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**


**Health System Accountability and Performance Division**
**Performance Improvement and Compliance Branch**

**Division de la responsabilisation et de la performance du système de santé**
**Direction de l'amélioration de la performance et de la conformité**

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670


## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Nov 25, 2015 | 2015_200148_0034 | O-002862-15 | Resident Quality Inspection |

### Licensee/Titulaire de permis

MOHAWK COUNCIL OF AKWESASNE
P.O. Box 579 CORNWALL ON K6H 5T3

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

TSIIONKWANONHSOTE
70 Kawehnoke Apartments Road Akwesasne ON K6H 5R7

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

AMANDA NIXON (148), ANANDRAJ NATARAJAN (573), ANGELE ALBERT-RITCHIE (545), MELANIE SARRAZIN (592)

### Inspection Summary/Résumé de l'inspection

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

**This inspection was conducted on the following date(s): November 2-6, 9, 10, 12 and 13, 2015.**

**This inspection included four complaints.**

**During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care (DOC), the Manager for Dietary/Housekeeping/Laundry, Activity Director, MDS RAI Coordinator, Maintenance Supervisor, Food Service Aides, Activity Aides, a Restorative Aide, the home's Administrative Assistant, Registered Nurses, Registered Practical Nurses, Personal Support Works, Family members and Residents.**

**The inspectors reviewed resident health care records, resident council minutes, staffing schedules. Policies including those related to the infection control system, minimizing of restraints, medication management system, skin and wound program and prevention of abuse of residents were reviewed. In addition, the inspectors observed meal service, medication administration, resident care and resident/staff interactions.**

**The following Inspection Protocols were used during this inspection:**

**Accommodation Services - Housekeeping**
**Admission and Discharge**
**Continence Care and Bowel Management**
**Dining Observation**
**Falls Prevention**
**Hospitalization and Change in Condition**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Nutrition and Hydration**
**Pain**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Residents' Council**
**Responsive Behaviours**
**Safe and Secure Home**
**Skin and Wound Care**
**Sufficient Staffing**

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

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 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 are administered to residents in accordance with the directions for use specified by the prescriber.

Resident #26 has a diagnosis that can cause pain. The resident was prescribed pain medication for pain management, every two days.

The Resident indicated to Inspector #545 that on a specified date, staff ran out of the resident's prescribed pain medication and the resident went without the medication for almost two days. When the resident complained of pain, the resident indicated that staff provided the resident with acetaminophen rather than the prescribed pain medication. Progress notes indicate that the resident's pain was not relieved by this intervention.

A review of Resident #26's health record was conducted by Inspector #545. Documentation in the electronic Medication Administration Record (MAR) indicated that the prescribed pain medication was not administered in accordance with the directions for use specified by the prescriber, on a specified date. Two days later the resident was provided the prescribed pain medication whereby the staff re-allocated supply of the medication from other resident's supply (as approved by the physician). The supply of the prescribed pain medication was reviewed by the Inspector. One day after the use of re-allocated medication, Resident' #26's prescribed pain medication supply arrived to the home.

During interviews with RPNs #111 and #122, they indicated that the resident's prescribed pain medication can be ordered easily by clicking the "reorder" button on the eMAR. They indicated that Resident #26 was administered the pain medication every second day, therefore when there are only 1 or 2 doses left for this resident, the evening nurse should reorder. They both indicated that medications reordered before 1400 hours were usually delivered by early evening, adding that the home's After-Hour Pharmacy was available if medications were needed outside of regular delivery times. Both RPNs indicated that the After-Hour Pharmacy was not contacted over the three days identified above, to request the pain medication for Resident #26. RPN #111 indicated that she informed RN #110 that Resident #26 did not have anymore of the prescribed pain medication on the date identified whereby the resident did not receive the medication, and that she had reordered by clicking the "reorder" button on the eMAR.

RN #110 indicated he could not specifically remember when he was made aware by RPN #111 that the pain medication had been reordered, for Resident #26. The RN indicated that after contacting the physician for approval for reallocation of other resident's pain medication, that the home's pharmacy and/or the After-Hour Pharmacy had not been contacted to inquire status of reorder of the prescribed pain medication for

this Resident or to request immediate delivery.

The DOC indicated to the Inspector that it was the home's expectation that residents have a reasonable supply of their medications on hand. She indicated that in emergency situations, staff were expected to contact the After-Hour Pharmacy. The DOC indicated that Resident #26 was not administered pain medication in accordance with the directions for use specified by the prescriber on an identified date.
(Log O-002749-15) [s. 131. (2)]

2. On November 9, 2015, Inspector #545 observed on the counter in the Drug Room, in presence of RPN #105, an individual medication package with the name of Resident #6. The package was unopened and contained a beta blocker, dated for administration the evening before.

RPN #105 indicated that she had observed the medication in Resident's #6's medication bin at the beginning of her day shift and had not verified with the Medication Administration Record (MAR) yet or reported it to the RN in charge and/or DOC. After verifying the electronic MAR with the Inspector, RPN #105 indicated that the medication had been signed as administered, however it was left in the medication bin and not administered. [s. 131. (2)]

3. On November 10, 2015, Inspector #545 observed RPN #106 prepare and administer medications at the 0800 hours Medication Pass, on the South Wing.

Resident #6 was prescribed two medications that were not administered in accordance with the directions for use specified by the prescriber:

•A medication for respiratory relief administered by use of aerochamber. RPN #106 checked the bottom drawer of the medication cart to locate Resident #6's aerochamber and when she was unable to find it, she indicated that the Resident did not have one; therefore the prescribed inhaler would not be administered as the aerochamber was unavailable.

•An antibiotic, RPN #106 was unable to locate the bottle of antibiotic in the drug room refrigerator or in the bottom drawer of the medication cart or in the box designated for surplus medications for destruction by pharmacist, located in the drug room. The RPN indicated that the antibiotic would not be administered as the medication was unavailable. RN #100 later indicated that Resident #6's last dose of antibiotic should

have been 3 days ago, however the Resident continued to be administered the antibiotic twice daily, therefore receiving 5 extra doses.

4. During the same Medication Pass observation with RPN #106, Inspector #545 observed another medication that was not administered in accordance with the directions for use specified by the prescriber.

Resident #37 was prescribed a laxative every morning.

RPN #106 was unable to locate Resident #37's supply of laxative. As she pulled another resident's bottle of lactulose, she indicated that she was not permitted to use another resident's lactulose. She then returned to the drug room in case a new supply had been delivered the evening before and not added to the medication cart. She later indicated that as none was ordered, she would reorder one today, however the resident would not get the laxative as prescribed at this medication pass.

As such, staff did not administer medications to four different residents, in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

***Additional Required Actions:***

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

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**WN #2: 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 are equipped with locks to restrict unsupervised access to those areas by residents, and locked when they are not being supervised by staff.

Inspector #148 observed a set of double doors located near the dining room (room #145), the doors were not equipped with a lock. The double doors lead to a hallway where there are various office spaces, storage areas, staff locker rooms and a door leading to the outside. With the exception of the locker rooms and dirty linen room, doors within the hallway area were equipped with locks and found to be kept locked when not supervised. On several observations, the non-residential area beyond the double doors was observed to be accessible to residents while unsupervised with potential hazards given the storage of equipment in the area.

The double doors were previously identified during the home's Resident Quality Inspection, report date of October 6, 2014 (#2014_330573_0015).

On October 11, 2015, the Maintenance Supervisor confirmed the area beyond the double doors to be a non-residential area. The Maintenance Supervisor indicated to the Inspector that a contractor was informed of the need to lock these doors and that it was decided a magnetic lock system would be applied. He is not sure why this work was not completed. [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 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., to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system**

**Specifically failed to comply with the following:**

**s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,**
**(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).**
**(b) is on at all times; O. Reg. 79/10, s. 17 (1).**
**(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).**
**(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).**
**(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).**
**(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).**
**(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the resident-staff communication and response system (call bell system) can be easily accessed and used by residents at all times.

On November 3, 2015 it was observed that the resident's multipurpose activity room and the lounge located near the nursing station on south and west wing units had call bell systems that were not accessible to residents who may be seated in wheelchairs. The call bell stations in these activity rooms and lounges were located approximately 4.75 feet high on the walls without any pull cord to the call bell system. The call bell station in the south wing lounge was located above a book self which was not accessible to residents seated in wheelchairs.

Inspector #573 discussed the above observations with the home's Maintenance Supervisor, who agreed that the call bell system in the above identified rooms would not be accessible to residents seated in wheelchairs. The Maintenance Supervisor further indicated to the Inspector that he will discuss options with the call bell system vendor to install pull cords in the identified call bell stations. [s. 17. (1) (a)]

2. The licensee has failed to ensure that the resident-staff communication and response system is available in every area accessible by residents.

There are two areas near the south and west wing unit nursing stations, whereby residents were observed to congregate, conduct recreation programing and watch television. During a tour of the home, Inspector #148 observed there to be no resident-staff communication and response system available in either of these areas.

On November 5, 2015 during an interview, Inspector #573 spoke with Restorative Aid #114 and RN #115, who both confirmed the use of the resident gathering areas in south and west wing units.

Inspector #573 discussed the above observations with the home's Maintenance Supervisor, who agreed that there are no call bell systems in either area. The Maintenance Supervisor further indicated to the Inspector that he will discuss with the call bell system vendor to install a resident-staff communication and response system in the residents sitting areas, as identified. [s. 17. (1) (e)]

***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 resident-staff communication and response system an be easily seen, accessed and used by residents, staff and visitors at all times and that the communication system is available in every area accessibly by residents, to be implemented voluntarily.***

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**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 the 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 #26 had a diagnosis that causes pain and discomfort. The resident was prescribed a pain medication for pain management.

The resident indicated to Inspector #545 that there was a specified time whereby the staff ran out of the prescribed pain medication and the resident went almost two days without the pain medication. The resident indicated that acetaminophen was provided, until staff decided to borrow the pain medication from other residents.

A review of Resident #26's health record was conducted by Inspector #545. Documentation in the electronic Medication Administration Record indicated that the prescribed pain medication was not administered in accordance with the directions for use specified by the prescriber, on a specified date. Two days later the resident was

provided the prescribed pain medication whereby the staff re-allocated supply of the medication from other resident's supply (as approved by the physician). The supply of the prescribed pain medication was reviewed by the Inspector. One day after the use of re-allocated medication, Resident' #26's prescribed pain medication supply arrived to the home.

RPNs #122 and #111 and RN #110 indicated to Inspector #545 that when Resident #26's pain was not relieved, she was not assessed using a clinically appropriate assessment instrument specifically designed for this purpose. They indicated that notes were documented in the Unit Daily Record (24-hr report) to indicate that the prescribed pain medication had not been delivered and the resident was not administered pain medication as ordered.

The DOC indicated that the home used a clinically appropriate assessment instrument specifically designed for assessing pain and it was available directly from the home's electronic health record (PointClickCare). She further indicated the home's Unit Daily Record (24-hr report) was not considered a legal document, or an assessment tool, and that staff were instructed that notes that were highlighted in this 24-hour report needed to be documented in the Residents' electronic chart, such as progress notes. The DOC added that she was aware that registered staff did not use the Pain Assessment Tool as often as they should, and in this case a Pain Assessment should have been done when Resident #26 suffered severe pain due to a missed administration of pain medication. [s. 52. (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 residents exhibiting altered skin integrity are accessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

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

During observation of lunch meal service on November 2, 2015, Inspector #573 observed PSW #118 assisting Resident #32 with a texture modified meal and fluids while in a standing position. Resident #32 was seated in a tilted position (approximately 120 degrees) in a tilt wheelchair with the resident neck in an extended position.

On November 9, 2015 at the lunch meal service, the Inspector observed Resident #36 to be seated in a tilt chair (with tilt approximately 130 degrees to 140 degrees) with resident's neck positioned towards right shoulder. It was observed that the resident was constantly coughing after each mouth full of the meal. PSW #104 went to Resident #36's table to assist with the feeding while the resident still remains in the same sitting position.

Inspector #573 spoke with PSW #104 and PSW #119 regarding the positioning of the resident #36. Both indicated that Resident #36 should be seated in upright position in the wheelchair while feeding. Further, PSW #119 immediately repositioned the resident's tilt wheelchair and indicated that she would usually place a pillow behind the resident back for better positioning while feeding.

On November 9, 2015 Inspector #573 reviewed the health care record of Resident #32 and Resident #36 and both residents were identified as having nutritional risks related to chewing difficulty and dysphagia. Further to this, Resident #36's plan of care identifies risk for choking/aspiration and it clearly directs staffs to position resident for feeding at 90 degrees angle for all meals.

Staff members are not using proper techniques to assist Resident #32 and Resident #36 with feeding, including safe positioning of residents who require assistance. [s. 73. (1) 10.]

***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 dining and snack service includes proper techniques to assist resident with eating, including safe positioning of resident who require assistance, to be implemented voluntarily.***

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**WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training**

**Specifically failed to comply with the following:**

**s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that all staff received training in the home's policy to promote zero tolerance of abuse and neglect of residents, annually.

In accordance with LTCHA 2007, s.76 and O.Reg 79/10 s.219, all staff at the home shall receive training on the home's policy to promote zero tolerance of abuse and neglect of residents prior to performing their responsibilities and annually thereafter.

Due to complaints received by residents and an incident of suspected staff to resident verbal abuse that occurred during the course of this inspection, Inspector #148 discussed orientation and training of the home's abuse and neglect policy with the home's DOC. Inspector #148 identified five staff members and upon review of the home's training program it was demonstrated that each of the five staff members, who included registered and non-registered nursing staff, did not have training in the home's policy to promote zero tolerance of abuse and neglect of residents within the last year. [s. 76. (4)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff receive training in the home's policy to promote zero tolerance of abuse and neglect of resident's, annually, to be implemented voluntarily.***

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**WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and the licensee shall ensure that the following are documented: (6) all assessment, reassessment and monitoring, including the resident's response.

Resident #24's plan of care related to the use and application of an external device for prevention of injury, indicates that Resident #24 requires two full side rails in the bed for safety. Inspector #573 reviewed the resident's health care record and noted that a physician's order was obtained for the use of two full bed rails as a restraint.

Resident #15's plan of care related to the use and application of an external device for the prevention of injury, indicates the resident requires a lap tray while in wheelchair for safety. Inspector #573 reviewed the resident's health care record and noted that a physician's order was obtained for the use of lap tray in the wheelchair as a restraint.

On November 10, 2015, during an interview, PSW #104 indicated that the monitoring of restraints is documented in the point of care (POC) electronic system.

The Inspector reviewed Resident #24`s bed rails restraint monitoring documentation in POC and there was no documented restraint monitoring on sixteen instances in October 2015, from 0000-0600 hours or onfour occasions in November, 2015, from 0000-0600 hours.

The Inspector reviewed Resident #15`s lap tray restraint monitoring documentation in the POC and there was no documentation on monitoring restraint record on thirteen instances in October, 2015, from 0700-1400 hours or on three instances in November, 2015, from 0700-1400 hours.

Inspector #573 spoke with the home's RAI Coordinator #100 who indicated that the two full bed rails for Resident #24 and lap tray while in the wheelchair for Resident #15 is used as restraint. Restraint monitoring documentation was reviewed by the #100 and she confirmed that the PSW staffs did not document the restraint monitoring for the use of two bed rails and lap tray as identified above. [s. 110. (7) 6.]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that monitoring related to the use of a physical device to restrain a resident is documented, to be implemented voluntarily.***

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**WN #8: 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 failed to ensure that the written policies and protocols related to the interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents, were developed, implemented and updated.

Inspector #545 reviewed the home's Medication Management policies, provided by the DOC.

The Medication Pass policy, revised March 2008 indicated under the Section Procedure:
4. Check each medication within the package and the label on the back of the package against MAR sheet to ensure accuracy
5. Open medication package and pour medications into a medication cup.
6. Administer medications to the resident.
7. Sign MAR in proper space for each medication administered or document by code if medication was not given or was refused by the resident.

9. If the medication had been poured and then refused by a resident, do not place it back into the original container. Document on the MAR sheet and in the resident's chart.
10. Place refused medication in designated labeled container on the cart, then place with surplus medications for destruction by pharmacist.

On November 9, 2015, Inspector #545 observed on the counter in the Drug Room, in presence of RPN #105, an individual medication package with the name of Resident #6. The package was unopened and contained a beta blocker, dated for administration the evening before.

RPN #105 indicated that she had observed the medication in Resident's #6's medication bin at the beginning of her day shift and had not verified with the Medication Administration Record (MAR) yet or reported it to the RN in charge and/or DOC. After verifying the electronic MAR with the Inspector, RPN #105 indicated that the medication had been signed as administered, however it was left in the medication bin and not administered.

The Administration of Medication/Treatment policy, revised March 2008 indicated under the Section Procedure:
8. Initial on the MAR/TAR in the appropriate space. If a dose is not administered, make the appropriate chart notation in the space. Note: if the administered medication is a narcotic, or controlled drug, sign other appropriate forms in addition to MAR/TAR

On November 9, 2015, Inspector #545 conducted an observation of the Narcotic and Controlled Substance storage area with RPN #105. On the Individual Monitored Medication Record for 7-Day Card for Resident's #30, a pink sticky note with the following note was observed: "RPN #106, please sign". The note had an arrow pointing to the dose of anxiety medication dated three days before. [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 related to the medication management system are developed, implemented and updated, to be implemented voluntarily.***

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**WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program.

The home's infection prevention and control program policy revised April, 2015, includes the detailed hand washing program for all staff to be used in the standard routine practices for all residents. Under Hand Washing, it clearly indicates hands must be washed "Immediately after removing gloves" and "Before preparing, handing, serving or eating food and before feeding a resident".

The medication pass was observed with RPN #105 on November 10, 2015, between 7:35 and 8:30am. The RPN had access to both a bottle of alcohol hand sanitizer located on top of the medication cart and to a box of non-sterile gloves. RPN #105 applied and removed clean, non-sterile gloves each time she provided a different type of medication to an identified resident:
-when she checked blood sugar
-when she prepared and administered insulin
-when she applied two different eye drops
-when she prepared and administered oral medications
-and after she documented administration of each type of medication in the electronic

Medication Administration Record (eMAR)
The RPN did not wash her hands with soap and water or use the available alcohol hand sanitizer before and after applying new non-sterile gloves.

The RPN wheeled an identified resident out of the Clean Utility Room into the Dining Room, applied new gloves and prepared and administered medications to Resident #37, then documented administration of medications in the eMAR. Again, the RPN did not wash her hands before and after applying new clean, non-sterile gloves

-Standard Routine practices for all residents: Hand Washing, Section 3.3 Standard Precautions, revised 04/15, it was indicated that "wash hands immediately after gloves are removed and between resident contact and when otherwise indicated to avoid transfer of microorganisms to other residents or the environment. It may be necessary to wash hands between tasks and procedures on the same resident to prevent cross-contamination of different body site." Under Section Gloves, it was indicated that Gloves should be used as an additional measure, not as a substitute for hand washing (item 2).

During an interview with RPN #105, she indicated that she did not need to wash her hands as she was wearing clean gloves during care provision.

The DOC indicated that it was the home's expectation that registered staff wash their hands before and after applying gloves, that hand sanitizers were readily available. She indicated that gloves should be used as an additional measure, and not as a substitute for hand washing. [s. 229. (4)]

2. On November 9, 2015, at approximately 1220 hours during the lunch meal service, Inspector #573 observed Dietary Aid #120 wearing gloves, removing resident's dirty dishes from various tables, clearing the remaining food in the garbage bin and placing the dirty dishes in a clearing tray. After placing the dirty dishes in a clearing tray, the staff member removed and disposes the gloves in the garbage. Then Staff #120 applied a new set of gloves and proceeded to feed Resident #36 at table 3. After a few minutes Staff #120 removed his gloves and went back to clear dirty dishes at table 2. At no time was the staff observed to wash his hands between gloves use.

On November 10, 2015, Inspector observed Dietary Aid #120 wearing gloves and feeding Resident #36 at table 3. After a few minutes Staff #120 went to clear dirty dishes at table 5 and 6. After placing the dirty dishes in a clearing tray, the staff member removed and disposed the gloves in the garbage and went to the kitchen to obtain two

desserts from the servery cart to serve residents at table 10. The Inspector observed the Staff #120 to apply a new set of gloves and proceed to feed residents at table 3. At no time was the staff member observed to use hand washing between gloves changes.

Inspector #573 observed a hand wash sink in the kitchen and alcohol based hand hygiene dispensers placed in the dining room walls.

During the meal service not all staff members were observed to participate in the home's infection prevention and control program, specifically hand washing. [s. 229. (4)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff participate in the implementation of the infection prevention and control program, specifically hand washing, to be implemented voluntarily.***

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**WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights**

**Specifically failed to comply with the following:**

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**
**11. Every resident has the right to,**
**i. participate fully in the development, implementation, review and revision of his or her plan of care,**
**ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,**
**iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and**
**iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that residents' personal health information within the meaning of the Personal Health Information Protection Act, 2004, is kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

During an observation of a medication pass on November 10, 2015, with RPN #105, the Inspector observed the RPN rip one corner of the individual medication packages for Resident #6, pre-poured the medications in a paper cup then tossed the ripped individual packages in a green garbage bag attached to the side of the medication cart. Upon request, the RPN gave the individual medication packages to the Inspector, and each one revealed the following personal health information for Resident #6: first and last name, room number, medication name, dose and date and time of expected administration. The RPN repeated the same action after preparing medications for Resident #37.

RPN #105 indicated to the Inspector that she should be putting all the individual medication packages in a bowl of water then rub the personal health information off before tossing them in the garbage. She further indicated that due to lack of space on the medication cart, she did not carry a bowl of water and simply tossed the opened individual medication packages into the garbage attached to the medication cart, and at the end of the day, the garbage bag was put with the rest of the home's garbage.

The DOC indicated to the Inspector that it was the home's expectation that registered staff rubbed off the residents' personal health information on the individual medication packages before tossing them into the garbage, in order to protect their privacy. [s. 3. (1) 11. iv.]

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**WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.**

**Findings/Faits saillants :**

1. The licensee failed to ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimeters (cm).

On November 3, 2015, during resident observations Inspector #573 observed windows in Resident #24 and Resident #34's bedrooms to open more than 15cm. The Inspector spoke with the Maintenance Supervisor who indicated that after the Resident Quality Inspection of October 2014 all the windows in the resident's bedrooms were installed with metal clips which prevented the windows from opening more than 15cm.

On November 5, 2015, Inspector observed the identified windows in Resident #24 and Resident #34's bedrooms in the presence of Maintenance Supervisor who confirmed that the widows were able to open beyond 15cm. The Maintenance Supervisor stated to the Inspector that he will arrange to make the necessary modifications to those windows immediately to ensure windows do not open more than 15 cm.

On November 6, 2015, the Maintenance Supervisor confirmed with Inspector #573 that the windows in Resident #24 and Resident #34's bedrooms, were modified to ensure that no window opened more than 15cm. [s. 16.]

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**WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance**

**Specifically failed to comply with the following:**

**s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,**
**(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).**
**(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).**
**(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).**
**(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).**
**(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).**
**(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).**
**(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).**
**(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents contains an explanation of the duty under section 24 of the Act to make mandatory reports.

The home's DOC provided the home's policy to promote zero tolerance of abuse and neglect of residents, upon the request of Inspector #148.

A review of the policy indicates elements of reporting to the Ministry of Health and Long Term Care (i.e Director). However, explanations related to the reporting of abuse and neglect of residents, do not indicate immediate reporting. The explanations provided to not clearly indicate that a person with reasonable grounds to suspect that abuse or neglect of a resident has occurred or may occur shall be reported. In addition, reporting requirements are described based on the results of the home's investigation, whereby when an investigation indicates that a resident has likely suffered abuse the Manager or designate will report to the MOHLTC in 24 hours.

In addition, the policy does not include the duty to report as it relates to improper/incompetent care, unlawful conduct and the misuse/misappropriation of resident's money or funding.

The home's policy to promote zero tolerance of abuse and neglect of residents, does not provide for a clear explanation of the duty under section 24 of the Act. [s. 20. (2)]

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**WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.**

**Specifically failed to comply with the following:**

**s. 29. (1) Every licensee of a long-term care home,**
**(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).**
**(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the written policy to minimize the restraining of residents, is complied with.

The home's restraints policy, #4.1.3 titled "Restraint consent form", indicates that the registered nursing staff are responsible to complete the restraint consent form and to review with the resident and/or the substitute decision maker regarding the reason for the restraints. It further directs the registered nursing staff to obtain a written consent for the use of restraints and to file the same in the resident's chart.

A review of Resident #24's health care record indicated that a physician's order was obtained for the use of two full bed rails as a restraint while in bed. The use of the two full bed rails as a restraint is also included in Resident #24's plan of care. However, there was no documentation found in the Resident's health care record regarding a written signed consent for the use of two bed rails as a restraint.

On November 12, 2015, the home's RAI coordinator #100 indicated to Inspector #573 that before any type of restraint is used, the registered nursing staff would obtain written consent for restraints from the Resident or the Substitute Decision-Maker (SDM). After reviewing Resident #24's health care record with the inspector, Staff #100 indicated that the SDM was made aware of the new physician orders and further confirmed that to date no follow up was done by the registered nursing staff to obtain a written signed consent from the SDM for the use of two bed rails as a restraint as per the homes policy. [s. 29. (1) (b)]

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**WN #14: 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 failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was not reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Resident #25 was identified as having pressure ulcers on two areas of the body.

A review of the resident's health care record was done and indicates that Resident #25 was admitted with pressure ulcers approximately 1 year ago, and was provided with daily monitoring and dressing changes since. As per the current physician orders, Resident #25 is to have daily dressing change. The treatment administration records indicate that a wound assessment is to be performed twice weekly.

On November 9, 2015, Registered Nurse #100, reported to Inspector #592 that registered nursing staff are to do a weekly skin assessments by putting their initials on the Treatment Administration Record (TAR) Sheet and then use a specific assessment tool in their electronic record whenever residents are exhibiting a skin breakdown. She further reported that in the case of Resident #25, the resident was to be assessed twice weekly due to the condition of the ulcers.

Upon review of the Treatment Administration Records (TAR) from August 2015 to

October 2015 it was demonstrated that there was no documented record of a skin assessment being provided, as scheduled, to Resident #25 for seven scheduled assessments. This resulted in periods of time whereby the resident did not receive weekly skin assessments.

2. Resident #26 is identified having a pressure ulcer to an identified area of the body.

A review of the resident's health care record was done and indicates that Resident #26 was provided with daily monitoring and dressing change for several months. The TARs indicated that a wound assessment is to be performed weekly.

On November 10, 2015, Registered Nurse #100, reported to Inspector #592 that Resident #26 is to receive a weekly skin assessment by the Registered staff members.

Upon review of the TARs from August 2015 to October 2015 it was noted that there was no documented record of a skin assessment being provided to Resident #26 for three scheduled assessments. This resulted in periods of time whereby the resident did not receive weekly skin assessments.

On November 10, 2015, Registered Nurse #100, reported Inspector #592 that if the skin assessment tool was not completed there was no other skin assessment tool used.

On November 10, 2015, the DOC reported to Inspector #592 that the home's expectation is to have a skin assessment provided weekly to all residents who are exhibiting a skin breakdown. She further indicated that she was aware that weekly wound assessments were not always provided by Registered nursing staff members as indicated and that if the weekly skin assessment were not recorded in the health care record, none was being done. [s. 50. (2) (b) (iv)]

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**WN #15: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council**

**Specifically failed to comply with the following:**

**s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that a response in writing is provided within 10 days of receiving Residents' Council advice related to concerns or recommendations.

Resident #41, a member of the Residents' Council, indicated to the Inspector that the Council usually meets monthly and that at the present time there was no president. Resident #41 indicated that she was not aware of any written response received from the licensee when the Council expressed advice related to concerns or recommendations.

The Activity Director, assigned to assist the Council, indicated that the meetings use to occur monthly until the President passed away in February 2015. The Assistant provided to Inspector #545, minutes for the meetings of October and November 2015, and added that she was unable to find minutes for the other meetings.

In the October 2015 minutes, the following concerns and recommendations indicated that the residents:
- disliked the change in lift/sling being used by staff; Activity Director provided education on process, assessment and regulations regarding lifts and she encouraged residents to discuss concern with the physiotherapist at their next monthly visit
- were concerned about missing clothing items; Activity Director reminded residents to approach staff members for assistance
- suggested specific items for their Thanksgiving Dinner, would like meats to be more tender, and to add meatloaf & hamburgers on the menu
- suggested specific recreation activities such as one shopping trip per month, attending a play at Upper Canada Village, monthly birthday parties with cupcakes and singing and bus ride to see fall foliage.

During an interview with the Activity Director, she indicated that she use to distribute the Residents' Council meetings minutes to all management, but had stopped this practice in the recent past. The Activity Director indicated that the licensee did not respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

The Administrator indicated that she was designated to represent the licensee and that she did not respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations. [s. 57. (2)]

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**WN #16: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 67. A licensee has a duty to consult regularly with the Residents' Council, and with the Family Council, if any, and in any case shall consult with them at least every three months. 2007, c. 8, s. 67.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the licensee consult regularly with the Residents' Council, and in any case, at least every three months.

Resident #41, a member of the Residents' Council, indicated to the Inspector that the licensee did not consult with the Residents' Council in the past year.

During an interview with the Activity Director, she indicated that she was assigned to assist the Residents' Council, but not to represent the licensee. She indicated that the licensee had not consult with the Residents' Council in the past year.

The Administrator indicated that she started in her role as Administrator of the home in September 2014, and was designated to represent the licensee. She indicated that she had not consulted with the Residents' Council from September 2014 to date. [s. 67.]

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**WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 67. Recreational and social activities qualifications**

**Specifically failed to comply with the following:**

**s. 67. (1) Every licensee of a long-term care home shall ensure that staff members providing recreational and social activities in the home,**
**(a) have a post-secondary diploma or degree in recreation and leisure studies, therapeutic recreation, kinesiology or other related field from a community college or university; or O. Reg. 79/10, s. 67 (1).**
**(b) are enrolled in a community college or university in a diploma or degree program in such a field. O. Reg. 79/10, s. 67 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that staff members providing recreational and social activities in the home, have a post-secondary diploma or degree in recreation and leisure studies, therapeutic recreation, kinesiology or other related field from a community college or university; or are enrolled in a community college or university in a diploma or degree program in such a field.

As described by the home's Activity Director, the home has two staff members working as recreation aides in the home, providing recreational and social activities to residents. The home recently hired Staff member #117 as a recreational aide. Upon review of the staff member's qualifications it was demonstrated that she did not have a post-secondary diploma or degree in recreation and leisure studies, therapeutic recreation, kinesiology or other related field from a community college or university nor is she enrolled in such a program.
(Log 030554-15) [s. 67. (1)]

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**WN #18: 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 weight monitoring system measures and records with respect to each resident the height upon admission and annually thereafter.

During health care record reviews conducted during Stage 1 activities, it was noted by the inspection team that resident heights were recorded near a resident's admission to the home but were not completed on an annual basis. A review of the forty randomly selected residents, demonstrated that thirty-three residents did not have a height measure within the last year, with twenty-seven resident's last measured in 2013.

Inspector #148 spoke with two PSW staff members and the home's RAI Coordinator/RN. Staff reported that resident height is measured on admission but not conducted annually thereafter. [s. 68. (2) (e) (ii)]

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**WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning**

**Specifically failed to comply with the following:**

**s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,**
**(f) is reviewed by the Residents' Council for the home; and O. Reg. 79/10, s. 71 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the menu cycle was reviewed by the Residents' Council.

Resident #41, a member of the Residents' Council, indicated to the Inspector that the Council did not review the menu cycle in the past year.

The Activity Director, who was assigned as assistant to the Residents' Council, indicated to Inspector #545 that the home had two menu cycles: spring/summer and fall/winter. She indicated that the Food Services Supervisor (FSS) met with Residents at the Food Committee meeting to review their likes and dislikes. She provided the inspector with a two page list of food items, however she was unable to demonstrate when this list was reviewed, the names of the residents who reviewed the list and during which meeting.

During an interview with the Dietary Manager, he indicated that the menu cycle usually started in April or May for the spring/summer menu and in October for the fall/winter menu. He indicated that he use to review the menu cycle with the Residents' Council but could not remember when it was last reviewed with the members. The Dietary Manager was unable to demonstrate a date of menu cycle review by the Residents' Council. [s. 71. (1) (f)]

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**WN #20: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information**

**Specifically failed to comply with the following:**

**s. 79. (3) The required information for the purposes of subsections (1) and (2) is,**
**(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)**
**(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)**
**(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)**
**(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)**
**(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)**
**(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)**
**(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)**
**(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)**
**(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)**
**(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)**
**(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)**
**(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)**
**(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)**
**(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)**
**(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)**
**(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)**
**(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)**

**Findings/Faits saillants :**

1. The licensee failed to ensure that required information, as described by 79(3) of the Regulation, is posted in the home, in a conspicuous and easily accessible location.

Upon the initial tour of the home, Inspector #148 was unable to locate the required posting of information including the home's policy to promote zero tolerance of abuse and neglect of residents.

On November 11, 2015, Inspector #148 toured the home and spoke with the home's DOC and Administrative Assistant related to the required postings. The following were found to not be posted in the home:
- the long term care home's policy to promote zero tolerance of abuse and neglect of residents;
- notification of the long term care home's policy to minimize restraining of residents, and how a copy of the policy can be obtained;
- a copy of the service accountability agreement; and
- copies of the inspection reports from the past two years for the long term care home. [s. 79. (3)]

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**WN #21: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey**

**Specifically failed to comply with the following:**

**s. 85. (1) Every licensee of a long-term care home shall ensure that, at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home. 2007, c. 8, s. 85. (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home.

The Quality Improvement & Required Programs LTCH Licensee Confirmation Checklist was reviewed by Inspector #545. The DOC who signed the checklist indicated that a survey had not been taken, at least annually, of the residents and their families to measure their satisfaction with the home and the care, services programs and goods provided in home.

During an interview with the Administrator, she indicated that a satisfaction survey had been revised and was presently being reviewed by their communication department. She confirmed that since her appointment as Administrator in September 2014, a survey had not been taken. [s. 85. (1)]

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**WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 228. Continuous quality improvement**
**Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:**
**1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.**
**2. The system must be ongoing and interdisciplinary.**
**3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.**
**4. A record must be maintained by the licensee setting out,**
**i. the matters referred to in paragraph 3,**
**ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and**
**iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that that improvements made through the quality improvement and utilization review system to accommodations, care, services, programs, and goods provided to the residents are communicated to the Residents' Council.

Resident #41, a member of the Residents' Council, indicated to the Inspector that the licensee did not communicate improvements made through the quality improvement and utilization review system.

The Activity Director who was assigned as assistant to the Residents' Council and the Administrator who was designated as representative of the licensee, indicated to Inspector #545, that the improvements made through the quality improvement and utilization review system to accommodations, care, services, programs, and goods provided to the residents had not been communicated to the Residents' Council in the past year. [s. 228. 3.]

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**Issued on this 10th day of December, 2015**

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

**Original report signed by the inspector.**

Ontario

**Ministry of Health and Long-Term Care**

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

**Ministére de la Santé et des Soins de longue durée**

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

**Health System Accountability and Performance Division**
**Performance Improvement and Compliance Branch**

**Division de la responsabilisation et de la performance du système de santé**
**Direction de l'amélioration de la performance et de la conformité**

## Public Copy/Copie du public

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|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | AMANDA NIXON (148), ANANDRAJ NATARAJAN (573), ANGELE ALBERT-RITCHIE (545), MELANIE SARRAZIN (592) |
| **Inspection No. / No de l'inspection :** | 2015_200148_0034 |
| **Log No. / Registre no:** | O-002862-15 |
| **Type of Inspection / Genre d'inspection:** | Resident Quality Inspection |
| **Report Date(s) / Date(s) du Rapport :** | Nov 25, 2015 |
| **Licensee / Titulaire de permis :** | MOHAWK COUNCIL OF AKWESASNE<br>P.O. Box 579, CORNWALL, ON, K6H-5T3 |
| **LTC Home / Foyer de SLD :** | TSIIONKWANONHSOTE<br>70 Kawehnoke Apartments Road, Akwesasne, ON, K6H-5R7 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Patti Adiaconitei |

To MOHAWK COUNCIL OF AKWESASNE, 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. 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 :**

The licensee will ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber by:
1. Ensuring that all medications and accessories such as aerochamber for inhalers are available for administration in accordance with the directions for use specified by the prescriber
2. Reviewing and updating the home's Medication Management, including procedures related to narcotic and controlled substances.
3. Developing and implementing a process to ensure ongoing monitoring of the management of medication administration, including narcotic and controlled substances, and the reordering of medications/accessories, in partnership with the home's pharmacist
4. Providing registered staff with training of safe administration of medications, based on the College of Nurses of Ontario Best Practices, and the home's revised & updated Medication Management policies and procedures

**Grounds / Motifs :**

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

Resident #26 has a diagnosis that can cause pain. The resident was prescribed pain medication for pain management, every two days.

The Resident indicated to Inspector #545 that on a specified date, staff ran out of the resident's prescribed pain medication and the resident went without the medication for almost two days. When the resident complained of pain, the resident indicated that staff provided the resident with acetaminophen rather than the prescribed pain medication. Progress notes indicate that the resident's

pain was not relieved by this intervention.

A review of Resident #26's health record was conducted by Inspector #545. Documentation in the electronic Medication Administration Record (MAR) indicated that the prescribed pain medication was not administered in accordance with the directions for use specified by the prescriber, on a specified date. Two days later the resident was provided the prescribed pain medication whereby the staff re-allocated supply of the medication from other resident's supply (as approved by the physician). The supply of the prescribed pain medication was reviewed by the Inspector. One day after the use of re-allocated medication, Resident' #26's prescribed pain medication supply arrived to the home.

During interviews with RPNs #111 and #122, they indicated that the resident's prescribed pain medication can be ordered easily by clicking the "reorder" button on the eMAR. They indicated that Resident #26 was administered the pain medication every second day, therefore when there are only 1 or 2 doses left for this resident, the evening nurse should reorder. They both indicated that medications reordered before 1400 hours were usually delivered by early evening, adding that the home's After-Hour Pharmacy was available if medications were needed outside of regular delivery times. Both RPNs indicated that the After-Hour Pharmacy was not contacted over the three days identified above, to request the pain medication for Resident #26. RPN #111 indicated that she informed RN #110 that Resident #26 did not have anymore of the prescribed pain medication on the date identified whereby the resident did not receive the medication, and that she had reordered by clicking the "reorder" button on the eMAR.

RN #110 indicated he could not specifically remember when he was made aware by RPN #111 that the pain medication had been reordered, for Resident #26. The RN indicated that after contacting the physician for approval for reallocation of other resident's pain medication, that the home's pharmacy and/or the After-Hour Pharmacy had not been contacted to inquire status of reorder of the prescribed pain medication for this Resident or to request immediate delivery.

The DOC indicated to the Inspector that it was the home's expectation that residents have a reasonable supply of their medications on hand. She indicated that in emergency situations, staff were expected to contact the After-Hour

Pharmacy. The DOC indicated that Resident #26 was not administered pain medication in accordance with the directions for use specified by the prescriber on an identified date.
(Log O-002749-15) [s. 131. (2)]

2. On November 9, 2015, Inspector #545 observed on the counter in the Drug Room, in presence of RPN #105, an individual medication package with the name of Resident #6. The package was unopened and contained a beta blocker, dated for administration the evening before.

RPN #105 indicated that she had observed the medication in Resident's #6's medication bin at the beginning of her day shift and had not verified with the Medication Administration Record (MAR) yet or reported it to the RN in charge and/or DOC. After verifying the electronic MAR with the Inspector, RPN #105 indicated that the medication had been signed as administered, however it was left in the medication bin and not administered. [s. 131. (2)]

3. On November 10, 2015, Inspector #545 observed RPN #106 prepare and administer medications at the 0800 hours Medication Pass, on the South Wing.

Resident #6 was prescribed two medications that were not administered in accordance with the directions for use specified by the prescriber:

•A medication for respiratory relief administered by use of aerochamber. RPN #106 checked the bottom drawer of the medication cart to locate Resident #6's aerochamber and when she was unable to find it, she indicated that the Resident did not have one; therefore the prescribed inhaler would not be administered as the aerochamber was unavailable.

•An antibiotic, RPN #106 was unable to locate the bottle of antibiotic in the drug room refrigerator or in the bottom drawer of the medication cart or in the box designated for surplus medications for destruction by pharmacist, located in the drug room. The RPN indicated that the antibiotic would not be administered as the medication was unavailable. RN #100 later indicated that Resident #6's last dose of antibiotic should have been 3 days ago, however the Resident continued to be administered the antibiotic twice daily, therefore receiving 5 extra doses.

4. During the same Medication Pass observation with RPN #106, Inspector #545

observed another medication that was not administered in accordance with the directions for use specified by the prescriber.

Resident #37 was prescribed a laxative every morning.

RPN #106 was unable to locate Resident #37's supply of laxative. As she pulled another resident's bottle of lactulose, she indicated that she was not permitted to use another resident's lactulose. She then returned to the drug room in case a new supply had been delivered the evening before and not added to the medication cart. She later indicated that as none was ordered, she would reorder one today, however the resident would not get the laxative as prescribed at this medication pass.

As such, staff did not administer medications to four different residents, in accordance with the directions for use specified by the prescriber. [s. 131. (2)] (545)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Jan 31, 2016

## 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 or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance 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 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
Performance Improvement and Compliance 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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

**Issued on this 25th day of November, 2015**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** AMANDA NIXON

**Service Area Office /**
**Bureau régional de services :** Ottawa Service Area Office