Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 27, 2017	2017_674610_0007	013331-17	Resident Quality Inspection

Licensee/Titulaire de permis

THE CORPORATION OF THE COUNTY OF ELGIN MUNICIPAL HOMES
475 Talbot Street E. AYLMER ON N5H 3A5

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

TERRACE LODGE
475 TALBOT STREET EAST 49462 TALBOT LINE AYLMER ON N5H 3A5

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

NATALIE MORONEY (610), MELANIE NORTHEY (563), NEIL KIKUTA (658)

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): July 4, 5, 6, 7, 11, 12, 13 and 14, 2017.

The following concurrent inspections were conducted during the Resident Quality Inspection related to alleged abuse:

Critical Incident Log #030322-16/CI M583-000024-16
Critical Incident Log #029484-16/CI M583-000020-16
Complaint and Critical Incident Log #010166-16 IL #44037-LO and CI M583-000007-16
Critical Incident Log #008348-16/CI M583-000004-16
Critical Incident Log #025858-16/CI M583-000018-16
Complaint Log #004028-17 IL #49432-LO

During the course of the inspection, the inspector(s) spoke with the Administrator, the Manager of Resident Care, the Manager of Program Services Support Services, Manager of Support Services, Resident Care Coordinator, Registered Nurses, Registered Practical Nurses, Recreational staff member, Personal Support Workers, Pharmacy Consultant, Manager of Operational Services, the Cook, Dietary Aids, Housekeeping, Family, Residents' Council Representatives and over forty residents.

Inspectors also toured the resident home areas and common areas, medication rooms, spa rooms, observed resident care provision, resident/staff interaction, dining services, medication administration, medication storage areas, reviewed relevant resident clinical records, posting of required information, relevant policies and procedures, as well as meeting minutes pertaining to the inspection, and observed general maintenance and cleanliness of the home.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **18 WN(s)**
- **16 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A resident's plan of care outlined nutritional interventions. This was documented in the plan of care for the Registered Dietitian.

Further review of the plan of care showed that the resident was to receive this intervention three times a day.

The inspector observed the resident in the dining area. The inspector observed a Personal Support Worker (PSW) assisting the resident. The resident did not receive the specified nutritional interventions.The PSW stated in an interview that the resident did not receive the nutritional intervention. The PSW corroborated this statement, and added that they had never provided the nutritional intervention to the resident since the resident's admission.

The RD explained that prior to resident's admission, the home had determined the resident had weight loss. The RD had set up the nutritional supplement to be implemented at meals to maintain or gain weight, and this was captured in the care plan; resident was admitted to the home and the nutritional supplement was added to the plan of care. The RD acknowledged that the resident continued to lose weight, and this was also shown in the monthly weights. The RD stated that they expected the resident to receive their high protein and high caloric nutritional supplement three times a day.

The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was isolated during the course of this inspection. There was a compliance history of this legislation being issued in the home on April 25, 2015 as a Voluntary Plan of Correction (VPC) in a Resident Quality Inspection #2015_263524_0012. [s. 6. (7)]

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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: 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 or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, protocol, or procedure, the licensee was required to ensure that the policy, protocol, or procedure was in compliance with and was implemented in accordance with all applicable requirements under the Act.

Ontario Regulation 79/10, s. 30 (1) states that the following is complied with in respect of each of the organized programs required under each of the interdisciplinary programs under section 48 of the 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.

Under O. Reg. 79/10, s. 48 (1), every licensee shall ensure that the following interdisciplinary program is developed and implemented in the home: 2. A skin and

wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.

O. Reg. 79/10, s. 50 (2) states in part the following:
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

During the inspection, non-compliance was identified related to O. Reg. 79/10, s.50 (2) (iv), where residents with altered skin integrity were not being reassessed at least weekly. Evidence of weekly reassessments not being completed by registered nursing staff was evident in the review of assessment and reassessment reports for two residents. In an interview the Registered Practical Nurse (RPN) shared that they would document under a skin and treatment progress note, instead of using the assessment and reassessment tools for altered skin integrity. The Manager of Resident Care (MRC) acknowledged that Appendix D: Pressure Ulcer/Wound Assessment record was the assessment and reassessment tool for pressure ulcers, and that the Weekly Skin/Wound Assessment record was the assessment and reassessment tool for altered skin integrity other than pressure ulcers.

The inspector reviewed Terrace Lodge Policy and Procedure manual on Skin Care and Wound Management with a revision date of December 2016. In review of the policy, pressure ulcers were addressed under prevention of pressure ulcers, interdisciplinary roles related to pressure ulcers, program evaluation related to pressure ulcers, a skin and wound care overview related to pressure ulcers, pressure ulcer risk assessments, pressure ulcer assessment and reassessment instruments, and other supplemental forms designed under the skin and wound care program related to pressure ulcers.

As stated in O. Reg. 79/10, s.50 (3) and the Skin Care and Wound Management policy,

altered skin integrity is defined as the potential or actual disruption of epidermal or dermal tissue. Altered skin integrity, including skin breakdown, pressure ulcers, skin tears, or wounds, and the requirements laid out in O. Reg. 79/10, s. 50 (2), would be required to be developed and implemented in the skin and wound care program, as part of the relevant policies, procedures, and protocols of the program. The Skin Care and Wound Management policy addressed pressure ulcers, but failed to incorporate altered skin integrity other than pressure ulcers including skin breakdown, skin tears, or wounds. The policy did not identify altered skin integrity other than pressure ulcers in the policy related to prevention, interdisciplinary roles, program evaluation, and assessments, specifically the Weekly Skin/Wound Assessment form completed for altered skin integrity other than pressure ulcers.

The MRC reviewed the Skin Care and Wound Management policy and acknowledged that while it discussed pressure ulcers, it did not address altered skin integrity other than pressure ulcers.

The licensee has failed to ensure that the home’s Skin Care and Wound Management policy was in compliance with and was implemented with all applicable requirements under the Act including O. Reg. 79/10, s. 30 (1) relevant policies related to the skin and wound care required program, O. Reg. 79/10, s. 48 (1) a skin and wound care program to promote skin integrity, prevent the development of wounds, and provide effective skin and wound care interventions, and O. Reg. 79/10, s.50 (2) addressing the needs of residents exhibiting altered skin integrity, including skin breakdown, skin tears, or wounds.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was widespread during the course of this inspection. There was a compliance history of this legislation being issued in the home on April 24, 2015, as a Voluntary Plan of Correction (VPC) in a Resident Quality Inspection #2015_263524_0012 [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, protocol, or procedure, the licensee is required to ensure that the policy, protocol, or procedure is in compliance with and was implemented in accordance with all applicable requirements under the Act, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas were kept locked and closed when they were not being supervised by staff.

During the initial tour of the home the Inspector observed a door to a room near the resident lounge opened, unlocked, and unattended. A sign on the door stated “staff access,” and would require a fob to be unlocked. Inside the room was a refrigerator with food and fluids, and two drawers with large scissors in each. The Personal Support Worker (PSW) acknowledged that the door was opened and accessible, and should be closed and locked at all times when unattended.

The Inspector observed the same room opened, unlocked, and unattended. The refrigerator was stocked with food and fluids, and large scissors were located in two drawers. The PSW stated that the door to the kitchenette should be locked, and acknowledged that one of the four residents sitting in the lounge beside the kitchenette was mobile.

The Manager of Resident Care (MRC) acknowledged that all staff rooms near the resident lounge on all home care areas were to be closed and locked at all times when unattended.

The licensee has failed to ensure that all doors leading to non-residential areas were kept locked and closed when they were not being supervised by staff.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was isolated during the course of this inspection. The home does not have a history of non-compliance in this subsection of the legislation. [s. 9. (1) 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 all doors leading to non-residential areas are kept locked when they were not being supervised by staff, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails are used, (a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; (b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

The home's policy for Bed Safety Prevention of Entrapment revised in June 2017 stated in part that the Bed Safety Assessment would be completed whenever bed audits are being completed. The "Entrapment Bed Audit" of the entire home will be completed biannually and the "Bed Assessment Audit" will be completed and added to the resident chart.

The home's Bed Rails Policy revised July 2017 stated in part that before bed rails are

used for the resident the following must occur:
* The resident must be assessed and the his or her bed system evaluated.

The RPN told the inspector during an interview that a specified resident used bed rails when the resident was in bed.

The inspector requested the completed bed safety assessment for the resident during an interview with the DOC. The DOC said the Resident Care Coordinator would be able to provide those assessments.
The Resident Care Coordinator said that resident did not have an entrapment bed audit assessment completed to identify potential zones of entrapment and to litigate the risk of entrapment to the resident.

The Resident Care Coordinator #120 said that the home did not complete a bed assessment for any resident using bed rails and said there was no formal assessment in PointClickCare (PCC) to assess a resident where bed rails were used.

The Director of Care said that they are working on completing the bed safety assessments for all residents and that they had not completed any bed assessments and should have. [s. 15. (1) (a)]

2. The home's policy for Bed Safety Prevention of Entrapment revised in June 2017 stated in part that the Bed Safety Assessment would be completed whenever bed audits are being completed. The "Entrapment Bed Audit" of the entire home will be completed biannually and the "Bed Assessment Audit" will be completed and added to the resident chart.

The home's Bed Rails Policy revised July 2017, stated in part that before bed rails are used for the resident the following must occur:
* The resident must be assessed and the bed system evaluated.

During an interview, a RPN said that a specified resident used bed rails when in bed.

The inspector requested the completed "Entrapment Bed Audits" for the resident during an interview.

Further review of documentation provided showed that, the Resident Care Coordinator completed the Bed System Measurement Device Test Results Worksheet for the

and that the bed system failed for zone entrapment risk. The Bed Assessment box was ticked as passed. There was no documented evidence for corrective action for the zone that had failed.

During a staff interview the Resident Care Coordinator said that resident did not have an Entrapment Bed Audit assessment completed that could be provided to identify potential zones of entrapment and to litigate the risk of entrapment to the resident. The Director of Care said that they are working on completing the bed entrapment audits assessments for all residents.

The licensee has failed to ensure that where bed rails were used, the resident had been assessed and the resident's bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was widespread during the course of this inspection. The home does not have a history of non-compliance in this subsection of the legislation. [s. 15. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where bed rails are used, the resident has been assessed and the resident's bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

The Critical Incident System (CIS) report documented an incident of staff to resident alleged abuse.

The MRC acknowledged that staff did not follow the home's expectations or policy related to the mandatory reporting of all suspected and witnessed abuse and neglect and shared that all abuse should be reported immediately.

Record review of the Elgin County Homes and Senior Services policy and procedure number: 2.12 “Staff Reporting and Whistle Blower Protection” last reviewed March 2017 was intended to encourage staff volunteers and others to report suspected or actual occurrence of illegal, unethical or inappropriate events without retribution. The reporting individual should promptly report the suspected or actual event to the supervisor and if the reporting individual would be uncomfortable or otherwise reluctant to report to the supervisor than the reporting individual could report the event to the next highest or another level of management including the administrator.

Record review of the Elgin County Homes and Senior Services policy and procedure number: 2.11 “Resident Abuse” last reviewed March 2017 outlined a policy purpose to ensure compliance with sections 19 and 20 of the Long Term Care Homes Act. The policy outlined that in any case of alleged or suspected abuse, it was the employee’s responsibility for immediate reporting if abuse was witnessed or if the staff had knowledge of an incident of abuse.

The licensee has failed to ensure that the resident was protected from abuse by anyone and free from neglect by the licensee or staff in the home. The staff came forward after the termination of the PSW and talked about the PSW's abrupt and abusive care of other residents and the home was aware that the PSW was a bully prior to the this incident.

The severity was determined to be a level 3 actual harm. The scope of this issue was isolated during the course of this inspection. The home does not have a history of non-compliance in this subsection of the legislation. [s. 19. (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 residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that any of the following had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director: abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

The Critical Incident System (CIS) report documented an incident of alleged staff to resident. The incident was reported to the Ministry of Health and Long Term Care three days after the incident occurred.

The Manager of Resident Care (MRC) acknowledge that the incident occurred and that the RPN reported the incident to the MRC and that the Ministry of Health and Long Term Care were notified at a later date.

The Executive Director (ED) in an interview with the Inspector acknowledged there needed to be better communication between the Manager of Resident Care (MRC) and the ED related to mandatory reporting. The ED also acknowledged that staff need to immediately report all incidents of abuse and neglect. The ED also shared that only the MRC and ED had access to the Critical Incident System for reporting.

Record of the Elgin County Homes and Senior Services Policy and Procedure number: 1.3 "Mandatory and Critical Incident Reporting (formally Unusual Occurrence Reporting)" last reviewed March 2017, stated that when a critical incident occurs, the Administrator/Director of Homes and Senior Services or designate shall ensure the online critical incident reporting process was initiated and that the immediate report of incidents listed in the regulations "occurs either during normal business hours Monday to Friday 8:30 AM to 4:30 PM or by using the Ministry's after hours emergency contact." [s. 24. (1)]

2. The Critical Incident System (CIS) report documented an incident of staff to resident neglect. The incident was reported to the Ministry of Health and Long Term Care (MOHLTC) seventeen days after the incident occurred.

Review of the investigation notes and interviews provided by the home included an email correspondence sent to the Manager of Resident Care that on a specific date there were several residents who had continence care concerns. Although there was also a hand written letter describing the events.

The Executive Director acknowledged that the email documented the suspected neglect of multiple residents and was not reported to the MOHLTC immediately.

The Manager of Resident Care (MRC) acknowledged that all abuse and neglect should be reported immediately to the MOHLTC when the person who had reasonable grounds to suspect that neglect or abuse occurred. [s. 24. (1)]

3. The Critical Incident System (CIS) report that had occurred whereby a staff member had allegedly abused a resident. The MOHLTC after-hours pager was not contacted and

the Director did not receive the report until twelve days after the occurrence.

The Critical Incident System (CIS) report whereby a staff member had allegedly neglected two resident's care needs, the MOHLTC after-hours pager was not contacted and the Director did not receive the report until one day after the occurrence.

The home's Mandatory and Critical Incident reporting policy revised March 2017, stated in part that the Mandatory Report would be completed immediately upon having reasonable grounds to suspect that abuse had occurred and may occur.

The Director of Care (DOC) said that the policy and expectation of the home was to immediately inform the Director of the CIS regarding abuse and had failed to do so.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone, that resulted in harm or a risk of harm to the resident had occurred, shall immediately report that suspicion and the information to the Director.

The severity was determined to be a level 1 minimal risk. The scope of this issue was widespread during the course of this inspection. There was a compliance history of this legislation being issued in the home on March 10, 2016, as a Voluntary Plan of Correction (VPC) in a Critical Incident Inspection #2016_262523_0015. [s. 24. (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 person who has reasonable grounds to suspect that any of the following has occurred or may occur, immediately reported the suspicion and the information upon which it is based to the Director: abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the restraint plan of care included an order by the physician or the registered nurse in the extended class (RNEC).

A review of the home's policy for Restraints, Minimizing Restraining of Residents, Use of Restraints and Use of PASDS revised December 2016 stated in part: "A Physician or RNEC in collaboration with the interdisciplinary team may prescribe a physical restraint" and "include in the written order what device is being ordered and instructions related to the order.

A specified resident was observed using a restraint device during stage one of the RQI process.

Review of the resident's plan of care showed that the resident used two types of physical restraining device's.

The plan of care showed that a RPN documented that consent was required from the SDM and the physician for the use of these physical restraint devices

The current physician's showed that the device restraint was used for a specific reason. There was no current prescribed order for the second device that was being used as a physical restraint.

During an interview the RPN said they did not have an order for one of the current

physical restraint devices that were being used.

The DOC acknowledged that the expectation was that an order would be obtained for all restraints.

The licensee has failed to ensure that the restraint plan of care included an order by the physician or the registered nurse in the extended class (RNEC). [s. 31. (2) 4.]

2. The licensee has failed to ensure that restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied; the restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.

A review the resident plan of care in PCC showed that the resident was using two types of restraining devices.

The plan of care showed that the RPN documented consent needed to be obtained from Doctor and SDM for the restraint devices.

The home's policy for Restraints, Minimizing Restraining of Residents, Use of Restraints and Use of PASDS revised December 2016 stated in part that informed consent would be obtained for the treatment from the resident or the SDM for the use of a physical restraint.

Further review of the plan of care showed that the SDM was to be involved and were to provide consent prior to restraint application, this would be completed quarterly.

Review of the Health Care Record (HCR) for restraint consent showed that there was no documented evidence that consent had been obtained from the SDM for the use of restraint devices.

The DOC said that the expectation of the licensee was that consent, would be obtained for all restraint usage in the home, however this was incomplete for the resident.

The licensee has failed to ensure that restraining of a resident by a physical device was included in a resident's plan of care only if all of the following are satisfied; and that the restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was a pattern during the course of this inspection. The home does not have a history of non-compliance in this subsection of the legislation. [s. 31. (2) 5.]

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 where bed rails are used, the resident is assessed and the resident's bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident, to be implemented voluntarily.

WN #8: 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 use safe transferring and positioning devices or techniques when assisting residents.

An observation of a specified resident was completed by the inspector during stage one of the Resident Quality Inspection. During the observation the resident was left unattended to a specified device.

An interview with two PSW's, both said the resident could be left unattended and attached to the specified device.

The DOC told the inspector, that the resident should not have been left unattended and attached to a specified device

The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting the residents.

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 #9: The Licensee has failed to comply with O.Reg 79/10, s. 41. Every licensee of a long-term care home shall ensure that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep. O. Reg. 79/10, s. 41.

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home have his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep.

The Critical Incident System (CIS) report documented an incident of staff to resident alleged abuse.

The resident shared that they recalled an incident involving a staff member related to the incident.

The plan of care in PointClickCare (PCC) related to bedtime and rest routines for the resident was documented that the resident's sleep and rest patterns will be requested.

Review of documentation in PCC showed that the resident had a fall. The resident stated they had completed a self-transfer and fell on the floor next to the bed.

The Manager of Resident Care (MRC) and the inspector discussed the resident complaint that staff were not providing care according to the resident's preference. The MRC acknowledged that the resident's preference was not followed according to the plan of care.

The licensee has failed to ensure that the resident had their desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was isolated during the course of this inspection. The home does not have a history of non-compliance in this subsection of the legislation. [s. 41.]

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 has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

The resident's health care record showed that a resident had an area of altered skin integrity.

There was no documentation completed on the assessment record to indicate a weekly reassessment of the altered skin integrity.

The Manager of Resident Care (MRC) explained that they expected registered staff to complete weekly reassessment for an area of altered skin integrity

The licensee has failed to reassess the resident that had area of altered skin integrity at least weekly. [s. 50. (2) (b) (iv)]

2. Review of weekly skin assessment for the resident indicated ongoing area of altered skin integrity.

MRC reviewed the assessment record of the resident and stated that they expected a reassessment to be completed. The Weekly assessment record, related to an area of altered skin integrity indicated reassessments should have been done.

The MRC acknowledged that staff were completing documentation in progress notes for the area of altered skin integrity and stated that they should also be documenting in the weekly assessment record.

The licensee has failed to reassess the resident that had area of altered skin integrity at least weekly.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was a pattern during the course of this inspection. There was a compliance history of this legislation being issued in the home on October 20, 2016 as a Voluntary Plan of Correction (VPC) in a Resident Quality Inspection ##2016_243634_0020 [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the nutrition care and hydration program included a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.

A specified resident's plan of care indicated that they had nutritional interventions. The Registered Dietitian (RD) completed a quarterly nutrition assessment on the resident and documented that the resident received nutritional interventions.

Record review of the resident's documentation included asking Personal Support Workers (PSW) what was the resident’s fluid intake in millilitres. PSW was not able to differentiate the nutritional intervention from other fluid intake of the resident.

The inspector observed the resident in the dining area. The inspector observed a staff member assisting the resident. There was no nutritional intervention provided to the specified resident.

The RD acknowledged that they were unable to distinguish the nutritional intervention from other fluids consumed.

The licensee has failed to ensure that the nutrition care and hydration program included a system to monitor and evaluate the fluid intake of the nutritional intervention.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was isolated during the course of this inspection. The home does not have a history of non-compliance in this subsection of the legislation. [s. 68. (2) (d)]

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 nutrition care and hydration program includes a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that in making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the names of all residents involved in the incident in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff.

The Critical Incident System (CIS) report documented an incident of alleged abuse involving a staff member and a resident. The incident was reported to the Ministry of Health and Long Term Care (MOHLTC). The CIS report included the name of one resident.

The CIS report did not involve a list all of the residents involved.

The Executive Director (ED) discussed that the allegation of resident neglect was first submitted to the Manager of Resident Care (MRC) and acknowledged that the email documented that several residents were involved.

The licensee has failed to ensure that the report to the Director included the names of all residents involved in the incident reported to the MRC on October 1, 2016. [s. 104. (1) 2.]

2. The licensee has failed to ensure that the report to the Director included the following description of the individuals involved in the incident, names of any staff members or other persons who were present at or discovered the incident.

CIS report was first submitted to the MOHLTC where by a staff member allegedly abused two residents. The staff who were present and or discovered the incident were not identified on the CIS report.

The CIS report showed that the home submitted an amended report with the follow up and analysis at the completion of the licensee internal investigation but did not include the staff member that was involved in the incident.

The Director of Care (DOC) said that the policy and expectation of the home was to document all the staff members that were present and report those to the Director regarding abuse. [s. 104. (1) 2.]

3. The licensee has failed to ensure that in making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the names of all residents involved in the incident in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff.

The home submitted a Critical Incident System (CIS) report related to abuse/neglect of a resident by a staff member. The incident involved several residents and none of them were named in writing in the CIS report.

The Manager of Resident Care (MRC) reviewed the CIS report and stated that it should list all of the individual residents who were involved in the incident.

The severity was determined to be a level 2 as there was minimal harm or potential for

actual harm. The scope of this issue was a pattern during the course of this inspection. The home does not have a history of non-compliance in this subsection of the legislation. [s. 104. (1) 2. i.]

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 report to the Director includes the names of all residents involved in the incident and staff members or other persons who were present at or discovered the incident, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

The licensee has failed to ensure that there was documentation that included the removal of the restraint device, including time of removal or discontinuance and the post-restraining care.

The home's policy for Physical Restraint Monitoring Record revised December 2016 stated in part that the PSW staff will document in POC for every resident utilizing a physical restraint and when the restraint was released, reapplied, and removed.

The Resident plan of care showed that the resident used physical devices for a specified reason

The Plan of Care (POC) documentation showed that staff would not always chart after care had been provided to the resident for restraints until the end of their shift and there was no clear indication when the restraints were released, when the resident was being repositioned, when the restraint was being reapplied, and removed.

The Resident Care Coordinator said that staff should be checking on the resident every hour and the restraint should be released every two hours, that there should be documentation as to when each of the restraints are removed and reapplied.

DOC said that the expectation was that documentation on restraints would include the removal of the restraint device, including time of removal or discontinuance and the post-restraining care.

The licensee has failed to ensure that there was documentation that included the removal of the restraint device, including time of removal or discontinuance and the post-restraining care.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was a pattern during the course of this inspection. The home does not have a history of non-compliance in this subsection of the legislation. [s. 110. (7) 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 there is documentation that included the removal of the restraint device, including time of removal or discontinuance and the post-restraining care, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policies and protocols developed for the interdisciplinary medication management system to ensure accurate storage of all drugs used in the home were developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

Ontario Regulation 79/10, s. 129(1)(b) states that controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

The Pharmacy policy 6-5 Storage of Narcotic and Controlled Medications, last reviewed in April 2016, stated in part to "Store ALL narcotics and controlled medications separate from other medications, in a locked compartment of the med cart or med room. The Narcotic Box should be locked after placing the medications and the Med Cart locked

thereafter. (Double lock system)"

Lead Consultant Pharmacist explained that Terrace Lodge utilized policies and procedures related to medication storage. The Lead Consultant Pharmacist stated that the Pharmacy policies and procedures were developed in accordance with best practice, and referenced the Long-Term Care Homes Act (LTCHA)(2007) and its regulations as well. The Pharmacist acknowledged that policy 6-5 on the storage of narcotics and controlled medications was last reviewed in April 2016. During the interview, the inspector recounted the events that occurred where injectable ativan, a controlled substance, was observed in a non-stationary locked metal box within an unlocked fridge in the locked medication room. The Lead Consultant Pharmacist stated that narcotics and controlled substances stored outside of the medication cart should be kept in a stationary area, and that there should be a lock on the fridge.

The licensee has failed to ensure that the policy developed for the storage of medications was developed in accordance with prevailing practices including the LTCHA 2007, and its regulations. Where O. Reg. 79/10, s. 129(1)(b) states that controlled substances are to be stored in a separate, double locked stationary cupboard in the locked area, Pharmacy policy 6-5 stated that controlled substances are stored in a locked compartment of the locked med room. The Pharmacy Policy 6-5 did not capture the requirements to double lock controlled substances in a stationary cupboard in the locked area.

The severity was determined to be a level 1 as there was minimal risk. The scope of this issue was widespread during the course of this inspection. The home does not have a history of non-compliance in this subsection of the legislation. [s. 114. (3) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the written policies and protocols are developed for the interdisciplinary medication management system is developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to be implemented voluntarily.

WN #15: 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 controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

The Inspector observed a nursing station. Inside the nursing station were two unlocked refrigerators, where one of the refrigerator contained a locked metal box with a label stating "keep locked use for refrigerated controlled and narcotic drugs only." Inside the locked metal box were two vials of an injectable controlled substance. The inspector was able to remove the metal box containing the controlled substance from the unlocked refrigerator.

The licensee has failed to ensure that the controlled substance was kept double locked in a stationary cupboard in the locked nursing station. The metal box that held the controlled substance was not stationary, and the safety of the drug did not meet the requirements set out in the legislation stating controlled substance are to be double-locked in the locked area.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was isolated during the course of this inspection. The home does not have a history of non-compliance in this subsection of the legislation. [s. 129. (1) (b)]

Additional Required Actions:

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

WN #16: 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 access to areas where drugs were stored were restricted to persons who dispensed, prescribed, or administered drugs in the home.

The Inspector observed the nursing station. Inside the room was a Registered Dietitian (RD) and a Registered Nurse (RN) documenting on computers, and Personal Support Workers (PSW) were entering and exiting the room with key fob access. Inside the nursing station was a locked medication cart, cupboards stocked with supplies, and another locked room that housed government stock medications. Two refrigerators were sitting side by side on the floor opposite to one of the computers. Both refrigerators were unlocked, and one of the refrigerator contained medication and a locked metal box.

Observations were completed on the second floor nursing station. In an unlocked clear organizing bin, the inspector observed medications. The nursing station also had two refrigerators, and one of the fridges contained medications.

The Registered Practical Nurse (RPN) stated that any staff who had a key fob had access to the nursing station including PSWs, housekeeping, and dietary. The RPN acknowledged that the medication should be in a locked area, and that the refrigerator contained medications that were not locked.

The Manager of Resident Care (MRC) explained that medications were to be stored in a securely locked area. MRC acknowledged that PSW and recreation staff had access to the nursing stations, but that only registered staff were allowed to be in contact with medications. MRC reviewed the unlocked refrigerator on LS nursing station and stated that the refrigerator should be locked because it stored medications. MRC also stated that the medication sitting in the unlocked organizing bin should be locked.

The licensee has failed to ensure that access to the refrigerator and areas where drugs were stored were restricted to persons who dispensed, prescribed, or administered drugs in the home. These areas were accessible to any staff that had key fob access to the nursing stations including PSWs and recreation staff.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was isolated during the course of this inspection. There was no previous compliance history for this home.

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 access to areas where drugs are stored are restricted to persons who dispensed, prescribed, or administered drugs in the home, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
12. Dental and oral status, including oral hygiene. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a plan of care must be based on, at a minimum, interdisciplinary assessment of the resident's dental and oral status, including oral hygiene.

The Resident was admitted to the home and an admission progress note showed that that resident required specific oral care.

Review of the resident's plan of care showed no indication that resident had specific oral care, or what type of oral care was to be provided for the resident.

PSW said that the resident received oral care twice a day.

The Manager of Resident Care stated that oral and dental care should be captured in the care plan by the registered staff.

The licensee has failed to ensure that a plan of care must be based on, at a minimum, interdisciplinary assessment of the resident's dental and oral status, including oral hygiene.

The severity was determined to be a level 1 as there was minimal risk. The scope of this issue was isolated during the course of this inspection. The home does not have a history of non-compliance in this subsection of the legislation. [s. 26. (3) 12.]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that corrective action was taken as necessary of every medication incident involving a resident and every adverse drug reaction.

Review of a medication incident report completed, indicated that a Registered Practical Nurse had identified a medication incident.

The RPN explained that two medications were ordered for a resident but they were not processed by pharmacy. RPN said that it was the registered staff's responsibility to check the order with the electronic medication administration record (eMAR) before leaving their shift, and that this was missed.

Documentation on the medication incident report showed that Manager of Resident Care (MRC) had spoken to each nurse individually to verify reason for the error. The MRC had not documented in the box stating "action taken to prevent reoccurrence, to be completed by DOC or Pharmacy Manager."

The MRC reviewed the medication incident report and stated that they should have completed actions to prevent reoccurrence.

The licensee has failed to ensure that corrective action was taken as necessary of every medication incident involving a resident and every adverse drug reaction.

The severity was determined to be a level 1 as minimal risk. The scope of this issue was a pattern during the course of this inspection. The home does not have a history of non-compliance in this subsection of the legislation. [s. 135. (2)]

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Issued on this 19th day of December, 2017

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

Original report signed by the inspector.