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

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 # / No de registre	Type of Inspection / Genre d'inspection
Nov 22, 2017	2017_617148_0031	009569-17	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), JOANNE HENRIE (550), LISA KLUKE (547)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 30, 31 and November 1, 2, 3, 6 and 7, 2017

This RQI included one critical incident inspection (Log #030459-16) and one complaint inspection (Log #015541-17)

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Food Service Manager (FSM), Recreational Supervisor, a Restorative Aide, residents and family members.

In addition, the inspectors observed resident care and services in the home, resident-staff interactions, the resident's home environment and medication administration. The inspectors reviewed resident health care records, resident council meeting minutes and related documents, relevant polices and procedures including those related to infection control and restraints and documents pertaining to medication incidents in the home.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Dignity, Choice and Privacy
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Residents' Council

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

13 WN(s)
5 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. 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 restraining of a resident by a physical device may be included in the plan of care only if a physician or a registered nurse in the extended class has ordered or approved the restraining.

On October 31 and November 1, 2017, Inspector #550 observed resident #016 in bed with two full bed rails applied.

The plan of care for resident #016 describes the use of two side rails up at all times while in bed for safety/repositioning.

During interviews on November 1, 2017, RN #110, RPN #101 and PSW #102 indicated to the Inspector that resident #016 requires two full rails up when the resident is in bed to prevent the resident from falling off the bed. As indicated by these staff members, although the resident requires staff assistance for bed mobility, the resident could fall off the bed if the rails were not in place.

Inspector #550 reviewed the resident's health care record in the presence of RN #110. A physician order documented on the "Consolidated Orders (Chart) Report" and signed by the physician, indicated the use of two quarter rails while in bed for positioning. There was no physician order for the use of two full bed rails as a restraint.

As such, the restraining of resident #016's by use of two full bed rails, was included in the resident's plan of care without an order or approval by the physician or the registered nurse in the extended class. [s. 31. (2) 4.]

2. The licensee has failed to ensure that the restraining of a resident by a physical device may be included in the plan of care only if the restraining of the resident has been consented to by the resident or, if the resident is incapable, by the substitute decision maker.

As described above, the plan of care for resident #016, along with staff interviews describe the use of two full bed rails as a restraint.

RN #110 indicated to the Inspector that consent is documented on the restraint consent form and the form is kept on the resident's health care record. Inspector #550 reviewed the resident's health care record in the presence of RN #110 and was not able to locate a consent form for the two full bed rails used as a restraint.

As such, the restraining of resident #016's by use of two full bed rails, was included in the resident's plan of care without consent by the resident or the resident's substitute decision maker. [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 restraining of a resident by a physical device may be included in a resident's plan of care only if the restraining of the resident has been consented to and an order or approval has been obtained, to be implemented voluntarily.

WN #2: 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 the licensee respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

On October 31, 2017, Inspector #547 interviewed resident #002 and resident #042 separately regarding their experience with Residents' Council. Both residents indicated that they did not receive written responses from the licensee within 10 days of them providing concerns or recommendations about the home.

On November 1, 2017, the Assistant appointed to Residents' Council in the home indicated to Inspector #547 that she has been acting in this role for the last 14 years. She indicated that she does compile the Residents' Council advice on to a Residents' Council Concerns Form and provides these to the Administrator. The Administrator is then responsible to forward them to each manager for response. She further indicated that often the responses do not come back, and then she forgets to add them to the next meeting agenda.

On November 2, 2017, the Administrator indicated to Inspector #547 that he received all the Residents' Council Concern Forms after their meetings from the Assistant to the Council. He indicated that sometimes he does not get to them within the 10 days as required. He indicated that he does forward these concern forms to the appropriate managers as required, but was unaware if the managers were responding within 10 days,

The March 14, 2017, council minutes identified the need for follow-up about a concern raised from the Residents' Council about cell phone use during care by nursing staff. On November 3, 2017, the DOC indicated that she recalled receiving this concern, but that she did not complete the form with her response, and cannot remember when she responded or if she did. The DOC indicated that she really needs to use the form to complete this communication back to the Assistant to the Council, and work within the timelines as required. [s. 57. (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 the licensee respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations, to be implemented voluntarily.

WN #3: 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. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that they seek the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results.

On October 31, 2017, resident #002 and resident #042 indicated to Inspector #547 that they were members of the Residents' Council in the home for many years, and that they had not been asked to develop the resident satisfaction survey in the home. They were provided some examples of surveys, and they chose the easiest one, but resident #042 indicated that they were never asked if they could add or remove some of the questions that they would have wanted asked in the survey. Resident #002 and resident #042 both further indicated that the Residents' Council were not asked how they wanted the satisfaction survey carried out or how they would like the home to act on its results.

On November 1, 2017, the Assistant to Residents' Council indicated to Inspector #547 that she remembers bringing the Residents' Council three satisfaction surveys to choose from, and they chose the easiest one to complete as the home's survey for this year. She indicated that she did not ask them about the questions of the survey, or ask them how they wanted the survey to be carried out in the home as she was not aware this was required. As such, the Assistant of the Residents' Council indicated that the Residents' Council chose a satisfaction survey, however were not involved in developing the survey or how this survey was to be carried out for resident's and families. [s. 85. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the licensee seeks out advice from the Residents' council in developing and carrying out the satisfaction survey, and in acting on its results, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Inspector #547 reviewed the home's medication incident reports for the last completed quarter of 2017. These incidents identified a trend in this quarter, as drugs were not administered to resident in accordance with the directions for use specified by the prescriber. In review of the quarter, it was demonstrated that there were ten incidents, including seven residents (one additional resident that was not identified), whereby drugs such as antibiotic, antidepressants and beta blockers were not administered to the resident as specified by the prescriber.

On October 31, 2016 Inspector #547 interviewed RPN #101, who indicated staff document all medication administration in the Electronic Medication Administration Record (EMAR) system now in the home. RPN #101 indicated that staff are still working on this process, and have recently reviewed the policy and procedure regarding medication administration documentation processes. RPN #101 indicated that there were several incidents over a period of time in the summer, that registered nursing staff were signing for medications prior to administration or missing medications that may have been outside the dispill packages provided by the pharmacy and that documentation may reflected the drugs were administered when they were not.

On November 6, 2017 the DOC indicated that her review into these medication incidents identified a need for review of the home's policy and procedure related to the documentation of medication administration and the EMAR process for ensuring the correct medications are being administered to residents.

As such, residents #003, #005, #009, #010, #044, #045, #046 did not receive their prescribed drugs in accordance to directions for use as specified by the prescriber. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #5: 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 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, the matters referred to in paragraph 3, the names of the persons who participated in evaluations, and the dates improvements were implemented, and the communications under paragraph 3.

In accordance with section 84 of the Act, every licensee of a long-term care home shall develop and implement a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents of the long-term care home.

The Licensee Confirmation Checklist related to quality improvement and required programs was completed by the home's Administrator and received by Inspector #148 on October 30, 2017. Upon review of the checklist, "n/a" was answered for questions related to the maintaining of records of improvements and the persons involved in the evaluation and dates improvements were implemented. The Inspector spoke with the home's Administrator and later the home's DOC regarding the licensee's quality improvement and utilization system.

During discussions with Inspector #148 about the quality improvement system, the Administrator and DOC described that they had recently disseminated a satisfaction survey, had recently started a fall and skin committee and purchased new mechanical lifts.

The Administrator and DOC expressed that at this time there was no written description of the quality improvement and utilization system, including goals and policies nor were there any records maintained of the improvements made, persons who participated in evaluations and dates improvements were made.

Further related to the requirements of section 228, Inspector #547 interviewed two members of the Residents' Council. Resident #002 indicated that he/she has been on and off of the resident's council for almost eight years in the home, and that improvements made to accommodation, care, services, programs and goods are not communicated to the Residents' Council. Resident #042 indicated the same information and added that they are just the residents that live there, they are not involved in any changes, improvements or informed about anything really. Resident #042 further indicated that things just change suddenly.

On November 1, 2017, the Assistant to Residents' Council indicated to Inspector #547 that she does not recall bringing improvements made in the home to Residents' Council before, and was not aware of this requirement. She indicated that the home has made improvements that could affect the residents such as changing of window coverings in resident rooms to better provide for privacy; she reported that this item was not brought forward to Residents' Council. [s. 228. 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 licensee's quality improvement and utilization review system required under section 84 of the Act complies with legislative requirements, to be implemented voluntarily.

WN #6: 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:
19. Safety risks. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

The licensee failed to ensure that the plan of care must be based on, at a minimum, interdisciplinary assessment of safety risks, with respect to resident #018 and the use of a wheelchair in disrepair during transfers.

Resident #018 uses the assistance of a mobility device to mobilize in and out of the long-term care home and was noted to have recent falls. During an interview with the resident, he/she reported that at times the resident will transfer him/herself using the mobility device, but that the transfer doesn't always work because the device is broken. Upon the Inspector's observation it was discovered that the mobility device was in disrepair.

In discussion with staff, RPN #101, PSW #102 and #103 along with the home's DOC and Restorative Aide #105, it was reported that due to the resident's use of the mobility device, there are times whereby the device is in disrepair. Restorative Aide #105 noted that there has likely been 2-3 repairs since the spring of 2017. RPN #101 reported that the current disrepair noted by Inspector #148, has likely been present for approximately two months. It was reported that an external company has assessed the damage and it was confirmed by the Restorative Aide, that needed parts have been ordered. It is unclear when the repairs will take place.

Inspector #148 reviewed the resident's health care record and spoke with two PSW staff members and an RPN. Staff reported that the resident is known to self-transfer using the mobility device and has had falls related to such transfers. The health care record supports three falls in the last two months; each fall is described noting the use of the mobility device. (see WN #7).

On November 2, 2017, Inspector #148 spoke with the DOC and Restorative Aide #105. It was determined that resident #018 is known to conduct self-transfers using the mobility device and this same device is in disrepair. At the time of the interview, the DOC was not aware of a transfer incident on a specified date. The plan of care for resident #018 describes the use of two person transfers with belt and use of mobility device. The resident has had three falls related to transfers while using a device that is unsafe for transfers; the plan of care does not provide for the safety risks related to the resident using a mobility device that is in disrepair. [s. 26. (3) 19.]

WN #7: 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 on October 29, 2017, staff used safe transferring and positioning devices or techniques when assisting resident #018.

Resident #018 uses a mobility device to mobilize in and out of the long-term care home and was noted to have recent falls. During interviews with the resident and staff members it was reported that the mobility device is used to assist during transfers. The resident will transfer him/herself and at other times will accept assistance from staff. Upon the Inspector’s observation it was discovered that the mobility device used during these transfers is in disrepair. In review of the plan of care, transfer poster at the head of bed and most recent physiotherapy assessment, the resident is care planned to receive two person transfer assist with use of transfer belt.

On a specified date, a progress notes describes that PSW #109 was assisting resident #018 with a transfer. Due to the disrepair of the mobility device being used during the transfer, the resident fell to the floor, no injuries were sustained. When interviewed, PSW #109 indicated that the resident is usually transferred by one staff member. She further noted that she was aware of the disrepair of the mobility device; she was not sure how long the device had been in disrepair.

Inspector #148 spoke with PSW #102, PSW #103, and RPN #101 who indicated that the resident's mobility device has been in disrepair for sometime; RPN #101 indicating at least two months. Staff reported that when assistance is accepted by the resident, a one person transfer is conducted with no use of transfer belt.

On November 2, 2017, the transfer incident above was discussed with the home's DOC. After review of the plan of care and most recent physiotherapy assessment, the DOC indicated that the resident is a two person transfer. She acknowledged the disrepair of the mobility device and that the disrepair did not ensure safe transfer technique or device.

Staff member #109 did not use safe transferring techniques or positioning device with resident #018 on a specified date, as a one person transfer was conducted, contrary to the resident's plan of care, and the transfer was conducted with a device in disrepair. [s. 36.]

WN #8: 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.

On October 31, 2017, resident #002 indicated to Inspector #547 that as a member of the Residents' Council the licensee has not consulted with the Council in many months, if at all in the last year.

On November 1, 2017, the Assistant to the Residents' Council indicated to Inspector #547 that the Administrator was the representative of the licensee in the home, and that he has not been invited in a long time to any Residents' Council meetings. She indicated that she was not aware if he had consulted with the Residents' Council at least every three months.

On November 2, 2017, the Administrator indicated to Inspector #547 that he was not aware that he had to consult with the Residents' Council quarterly. [s. 67.]

WN #9: 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 is reviewed by the Residents' Council.

On October 31, 2017, Inspector #547 interviewed two members of the Residents' Council in the home. Resident #002 and resident #042 indicated that they used to review the menus at Residents' Council, but that they have not in quite some time. Both residents indicated concern with the menu.

On November 2, 2017, the Food Services Manager (FSM) indicated to Inspector #547 that she had not had a chance to review the Spring-Summer menu with Residents' Council before implementing it on May 1, 2017, as she was new to the home. The FSM further indicated that she changed food providers in the Fall and was provided the menu for the Fall-Winter menu around the beginning of October. The FSM wanted to get the menu out as it was already Fall so she did not consult Residents' Council about the Fall-Winter menu, that was implemented on October 23, 2017. [s. 71. (1) (f)]

WN #10: 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:
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the dining and snack service includes a review of the meal and snack times by the Residents' Council.

On October 31, 2017, Inspector #547 interviewed two members of the Residents' Council in the home. Resident #002 and resident #042 indicated that they have raised a concern related to snack times at Council meetings. They were not able to recall when such concerns were brought forward but noted current concerns with the time of the afternoon and evening snack service scheduled so soon after the main meals. Resident #002 indicated that the afternoon snack service often will be offered at 1330 hours, when resident's have just left the dining room from lunch at approximately 1255 hours. Resident #042 indicated that the evening snack is also passed around to residents around 1900, and they complete supper meal around 1800 hours. Both resident #002 and resident #042 indicated that the home has done nothing about this, nor has there been an opportunity to review meal or snack times with the Council.

On November 1, 2017, the Assistant to Residents' Council indicated that she did not think dining or snack service times were reviewed at Residents' Council, but asked the Inspector to verify with the Food Services Manager.

On November 2, 2017, the Food Services Manager (FSM) indicated that she was not aware that dining or snack service times were required to be reviewed with Residents' Council. The FSM indicated that she was not aware of the issues related to the afternoon or evening snack times and would need to table this to the next Residents' Council Meeting to review times for meals and snacks as required. [s. 73. (1) 2.]

WN #11: 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. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

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:
1. The circumstances precipitating the application of the physical device. O. Reg. 79/10, s. 110 (7).
2. What alternatives were considered and why those alternatives were inappropriate. O. Reg. 79/10, s. 110 (7).
3. The person who made the order, what device was ordered, and any instructions relating to the order. O. Reg. 79/10, s. 110 (7).
4. Consent. O. Reg. 79/10, s. 110 (7).
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).
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 :

1. The licensee has failed to ensure that the resident's condition was reassessed and the effectiveness of the restraining was evaluated by a physician or a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time based on the resident's condition or circumstances.

On October 31 and November 1, 2017, Inspector #550 observed resident #016 in bed with two full bed rails applied.

As described earlier in WN #1, a review of the resident's health care record and interviews with staff indicated the application of two full bed rails as a physical restraint to prevent the resident from falling from bed.

During an interview on November 7, 2017, the DOC and RPN #111 indicated to the Inspector that registered nursing staff are responsible to reassess the resident's condition and evaluate the effectiveness of the restraining at least every eight hours and document this in the Medication Administration Records (MAR) at the end of their shift to indicate that this was done.

The Inspector reviewed the MAR for October 2017 for resident #016 and was not able to find any documentation indicating that the resident's condition was reassessed and the effectiveness of the restraining was evaluated by the registered nursing staff.

The DOC and RPN #111 indicated that the full bed rails were not added to the resident's MAR for registered nursing staff to document the assessment of the resident's condition and evaluated the effectiveness of the restraining. [s. 110. (2) 6.]

2. On November 1, 2017, during the resident observation, Inspector #550 observed resident #018 to have two full bed rails applied.

During an interview on November 1, 2017, RPN #101 indicated the resident has two bed rails applied when in bed otherwise the resident would fall from bed. RN #110 indicated that the resident requires two bed rails applied when in bed as the resident would try to get up on his/her own and would fall. RPN #101 reported that registered nursing staff are required to document the reassessment of the resident's condition in the MAR at the end of each shift.

The Inspector reviewed the MAR for October 2017 for resident #018 which indicated bed rails when in bed; this item was scheduled and signed at 2000 hours. An additional entry indicated bed rails in use for safety and repositioning purposes; this item was scheduled and signed at 0600 hours and 2200 hours.

The DOC indicated to the Inspector that the assessment of the resident's condition and the evaluation of the effectiveness of the restraining done by registered nursing staff

should be scheduled for and documented in the MAR at 0600, 1500 and 2200 hours and not at 0600, 2000 and 2200 hours.

As described above, the licensee failed to ensure that the condition of resident #016 and #018 was reassessed and the effectiveness of the restraining evaluated at least every eight hours. [s. 110. (2) 6.]

3. The licensee failed to ensure that every use of a 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, more specifically:
5. The person who applied the device and the time of application.
6. All assessment, reassessment and monitoring, including the resident's response.
7. Every release of the device and all repositioning.
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care.

On October 31 and November 1, 2017, Inspector #550 observed resident #016 in bed with two full bed rails applied.
On November 1, 2017, Inspector #550 observed resident #018 to have two full bed rails applied.

As described earlier, it was established that the use of two full bed rails for resident #016 and resident #018 indicate the application of the bed rails as a physical restraint to prevent each resident from falling from bed.

During an interview with PSW #102 on November 1, 2017 and PSW #104 on November 7, 2017, it was reported that the PSWs are responsible to document the time the restraint was applied, the assessment, reassessment, monitoring, resident's response, release of the device, all repositioning, the removal or discontinuance of the device including the time of removal or discontinuance and post-restraining care in the resident's electronic health care record (Point of Care (POC). Inspector #550 reviewed the documentation in POC with these staff members and noted that there was no documentation in POC for either resident #016 or resident #018 in relation to the use of the bed rails as restraints. The PSWs indicated that the documentation for both residents was not completed as there was no task assigned in POC to allow them to document it.

During an interview on November 7, 2017, the DOC indicated that the PSWs are

responsible for documenting the restraints in POC but that this has to be set-up in POC by a registered nursing staff member. She confirmed that there was no documentation in POC for either resident #016 or #018 as it relates to the use of full bed rails as restraints.

The licensee failed to ensure that documentation of the use of a device as a restraint was completed as required by section 110 of the Regulations, for both residents #016 and #018. [s. 110. (7)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident taking any drug or combination of drugs, including psychotropic drugs, is there monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

Resident #016 was admitted to the home on a specified date with several diagnoses. The resident's last Minimum Data Set (MDS) assessment identified the resident to have mild pain daily. The last pain assessment indicated the resident had moderate pain daily with non-verbal signs of pain.

On November 2, 2017, RPN #101 indicated to Inspector #547 that resident #016's pain medication was changed as nursing staff noticed the resident was having a lot of pain; in addition to pain medication available through the resident's Medical Directive. The RPN indicated that the resident sometimes required an anti-depressant as needed for responsive behaviours that were thought to also be related to the resident's pain. RPN #101 indicated that if they give a PRN (as needed) dose to a resident, staff have to document the reason the medication was provided, in the medication administration record (MAR).

On November 2, 2017, Inspector #547 reviewed the resident's MAR for a specified period of time and noted that the resident received an anti-depressant, however the reason it was provided to the resident or if it was effective was not documented. The Inspector further noted the resident later received a pain medication the following morning and afternoon, however the reason the medication was provided to the resident or if the medication was effective was not documented.

On November 2, 2017, the DOC indicated to Inspector #547, upon review of resident #016's MAR records for the specified period of time, that she did not know the reason for which the resident received these PRN medications or if they were effective for the resident. The DOC further indicated that at the last medication incident review with the home's pharmacy that Medical pharmacy indicated in their report, that registered nursing staff are not always indicating reason or effect for PRN medications given to residents. The DOC indicated that she will have to review this nursing practice requirement for medication administration with all registered nursing staff in the home. [s. 134. (a)]

WN #13: 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. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction is:

(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and
(b) reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care.

On November 6, 2017, the home's DOC provided the last quarterly review of medication incidents. Upon review of these incidents with reference to the MEDE Report from Medical Pharmacies, it was noted that not all medication incidents were documented or documented immediate actions taken to maintain the resident's health.

On November 3, 2017, the DOC reviewed her medication incident report binder and indicated that she was missing documentation for a specified incident that was reported to the pharmacy on a specified date related to dose omissions for antibiotic therapy for a resident who had an infection. The DOC could not locate any documentation to this incident, the name of the resident, or what actions were taken to maintain the resident's health.

On November 3, 2017, the DOC further indicated to Inspector #547 that all medication incidents are to be completed in the home's electronic medical pharmacies reporting system which sends a direct report of the incident to the pharmacy, and the physician is made aware after it is printed and reviewed by the DOC. Upon review of the medication incidents, it was noted that the registered nursing staff completing these incident reports, are not documenting if the resident or the resident's substitute decision maker (SDM) if any were informed of these medication incidents. The DOC further indicated that she was aware that registered nursing staff often forgot to inform the resident or SDM's of medication incidents or staff will fail to document that the resident or the resident's SDM were informed. The DOC indicated that she had not noticed this upon her review and analysis of these incidents, and will ensure that this information documented for all medication incidents moving forward. [s. 135. (1)]

Issued on this 24th day of November, 2017

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

Original report signed by the inspector.