's policy tilted "Readmission of Residents from Hospital" (policy #7-5) indicated when a resident returned from the hospital:
- Pharmacy should be notified of all medication changes with a readmission order form,
- Discharge Summaries, Discharge Hospital and Medication Reconciliation documents, copies of Hospital Medication Administration Record (MAR)s and relevant comments from Hospital Progress Notes should be shared with pharmacist upon readmission, and
- Review readmission orders carefully.

Review of the above mentioned CIR and resident #017's health record revealed that the resident has been followed up by a specialist at the hospital. On an identified date, resident #017 attended the scheduled appointment with the specialist at the hospital. The resident was admitted to the hospital after the consultation with the specialist for assessment of his/her recent condition.

Review of resident #017's progress notes revealed that the resident was discharged from the hospital three weeks later. Review of the Treatment Prescription & Discharge Instructions dated the day prior to the discharge, revealed that the above mentioned specialist recommended the following medications changes for resident #017 after

discharging from the hospital:
- Medication A of an identified dosage and frequency
- Discontinued Medication B

Review of the Best Possible Medication History Reconciliation/ Admission (BPMH) Reconciliation Orders dated the day resident #017 was discharged from the hospital, revealed that resident #017 was to continue:
- Medication A with ten times of recommended dosage, and same frequency as recommended
- discontinue Medication B
- continue Medication C of previous dosage and frequency prior to hospitalization

Review of resident #017's health record and Medication/ Treatment Incident Forms dated on two identified dates and an interview with RPN #109 revealed that resident #017 followed up with the above mentioned specialist on an identified date (eight weeks after being discharged from the hospital) at the hospital. When reviewing the resident's Medication Administration Record (MAR) from the home, the specialist discovered resident #017's Medication B has not been discontinued since the day the resident was discharged from the hospital. The specialist recommended to taper off and discontinue Medication B and to increase the dosage of Medication A.

Review of the MAR revealed that resident #017 received Medication A during the period of being discharged from the hospital and following up with the specialist at the recommended frequency, but ten times of the recommended dosage. Interview with RN #109 revealed that he/she had administered Medication A at the dosage of 10 times of the recommended dosage during the above mentioned period. Prior to the administration of the first dose of Medication A to the resident, RN #109 reviewed the MAR, the Quarterly Physician Medication Review, and the label on the medication bottle, all indicated Medication A was to be given to resident #017 at ten times of the recommended dosage. RN #109 further revealed that he/she contacted the pharmacy service provider in regards to the high dosage of Medication A and was informed that it was possible for a patient to receive Medication A at such a high dosage.

Review of the above mentioned BPMH Reconciliation Orders revealed the medication list was recorded by RPN #136, and the telephone order from the resident's Home Physician was taken by RPN #136. RPN #136 signed as Nurse Process 1 on the day when resident #017 was discharged from the hospital. RPN #138 signed as Nurse Process 2 on the same day at a later time.

Interview with RPN #136 revealed that he/she received resident #017 when the resident returned from the hospital on the above mentioned date. RPN #136 transcribed resident #017's medications from the resident's MAR prior to hospitalization and the medications from the discharge note from the hospital onto the BPMH Reconciliation Orders. RPN #136 also revealed that he/she contacted the resident's Home Physician and read the list of medications on the BPMH Reconciliation Orders to the Home Physician. When the order from the Home Physician was obtained, the BPMH Reconciliation Orders was faxed to the pharmacy service provider for medication delivery. RPN #136 further revealed that he/she had transcribed the dosage of Medication A incorrectly onto the BPMH Reconciliation Orders by transcribing 10 times of the dosage of Medication A as indicated on the discharge note. In addition, RPN #136 stated that he/she did not recognize Medications B and C were the same medications with brand and generic names, despite both names were printed on previous MARs.

Interview with RPN #138 revealed that after reviewing the BPMH Reconciliation Orders recorded by RPN #136 and the discharge note from the hospital, he/she signed the BPMH Reconciliation Orders on the day when resident #017 was discharged from the hospital indicated he/she had reviewed and confirmed there were no discrepancies. RPN #138 further revealed that he/she did not review both medication lists thoroughly.

An interview with resident #017's Home Physician revealed that he/she was contacted in regards to resident #017's medication orders when the resident returned from the hospital on the above mentioned date, and provided a verbal order for the medications and dosages based on the information the nurse communicated to him/her over the phone.

Interview with NM #144 confirmed that a medication incident occurred due to incorrect transcription of the dosage of Medication A and the failure of recognizing the trade and generic names of Medications B and C by RPN #136. In this case, the home has failed to ensure that the written polices and protocols for the medication management system are implemented. [s. 114. (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 written polices and protocols for the medication management system are developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #5: 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 labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed.

On an identified date at an identified time, the inspector observed a medication cart in the hallway between the family lounge and the medication room on an identified unit. There were two stacked medication cups with medications, and a red and yellow capsule on the top of the medication cart. There were no staff members observed in the vicinity of the medication cart. Approximately thirty seconds later, the inspector observed two workmen walked by the medication cart. Another 20 seconds later, PCAs #129 and #130 came out from a resident's room with a resident. Another 20 seconds later, RPN #136 came out from a resident's room which was two rooms away from the medication cart. RPN #136 immediately placed the medication cart in the medication room.

Interview with RPN #136 revealed that while he/she was preparing for medication administration, he/she heard a resident called his/her name. RPN #136 thought that the resident had a fall and ran to the resident's room without putting the medication in the medication cart. One hour later, the inspector interviewed RPN #136 revealed that he/she administered the above mentioned medications to three different residents after the inspector left the unit earlier.

Review of the home's policy titled "Medication Administration" (policy #MM-0201-00, effective April 1, 2016), indicated that the procedures for medication administration included the following:
- Do not pre-pour medications. Medication must be administered immediately after preparation.
- Administer medication from a clearly labelled original strip package, bottle or containers.

Interview with the NM #137 confirmed that it was not acceptable to administer pre-poured medications. In this case, the home has failed 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. [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 #6: 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 were stored in an area or a medication cart that is secure and locked.

On an identified date at an identified time, the inspector observed a medication cart in the hallway between the family lounge and the medication room on an identified unit. The medication cart was unlocked. There were two stacked medication cups with medications, and a red and yellow capsule on the top of the medication cart. There were no staff members observed in the vicinity of the medication cart. Approximately thirty seconds later, the inspector observed two workmen walked by the medication cart. Another 20 seconds later, PCAs #129 and #130 came out from a resident's room with a resident. When PCA #129 pushed the medication cart aside, the two bottom drawers of the medication cart came out, and the PCA pushed them back in place. Another 20 seconds later, RPN #136 came out from a resident's room which was two rooms away from the medication cart and apologized to the inspector for leaving the medication cart unlocked and unattended. RPN #136 immediately locked the medication cart and placed it in the medication room.

Interview with RPN #136 revealed that while he/she was preparing for medication administration, he/she heard a resident called his/her name. RPN #136 thought that the resident had a fall and ran to the resident's room without putting the medication in the medication cart and locking the medication cart.

Interview with the NM #137 confirmed that it was not acceptable to leave the medications unattended in a public area and unacceptable to leave the medication cart unlocked and unattended. [s. 129. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are stored in an area or a medication cart that is secure and locked, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b) were reported to the Director.

a) The home notified the MOHLTC on an identified date via after hours LTC Home Emergency Pager that resident #013 alleged a staff member physically abused him/her.

Review of resident #013's progress notes and the electronic CIR template completed by RN #125, and interviews with RN #125 and RPN #128 revealed that an investigation was completed for the above mentioned allegation. It was concluded that the alleged staff member did not physically abuse the resident.

Interview with RN #125 further revealed that he/she made calls to the on-call NM and the MOHLTC to report the allegation of abuse. An email including the completed CIR template was sent to the on-call Manger and the unit NM, so that the NM could submit a report through the Critical Incident System.

Interview with the DON revealed that when a resident has alleged he/she was abused by a staff member, the home would initiate the investigation immediately. Registered staff were required to provide all information to their unit Nurse Manger by completing the electronic Critical Incident Report template. The Nurse manger would report to the MOHLTC by submitting the CIR via the Critical Incident System (CIS) as registered staff were not authorized the access to the CIS. The DON confirmed that the result of the investigation and action taken in regards to resident #013's allegation of abuse by staff were not reported to the MOHLTC. [s. 23. (2)]

b) A CIR was submitted to the MOHLTC related to an incident of physical abuse from resident #018 towards resident #019 on an identified date. Review of the CIR indicated that resident #018 had hit resident #019 three days prior.

Interview with Nurse Manger (NM) #144 revealed that the home had completed an investigation for the incident mentioned above within a week after the incident, and as per the home's investigation allegations of abuse were not substantiated.

Interview with the DON revealed that as per the home's expectations were that every incident of alleged abuse should be investigated and results of every investigation should be reported to the Director by a NM.

Record review of the CIR mentioned above and interviews with NM #144 and DON confirmed that the results of the investigation regarding the incident mentioned above had not been reported to the Director as required. [s. 23. (2)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home had a dining and snack service that included proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

Observations conducted by the inspector on an identified date at an identified time revealed PCA #107 standing in front of resident #003 in the lounge area on an identified unit. The Inspector noted PCA #107 to be assisting resident #003 with eating at that time. Resident #003 was observed with his/her head tilted back slightly, and did not appear to be in distress.

Record review of resident #003's plan of care revealed that he/she required the assistance of staff with feeding. Staff were instructed to sit to feed, make eye contact, and ensure resident #003's head was positioned for safe swallowing.

In an interview, PCA #107 stated that the proper position of a staff member while assisting a resident with feeding is sitting, and had not been in proper position during this time. PCA #107 was not aware that this feeding technique placed resident #003 at risk for aspiration.

In an interview, RN #108 stated staff should be sitting at eye level with a resident while assisting with feeding. RN #108 further stated the reason for this position is for staff to make sure the resident is able to swallow and prevent choking.

In an interview the DON stated that the expectation of the home was for anyone providing feeding assistance to a resident to be seated in a feeding chair that is provided by the home. The DON further stated that PCA #107 feeding resident #003 from a standing position placed the resident at risk for aspiration. In this case the licensee has failed to ensure that the home had a dining and snack service that included proper techniques to assist residents with eating, including safe positioning of residents who require assistance. [s. 73. (1) 10.]

Issued on this 19th day of April, 2017

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

Original report signed by the inspector.