Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 30, 2017	2017_544527_0014	024619-17	Resident Quality Inspection

Licensee/Titulaire de permis

CVH (No. 8) GP Inc. as general partner of CVH (No. 8) LP
766 Hespeler Road Suite 301 CAMBRIDGE ON N3H 5L8

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

Shelburne Long Term Care Home
200 ROBERT STREET SHELBURNE ON 000 000

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

KATHLEEN MILLAR (527), HEATHER PRESTON (640), LEAH CURLE (585)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 27 and November 1, 2, 3, and 6, 2017

The following Critical Incident System (CIS) Intakes were completed concurrently with the RQI:

000314-17 related to a resident fall
020927-17 related to a resident fall
023465-17 related to a resident fall

The following Complaint Intake was completed concurrently with the RQI:
021252-17 related to a fall

The following On-Site Inquiries were completed concurrently with the RQI:
009944-17 related to alleged neglect
021842-17 related to alleged resident to resident abuse
024566-17 related to alleged resident to resident abuse
007249-17 related to alleged resident to resident abuse
024303-17 related to safe and secure home

During the course of the inspection, the inspector(s) spoke with the General Manager (GM), the Director of Care (DOC), Restorative Care Coordinator (RCC), Resident Services Coordinator (RSC), Program Manager, Physiotherapist (PT), Maintenance, registered nurses (RNs), registered practical nurses (RPNs), personal support workers (PSWs), residents and families.

During the course of the inspection, the inspector(s) reviewed resident clinical records, internal investigative notes, policies and procedures; toured the home; and observed residents and care.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Medication
Pain
Reporting and Complaints
Residents' Council
Safe and Secure Home

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

- **7 WN(s)**
- **3 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with 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 failed where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, to ensure that the plan, policy, protocol, procedure, strategy or system, (b) was complied with.

In accordance with Regulation, s.48, required the licensee to ensure that the interdisciplinary programs including fall prevention, programs were developed and implemented in the home and each program must, in addition to meeting the requirements set out in section 30, provide for screening protocols; and provide for assessment and reassessment instruments.

A) In August 2017, resident #016 had a fall. The Long Term Care Home (LTCH) Inspector #640 reviewed the clinical record, which revealed a fall incident note. The incident description, found in the resident's clinical record, documented that the resident was noted to have had a fall, which was witnessed by staff and the resident was injured.
The Fall Management – Post Fall Assessment revealed that staff had difficulty getting the resident up from the fall and transferring the resident to bed.
The home's policy called "Fall Management", number RC-15-01-01, and last revised February 2017, directed staff to complete a focused assessment of the resident by the first registered staff on the scene. Appendix 12 of the same policy directed staff to also conduct a post fall team huddle within an hour of the fall and complete a post fall assessment as soon as possible.
Resident #016's clinical record was reviewed and revealed that the post fall assessment was incomplete, and the post fall huddle was not conducted as per the home's Fall Management policy and procedures.
During an interview with Registered Practical Nurse (RPN) #123 who told the LTCH Inspector they had attended to the scene of the fall and confirmed they conducted a partial assessment of the resident upon arrival.
During an interview with RN #120, they confirmed they were the first registered staff on the scene. The RN confirmed they had not completed a full post fall assessment and post fall huddle as per the home's policy. They confirmed they had not completed a head to toe assessment for injury.

B) In January 2017, resident #017 sustained an unwitnessed fall.
The LTCH Inspector #640 reviewed the clinical record and was unable to identify a head-to-toe assessment, a falls progress note and the notification of the resident's physician.

The home’s policy called "Fall Prevention and Management Program", number RC-2.010, with an effective date of May 2011, directed staff to complete a head-to-toe and pain assessment of the resident prior to moving the resident; notify the physician; document in the electronic clinical record in the risk management report; and to complete a falls progress note.
RPN #125 was interviewed and confirmed a head-to-toe assessment was not completed, a falls progress note was not completed and the physician was not notified of the resident's fall.
The Director of Care was interviewed and confirmed that staff did not complete a head-to-toe assessment, a falls progress note and did not notify the physician of the resident's fall as per the home’s policy and procedures.

The home failed to ensure that staff complied with the Falls Prevention and Management Program for resident #016 and #017.

C) The home was in a suspected upper respiratory infection outbreak in 2017 as declared by the Public Health Department. The outbreak management protocols were implemented.
During the suspected outbreak the home had a community program and the participants attended the home during the outbreak.
The home's policy called "Outbreak Management - External Communications", number IC-04-01-04, and last revised September 2016, which directed staff that upon confirmation of an outbreak, the home notify external partners of the outbreak and that organizations must be informed of the home's outbreak status in order to safeguard the community from the possible spread of the infectious disease.
According to "Public Health Ontario's Guide to the Control of Respiratory Infection Outbreaks in Long-Term Care Homes", last revised September 2016, and section 4.4.3 "Communal and Other Activities", the following should be implemented during an outbreak, such as reschedule communal meetings on the affected unit/floor, and do not permit visits by outside groups.
The Program Manager #124 was interviewed and confirmed the program occurred in 2017. They indicated that they did not cancel the program and did not notify the community representatives until they arrived at the home. The Program Manager also indicated that they usually cancel communal programs when the home was in an outbreak.
The DOC was interviewed by LTCH Inspector #527 and they confirmed that the Program Manager was notified to cancel all programs prior to the program start date and they did not cancel the program. The DOC confirmed that during an outbreak, the home cancels

all community programs.
The home failed to comply with their outbreak management policy and the prevailing practices governing LTCH when in a respiratory outbreak.

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Resident #003 was ordered a specific medication by the physician and to be administered every three to four hours, when needed.
The clinical record was reviewed and the LTCH Inspector #527 identified that RN #122 had administered the wrong medication.
The resident was found unresponsive by RN #126. The physician was notified and ordered a specific treatment to be administered immediately; however the home did not have the treatment in the home. The physician then ordered that the resident be transferred to the hospital. At the hospital the resident required administration of a specific treatment to counteract the effects of the wrong medication.
RN #122 was interviewed by their DOC and GM and confirmed that they had transcribed the physician's order incorrectly onto the electronic medication record (eMAR). RN #122 also confirmed that when RPN #125 had conducted the independent double-check prior to administering the resident's medication, the RPN had checked the medication to the eMAR and not to the physician's order.
Interview with the DOC confirmed that RN #122 had not administered the correct medication to resident #003 as specified by the physician, and as a result resident #003 required transfer to the hospital for treatment. The DOC also confirmed that the RN and RPN did not conduct an independent / double-check correctly when administering the high risk medication.
The home failed to ensure that resident #003 was administered the correct medication in accordance with the directions for use specified by the physician.

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure the written record related to the Falls Prevention program annual evaluation included the date of the evaluation, a summary of the changes made and the date that those changes were implemented.

During a review of the home's annual evaluation of the Falls Prevention program, the Long Term Care Homes (LTCH) Inspector #640 was unable to identify the date the evaluation was held, the summary of changes made and the date that those changes were implemented.
During an interview with the Director of Care (DOC), they confirmed the date was not

included in the annual evaluation and there were no summary of changes made to the Fall Prevention program or dates of when any changes were implemented.

2. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident’s responses to interventions were documented.

A) In August 2017 resident #016 had a fall. RPN #123 attended the scene of the fall to assist RN #120.
During a review of the clinical record, the Long Term Care Homes (LTCH) Inspector #640 was unable to identify any documentation made by RPN #123.
The home's policy called "Falls Management", RC-15-01-01, and last updated February 2017, directed staff to implement the Post-Fall Clinical Pathway, Appendix 9, immediately following a fall of a resident. Appendix 9 directed staff to do a focused assessment by the first registered staff on the scene.
During an interview with the home’s Fall Lead/Restorative Care Coordinator, they confirmed it was an expectation of the home that all assessments were documented in the clinical record.
During an interview with RPN #123, they informed the LTCH Inspector that they had completed a partial assessment of the resident when they arrived at the scene. RPN #123 confirmed that they did not document their assessment of the resident.

B) Resident #001 had a specific device in place.
The clinical record was reviewed and the Point of Care (POC) notes documented by the Personal Support Workers (PSWs) reflected that the resident's results were not documented in POC on multiple shifts for four consecutive months in 2017.
PSW #105 was interviewed and indicated that they were expected to empty the resident's specific device on every shift and document in POC in Point Click Care (PCC). The PSW also indicated that they would also make note of any abnormalities and report to the charge nurse. The PSW confirmed that not every shift had documented the resident's results for four consecutive months in 2017, as expected.
The home failed to document every shift as required by their policy.

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 following was complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. In addition, to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented., to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Resident #004 had multiple diagnosis and as a result of these diagnosis the resident had experienced pain.
The clinical record was reviewed and the resident's pain score had escalated from zero to six out of ten (6/10) starting in July 2017, and a score of five out of ten (5/10) in August 2017. There was no pain assessment completed in August 2017, related to resident #004's increased pain.
The home's policy called "Pain Management", number RESI-10-03-01, and version March 2014, directed staff to complete a pain assessment using their clinically appropriate assessment instrument designed for pain when a common assessment protocol (CAP) was triggered from the Minimum Data Set (MDS) assessment or with a change in the resident's condition associated with the onset of pain.
RPN #100 was interviewed and indicated that as a result of the resident's increase in pain and because they had triggered for pain from the MDS assessment that they were expected to complete a pain assessment using the pain assessment tool in PCC. The RPN identified that the pain assessment tool was designed specifically for pain and they also had another tool they could use for residents that were cognitively impaired.
The home failed to assess resident #004's pain using a clinically appropriate assessment instrument when they had increased pain and had triggered a CAP from the MDS assessment.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident’s pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #5: 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 failed to ensure that, (a) drugs were stored in an area or a medication cart, (ii) that was secure and locked.

LTCH Inspector #527 observed the medication cart on a specific unit that was unlocked in October 2017, and there was no RN or RPN visible in the hallway. Cognitively impaired residents were wondering up and down the hallway. All five drawers of the medication cart were accessible to residents. Resident #003 was sitting stationary in their wheelchair beside the opened medication cart. Resident #003 was severely cognitively impaired and had access to the open cart.
The home's policy called "Medical Pharmacies User's Manual - Chapter 6 - MED PASS", version 1.0, and dated 2014, directed registered staff to lock the medication cart and electronic medication administration record (eMAR) screen if stepping away.
When RPN #112 came out of a resident's room they returned to their medication cart. The RPN realized they had left the medication cart unlocked and accessible to resident #003 and other residents wandering the hallway. RPN #112 indicated that they were expected to lock their medication cart for resident safety.
The home failed to ensure their drugs were stored in a medication cart that was secure and locked.

Additional Required Actions:

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

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that resident had their personal items, including personal aids such as dentures, glasses and hearing aids, cleaned as required.

In October 2017, resident #006's wheelchair was observed and appeared soiled with notable dry white fluid debris on the left side of the chair cushion. On another specific date in October 2017, the same debris was observed as well as notable built-up dry debris covering the majority of the wheelchair frame.
Interview with PSW #108 revealed the home's expectation was for wheelchairs and walkers to be cleaned on bath days. PSW #108 reported the date of the resident's most recent bath; however they confirmed that the resident's wheelchair was unclean.
Review of the POC documentation confirmed that on a specific date in October 2017, the resident received their bath and their wheelchair was not cleaned.
Interview with the Resident Services Coordinator confirmed the home's expectation that mobility devices, including wheelchairs were to be cleaned on the first bath or shower day of the week and the home did not comply with their process to clean resident personal items, as required.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 219. Retraining

Specifically failed to comply with the following:

s. 219. (4) The licensee shall ensure that the training and retraining for staff in infection prevention and control required under paragraph 9 of subsection 76 (2) and subsection 76 (4) of the Act includes,
(a) hand hygiene; O. Reg. 79/10, s. 219 (4).
(b) modes of infection transmission; O. Reg. 79/10, s. 219 (4).
(c) cleaning and disinfection practices; and O. Reg. 79/10, s. 219 (4).
(d) use of personal protective equipment. O. Reg. 79/10, s. 219 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the training and retraining for staff in infection prevention and control required under paragraph 9 of subsection 76 (2) and subsection 76 (4) of the Act included, (a) hand hygiene; (b) modes of infection transmission; (c) cleaning and disinfection practices; and (d) use of personal protective equipment.

The home's Infection, Prevention and Control Program (IPAC) was reviewed during the Resident Quality Inspection (RQI).
The DOC provided an audit conducted by the Regional Infection Control Network (RICN) for South Eastern Ontario, which was for the period 2015. The audit indicated that "the home needs to ensure ALL staff are completing mandatory education annually". In addition, the home had developed and were implementing a list of priorities for improvement as a result of the RICN audit of their IPAC program. One of the priorities was to ensure all staff completed the IPAC education by December 2016.
The home's IPAC education was reviewed and indicated that they did not achieve 100% of all staff trained in IPAC. The training documentation reflected that 95.4% of staff completed the IPAC training for 2016.
The DOC and General Manager (GM) were interviewed and confirmed that not all staff completed the mandatory IPAC training for 2016.
The home failed to ensure that all staff were trained in all elements of the IPAC program.

Issued on this 6th day of December, 2017

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

Original report signed by the inspector.

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KATHLEEN MILLAR (527), HEATHER PRESTON (640), LEAH CURLE (585)
Inspection No. / No de l'inspection :	2017_544527_0014
Log No. / No de registre :	024619-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 30, 2017
Licensee / Titulaire de permis :	CVH (No. 8) GP Inc. as general partner of CVH (No. 8) LP 766 Hespeler Road, Suite 301, CAMBRIDGE, ON, N3H-5L8
LTC Home / Foyer de SLD :	Shelburne Long Term Care Home 200 ROBERT STREET, SHELBURNE, ON, 000-000
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Heidi Vanderhorst

To CVH (No. 8) GP Inc. as general partner of CVH (No. 8) LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

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 :

1) The licensee shall provide education to all direct care staff related to the home's Fall Prevention and Management Program policies and procedures.
2) The licensee shall ensure that all direct care staff comply with all aspects of the Fall Prevention and Management Program policy and procedures, which includes developing and implementing an auditing process.

Grounds / Motifs :

1. The licensee failed to ensure that where the Act or this Regulation required 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 was required to ensure that the plan, policy, protocol, procedure, strategy or system, (b) was complied with.

2. The Order is made based upon the application of the factors of severity (3), scope (1) and compliance history (4), in keeping with s.299(1) of the Regulation, in respect of the actual harm / risk experienced by residents, the scope was isolated, and the Licensee's history of ongoing non-compliance.

3. In accordance with Regulation, s.48, required the licensee to ensure that the interdisciplinary programs including fall prevention, programs were developed and implemented in the home and each program must, in addition to meeting the requirements set out in section 30, provide for screening protocols; and provide for assessment and reassessment instruments. O. Reg. 79/10, s.48

A) In August 2017, resident #016 had a fall. The Long Term Care Home (LTCH) Inspector #640 reviewed the clinical record, which revealed a fall incident note. The incident description, found in the resident's clinical record, documented that the resident was noted to have had a fall, which was witnessed by staff and the resident was injured.
The Fall Management – Post Fall Assessment revealed that staff had difficulty getting the resident up from the fall and transferring the resident to bed.
The home's policy called "Fall Management", number RC-15-01-01, and last revised February 2017, directed staff to complete a focused assessment of the resident by the first registered staff on the scene. Appendix 12 of the same policy directed staff to also conduct a post fall team huddle within an hour of the fall and complete a post fall assessment as soon as possible.
Resident #016's clinical record was reviewed and revealed that the post fall assessment was incomplete, and the post fall huddle was not conducted as per the home's Fall Management policy and procedures.
During an interview with Registered Practical Nurse (RPN) #123 who told the LTCH Inspector they had attended to the scene of the fall and confirmed they conducted a partial assessment of the resident upon arrival.
During an interview with RN #120, they confirmed they were the first registered staff on the scene. The RN confirmed they had not completed a full post fall assessment and post fall huddle as per the home's policy. They confirmed they had not completed a head to toe assessment for injury.

B) In January 2017, resident #017 sustained an unwitnessed fall.
The LTCH Inspector #640 reviewed the clinical record and was unable to identify a head-to-toe assessment, a falls progress note and the notification of the resident's physician.
The home's policy called "Fall Prevention and Management Program", number RC-2.010, with an effective date of May 2011, directed staff to complete a head-to-toe and pain assessment of the resident prior to moving the resident; notify the physician; document in the electronic clinical record in the risk management report; and to complete a falls progress note.
RPN #125 was interviewed and confirmed a head-to-toe assessment was not completed, a falls progress note was not completed and the physician was not notified of the resident's fall.
The Director of Care was interviewed and confirmed that staff did not complete a head-to-toe assessment, a falls progress note and did not notify the physician of the resident's fall as per the home's policy and procedures.

The home failed to ensure that staff complied with the Falls Prevention and Management Program for resident #016 and #017.

(640)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 29, 2017

Order # / Ordre no : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

1) The licensee shall educate the registered staff on high risk medications.
2) The licensee shall educate the registered staff on policies and procedures related to narcotic administration, as well as high alert medications, and the expectations when obtaining physician orders and administration.
3) The licensee shall educate the registered staff on the independent and/or double-check system for high alert medications.
4) The licensee shall develop and implement a communication and re-stocking system in collaboration with Pharmacy Services related to the emergency drug box medications.
5) The licensee shall develop and implement a quality improvement process to include auditing to ensure registered staff are compliant with their high alert / narcotic administration policies and procedures. This will also include auditing to ensure the emergency drug box and process for checking, stocking and internal communication is working effectively.

Grounds / Motifs :

1. The Order is made based upon the application of the factors of severity (3), scope (1) and compliance history (3), in keeping with s.299(1) of the Regulation, in respect of the actual harm / risk experienced by residents, the scope was isolated, and the Licensee's history of noncompliance.

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

Resident #003 was ordered a specific medication by the physician and to be administered every three to four hours, when needed.
The clinical record was reviewed and the LTCH Inspector #527 identified that RN #122 had administered the wrong medication.
The resident was found unresponsive by RN #126. The physician was notified and ordered a specific treatment to be administered immediately; however the home did not have the treatment in the home. The physician then ordered that the resident be transferred to the hospital. At the hospital the resident required administration of a specific treatment to counteract the effects of the wrong medication.
RN #122 was interviewed by their DOC and GM and confirmed that they had transcribed the physician's order incorrectly onto the electronic medication record (eMAR). RN #122 also confirmed that when RPN #125 had conducted the independent double-check prior to administering the resident's medication, the RPN had checked the medication to the eMAR and not to the physician's order.
Interview with the DOC confirmed that RN #122 had not administered the correct medication to resident #003 as specified by the physician, and as a result resident #003 required transfer to the hospital for treatment. The DOC also confirmed that the RN and RPN did not conduct an independent / double-check correctly when administering the high risk medication.

The home failed to ensure that resident #003 was administered the correct medication in accordance with the directions for use specified by the physician. (527)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 29, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e) 151, rue Bloor Ouest, 9e étage Toronto ON M5S 2T5	Directeur a/s du coordonnateur/de la coordonnatrice en matière d'appels Direction de l'inspection des foyers de soins de longue durée Ministère de la Santé et des Soins de longue durée 1075, rue Bay, 11e étage Toronto ON M5S 2B1 Télécopieur : 416 327-7603

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

Issued on this 30th day of November, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Kathleen Millar

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