Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

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

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Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Nov 12, 2019	2019_714673_0007 (A1)	001257-18, 008127-18, 013581-18, 016120-18, 016134-18, 017596-18, 017986-18, 018004-18, 019528-18, 025229-18, 005201-19, 007683-19	Complaint

Licensee/Titulaire de permis

City of Toronto
c/o Seniors Services and Long-Term Care 365 Bloor Street East, 15th Floor
TORONTO ON M4W 3L4

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

Amended by BABITHA SHANMUGANANDAPALA (673) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Compliance due dates changed for Co #001, 002, and 003 as home requested extension.

Issued on this 12nd day of November, 2019 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Amended by BABITHA SHANMUGANANDAPALA (673) - (A1)

Amended Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 13-16, 19-23, and 26-29, 2019, with off-site interviews conducted on September 10, 2019.

The following intakes were completed in this Complaints Inspection:

-Log #018004-18 related to plan of care, skin and wound care, and personal support services

-Log #016120-18 related to operations of the home,

-Log #025229-18, related to staffing, continence and personal support services

-Log #019528-18, Log #017986-18, and-Log #017596-18 related to medication, neglect, and staffing

-Log #005201-19 related to abuse and medication

-Log #016134-18 related to air temperatures

-Log #013581-18 related to maintenance, staffing, plan of care, and resident's rights

-Log #008127-18 and Log #001257-18 related to admissions and discharge

-Log #007683-19 related to a follow up on complaints process in the home.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Interim Director of Care (IDOC), Nurse Managers (NM), Manager of Resident Services (MRS), Food and Nutrition Manager (FNM), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Behvioural Support Team Staff (BSO), Pharmacy Consultant (PC), family

members and residents.

During the course of the inspection, the inspectors conducted observations of the home including resident home areas, medication administration observations, resident and staff interactions, reviewed clinical health records, relevant home policies and procedures, and other pertinent documents.

PLEASE NOTE: A Written Notification and Compliance Order related to LTCHA, 2007, c.8, s. 19 (1), and a Written Notification and Voluntary Plan of Correction related to O. Reg. 79/10, s. 221 (2) identified in a concurrent inspection #2019_714673_0008 (Log #013866-18, M571-000024-18, Log #005920-18, CIS #M571-000008-18, and Log #000954-18, CIS #M571-000002-18) were issued in this report.

The following Inspection Protocols were used during this inspection:

Admission and Discharge
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

19 WN(s)
16 VPC(s)
3 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. 101. (2)	CO #001	2019_414110_0001	699

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

WN #1: The Licensee has failed to comply with 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 where the Act and Regulation required the licensee of a long-term care home to have, institute or otherwise put in place

any system, the system was complied with.

In accordance with s.68 (2) (d), the licensee was required to ensure that the Nutrition Care and Hydration program includes a system to monitor and evaluate food and fluid intake of residents with identified risks related to nutrition and hydration.

Specifically, staff did not comply with the licensee's Food and Fluid Intake Record which is part of the licensee's Nutrition and Hydration program.

A) A review of the home's Food and Fluid Intake Record indicated the following instructions:
- Night shift PSW will add up the number of servings from days, evenings and nights
- Night shift RN/RPN will initial daily to indicate record is complete. If incomplete, they shall inform Nurse Manager, operations to follow up
- Night shift RN/RPN will calculate daily fluid (125 ml x number of Servings) document in the progress notes
- Refer to Registered Dietitian and notify Physician/Nurse Practitioner if:
(a) resident's daily food intake is 0% and/or
(b) resident consumes less than 8 servings of fluid over 48 hours and/or show signs and symptoms of dehydration.

A complaint was submitted to the Ministry of Long-Term Care (MLTC) on an identified date. The complainant reported that resident #003 was admitted and treated at the hospital for a nutrition/hydration related condition.

A review of resident #003's medical records identified the resident as being at high risk for nutrition and hydration related issues due to a specified condition and diagnosis. It also indicated that upon resident #003's return from the hospital on an identified date, identified aspects of their health condition was noted to have deteriorated.

A review of resident #003's Food and Fluid Intake Record twelve days prior to their specified date of hospitalization indicated the following:
- food and fluid intakes were not recorded for identified meals on five identified days
- morning and evening snacks were not documented,
- the food and fluid intake form did not identify a calculation of the daily fluid

intake.

B) As there was a non-compliance related to the home's Food and Fluid Intake Record, the inspector expanded the sample to include resident #015, #016, and #017.

A review of resident #015's Food and Fluid Intake Record for an identified time period of 21 days indicated that the resident received less than eight servings of fluid on four identified consecutive days.

In this case, resident #015 consumed less than eight servings of fluid over 48 hours and was not referred to the Registered Dietitian. The Physician/Nurse Practitioner was also not notified. In addition, nine days of the daily fluid intake was not calculated within the time period identified above.

A review of resident #016's Food and Fluid Intake Record for 21 days of an identified time period indicated that the daily fluid intake was not calculated for the period identified above.

A review of resident #017's Food and Fluid Intake Record for six days of an identified time period indicated that the daily fluid intake was not calculated.

In an interview, RPN #107 indicated that hydration is monitored in the home by nursing staff where the staff on days and evening shifts document the food and fluid intake of each resident, and the night shift RPN records the totals of the daily fluid intake. The RPN also indicated they were unclear about this as the home did not give them an in-service related to it. Furthermore, they stated that after informing the RN that they needed training in the process on what to complete as part of the form and how to analyze the data, they stopped looking at the food and fluid intake forms.

The RN identified by the RPN was no longer in the home.

In an interview with NM# 102, they acknowledged that the food and fluid intake forms were not completed as per the home's expectations. They indicated that the recorded numbers were not always correct on the forms as staff sometimes copied the numbers from the previous days. They indicated that staff may need additional training.

From the review of the instructions in the home's Food and Fluid Record, residents' daily fluid intake records, and staff interviews, the inspector concluded that staff in the home did not comply with the home's system to monitor and evaluate food and fluid intake of residents with identified risks related to nutrition and hydration. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended: CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #011 was protected from physical abuse by anyone in the home.

As per O. Reg. 79/10, s.2 (1), the definition of "physical abuse", subject to subsection (2) (1) of the Act, includes the use of physical force by a resident that causes physical injury to another resident.

A Critical Incident System (CIS) report was submitted to the MLTC on an identified date related to resident to resident physical abuse. A review of the CIS report indicated that on an identified date and time, resident #010 entered a common area in their mobility aide and pushed resident #011, who was sitting at a table. The force from resident #10's mobility aide pushed the table that resident

#011 was sitting at and resident #011 sustained identified injuries/harm to an identified location of their body as a result of it hitting the edge of the table.

A review of the home's investigation records indicated that following the incident on a specified date, both residents were separated and assessed. Resident #011 sustained an identified injury to an identified location of their body where the table had made contact.

A review of resident #011's health records indicated they had an identified level of cognitive impairment and identified diagnoses, but did not have any communication, relationship, or history of altercation with resident #010.

As per the CIS report, resident #010 was cognitively intact. A review of resident #010's health records indicated identified diagnoses. At the time of the assessment period, resident #010 had exhibited identified behaviours which could be easily altered and the resident was independent for locomotion on and off the unit with their mobility aide. A review of resident #010's most recently updated written plan of care indicated that the resident was identified to have specified behavioural problems. The staff attributed some of the resident's identified behaviours to their identified diagnosis. The goal and interventions were set in the plan of care to assist the staff in managing resident #010's behaviour.

In separate interviews, resident #011 was not able to recall the incident, and resident #010 refused to talk to the inspector.

In an interview, PSW #118 indicated that they were aware of resident #010's identified behaviours and they always approached them cautiously when providing care. They stated that they first ask them if they are ready for assistance before providing care to the resident, but the resident's behaviour could be unpredictable. In these situations, they try to calm the resident and if resident #010's behaviour escalates, they notify the nurse in charge who then comes and takes over the care. The PSW further indicated that this did not happen often, but when it did, the nurse would call a code white, and sometimes call the police. The PSW also acknowledged that resident #011 was physically abused by resident #010 during the incident with their mobility aide in the common room.

In an interview, RPN #110, a lead of the behavioural support outreach (BSO) program, indicated that they had assessed the resident and included them in the BSO program. BSO had monitored and assessed the resident and after

evaluating their behaviour to be calm and pleasant, they discharged the resident from the BSO program. The BSO lead stated that after the incident specified in the CIS report, the resident was placed on dementia observation system monitoring for seven days and was visited by the BSO lead on a daily basis; however, the resident did not exhibit any responsive behaviours during this time. The BSO lead also stated the team tried many different interventions, but none of them worked due to a specified action of the resident and that implementing an intervention to address this action was not effective.

In an interview, RN #113, who was the Acting Nurse Manager and RN on the floor at the time of the incident described in the CIS, indicated that they were administering medication when resident #010, who was unprovoked, pushed resident #011 who was sitting at the table. The RN further confirmed that resident #010 was identified to have an identified issue and that when they experienced this issue, they used their mobility aide to express it. The RN explained the resident used their mobility aide in this way with the staff. The multidisciplinary team also decided to adjust a setting on resident #010's mobility aide as a safety measure. The RN stated no new incident was identified until the date of the incident identified in the CIS, and there had been no incident after that. The RN confirmed that resident #011 in this incident was physically abused by resident #010.

In an interview, NM #102 indicated that based on the information provided in the CIS and the progress notes, resident #011 was not protected from physical abuse by resident #010 who used their mobility aide to run over resident #011. [s. 19.]

2. The licensee has failed to ensure that resident #019 and resident #020 were protected from sexual abuse by anyone in the home.

As per O. Reg. 79/10, s.2 (1), the definition of "sexual abuse", subject to subsection (2) (1) of the Act, includes any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident.

The MLTC received a CIS report related to sexual abuse of resident #019 by resident #018 which occurred on an identified date. Both residents were separated and dementia observation system (DOS) tool was initiated. A second CIS report was submitted to the MLTC on an identified date related to sexual abuse of resident #020 by resident #018 which occurred on an identified date approximately three months after the date identified in the first CIS. Both residents

were separated and DOS was initiated.

A record review of resident #018, #019, and #020's Continuing Care Reporting System 2.0 (CCRS) assessments completed on specified dates closest to the dates of the incidents described in the CIS reports showed that all three residents' cognitive skills for daily decision making were impaired at the same identified level.

A review of resident #018 and #019's progress notes indicated that at the time of the reported incident involving both residents, resident #019's identified behaviour resulted in them entering resident #018's bedroom to use their bathroom. Resident #019 then proceeded to lay down on resident #018's bed without having fully dressed. Resident #018's progress notes did not indicate any previous sexual behaviours and that at the time of this incident, they had thought that resident #019 was their spouse.

A record review of resident #018's written plan of care related to behavioural problems, updated approximately a week and a half from the time of the incident described above with resident #019, indicated that staff were to monitor the resident for one more week. A record review of resident #018's behaviour assessment tool (BAT) beginning on the date of the incident did not identify any trial interventions related to the resident's sexual behaviour and was incomplete.

A record review of resident #020's progress notes indicated that there were instances prior to the incident when resident #020 exhibited an identified behaviour which required redirecting.

A record review of resident #020's clinical health records prior to the identified date of the incident involving resident #018 did not contain any assessments or interventions related to their identified behaviour, to indicate implementation of a plan of care based on an interdisciplinary assessment of resident #020's identified behaviour.

A record review of resident #018 and #020's progress notes related to the incident described in the CIS that was submitted, indicated that resident #020 exhibited an identified behaviour into resident #018's room and laid down beside resident #018. Resident #018 thought resident #020 was their spouse and proceeded to undress. Following the incident, resident #018 and #020 were assessed by the physician, and no injuries were noted to either resident.

In an interview, NM #102 stated that the expectation for residents identified to be exhibiting responsive behaviours was for triggers to be identified and strategies to be implemented to prevent reoccurrence.

In an interview, BSO staff RPN #129 indicated that there were no interventions in place to address resident #020's identified behaviour. BSO RPN #129 further indicated that resident #018's sexual behaviour was related to resident #019 and resident #020 specified behaviours, and that they had not identified resident #018's specific triggers for sexual behaviour in their plan of care.

BSO RPN #129 and NM #102 both acknowledged that residents #018 and #020 were not protected from harm as steps had not been taken to minimize potentially harmful interactions between them and resident #018 by identifying and implementing interventions.

A record review of the Abuse and Neglect Prevention and Response Protocol for 2018 showed that 70.28% of staff had completed the annual training. In an interview, NM #102 indicated that it was mandatory for all staff to have completed the abuse recognition and prevention training. [s. 19.]

Additional Required Actions:

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

(A1)
The following order(s) have been amended: CO# 002

WN #3: 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. (1) Every licensee of a long-term care home shall develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents. O. Reg. 79/10, s. 114 (1).

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 the development of an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents.

A) Policy MM-0201-00 indicated that staff must adhere to the eight rights of medication
administration (right resident, medication, dose, time, route, site, frequency and reason), and during medication administration:
-verify resident using 2 identifiers such as the identification band and picture in the Medication
Administration Record (MAR) binder prior to administering medications,
-compare the label on the strip package, bottle, or container with the MAR sheet and verify expiry date prior to administration, and
-document on the medication administration record after each medication administration by recording the nurse's initials in the space provided.

A review of the home's Quarterly Professional Advisory Committee Reports, detailed below, all identified a persisting problem related to documentation and medication administration in the home:
- June 22, 2018 (for the period of March to May 2018),
- September 7, 2018 (for the period of June to August 2018) and - March 29, 2019 (for the period of December 2018 to February 2019).

The reports specifically identified missing documentation as persisting trends where medications were not always signed or coded for in the MAR/Treatment Administration Record (TAR) (many
"missing signatures") and medications were not always being signed for at the time of administration (either pre-signed or post-signed in bulk). It identified that such trends can increase the risk of medication incidents and the risk of dose omissions.

The MLTC received complaints regarding the late administration of medications. A complaint was also submitted to the MLTC on a specified date, about medication incidents related to resident #006. A review of a Medication Incident Meeting Minutes document with a specified date, was identified to be related to resident #006 by the home. Contributing factors identified in the meeting were that medications may had been left unobserved but signed for as having been administered. It further stated that other ongoing trends identified in the home that could increase such incidents of dose omissions included medications not always being signed for in the MAR at the same time as their administration.

In interviews, NM #102 and IDON #134 indicated that registered staff are expected to follow CNO's standards of practice and the home's policies as it relates to medication administration and documentation. They further acknowledged that this had not been done by the nurses involved in the medication incidents described above, or RPN #101, RPN #137, RPN #132, and RPN #126 in the situations described below (Part A) from i) to iii):

i) On an identified date and time, RPN #137 was observed by Inspector #673 to be administering topical treatments to residents but was not observed to be checking a MAR or TAR before administration nor signing a MAR or TAR after administration. RPN #137 was also observed to only be checking the orders written on the medication packages before administering them to residents.

RPN #137 was later observed by Inspector #673 with a medication cart administering medications to residents. Upon review of the MAR located on top of the medication cart being used by RPN #137, it was noted that none of the residents' medications ordered to be administered at 1000hrs or 1200hrs contained a signature to indicate that they had been administered. This observation was immediately confirmed by RN #142. In an interview, RPN #137 stated that the medications ordered to be administered to residents at 1000hrs

and 1200hrs had already been administered.

In interviews, RPN #137 and RN #142 acknowledged that RPN #137 should have immediately completed documentation of the administered medications in the residents' MARs as per the home's policy. RPN #137 also acknowledged that they should have been checking the ordered medications against the residents' MARs and not just the medication labels. They both confirmed that RPN #137 was not following CNO's practice standards or the home's policies in these situations.

ii) In an observation conducted by Inspector #699 on an identified date, the inspector observed RPN #132 signing the resident's MAR prior to administrating the medications. In an interview, RPN #132 stated the correct procedure would have been to administer the medication and then record in the MAR once the medication is taken.

A record review of the home's training record for medication management for 2018, indicated that RPN #132 had not completed the home's annual mandatory training.

In separate interviews, NM #102 and IDON #134 both indicated that registered staff should be signing the MAR after the administration of medications.

iii) On an identified date and time, Inspector #673 observed RPN #101 holding a medication cup containing crushed medications mixed with apple sauce. Upon examination of the medication cart, another medication cup with crushed medication mixed in apple sauce was observed.

RPN #101 identified the two residents that these medications belonged to and indicated that these medications had been ordered to be administered at 1200hrs. Upon review of the MAR, it was noted that RPN #101 had already documented all medications ordered to be administered to residents at 1200hrs as having been administered. This included the medications mixed in apple sauce for two different residents, which had not yet been administered.

In an interview, RPN #101 acknowledged that the home's policy was to document each medication as having been given at the time of administration instead of before administration.

B) A review of the home's policy titled "Narcotic and Controlled Medications", MM-0106-00, published January 4, 2016, indicated that at shift change, one nurse from the outgoing shift and another nurse from the oncoming shift, will count narcotics and controlled medications and document the count by utilizing the Combined Monitored Medication Record With Shift Count document.

On an identified date, a MAR binder was observed to have a single signature, identified as RPN #126's initials, on each of the narcotic/controlled substances shift count sheets indicating that a shift count had been completed at 1500hrs that day. The time of observation of this documentation was at approximately 1151hrs.

In an interview, on the same day as the above observation at 1410hrs, RPN #126 acknowledged that by signing the count sheets before the actual time it was recorded for, and without a second registered staff, they were not following CNO's practice standards or the home's policies related to controlled substances.

C) A review of the Medical Pharmacies policy, Section 5, Handling of Medication, Policy 5-1, titled Expiry and Dating of Medications, dated February 2017, stated that there should be a system in place to ensure that an adequate and non-expired supply of medication is maintained for each resident. It further stated that the expiry date of all medications should be examined on a regular monthly basis and if an expiry date is not stated on the packaging, it shall be the last day of the month of the specified year.

i) On an identified date, the inspector observed two containers of an identified medication of aqueous mixture dated July 10, and August 8, 2019, on resident #023's bedside table.

A review of resident #023's medical records indicated a current order for this same identified medication, with specifications related to dosage and instructions for administration.

Upon informing RN #138 of the findings in resident #023's room, they stated that they were not aware of the medication being in resident #023's room but had administered the identified medication earlier that day to resident #023, and showed the inspector a container of the identified medication dated May, 2019.

A review of the Medical Pharmacies policy, Section 5, Handling of Medication,

Policy 5-2, titled Recommended Expiry Dates Once Product is Open, dated April 2017, revised November 2018, stated that if the product is a topical mixture, the expiry date is after one month for aqueous mixtures.

When asked why RN #138 had not questioned the date on the medication dated May 2019, they acknowledged that it may have expired and responded that they had made a phone call to the pharmacy to order a new tube that day.

ii) A review of the Quarterly Professional Advisory Committee Reports dated November 30, 2018, (for the period of September-November 2018) and June 28, 2019 (for the period of March-May 2019), identified a trend of discontinued and expired medications, including insulin cartridges, being found in medication carts. A review of the Quality Assurance Summary Report from Medical Pharmacies dated March 20, 2019, indicated findings of discontinued or expired medications including narcotics, insulin and vaccines failing to be removed from all 5 floors' medication carts and other storage areas.

On an identified date, the inspector observed an identified topical medication on resident #027's bedside table.

A review of resident #027's physician's orders indicated that on a specified date approximately a month prior to the above observation, they had been ordered two specified topical medications with specified instructions of administration to treat identified skin concerns for an identified period of time. There were no current orders for this medication for resident #027, indicating that the medication observed in the room had been discontinued.

The above observation and record review was confirmed by RN #138 who stated that resident #027 was not currently receiving any topical treatment. RN #138 acknowledged that this medication had been discontinued and should have been disposed of appropriately as per the home's policy.

This noncompliance is being issued because in addition to the findings described above, noncompliances were identified and issued elsewhere in the report related to the Medication Management System including noncompliance related to management of medication incidents and adverse drug reactions, approval of policies and protocols of the medication management system, quarterly reviews of the medication management system, completion of an annual evaluation of the medication management system and completion of monthly audits of narcotic and

controlled medications.

Furthermore, a review of the home's policy titled Medication Administration, MM-0201-00, dated April 1, 2016, indicated that medications are to be administered in accordance with the College of Nurses of Ontario's (CNO) Standards, Long-Term Care Homes and Services policies and procedures. Noncompliances were issued elsewhere in the report for failure to implement this policy related to purchasing and handling of drugs, drugs being kept in their original labelled
container/package until administered or destroyed, safe storage of medications, drug administration in accordance with directions for use specified by the prescriber and implementation of the infection prevention and control program during medication administration. [s. 114. (1)]

2. The licensee has failed to ensure that the written policies and protocols developed for the medication management system are reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director.

Upon request of the home's medication management policies, NM #102 provided Inspector #637 with policies by Medical Pharmacies and indicated that these were the policies used by the staff in the home.

Upon request of a specific medication management policy by Inspector #699, NM #115 provided Inspector #699 with a policy by the City of Toronto, which differed from the policies provided to Inspector #637.

In an interview, NM #115 clarified that the home used the policies developed by the City of Toronto. A review of these policies indicated that they had been approved by a Nurse Manger with no indication that they had been approved by the Director of Nursing and Personal Care, and the pharmacy service provider or the Medical Director.

In an interview, Pharmacy Consultant #143 indicated that their evaluations, staff education, and policy revisions were solely based on the policies by Medical Pharmacies obtained by inspector #673. Pharmacy Consultant #143 further stated that they were not aware that the home had a different set of policies than the ones from Medical Pharmacies. [s. 114. (3) (b)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended: CO# 003

WN #4: 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #004's plan of care was followed.

The MLTC received several complaints regarding staffing levels in the home.

During observations conducted by Inspector #699, resident #004 was noted to be in bed after a specified meal time on three identified consecutive dates.

In an interview, PSW #121 indicated that resident #004 remains in bed until after the specified meal time due to their identified behaviours as directed by the nurse manager and receives their meal tray in bed. They further indicated that this was

in resident #004's written plan of care.

A record review of resident #004's ADL written plan of care last updated one day before the date the observations were conducted, indicated that resident #004 was to have their meals in the dining room.

Further review of resident #004's most recently updated written plan of care related to behavioural problems, review of progress notes for a period of two months approximately two weeks previous to the date of observations , and their clinical health records did not indicate that resident #004 was to be left in bed until after a specified meal time due to identified behaviours.

In an interview, NM #102 indicated that they did not give any direction to staff about leaving resident #004 in bed until after a specified meal time due to their behaviours. NM #102 was unable to locate any information or recommendations that indicated that resident #004 had this intervention in place. They further indicated that it should have been included in the written plan of care if this was an intervention to be implemented. NM #102 acknowledged that resident #004's plan of care was not followed. [s. 6. (7)]

2. The licensee has failed to ensure that the care set out in resident #013's plan of care was provided to them as specified in the plan.

The MLTC received several complaints regarding staffing levels in the home. During an interview conducted by the inspector, RN #125 indicated that resident #013 tended to be left in bed due to insufficient staffing as the resident had extensive care needs.

During observations conducted by Inspector #699, resident #013 was noted to be in bed during and after an identified mealtime on three identified consecutive dates.

In an interview, PSW #122 indicated that resident #013 would be left in bed until after the identified mealtime as an identified intervention for resident #013's identified skin condition, and that they would remain on bed rest every other day.

A record review of resident #013's plan of care indicated that they were to have their meals in the dining room, and it did not indicate that they were to be left in bed until after the identified mealtime nor that they were to remain on bed rest

every other day as an identified intervention for their identified skin condition.

A record review of resident #013's skin and wound assessment on an identified date indicated that the resident had altered skin integrity on an identified location of their body. The same altered skin integrity was identified in a skin and wound assessment completed one week later. A record review of resident #013's NPCR showed that they were not transferred out of bed on 24 out of 58 days from the time of the identified initial date. During this time, the altered skin integrity on the resident's identified location of their body progressed through different levels of deterioration as noted in their skin and wound assessments.

A record review of resident #013's progress notes did not indicate why the resident was not transferred from their bed or if there was a recommendation to initiate bed rest for the resident. Further review of resident #013's clinical health records did not contain a physician or nurse practitioner's order to keep the resident on bedrest for their identified skin alteration. A record review of resident #013's care conference document with an identified date which fell approximately two months from the previously identified time period indicated that resident #013 was kept on bed rest twice a week; however, it did not specify which days this intervention was to be implemented or when it was initiated.

In an interview, RN #125 stated that the resident is regularly put in the wheelchair for an identified meal and goes back to bed after a subsequent identified meal . They further indicated that they had asked staff about the resident's routine and was told that the resident is out of bed every other day. RN #125 indicated that it would have been care planned if resident is to be maintained on bed rest every other day.

In an interview, NM #102 indicated that based on the information noted above, the staff could have assessed resident #013 more adequately.

In an interview, IDON #134 acknowledged that resident #013 was not being provided care that was required for them. [s. 6. (7)]

3. The licensee has failed to ensure that staff and others who provided direct care to a resident were kept aware of the contents of the plan of care and given convenient and immediate access to it.

The MLTC received several complaints regarding staffing levels in the home.

In observations conducted by Inspector #699, residents #004 and #013 were observed to be in bed after an identified mealtime on an identified date, another identified date six days after the first, and two subsequent dates thereafter. Review of both residents' plan of care did not indicate that residents should remain in bed until after the identified mealtime.

In an interview, PSW #121 indicated that they would access residents' written plan of care from the NPCR binder as they did not have access to the online written plans of care.

A review of the care plans on Gold Care, the home's online documentation system containing residents' online written plans of care, indicated that identified parts of resident #004, #009, and #012's care plan was last updated on specified dates in the current year.

A review of the NPCR binder showed that the same identified parts of resident #004, #009, and #012's care plan had not been updated since specified dates in the previous year.

In an interview, PSW #121 stated that resident #004's care plan was not current and acknowledged that they did not have immediate access to the plan of care for resident #004.

In an interview, NM #102 indicated that staff would access information from the NPCR binder. They further stated that the PSWs do not have access to the Goldcare system. NM #102 acknowledged that the care plans for resident #004, #007, #009 and #014 were not current and that staff did not have immediate access to the residents' plan of care. [s. 6. (8)]

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 residents are kept aware of the contents of their plan of care and given convenient and immediate access to it, and that these plans of care are followed, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #007, #009, and #012 were provided their scheduled showers, at a minimum, twice a week.

TThe MLTC received several complaints regarding staffing levels in the home.

In separate interviews, residents #007, #009 and #012 stated that they missed their scheduled showers due to staff shortage, or the lack of availability from the staff that were present. Resident #009, who had a visual impairment, indicated they do not use the call bell to call for assistance as the staff are too busy.

A record review of resident #007's nursing and personal care record (NPCR) for the month of July 2019, showed that resident #007 did not receive five of their scheduled showers. There was no documentation for another scheduled shower during this time period to indicate whether or not the resident received their shower. A record review of resident #007's progress notes for the same time period, did not indicate why the resident missed their showers.

A record review of resident #009's NPCR showed that between June 1, 2019 to July 31, 2019, resident #009 did not receive two of their scheduled showers, and there was no documentation on five other scheduled shower days during this time period to indicate whether or not the resident received showers. A record review of resident #009's progress notes for the same time period did not indicate why the resident missed their showers.

A record review of resident #012's NPCR showed that between June 1, 2019 to July 31, 2019, the resident did not receive three of their scheduled showers. A record review of resident #012's progress notes did not indicate why the resident missed their showers.

In interviews, PSW #122 and RN #125 indicated that if they are short staffed, sometimes residents' showers will not be completed. They further indicated that if that happens, management will bring in additional staff the next day to complete the missed showers, however this has not occurred recently. [s. 33. (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 each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring techniques when assisting resident #014.

During an observation conducted by Inspector #699 on August 22, 2019, PSW #133 was alone in resident #014's room operating a mechanical hoyer lift with resident #014 attached in the sling, already in a semi raised position off of the bed when Inspector #699 walked into the resident's room. RPN #132 followed Inspector #699 and assisted PSW #133 to transfer resident from bed to their identified mobility device.

A record review of the home's policy titled [3]Assessment of Resident for Transfer or Lift´RC-052210, published January 01, 2019, indicated that two staff are required when using a mechanical lift, one staff to operate the lift and one staff to guide the lifting motion and offer reassurance to the resident.

In an interview, PSW #133 indicated that resident #014 required a mechanical lift for all transfers. They further stated that all mechanical lift transfers required two person assistance. PSW #133 acknowledged that they did not follow appropriate safe transfer techniques.

In an interview, RPN #132 indicated that the PSWs should be calling the registered staff or another person when they are ready to transfer a resident. They stated together with the second staff member, they would apply the sling, hook the sling up, transfer the resident and remove the sling. They acknowledged that for resident #014, the transfer was not done correctly.

A record review of the training record for 'Mechanical Lifts 2018' indicated that PSW #133 had not completed their yearly mandatory training.

In an interview, IDON #134 indicated that two staff are required for all mechanical lift transfers. They acknowledged that for resident #014, a safe transferring technique was not followed. [s. 36.]

Additional Required Actions:

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

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 115. Quarterly evaluation

Specifically failed to comply with the following:

s. 115. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 115 (1).

s. 115. (4) The licensee shall ensure that the changes identified in the quarterly evaluation are implemented. O. Reg. 79/10, s. 115 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

A review of the home's Health Advisory Committee (HAC) Terms of Reference (AD-0206-01, Appendix B-4) indicated that its purpose included monitoring and evaluating the medication management program on a quarterly and annual basis in the home.

In an interview, NM #102 stated that the minutes indicated those who attended the meetings.

A review of the meeting minutes from the HAC meetings indicated that the DON was not present at the following HAC meetings:
-June 22, 2018
-September 7, 2018
- and November 30, 2018.

Additionally, the Administrator/ED #135 was not present at the March 29, 2019, HAC meeting.

A dietician was not documented to have attended any of the quarterly meetings mentioned above.

The licensee failed to ensure that an interdisciplinary team, including the DON and the Administrator, met at least quarterly to evaluate the effectiveness of the medication management system in the home. [s. 115. (1)]

2. The licensee has failed to ensure that the changes identified in the quarterly evaluation were implemented.

In an interview, Pharmacy Consultant #143 stated that the pharmacy conducts quarterly medication audits and documents them as Quality Assurance Summary Reports. The same audits are repeated in the first and third quarter, and second and fourth quarter, and results are included in their Quarterly Professional Advisory Committee Reports which are presented at HAC meetings.

A) A review of the Quarterly Professional Advisory Committee Reports dated November 30, 2018, for the period of September to November 2018, indicated that individual count sheets were not always double signed when receiving Narcotic and Controlled substances. A review of the Quarterly Professional Advisory Committee Report dated June 28, 2019 (for the period of March-May 2019) also identified missing signatures on narcotic shift count documents.

The action plan noted in the above-mentioned documents to address the identified issues related to narcotic and controlled substances was for NM #102 to complete internal narcotic audits on a monthly basis.

In an interview, NM #102 stated that they were the lead for the medication administration system in the home. Upon request to review the results of the home's monthly audits of the daily count sheet of controlled substances, NM #102

stated that these audits had not been implemented by the home.

B) A review of the following Quarterly Professional Advisory Committee Reports all identified a persisting problem related to documentation and medication administration in the home:
- June 22, 2018 (for the period of March to May 2018)
-September 7, 2018 (for the period of June to August 2018) and
-March 29, 2019 (for the period of December 2018 to February 2019).

They specifically identified missing documentation as a persisting trend where medications were not always signed or coded for in the MAR/TAR (many "missing signatures"), and another trend that medications were not always being signed for at the time of administration (either pre-signed or post-signed in bulk). It identified that such trends can increase the risk of medication incidents and the risk of dose omissions.

Changes planned during these quarterly medication management reviews, with responsibility delegated to Nurse managers, DON, pharmacy consultant and associate, included, but not limited to:
- monthly audits and spot checks on the MARs/TARs for missing signatures and follow up with registered staff
-reminders to registered staff of best practice guidelines/CNO requirements related to medication administration and documentation
- re-education for registered staff for September
- internal audits assigned to night staff to complete every Monday to check each chart to ensure there are no missing signatures.

Upon request for documentation of medication related training and education provided to staff, documentation dated 2018 indicated that 60% of staff had completed the training. In interviews, NM #102 and Pharmacy Consultant #143 stated that education was provided to staff on an as needed basis; however, they could not indicate any other specific dates or provide any further documentation of medication related training/education that had been provided and completed by staff. They were also unable to provide documentation of the monthly audits or spot checks of the MARs/TARs for missing signatures to indicate that these had been completed.

C) A review of the Quarterly Professional Advisory Committee Reports dated November 30, 2018 (for the period of September-November 2018) and June 28,

2019 (for the period of March-May 2019), identified a trend of discontinued and expired medications being found in medication carts.

Changes planned during these quarterly medication management reviews included:
-NM #102 to follow up with night staff on 2nd floor to ensure they are completing monthly glucometer checks with the control solution
- Internal audits for medication carts, treatment carts, medication storage to be assigned to night staff to complete every Monday

In an interview, NM #102 stated that they did not have any records of completed medication audits. Furthermore, they could not provide any further documentation to indicate that the planned changes related to follow up with night staff, or audits, had been implemented. [s. 115. (4)]

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 an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home, and to recommend any changes necessary to improve the system, and implement these changes, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 116 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

In an interview, NM #102 stated that they were the lead for the medication administration system in the home. Upon request to review documentation of the 2018 annual review of the home's annual evaluation of the effectiveness of the medication management system, NM #102 stated that they had not completed this evaluation. [s. 116. (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 an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 122. Purchasing and handling of drugs

Specifically failed to comply with the following:

s. 122. (1) Every licensee of a long-term care home shall ensure that no drug is acquired, received or stored by or in the home or kept by a resident under subsection 131 (7) unless the drug,
(a) has been prescribed for a resident or obtained for the purposes of the emergency drug supply referred to in section 123; and O. Reg. 79/10, s. 122 (1).
(b) has been provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario. O. Reg. 79/10, s. 122 (1).

Findings/Faits saillants :

1. The license has failed to ensure that no drug is acquired, received or stored by or in the home or kept by a resident unless the drug has been prescribed for a resident or obtained for the purposes of the emergency drug supply, and has been provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario.

1) On August 13, 2019, at 1640hrs, the inspector observed an almost full bottle of an identified medication containing as per label 120 tablets on the bedside table in resident #025's room.

The observation was confirmed with RPN #120 who stated they had recently completed resident #025's admission, at which time the family had said that the resident takes it for an identified reason; however, RPN #120 stated that they were unaware that the family had left the medication there. RPN #120 checked resident #025's orders and current MAR and confirmed that the identified medication had not been prescribed for the resident and acknowledged that it should not have been in resident #025's room.

2) On an identified date, the inspector observed two tubes of an identified medication and one container of another identified medication on resident #023's bedside table. Upon informing RN #138 of the findings in resident #023's room, RN #138 further found two additional and different tubes of identified medications in resident #023's room.

In an interview, after reviewing resident #023's orders, RN #138 stated that only the identified medications found by the inspector were ordered for resident #023 and that they did not know where the rest of the medications had come from. RN #138 further acknowledged that residents should only have medications that were prescribed for them. [s. 122. (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 no drug is acquired, received or stored by or in the home or kept by a resident unless the drug has been prescribed for a resident or obtained for the purposes of the emergency drug supply, and is provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario, to be implemented voluntarily.

WN #10: 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.

A complaint was submitted to the MLTC on an identified date about medication incidents related to resident #006.

A review of the home's policy titled Medication Administration, MM-0201-00, dated April 1, 2016, indicated that staff should not pre-pour medications and administer medications immediately after preparation.

A review of a Medication Incident Meeting Minutes document dated August 28, 2018, indicated that there had been one medication incident involving dose omission in August 2018. It stated that family members had brought to the DON's attention that they had found identified medications on multiple occasions in the resident's room over the last few months. The resident was identified by NM #102 to be resident #006. Contributing factors identified in the meeting were that medications may have been left unobserved but signed for as having been administered.

On August 20, 2019 at 1151hrs, the inspector observed RPN #101 wheel a medication cart to near dining room area, remove something from the medication cart and head into the dining room. Upon returning to the cart, RPN #101 was not witnessed signing the MAR nor preparing any other medications and was instead witnessed removing something else from the medication cart and once again heading into the dining room. Upon requesting to see what was in their hand, RPN #101 displayed a medication cup containing crushed medications mixed with apple sauce. Upon examination of the medication cart, another medication cup with crushed medication mixed in apple sauce was observed.

In an interview, RPN #101 acknowledged that the home's policy was to prepare the medications at the time of administration and not before, and that they had not ensured that the drugs remained in their original labelled packaging until they were destroyed or administered to the appropriate resident. [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 #11: 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.

A review of the home's policy titled Medication Administration, MM-0201-00, dated April 1, 2016, indicated that all areas where medications are stored (medication/treatment carts, medication/treatment rooms, government stocks cupboards) must be kept locked at all times when not in use, and that medications are not to be left at the bedside.

A) On an identified date, time, and location, RPN #140 was observed conducting a medication pass. When RPN #140 stepped away from the medication cart and into a room, the inspector observed that the medication cart was left unlocked. One resident was observed walking in the hallway nearby. On the third floor, RPN #141 was observed conducting a medication pass. When RPN #141 stepped away from the medication cart and into a room, the inspector observed that the medication cart was left unlocked. In an interview, RPN #141 acknowledged the cart had not been in their line of vision.

In interviews, RPN #140 and #141 acknowledged that the medication cart should always be locked when left unattended.

B) On an identified date, the inspector observed an identified medication on resident #027's bedside table and on resident #024's bedside table. In addition, on another identified date, the inspector observed two tubes of an identified medication and one container of another identified medication on resident #023's bedside table. Upon informing RN #138 of the findings in resident #023's room, RN #138 further found two additional and different tubes of identified medications in resident #023's room.

The observations made on these two identified dates were confirmed by PSW #121 and RN #138. In an interview, RPN #137 stated that prescribed treatments should be stored and locked in the treatment cart when not in use as they can present a safety risk if left in residents' rooms. [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 #12: 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 monthly audits of the daily count sheets of controlled substances were undertaken to determine if there were any discrepancies, and that immediate action was taken if any discrepancies were discovered.

On an identified date, a MAR binder was observed to have a single signature, identified as RPN #126's initials, on each of the narcotic/controlled substances shift count sheets indicating that a shift count had been completed at 1500hrs for that same day. The time of observation of this documentation was at approximately 1151hrs. In an interview, on the same day at 1410hrs, RPN #126 acknowledged that by signing the count sheets before the actual time it was recorded for, and without a second registered staff, they were not following CNO's practice standards or the home's policies related to controlled substances.

A review of the Quarterly Professional Advisory Committee Reports dated November 30, 2018, for the period of September to November 2018, indicated that individual count sheets were not always double signed when receiving Narcotic and Controlled substances. Review of the Quarterly Professional Advisory Committee Reports dated June 28, 2019 (for the period of March-May 2019) identified missing signatures on narcotic shift count documents; however, it did not note the immediate actions taken to address these discrepancies.

A review of the Quality Assurance Summary Report from Medical Pharmacies dated March 20, 2019, indicated findings of discontinued or expired medications including narcotics failing to be removed from all 5 floors' medication carts and other storage areas.

The action plan noted in all three above mentioned documents to address the identified issues related to narcotic and controlled substances was for NM #102 to complete internal narcotic audits on a monthly basis.

In an interview, NM #102 stated that they were the lead for the medication administration system in the home. Upon request to review the results of the home's monthly audits of the daily count sheet of controlled substances, NM #102 stated that the home had not completed these audits. [s. 130. 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 monthly audits of the daily count sheets of controlled substances are undertaken to determine if there are any discrepancies, and that immediate action is taken if any discrepancies are discovered, to be implemented voluntarily.

WN #13: 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 for residents #005, resident #006 and resident #024, drugs were administered in accordance with the directions for use specified by the prescriber.

A review of the home's policy titled Medication Administration, MM-0201-00, dated April 1, 2016, indicated that each resident shall receive medications prescribed by the physician or the Nurse Practitioner in a manner consistent with professional standards and evidence-based care.

A) The MLTC received a complaint regarding the late administration of medications.

In an observation conducted by Inspector #699 on August 23, 2019, the inspector

observed RPN #132 administering an identified medication to resident #005 at 0918hrs. Inspector #699 reviewed the administration of the identified medication with RPN #132, who confirmed that the medication was due at 0730hrs and was to be given prior to meals.

A record review of resident #005's MAR indicated the identified medication was ordered to be administered 30 minutes before breakfast for an identified diagnosis.

In an interview, RPN #132 that if a resident was resistive to taking medications, they would re-approach. They further stated that resident #005 resisted to take water from them at 0745hrs that day and they had considered that to be an assessment that the resident would be resistive, so they did not administer the medication. RPN #132 confirmed that they did not re-approach resident #005 to give their scheduled 0730hrs medication and acknowledged that the physician order was not followed.

In an interview IDON #134 acknowledged that the medication was not given as per physician orders for resident #005.

B) A complaint was submitted to the MLTC on an identified date about medication incidents related to resident #006.

A review of resident #006's medical records indicated that on an initial identified date, they were assessed by a specialist due to an identified issue and diagnosed with an identified diagnosis. The recommended course of treatment was an identified medication on a long-term basis.

i) A review of the physician's orders on the initial identified date revealed an order for the identified medication, with a specified dose to be administered before meals twice a week for two weeks, then once daily forever for the identified diagnosis. It also specified instructions related to how to take the medication and positioning of the resident after taking the medication.

A review of the physician's orders and MARs displayed that the above order for the identified medication was administered correctly before breakfast for two weeks from the initial identified date. Following this, although the order and subsequent orders for the identified medication continued to indicate that it was to be administered before meals, the identified medication was administered at an

identified time after breakfast for approximately five months.

In an interview, RPN #137 stated that they had generally administered resident #006's medications after breakfast. Upon examination of the resident's MARs, and physician's orders, RPN #137 identified that the identified medication was ordered to be administered before meals, and the identified time it was eventually administered was not an administration time considered to be before a meal.

In interviews, NM #102 and IDON #134 acknowledged that during the identified five-month period, resident #006 did not receive the identified medication as prescribed by the physician.

ii) A review of the complaint received by the MLTC and resident #006's progress notes indicated that on an initial identified date, resident #006's family member handed a nurse manager a packet containing four identified pills found on various dates. The nurse manager at the time placed a large note inside the MAR instructing nurses to begin administering pills one at a time given the resident's specified conditions and to ensure that resident #006 swallows their pills.

Furthermore, a review of the resident's chart included a prescription note from the specialist and a telephone order from the physician in the home dated two weeks from the initial identified date which addressed to the staff in the home through an order that resident #006 is to take medications with specified instructions while sitting in an identified position as they were at risk of having pills stuck in their esophagus which can cause an identified medical condition.

A review of resident #006's MARs showed that the above order was correctly administered for approximately one month following the initial identified date; however, review of the MARs for the subsequent three months after that showed that it did not accurately reflect the order noted above. More specifically, the instructions on how to administer all medications for resident #006 related to positioning and specified instructions were included only under one identified medication.

The complaint submitted to the MLTC stated that during the identified three month period and approximately a week following it, 13 identified medication pills/capsules were found in resident #006's room during 12 specified dates and times, of which some were handed to ED #135 on an identified date.

Furthermore, a review of resident #006's progress notes by a registered staff member with an identified date within this same three month period, stated that resident #006's family member had brought forward a concern to them. The concern was that the order for an identified medication describing to take it with specified instructions while sitting in an identified position was solely noted under this identified medication in the MAR, and that this made it unclear that these instructions were applicable each time medication was administered for resident #006. A review of resident #006's MAR that the family member was referring to at the time, and the subsequent monthly MAR after that did not indicate that any changes were made to the order for the identified medication or specific instructions as a result of the family member's voiced concern.

A review of the physician's orders with an identified date at the end of the identified three month period indicated an order for resident #006 to be referred back to the specialist as they were continuing to have an identified medical concern despite the prescribed identified medication. A review of resident #006's medical records revealed documentation from the specialist with an identified date stating that resident #006 was assessed to have an identified diagnosis. An identified intervention was implemented, and a recommendation for the same identified medication was made. The documents further advised that after taking medication, specified instructions while sitting in an identified position should be followed. A review of resident #006's physician's order indicated an order with an identified date three days later, ordering the specialists' advice to be followed after each "medication pass".

A review of the MAR for the subsequent ten days following the physician's order did not include this order. A review of the next monthly MAR contained a dietary order which included specified instructions to be followed after each med pass with administration times signed at three identified times; however, it did not include the additional instructions related to positioning as indicated by the specialist and physician in previous orders. A review of the second monthly MAR following the specialist and physician's most recent orders contained handwritten instructions about the specified instructions.

As per resident #006's medical records, they significantly declined in health at the end of the time of this second monthly MAR and subsequently deceased on an identified date. A review of resident #006's Medical Certificate of Death indicated that significant conditions that had contributed to the death (but not causally to the immediate causes) included the identified diagnosis for which resident #006 was

seeing the specialist.

In interviews, NM #102 and IDON #134 acknowledged that drugs had not been administered to resident #006 in accordance with the physician's directions related to following the specified instructions and positioning of resident #006 when administering medications as specified. They further acknowledged that this was evidenced by the records in the MARs not reflecting the orders of the physician and the medications found in resident #006's room.

C) An identified medication was observed in resident #024's room, on their bedside table as confirmed by PSW #121 on an identified date and time. In an interview, PSW #121 stated that the resident self-administers this medication.

A review of resident #024's current MAR dated and most recent orders indicated that the resident was ordered the identified medication observed in their room to be applied twice daily to identified locations until healed. They were also ordered two other identified medications twice a day to be applied to identified locations for an identified period of time. Administration times for both medications were noted to be at 0600hrs and 2000hrs; however, the MAR did not contain signatures for an identified date that it was ordered to be administered at 0600hrs for either medication to indicate that they had been administered. A review of the records did not indicate that the resident self-administers medication.

In an interview, resident #024 stated that staff administer these topical medications to them and that the night nurse usually applies it, but that the current night nurse did not do so because they were new.

In an interview, RN #138 stated that the above-mentioned topical medications should have been administered to resident #024 by the nurse on the identified date at 0600hrs, and that the nurse should have signed off on the MAR to indicate it had been administered. RN #138 further acknowledged that these medications had not been administered to resident #024 as per the physician's direction. [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 residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Findings/Faits saillants :

1. A) The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and reported to 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.

i) A complaint was submitted to the MLTC on an identified date, about medication incidents related to resident #006. A review of the complaint outlined concerns about negligence around drug administration including medications being left in residents' rooms. It stated that on an identified date, a packet containing four identified medication pills that family members had found on various dates in resident #006's room was handed to the nurse manager on the unit.

A review of resident #006's progress notes on the same date identified in the complaint, indicated that resident #006's family member handed a nurse manager a packet containing four identified medication pills found in resident #006's room on various dates. The note did not indicate whether the resident was assessed, or whether the issue was reported to the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the pharmacy service provider.

The complaint further stated that approximately two months following the above

incident, and between a period of approximately two identified months, eight identified medication capsules/pills and two used/empty identified medication capsules were found during nine specified dates and times. These medications were later handed to ED #135 five days from the date that the last medications were found.

A folder retrieved from the DON's office contained the above-mentioned medications handed to the nurse manager by the family member and was dated in the folder three months after the time it was handed to them. It also included a packet of three identified medication tablets received from NM #115 with attached documentation indicating resident #006's name and that the medication was found on two identified dates during the same month but prior to the identified date that medications were handed to ED #135. The folder also contained the medications handed to ED #135, which were dated nine days after the date that the complainant handed the medications to them.

Furthermore, the complaint received by the MLTC further stated that after the date where medications were handed to ED #135, between a period of an identified week, on three specified dates and times, three different medications were found. The folder retrieved from the DON's office contained these medications with documentation indicating these medications were received by the DON from the family on an identified date approximately one month after the identified date that medications were handed to ED #135.

In an interview, Pharmacy Consultant #143 stated that the Pharmacy Consultant is informed of medication incidents during meetings with the management team before their quarterly Health Advisory Committee (HAC) meetings. During HAC meetings, they are informed of any medication incidents in the last three months, which are then discussed, and minutes of the meeting are documented. Pharmacy Consultant #143 also stated that these medication incidents are also included in their Quarterly Professional Advisory Committee Reports.

A review of a Medication Incident Meeting Minutes document dated the same month as the most recently obtained medications from the family, indicated that NM #102, and the previous Pharmacy Consultant were in attendance and ED #135 and another nurse manger were present for part of this meeting. It further stated that there had only been one medication incident for the review period between two identified months that captured the time of the incidents where medications were found in resident #006's room and handed to ED #135, resident

#006's medications were documented to have been received from a nurse manager, and where medications were found in resident #006's room and most recently received by the DON from the family. The incident was described as dose omission by nurses in the identified month where resident #006's medications had most recently been brought to the DON's attention by the family who had found identified medications on multiple occasions in the resident #006's room over the last few months.

This indicated that staff who were informed about the medications found in resident #006's room had not reported or documented the reporting of these incidents elsewhere. As a result, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician and the pharmacy service provider did not become aware of these incidents until resident #006's family brought the concerns forward themselves to the DON.

In an interview, NM #102 stated that each finding of medication ordered for resident #006 in their room would indicate incidents of missed doses and acknowledged that as per the home's policy, medication incident reports should have been completed each time a concern by resident #006's family member was reported to a staff member, or medications were found. NM #102 further acknowledged that the above mentioned incidents had not been reported, and documentation had not been kept as per the home's policy to indicate that it had been reported to the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician and the pharmacy service provider.

ii) In an interview, Pharmacy Consultant #143 stated that the Pharmacy Consultant is informed of medication incidents from the last three months during meetings with the management team before their quarterly HAC meetings. During this meeting about medication incidents, the incidents are discussed, and minutes of the meeting are documented. Pharmacy Consultant #143 also stated that these medication incidents are also included in their Quarterly Professional Advisory Committee Reports.

A review of the Quarterly Professional Advisory Committee Reports dated March 29, 2019, for the period of December 2018, to February 2019, indicated that there had been a medication incident in January 2019, involving a missed dose to a resident.

A review of the medication incident reports did not indicate such an incident had been documented.

In an interview, Pharmacy Consultant #143 stated that the only record he had of a medication incident in January was unrelated to a missed dose. Pharmacy Consultant further acknowledged that a medication incident report involving a missed dose had not been kept by the home as per their policy.

B) The licensee has failed to ensure that all medication incidents and adverse drug reactions were:
a) documented, reviewed and analyzed and b) corrective action was taken as necessary, and a written record was kept of everything required under clauses (a) and (b).

i) A CIS report and a complaint were submitted to the MLTC on an identified date about a medication incident involving resident #006's identified medications.

A review of the complaint stated that on an identified date, a near miss medication incident had occurred wherein RPN #144 had handed an identified medication to resident #006 which did not belong to them. Upon intervention by resident #006's family member, RPN #144 corrected the error and identified and administered the correct medication for this resident.

A review of the CIS described this incident as misappropriation and stated that the family member who bore witness to this incident had submitted a letter to a Nurse Manager describing this occurrence as a near miss incident.

In an interview, NM #115 stated that their responsibilities included being involved with any investigations involving medication incidents. They further stated that RPN #144 had received disciplinary action related to the incident involving resident #006 and the identified medication; however, they were not able to provide any documentation related to this investigation or actions taken.

A review of the medication incident reports, resident #006's progress notes, RPN #144's personnel file, and HAC meeting minutes covering the identified date of this incdient did not reveal documentation of this incident related to the near miss incident involving resident #006 and RPN #144.

iii) A review of a medication incident with an identified date involving resident

#029 indicated that they had been administered an incorrect medication at night time which was ordered for their co-resident. The identified contributing factor was that the medication had been "pre-poured" (prepared prior to administration instead of at the time of administration). The incident did not result in harm to the resident. The document did not contain a written record of the corrective action taken in relation to the staff member who had incorrectly administered the medication.

A review of a medication incident with an identified date involving resident #030 indicated that they had a visual impairment, and ingested a sip from an opened bottle of an identified medication located on their bedside table. The contributing factor for this incident was identified as the bottle of an identified medication not being securely stored in the treatment cart. The incident did not result in harm to the resident. Although the document stated that the nurse manager was to follow up with staff regarding this issue, it did not indicate the details of how and whether this was completed.

In an interview, NM #115 stated that all medication incidents are to be reviewed and analyzed by the nurse managers and DON, and disciplinary action or education provided as needed. They further stated that the information on the staff members involved in the incident and all actions taken should be documented. NM #115 further acknowledged that this was not done for the medication incidents which occurred on identified dates involving resident #029, and resident #030 respectively.

C) The licensee has failed to ensure that a quarterly review was 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, and that any changes and improvements identified in the review were implemented, and a written record was kept of everything.

In an interview, Pharmacy Consultant #143 stated that the Pharmacy Consultant is informed of medication incidents from the last three months during meetings with the management team before their quarterly HAC meetings. During this time, the incidents are discussed, and minutes of the meeting are documented. Pharmacy Consultant #143 also stated that these medication incidents are also included in their Quarterly Professional Advisory Committee Reports.

A review of medication incident reports indicated a medication incident had occurred on:
- an identified date involving resident #029
-and another identified date, involving resident #030.

A review of the Quarterly Professional Advisory Committee Reports, and Medical Advisory Committee and HAC meeting minutes dated November 30, 2018 (for the period of September to November 2018), and March 29, 2019 (for the period of December 2018 to February 2019), did not indicate that these medication incidents were reviewed.

In an interview, Pharmacy Consultant #143 acknowledged that these incidents had failed to be included in both quarterly reviews of all medication incidents. [s. 135.]

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 documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and reported to 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 be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 148. Requirements on licensee before discharging a resident

Specifically failed to comply with the following:

s. 148. (2) Before discharging a resident under subsection 145 (1), the licensee shall,
(a) ensure that alternatives to discharge have been considered and, where appropriate, tried; O. Reg. 79/10, s. 148 (2).
(b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident; O. Reg. 79/10, s. 148 (2).
(c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration; and O. Reg. 79/10, s. 148 (2).
(d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident. O. Reg. 79/10, s. 148 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that, before discharging resident #002 under subsection 145 (1), a written notice was provided to the resident, and their substitute decision-maker, if any, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident.

A complaint was submitted to the Director on an identified date, related to wrongful discharge of resident #002. The complainant reported that resident #002, who was admitted to the home for specified care within a specified program, was transferred to the hospital on an identified date, at which time they were admitted and treated for an identified condition. The resident was then discharged with the expectation that they were to return to the home.

A review of resident #002's Resident Conference notes dated the same day identified in the complaint as the day that resident #002 was sent to the hospital, indicated that resident #002 had experienced a change in condition in the last five

days, had identified issues with their respiratory system and elevations in identified bloodwork levels, and as a result, resident #002 could no longer participate in the identified program that they were admitted to. The resident was transferred to the emergency room in the hospital and subsequently discharged from the home.

In an interview, the attending physician in the hospital's emergency department indicated that resident #002 was admitted to the hospital with an identified diagnosis, and after treating the resident for this issue, they tried to transfer the resident back to the home. They further indicated that the home declined to re-admit the resident citing that they were not a good candidate for the identified program they were admitted to as they had a change in condition and was not participating in specified interventions.

In separate interviews, RPN # 105, SW #104, and Manager of Resident Services #103 indicated that the resident was unable to participate in the identified program they were admitted to and that the home had held a discharge conference with the resident and their SDM and the resident was transferred to the hospital. They indicated that it is the practice of the home to discharge to another long-term care home, hospital or back to the community, any resident who does not actively participate in the activities of the identified program that resident #002 was admitted to.

Manager of Resident Service #103 indicated that the resident was discharged to the hospital as they were medically unstable and would not benefit from the program.

A review of the discharge care conference notes and interviews with staff, indicated that the home had not provided a written notice given to resident #002 or to their SDM setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident. [s. 148. (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 before discharging residents under subsection 145 (1), a written notice has been provided to the resident, their substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 213. Director of Nursing and Personal Care

Specifically failed to comply with the following:

s. 213. (1) Every licensee of a long-term care home shall ensure that the home's Director of Nursing and Personal Care works regularly in that position on site at the home for the following amount of time per week:
1. In a home with a licensed bed capacity of 19 beds or fewer, at least four hours per week. O. Reg. 79/10, s. 213 (1).
2. In a home with a licensed bed capacity of more than 19 but fewer than 30 beds, at least eight hours per week. O. Reg. 79/10, s. 213 (1).
3. In a home with a licensed bed capacity of more than 29 but fewer than 40 beds, at least 16 hours per week. O. Reg. 79/10, s. 213 (1).
4. In a home with a licensed bed capacity of more than 39 but fewer than 65 beds, at least 24 hours per week. O. Reg. 79/10, s. 213 (1).
5. In a home with a licensed bed capacity of 65 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 213 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's Director of Nursing and Personal Care (DON) works regularly in that position on site at the home for at least 35 hours per week.

During the course of the inspection, the interim IDON #134 indicated that they would be only in the home every Monday, Tuesday and Friday as they were off on Wednesday and Thursday.

In an interview with the ED #135, they stated that the regular fulltime DON was currently on sick leave and the interim IDON #135 was in the home three days of the week. They further indicated there was no one in the home acting as DON during the two days the interim IDON #134 is away. ED #135 acknowledged that the required DON hours were not being met. [s. 213. (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 home's Director of Nursing and Personal Care (DOC) works regularly in that position on site at the home for at least 35 hours per week, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 219. Retraining
Specifically failed to comply with the following:

s. 219. (1) The intervals for the purposes of subsection 76 (4) of the Act are annual intervals. O. Reg. 79/10, s. 219 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff at the home have received training in infection prevention and control at annual intervals as required by paragraph 9 of subsection 76 (2) and subsection 76 (4) of the LTCHA.

A record review of the infection prevention and control training for 2018, showed that 68.53% of staff completed the annual training.

In an interview, NM #102 stated that it was mandatory for all staff to have completed the infection prevention and control training. [s. 219. (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 all staff at the home have receive training in infection prevention and control at annual intervals, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas of behaviour management on an annual basis.

A record review of the behaviour management training for 2018, showed that 63.83% of staff had completed the annual training.

In separate interviews with IDON #134 and NM #102, they indicated that if a staff was listed as "registered/overdue" on the training record, it indicated that the staff member had not completed their annual training. NM #102 further indicated it was mandatory for all staff to have completed the responsive behaviour training. [s. 221. (2) 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 all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act including training in the areas of behaviour management on an annual basis., to be implemented voluntarily.

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that RPN #132 participated in the implementation of the infection prevention and control program.

During an observation by Inspector #699 on an identified date, RPN #132 dropped a pill on the ground during medication administration for a resident. The inspector observed the RPN pick up the pill and place it back into the medication cup and administer the medications to the resident.

In an interview with RPN #132, confirmed that they had administered the pill that was dropped on the ground to the resident. They further stated that the appropriate course of action after dropping the pill would have been to discard the medication, go into the next day medication packet, administer the medication and call pharmacy to send a replacement for the missing medication. RPN #132 acknowledged that appropriate infection control practice was not implemented.

A record review of the home's policy titled "Medication Administration", MM-0201-00, published April 1, 2016, indicated that registered staff should maintain correct infection prevention and control practices during medication administration.

A record review of the home's training records for infection prevention and control training indicated that RPN #132 did not complete the mandatory training.

In an interview with IDON #134, they acknowledged that appropriate infection prevention and control practices were not maintained during the medication administration. [s. 229. (4)]

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 all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

Issued on this 12nd day of November, 2019 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

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

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by BABITHA SHANMUGANANDAPALA (673) - (A1)
Inspection No. / No de l'inspection :	2019_714673_0007 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	001257-18, 008127-18, 013581-18, 016120-18, 016134-18, 017596-18, 017986-18, 018004-18, 019528-18, 025229-18, 005201-19, 007683-19 (A1)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Nov 12, 2019(A1)
Licensee / Titulaire de permis :	City of Toronto c/o Seniors Services and Long-Term Care, 365 Bloor Street East, 15th Floor, TORONTO, ON, M4W-3L4
LTC Home / Foyer de SLD :	Seven Oaks 9 Neilson Road, SCARBOROUGH, ON, M1E-5E1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Peter Puiatti

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

To City of Toronto, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

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

Specifically, the licensee must ensure the home's system to monitor and evaluate the food and fluid intake of residents #015, #016, #017 and all other residents with identified risks related to nutrition and hydration is implemented and complied with. The licensee must ensure:

1) All staff providing direct care to residents, including nursing and PSW staff, are educated on all protocols and procedures related to the Food and Fluid Intake Record, and that a documented record of the education, who attended, when it was provided and by whom is kept

2) Development and implementation of a monitoring system to ensure the Food and Fluid Intake Record is implemented. Ensure that a documented record of the monitoring system is maintained

Grounds / Motifs :

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

In accordance with s.68 (2) (d), the licensee was required to ensure that the Nutrition Care and Hydration program includes a system to monitor and evaluate food and fluid intake of residents with identified risks related to nutrition and hydration.

Specifically, staff did not comply with the licensee's Food and Fluid Intake Record which is part of the licensee's Nutrition and Hydration program.

A) A review of the home's Food and Fluid Intake Record indicated the following instructions:
- Night shift PSW will add up the number of servings from days, evenings and nights
- Night shift RN/RPN will initial daily to indicate record is complete. If incomplete, they shall inform Nurse Manager, operations to follow up
- Night shift RN/RPN will calculate daily fluid (125 ml x number of Servings) document in the progress notes
- Refer to Registered Dietitian and notify Physician/Nurse Practitioner if:
(a) resident's daily food intake is 0% and/or
(b) resident consumes less than 8 servings of fluid over 48 hours and/or show signs and symptoms of dehydration.

A complaint was submitted to the Ministry of Long-Term Care (MLTC) on an identified date. The complainant reported that resident #003 was admitted and treated at the hospital for a nutrition/hydration related condition.

A review of resident #003's medical records identified the resident as being at high risk for nutrition and hydration related issues due to a specified condition and diagnosis. It also indicated that upon resident #003's return from the hospital on an identified date, identified aspects of their health condition was noted to have deteriorated.

A review of resident #003's Food and Fluid Intake Record twelve days prior to their specified date of hospitalization indicated the following:
- food and fluid intakes were not recorded for identified meals on five identified days
- morning and evening snacks were not documented,
- the food and fluid intake form did not identify a calculation of the daily fluid intake.

B) As there was a non-compliance related to the home's Food and Fluid Intake Record, the inspector expanded the sample to include resident #015, #016, and

#017.

A review of resident #015's Food and Fluid Intake Record for an identified time period of 21 days indicated that the resident received less than eight servings of fluid on four identified consecutive days.

In this case, resident #015 consumed less than eight servings of fluid over 48 hours and was not referred to the Registered Dietitian. The Physician/Nurse Practitioner was also not notified. In addition, nine days of the daily fluid intake was not calculated within the time period identified above.

A review of resident #016's Food and Fluid Intake Record for 21 days of an identified time period indicated that the daily fluid intake was not calculated for the period identified above.

A review of resident #017's Food and Fluid Intake Record for six days of an identified time period indicated that the daily fluid intake was not calculated.

In an interview, RPN #107 indicated that hydration is monitored in the home by nursing staff where the staff on days and evening shifts document the food and fluid intake of each resident, and the night shift RPN records the totals of the daily fluid intake. The RPN also indicated they were unclear about this as the home did not give them an in-service related to it. Furthermore, they stated that after informing the RN that they needed training in the process on what to complete as part of the form and how to analyze the data, they stopped looking at the food and fluid intake forms.

The RN identified by the RPN was no longer in the home.

In an interview with NM# 102, they acknowledged that the food and fluid intake forms were not completed as per the home's expectations. They indicated that the recorded numbers were not always correct on the forms as staff sometimes copied the numbers from the previous days. They indicated that staff may need additional training.

From the review of the instructions in the home's Food and Fluid Record, residents' daily fluid intake records, and staff interviews, the inspector concluded that staff in the home did not comply with the home's system to monitor and evaluate food and

fluid intake of residents with identified risks related to nutrition and hydration. [s. 8. (1) (a),s. 8. (1) (b)]

The severity of this issue was determined to be a level 2 as there was minimal harm to the residents. The scope of the issue was a level 3 as there was a pattern identified within four out of the four residents reviewed. The home had a level 3 history as they had on-going noncompliance with this subsection of the LTCHA, which included:
- Voluntary Plan of Correction (VPC) issued March 8, 2019 (2019_486653_0002);
- Written Notification (WN) issued February 27, 2018 (018_525596_0001);

Additionally, the LTCH has a history of 4 other compliance orders in the last 36 months.

Due to the severity, scope, and history, a compliance order is warranted. (502)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2020(A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Order / Ordre :

The licensee must be compliant with LTCHA, 2007 S.O. 2007, c.8, s. 19.

Specifically, the licensee must ensure:

1) Resident #011 and all other residents are protected from physical abuse by anyone, including resident #010

2) Resident #019 and resident #20, and all other residents are protected from sexual abuse by anyone, including resident #018

3) Identification, whenever possible, of triggers and strategies for any residents exhibiting responsive behaviours, including residents #010, #019, #020, and #18

4) The plan of care is updated with identified triggers and strategies for any residents, including residents #010, #019, #020, and #18, who are exhibiting responsive behaviours

5) The most updated written plan of care for each resident is readily accessible to all staff providing care, and that these plans are implemented. This includes all residents requiring two or more staff for transfers out of bed.

6) Development and implementation of an internal monitoring process including written audits monthly for the next three months as of the receipt of this order to ensure the implementation of the plan of care by staff for all residents. The written record must include the date of the audit, the resident's name, the name of the staff, the name of the person completing the audit, the outcome of the audit and any action taken as a result of the audit.

7) Completion of the mandatory annual training for abuse recognition and prevention as required under the LTCHA, 2007, c.8, s. 76.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that resident #011 was protected from physical abuse by anyone in the home.

As per O. Reg. 79/10, s.2 (1), the definition of "physical abuse", subject to subsection (2) (1) of the Act, includes the use of physical force by a resident that causes physical injury to another resident.

A Critical Incident System (CIS) report was submitted to the MLTC on an identified date related to resident to resident physical abuse. A review of the CIS report indicated that on an identified date and time, resident #010 entered a common area in their mobility aide and pushed resident #011, who was sitting at a table. The force from resident #10's mobility aide pushed the table that resident #011 was sitting at and resident #011 sustained identified injuries/harm to an identified location of their body as a result of it hitting the edge of the table.

A review of the home's investigation records indicated that following the incident on a specified date, both residents were separated and assessed. Resident #011 sustained an identified injury to an identified location of their body where the table had made contact.

A review of resident #011's health records indicated they had an identified level of cognitive impairment and identified diagnoses, but did not have any communication, relationship, or history of altercation with resident #010.

As per the CIS report, resident #010 was cognitively intact. A review of resident #010's health records indicated identified diagnoses. At the time of the assessment period, resident #010 had exhibited identified behaviours which could be easily altered and the resident was independent for locomotion on and off the unit with their mobility aide. A review of resident #010's most recently updated written plan of care indicated that the resident was identified to have specified behavioural problems. The staff attributed some of the resident's identified behaviours to their identified diagnosis. The goal and interventions were set in the plan of care to assist the staff in managing resident #010's behaviour.

In separate interviews, resident #011 was not able to recall the incident, and resident #010 refused to talk to the inspector.

In an interview, PSW #118 indicated that they were aware of resident #010's identified behaviours and they always approached them cautiously when providing care. They stated that they first ask them if they are ready for assistance before

providing care to the resident, but the resident's behaviour could be unpredictable. In these situations, they try to calm the resident and if resident #010's behaviour escalates, they notify the nurse in charge who then comes and takes over the care. The PSW further indicated that this did not happen often, but when it did, the nurse would call a code white, and sometimes call the police. The PSW also acknowledged that resident #011 was physically abused by resident #010 during the incident with their mobility aide in the common room.

In an interview, RPN #110, a lead of the behavioural support outreach (BSO) program, indicated that they had assessed the resident and included them in the BSO program. BSO had monitored and assessed the resident and after evaluating their behaviour to be calm and pleasant, they discharged the resident from the BSO program. The BSO lead stated that after the incident specified in the CIS report, the resident was placed on dementia observation system monitoring for seven days and was visited by the BSO lead on a daily basis; however, the resident did not exhibit any responsive behaviours during this time. The BSO lead also stated the team tried many different interventions, but none of them worked due to a specified action of the resident and that implementing an intervention to address this action was not effective.

In an interview, RN #113, who was the Acting Nurse Manager and RN on the floor at the time of the incident described in the CIS, indicated that they were administering medication when resident #010, who was unprovoked, pushed resident #011 who was sitting at the table. The RN further confirmed that resident #010 was identified to have an identified issue and that when they experienced this issue, they used their mobility aide to express it. The RN explained the resident used their mobility aide in this way with the staff. The multidisciplinary team also decided to adjust a setting on resident #010's mobility aide as a safety measure. The RN stated no new incident was identified until the date of the incident identified in the CIS, and there had been no incident after that. The RN confirmed that resident #011 in this incident was physically abused by resident #010.

In an interview, NM #102 indicated that based on the information provided in the CIS and the progress notes, resident #011 was not protected from physical abuse by resident #010 who used their mobility aide to run over resident #011. [s. 19.] (673)

2. The licensee has failed to ensure that resident #019 and resident #020 were protected from sexual abuse by anyone in the home.

As per O. Reg. 79/10, s.2 (1), the definition of "sexual abuse", subject to subsection (2) (1) of the Act, includes any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident.

The MLTC received a CIS report related to sexual abuse of resident #019 by resident #018 which occurred on an identified date. Both residents were separated and dementia observation system (DOS) tool was initiated. A second CIS report was submitted to the MLTC on an identified date related to sexual abuse of resident #020 by resident #018 which occurred on an identified date approximately three months after the date identified in the first CIS. Both residents were separated and DOS was initiated.

A record review of resident #018, #019, and #020's Continuing Care Reporting System 2.0 (CCRS) assessments completed on specified dates closest to the dates of the incidents described in the CIS reports showed that all three residents' cognitive skills for daily decision making were impaired at the same identified level.

A review of resident #018 and #019's progress notes indicated that at the time of the reported incident involving both residents, resident #019's identified behaviour resulted in them entering resident #018's bedroom to use their bathroom. Resident #019 then proceeded to lay down on resident #018's bed without having fully dressed. Resident #018's progress notes did not indicate any previous sexual behaviours and that at the time of this incident, they had thought that resident #019 was their spouse.

A record review of resident #018's written plan of care related to behavioural problems, updated approximately a week and a half from the time of the incident described above with resident #019, indicated that staff were to monitor the resident for one more week. A record review of resident #018's behaviour assessment tool (BAT) beginning on the date of the incident did not identify any trial interventions related to the resident's sexual behaviour and was incomplete.

A record review of resident #020's progress notes indicated that there were instances prior to the incident when resident #020 exhibited an identified behaviour which required redirecting.

A record review of resident #020's clinical health records prior to the identified date of the incident involving resident #018 did not contain any assessments or interventions related to their identified behaviour, to indicate implementation of a plan of care based on an interdisciplinary assessment of resident #020's identified behaviour.

A record review of resident #018 and #020's progress notes related to the incident described in the CIS that was submitted, indicated that resident #020 exhibited an identified behaviour into resident #018's room and laid down beside resident #018. Resident #018 thought resident #020 was their spouse and proceeded to undress. Following the incident, resident #018 and #020 were assessed by the physician, and no injuries were noted to either resident.

In an interview, NM #102 stated that the expectation for residents identified to be exhibiting responsive behaviours was for triggers to be identified and strategies to be implemented to prevent reoccurrence.

In an interview, BSO staff RPN #129 indicated that there were no interventions in place to address resident #020's identified behaviour. BSO RPN #129 further indicated that resident #018's sexual behaviour was related to resident #019 and resident #020 specified behaviours, and that they had not identified resident #018's specific triggers for sexual behaviour in their plan of care.

BSO RPN #129 and NM #102 both acknowledged that residents #018 and #020 were not protected from harm as steps had not been taken to minimize potentially harmful interactions between them and resident #018 by identifying and implementing interventions.

A record review of the Abuse and Neglect Prevention and Response Protocol for 2018 showed that 70.28% of staff had completed the annual training. In an interview, NM #102 indicated that it was mandatory for all staff to have completed the abuse recognition and prevention training. [s. 19.]

The severity of this issue was determined to be a level 3 as there was actual risk of harm to residents. The scope was level 1 as the issue was isolated to two out of eight residents reviewed. The home had a compliance history of level 2 as they had previous noncompliance to a different subsection of the LTCHA.

Additionally, the LTCH has a history of 4 other compliance orders in the last 36 months.

Due to the severity, scope, and history, a compliance order is warranted. (673)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2020(A1)

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 114. (1) Every licensee of a long-term care home shall develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents. O. Reg. 79/10, s. 114 (1).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 114 (1).

Specifically, the licensee must ensure:

1) All written protocols and policies are reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director

2) Drugs are administered to all residents in accordance with the direction for use specified by the prescriber

3) All registered nursing staff, and those managing the medication administration system are educated on the College of Nurses of Ontario's standards and nursing practice related to medication administration, the home's policies and processes related to the Medication Management System, and that these are implemented. This includes but is not limited to: -rights/checks of medication administration
-appropriate and timely documentation
-practices related to narcotics and controlled substances
-safe and secure storage of medications
-medication incidents and adverse drug reactions
-purchasing and handling of drugs
-implementation of IPAC

4) An interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and recommend any changes necessary to improve the system

5) Any changes identified in the quarterly evaluation of the medication management system are implemented, including those identified between 2018 and 2019

6) Completion of an annual evaluation of the medication management system

7) Steps are taken to ensure the security of the drug supply, including the following:
-All areas where drugs are stored shall be kept locked at all times, when not in use
-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

8) Development of an auditing tool to ensure ongoing compliance with all areas identified in this order, and ensure that a written record is maintained of the audits conducted in the home including the date of the audit, the type of audit, the name of the person completing the audit, the outcome of the audit and any action taken as a result of the audit.

Grounds / Motifs :

1. The licensee has failed to ensure the development of an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents.

A) Policy MM-0201-00 indicated that staff must adhere to the eight rights of medication
administration (right resident, medication, dose, time, route, site, frequency and reason), and during medication administration:
-verify resident using 2 identifiers such as the identification band and picture in the

Medication
Administration Record (MAR) binder prior to administering medications,
-compare the label on the strip package, bottle, or container with the MAR sheet and verify expiry date prior to administration, and
-document on the medication administration record after each medication administration by recording the nurse's initials in the space provided.

A review of the home's Quarterly Professional Advisory Committee Reports, detailed below, all identified a persisting problem related to documentation and medication administration in the home:
- June 22, 2018 (for the period of March to May 2018),
- September 7, 2018 (for the period of June to August 2018) and - March 29, 2019 (for the period of December 2018 to February 2019).

The reports specifically identified missing documentation as persisting trends where medications were not always signed or coded for in the MAR/Treatment Administration Record (TAR) (many
"missing signatures") and medications were not always being signed for at the time of administration (either pre-signed or post-signed in bulk). It identified that such trends can increase the risk of medication incidents and the risk of dose omissions.

The MLTC received complaints regarding the late administration of medications. A complaint was also submitted to the MLTC on a specified date, about medication incidents related to resident #006. A review of a Medication Incident Meeting Minutes document with a specified date, was identified to be related to resident #006 by the home. Contributing factors identified in the meeting were that medications may had been left unobserved but signed for as having been administered. It further stated that other ongoing trends identified in the home that could increase such incidents of dose omissions included medications not always being signed for in the MAR at the same time as their administration.

In interviews, NM #102 and IDON #134 indicated that registered staff are expected to follow CNO's standards of practice and the home's policies as it relates to medication administration and documentation. They further acknowledged that this had not been done by the nurses involved in the medication incidents described above, or RPN #101, RPN #137, RPN #132, and RPN #126 in the situations described below (Part A) from i) to iii):

i) On an identified date and time, RPN #137 was observed by Inspector #673 to be administering topical treatments to residents but was not observed to be checking a MAR or TAR before administration nor signing a MAR or TAR after administration. RPN #137 was also observed to only be checking the orders written on the medication packages before administering them to residents.

RPN #137 was later observed by Inspector #673 with a medication cart administering medications to residents. Upon review of the MAR located on top of the medication cart being used by RPN #137, it was noted that none of the residents' medications ordered to be administered at 1000hrs or 1200hrs contained a signature to indicate that they had been administered. This observation was immediately confirmed by RN #142. In an interview, RPN #137 stated that the medications ordered to be administered to residents at 1000hrs and 1200hrs had already been administered.

In interviews, RPN #137 and RN #142 acknowledged that RPN #137 should have immediately completed documentation of the administered medications in the residents' MARs as per the home's policy. RPN #137 also acknowledged that they should have been checking the ordered medications against the residents' MARs and not just the medication labels. They both confirmed that RPN #137 was not following CNO's practice standards or the home's policies in these situations.

ii) In an observation conducted by Inspector #699 on an identified date, the inspector observed RPN #132 signing the resident's MAR prior to administrating the medications. In an interview, RPN #132 stated the correct procedure would have been to administer the medication and then record in the MAR once the medication is taken.

A record review of the home's training record for medication management for 2018, indicated that RPN #132 had not completed the home's annual mandatory training.

In separate interviews, NM #102 and IDON #134 both indicated that registered staff should be signing the MAR after the administration of medications.

iii) On an identified date and time, Inspector #673 observed RPN #101 holding a medication cup containing crushed medications mixed with apple sauce. Upon examination of the medication cart, another medication cup with crushed medication

mixed in apple sauce was observed.

RPN #101 identified the two residents that these medications belonged to and indicated that these medications had been ordered to be administered at 1200hrs. Upon review of the MAR, it was noted that RPN #101 had already documented all medications ordered to be administered to residents at 1200hrs as having been administered. This included the medications mixed in apple sauce for two different residents, which had not yet been administered.

In an interview, RPN #101 acknowledged that the home's policy was to document each medication as having been given at the time of administration instead of before administration.

B) A review of the home's policy titled "Narcotic and Controlled Medications", MM-0106-00, published January 4, 2016, indicated that at shift change, one nurse from the outgoing shift and another nurse from the oncoming shift, will count narcotics and controlled medications and document the count by utilizing the Combined Monitored Medication Record With Shift Count document.

On an identified date, a MAR binder was observed to have a single signature, identified as RPN #126's initials, on each of the narcotic/controlled substances shift count sheets indicating that a shift count had been completed at 1500hrs that day. The time of observation of this documentation was at approximately 1151hrs.

In an interview, on the same day as the above observation at 1410hrs, RPN #126 acknowledged that by signing the count sheets before the actual time it was recorded for, and without a second registered staff, they were not following CNO's practice standards or the home's policies related to controlled substances.

C) A review of the Medical Pharmacies policy, Section 5, Handling of Medication, Policy 5-1, titled Expiry and Dating of Medications, dated February 2017, stated that there should be a system in place to ensure that an adequate and non-expired supply of medication is maintained for each resident. It further stated that the expiry date of all medications should be examined on a regular monthly basis and if an expiry date is not stated on the packaging, it shall be the last day of the month of the specified year.

i) On an identified date, the inspector observed two containers of an identified medication of aqueous mixture dated July 10, and August 8, 2019, on resident #023's bedside table.

A review of resident #023's medical records indicated a current order for this same identified medication, with specifications related to dosage and instructions for administration.

Upon informing RN #138 of the findings in resident #023's room, they stated that they were not aware of the medication being in resident #023's room but had administered the identified medication earlier that day to resident #023, and showed the inspector a container of the identified medication dated May, 2019.

A review of the Medical Pharmacies policy, Section 5, Handling of Medication, Policy 5-2, titled Recommended Expiry Dates Once Product is Open, dated April 2017, revised November 2018, stated that if the product is a topical mixture, the expiry date is after one month for aqueous mixtures.

When asked why RN #138 had not questioned the date on the medication dated May 2019, they acknowledged that it may have expired and responded that they had made a phone call to the pharmacy to order a new tube that day.

ii) A review of the Quarterly Professional Advisory Committee Reports dated November 30, 2018, (for the period of September-November 2018) and June 28, 2019 (for the period of March-May 2019), identified a trend of discontinued and expired medications, including insulin cartridges, being found in medication carts. A review of the Quality Assurance Summary Report from Medical Pharmacies dated March 20, 2019, indicated findings of discontinued or expired medications including narcotics, insulin and vaccines failing to be removed from all 5 floors' medication carts and other storage areas.

On an identified date, the inspector observed an identified topical medication on resident #027's bedside table.

A review of resident #027's physician's orders indicated that on a specified date approximately a month prior to the above observation, they had been ordered two specified topical medications with specified instructions of administration to treat

identified skin concerns for an identified period of time. There were no current orders for this medication for resident #027, indicating that the medication observed in the room had been discontinued.

The above observation and record review was confirmed by RN #138 who stated that resident #027 was not currently receiving any topical treatment. RN #138 acknowledged that this medication had been discontinued and should have been disposed of appropriately as per the home's policy.

This noncompliance is being issued because in addition to the findings described above, noncompliances were identified and issued elsewhere in the report related to the Medication Management System including noncompliance related to management of medication incidents and adverse drug reactions, approval of policies and protocols of the medication management system, quarterly reviews of the medication management system, completion of an annual evaluation of the medication management system and completion of monthly audits of narcotic and controlled medications.

Furthermore, a review of the home's policy titled Medication Administration, MM-0201-00, dated April 1, 2016, indicated that medications are to be administered in accordance with the College of Nurses of Ontario's (CNO) Standards, Long-Term Care Homes and Services policies and procedures. Noncompliances were issued elsewhere in the report for failure to implement this policy related to purchasing and handling of drugs, drugs being kept in their original labelled container/package until administered or destroyed, safe storage of medications, drug administration in accordance with directions for use specified by the prescriber and implementation of the infection prevention and control program during medication administration. [s. 114. (1)]

The severity of this issue was a level 2 as there was minimal risk to residents. The scope of the issue was a level 3 as the issue was widespread throughout the home. The home had a level 2 compliance history as they had previous noncompliances with a different subsection of the LTCHA.

Additionally, the LTCH has a history of 4 other compliance orders in the last 36 months.

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Due to the severity, scope, and history, a compliance order is warranted. (673)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2020(A1)

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
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À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 12nd day of November, 2019 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by BABITHA SHANMUGANANDAPALA (673) - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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Service Area Office / Bureau régional de services : Central East Service Area Office