Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 21, 2020	2020_816722_0003	010433-19, 019024-19, 019113-19, 021580-19, 021581-19, 000253-20	Critical Incident System

Licensee/Titulaire de permis

Rykka Care Centres LP
3760 14th Avenue Suite 402 MARKHAM ON L3R 3T7

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

Hawthorne Place Care Centre
2045 Finch Avenue West NORTH YORK ON M3N 1M9

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

COREY GREEN (722), JOY IERACI (665)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 15-17, 20-24, and 27-31, 2020

The following intakes were inspected during this inspection:

- Log #019113-19 related to medication administration;
- Log #019024-19 related to alleged staff-to-resident neglect; and
- Log #010433-19 and Log #000253-20 related to falls resulting in injury.

Two follow-up inspections were included during this inspection:
- Log #021581-19 to follow-up Compliance Order (CO) #001 related to nutrition from inspection #2019_767643_0027, with a compliance due date of December 6, 2019; and
- Log #021580-19 to follow-up CO #003 related to medication administration from inspection #2019_767643_0027, with a compliance due date of November 15, 2019.

A critical incident report (Log #000832-20) was also received by the Ministry of Long-Term Care (MLTC) related to a complaint of alleged staff-to-resident abuse identified in Log #000059-20. Information related to the critical incident was gathered as part of Complaint inspection #2019_816722_0002.

During the inspection, the inspectors made observations of residents, resident care, and resident home areas; and reviewed relevant administrative records (e.g., policies and procedures, protocols, staff schedules, etc.), and resident health records in both electronic and paper format.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Acting Directors of Care (DOCs), Assistant Directors of Care (ADOCs), Food Services Manager (FSM), Registered Dietician (RD), Social Services Coordinator (SSC), Program Manager (PM), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), a Dietary Aid (DA), residents' family members, and residents.

The following Inspection Protocols were used during this inspection:

Critical Incident Response
Dining Observation
Falls Prevention
Hospitalization and Change in Condition
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 131. (2)	CO #003	2019_767643_0027	665
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2019_767643_0027	665

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

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

Specifically failed to comply with the following:

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented for residents #001 and #005.

During a follow up inspection for Compliance Order (CO) #003, issued November 1, 2019, for inspection #2019_767643_0027, related to O.Reg 79/10, s. 131. (2), the electronic medication administration records (eMARs) for residents #001 and #005 were reviewed.

Review of the eMARs for residents #001 and #005 for a specified month did not have documentation that the residents were administered doses of identified medications on a specified date and time. A further review of the home's Missed Medication Administration Audit Report for the specified month also documented the prescribed doses of medications were missed for each resident on the date specified.

In an interview, RPN #114 stated that it was the home's process for the registered staff to immediately document in the eMAR when they have administered medications to residents. The RPN reviewed the eMARs for residents #001 and #005 and indicated that they had administered the identified medications as ordered on the specified date and time, and forgot to document it in the eMAR.

In separate interviews, ADOC #103 and acting DOC #119 indicated it was the home's process for registered staff to document in the eMAR immediately when medications were administered to residents. Both acknowledged that RPN #114 failed to ensure that the provision of the care set out in the plan of care was documented for residents #001 and #005.

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 provision of the care set out in the plan of care is documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

In accordance with O. Reg. 79/10, s. 114 (2), the licensee was required to have written policies and protocols developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration and destruction and disposal of all drugs used in the home.

Specifically, staff did not comply with the licensee's Medication Reconciliation Policy #RCS F-80, last revised September 18, 2018. The policy described a process for registered staff to prevent medication incidents on admission/readmission/transfers by documenting the best possible medication history (BPMH) from a minimum of two sources. Under item #4 in the Procedure for admission, the policy directed registered staff to indicate the status of each medication on admission with a check mark under one of the following key terms: continue, discontinue, or hold on the designated "Admission/Re-Admission Order Form", upon verification of orders by the physician. The registered staff were required to indicate that the orders had been approved by the physician, sign the form after orders were processed, and another nurse was required to co-sign the form.

A critical incident system (CIS) report was submitted to the Ministry of Long-Term Care (MLTC) for a medication incident that occurred on a specified date and involved resident #007. The CIS report documented that resident #007 was admitted to the home on a specified date and had an identified medical diagnosis. The medication reconciliation was not completed in a timely manner and was completed late for regular delivery of the

resident’s medications from pharmacy. The resident did not receive two consecutive doses of an identified medication on the day of admission, and the physician was not notified. Resident #007 was transferred to hospital the same day, and returned to the home the following day.

Review of the investigation documents showed an identified report completed by the previous DOC, documenting resident #007 was admitted to the home on a specified date and time. The report documented that RN #137 was expected to complete the medication reconciliation, contact the physician to confirm the orders and ensure medications were ordered from pharmacy before the 1500 hours cut off time, as orders received by 1500 hours were included in the evening delivery on the same day. The investigation determined that the medication orders were not confirmed with the physician until 1500 hours and were not faxed to the pharmacy until 1615 hours, which caused a delay in the delivery of the resident’s medications. Additionally, RN #137 failed to properly complete the medication reconciliation, as they did not sign the orders once confirmed with the physician. The report further documented that it was the home’s expectation for RN #137 to have contacted the physician for urgent orders as the resident required a specified high-risk medication at specified times during the day.

In an interview, RN #130 stated that when a new resident was admitted to the home, it was the home’s procedure for the medication reconciliation to be completed right away and in a timely manner, in order for the newly admitted resident to receive their medication from pharmacy. The pharmacy’s digital pen must be used and docked to complete the medication reconciliation procedure. The medication reconciliation must be completed and the digital pen docked before 1500 hours to ensure the orders were transmitted to the pharmacy. Otherwise, the registered staff must do manual entries in the eMAR for the resident's medications and notify pharmacy to ensure they deliver the resident’s medications. RN #130 also indicated if a resident required medication at a certain time, it was the home’s procedure for the registered staff to check the home’s emergency medication supply or call the pharmacy for an urgent delivery.

In an interview, ADOC #102 indicated when a resident is newly admitted to the home, it was the home’s policy and procedure for the registered staff to complete the medication reconciliation in a timely manner. The new admission order form was to be used for the medication reconciliation using the pharmacy’s digital pen. The medication reconciliation must be completed, and the pharmacy’s digital pen docked before the cut off time of 1500 hours for pharmacy to process the orders for delivery in the evening on the same day. They indicated that if a resident required medications before the pharmacy’s

delivery, it was the home's expectation for the registered staff to notify the physician for any new orders and/or interventions and call the pharmacy for an urgent delivery of the medications.

In the interview, ADOC #102 further indicated that the home's investigation identified that resident #007's medication reconciliation was completed late (after 1500 hours) by RN #137 on their date of admission. The pharmacy did not receive resident #007's orders in time for their usual evening delivery to the home. As a result, the resident missed two doses of a specified high-risk medication on admission day, developed specified symptoms related to the missed medication and their medical condition, and was transferred to hospital as per the resident's request. The ADOC acknowledged that the home's policy and procedure on medication reconciliation was not followed for resident #007's admission.

In an interview, acting DOC #119 indicated that when a resident was newly admitted to the home, it was the home's policy and procedure to complete the medication reconciliation within a few hours of admission, usually before 1500 hours so that pharmacy received the medication orders in time for the evening delivery. For any resident admitted later in the day, the registered staff were expected to call pharmacy regarding the medication orders. The evidence was reviewed with the DOC and they acknowledged that RN #137 did not follow the home's policy and procedure on medication reconciliation for resident #007.

Additional Required Actions:

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

WN #3: 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:
18. Special treatments and interventions. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The home has failed to ensure that the plan of care was based on, at a minimum, interdisciplinary assessment of interventions with respect to resident #007.

A CIS report was submitted to the MLTC for a medication incident/adverse drug reaction that occurred on a specified date and involved resident #007.

The CIS report documented that resident #007 was admitted to the home on a specified date and had an identified medical diagnosis. The medication reconciliation was not completed in a timely manner and was completed late for regular delivery of the resident's medications from pharmacy. The resident did not receive two doses of a high-risk medication on the day of admission and the physician was not notified. The resident was transferred to hospital on the same day, and returned to the home the following day.

A review of resident #007's clinical records indicated that the resident was admitted to the home from hospital with specified medical diagnoses. A review of the eMAR from the hospital showed resident #007 was prescribed several high-risk medications at specified times for identified medical conditions.

The home's investigation documents related to this incident were reviewed, and a new admission order form was identified for resident #007's medication reconciliation. ADOC #102 confirmed during an interview with the inspector that the new admission order form was the medication reconciliation that was completed by RN #137 on their admission day and included the medications identified in the hospital eMAR.

Further review of the investigation documents indicated that RN #137 was expected to complete the medication reconciliation, contact the physician to confirm the orders, and ensure medications were ordered from pharmacy before the 1500 hours cut-off time so that the medications would be included in the evening delivery on the same day. The investigation determined that the medication orders were not confirmed with the physician until 1500 hours and were not faxed to the pharmacy until 1615 hours, which

caused a delay in the delivery of the resident’s medication.

The same report further documented that RN #137 was made aware that resident #007 required an identified medication at a specified time on their admission day. RN #137 did not provide direction to the staff to monitor the resident’s condition, and did not contact the physician for immediate ("stat") orders and interim orders for the specified medication. According to the investigation documentation, resident #007 missed two doses of a high-risk medication, experienced symptoms related to their medical condition and missed medication, and was transferred to hospital as per the resident’s request.

A review of the progress notes in the electronic health record indicated that RN #137 measured resident #007's vital signs on admission to the home; however, there was no documentation to indicate that another specified test was done by RN #137 at a specified time related to the resident's medical condition. However, the home’s investigation documentation indicated that the resident’s specified test result was abnormal on admission.

A progress note by RPN #124 at a specified time indicated that resident #007 had specified tests/assessments with abnormal results, the resident requested their medications related to identified medical diagnoses and as identified on admission, the pharmacy was called to supply the resident's medications, the charge nurse and physician were notified, and the resident requested and was transferred to hospital.

In another progress note, RN #136 documented the sequence of events prior to resident #007’s transfer to hospital. The RN documented that at a specified time the resident was experiencing specified symptoms related to their medical condition and missed medication doses, and was heard complaining that they still had not received their medication. The progress note indicated that the resident's vital signs were checked with specified abnormal findings. The notes indicated that RPN #124 informed RN #136 that the resident was upset that they had not received their medications. RN #136 identified that the resident was angry and wanted to go to the hospital to receive their medications. The physician was called and ordered that the resident be transferred to hospital.

A progress note on the following day documented that the resident was treated for a specified medical condition in hospital that was related to two of the specified medications that were not administered on their admission day. Resident #007's health records were reviewed, as well as the investigation notes related to this incident, and there was no documentation identified that indicated the resident's specified conditions

were assessed or monitored more frequently, given that the resident had not received medications required to treat the conditions on their admission day.

In an interview, RPN #124 stated they were aware that resident #007 had medication orders for a specified high-risk medication to treat one of the resident's medical conditions; however, they were not aware the resident required other specified medications to treat a different specified medical condition until the resident informed them that they had not received the medications. During the interview, the RPN indicated that they had taken the resident’s vital signs and done a specified test at an identified time, but did not recall the specific time it was done and stated they had documented the values in the progress notes. The RPN reviewed the progress notes and stated they had done one set of vital signs and a specified test at the beginning of their shift as per their documentation in the progress notes. No further monitoring was done of the resident's vital signs and of the specified test.

In an interview, ADOC #102 stated that they were involved in the investigation of this CIS report involving resident #007. From the home’s investigation, it was identified that RN #137 completed the medication reconciliation late which delayed the delivery of the resident’s medications. ADOC #102 also confirmed that RN #137 was aware that the resident required high-risk medication at a specified time on their admission day, and acknowledged that they should have called the physician for any new orders or called the pharmacy for an urgent delivery to prevent the resident from missing their medications. The ADOC reviewed the resident’s progress notes and stated that there should have been more monitoring of the resident’s health status due to the missed medications for the day.

In an interview with acting DOC #119, the evidence above was reviewed, and they confirmed that resident #007 was transferred to hospital on the same day of admission and returned to the home the following day after treatment for a specified medical condition. The acting DOC indicated that there was a lack of monitoring and interventions to manage resident #007’s identified medical conditions related to the missed medications. They acknowledged that resident #007’s plan of care did not include an interdisciplinary assessment of interventions as a result of missing specified medications on the day of admission to the home.

This non-compliance has been issued as the staff in the home failed to ensure that the plan of care was based on, at a minimum, interdisciplinary assessment of resident #007 with respect to their missed doses of specified medications.

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 plan of care is based on, at a minimum, interdisciplinary assessment of special treatments and interventions with respect to the resident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

Conditions of licence
s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Connecting Care Act, 2019, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts.

Findings/Faits saillants :

1. The licensee has failed to comply with the following requirement of the LTCH Act: it is a condition of every license that the licensee shall comply with every order made under this Act.

On November 1, 2019, the following compliance order (CO) #001 from inspection #2019_767643_0027 was issued under LTCHA 2007, c.8, s. 6 (7):

The licensee must be compliant with s. 6 (7) of the LTCHA. Specifically, the licensee must:
1) Ensure that resident #002, and all other residents who require assistance with feeding, are provided with the appropriate level of assistance at meals and snacks as per their plan of care;
2) Ensure that resident #002, and all other residents, are provided with labeled individualized snacks as per their plan of care to meet their nutrition and hydration needs;

3) Ensure that resident #004, and all other residents, are provided with falls prevention and management interventions including hip protectors as per their plan of care;
4) Develop and implement an auditing system to ensure staff are providing care to residents as set out in the plan of care related to the provision of labeled snacks and fall prevention and management interventions; and
5) Maintain a written record of audits conducted in the home. The written record must include the date of the audit, the resident's name, staff member(s) audited, the name of the person completing the audit and the outcome of the audit.

The compliance due date was December 6, 2019.

The licensee completed items 3), 4), and 5), and failed to complete items 1) and 2).

Resident #002's electronic health record was reviewed and indicated that the resident was at a specified nutritional risk. Review of the resident's care plan indicated that on a specified date, Registered Dietician (RD) #120 ordered the resident to have a specified nutritional supplement at a specified mealtime as a trial to improve their quality of life.

A) Day 1: During observations conducted on a specified day during a specified mealtime, the identified nutritional supplement was not observed to be provided to resident #002 during the meal service.

In an interview on Day 1, RPN #110 indicated they did not review resident #002’s physician orders, progress notes or their care plan at the beginning of their shift, and was not aware that resident #002 was to have the identified nutritional supplement at the specified mealtime. The RPN further stated that the change in the plan of care for resident #002 related to the nutritional supplement was not mentioned in the change of shift report. During the interview, RPN #110 went into the unit dining room’s kitchen and found resident #002’s labelled nutritional supplement in the refrigerator. The RPN was observed feeding resident #002 their nutritional supplement after the identified mealtime. The RPN stated that they did not follow resident #002’s plan of care as their labelled nutritional supplement was not provided as per the plan of care on Day 1, until it was brought to their attention by Inspector #665.

B) Day 2: Review of resident #002's progress notes indicated that RPN #107 documented that the resident’s nutritional supplement was not sent to the unit by the kitchen. The note indicated that the home’s kitchen was called but there was no answer.

In an interview, RPN #107 confirmed that resident #002's nutritional supplement was not provided to the unit by the kitchen on Day 2. They stated that resident #002 was not provided their nutritional supplement at the specified mealtime as it was unavailable.

In an interview, Food Service Manager (FSM) #113 stated they were not aware that resident #002's nutritional supplement was not sent to the unit on Day 2. They stated when the RD orders snacks for a resident, labels are made for snacks at meals and for nourishment pass throughout the day, two Dietary Aides (DAs) label the snacks, and then take the labelled snacks to the unit. The FSM acknowledged that resident #002's identified nutritional supplement was not provided at the specified mealtime on Day 2, as per the plan of care.

C) Day 3: During an observation on Day 3 at a specified time, RPN #115 was observed administering resident #002's medications. Inspector #665 did not observe RPN #115 provide a specified level of assistance to resident #002 for their nutritional supplement during the observation. After the observation, a review of resident #002's electronic Medication Administration Record (eMAR) for a specified period showed that RPN #115 had signed that they had administered the resident's nutritional supplement on Day 3 at the specified time.

In an interview with RPN #115 on Day 3, RPN #115 stated that they had not administered resident #002's specified nutritional supplement and documented that they had provided it in the eMAR by mistake. The RPN went into the unit dining room to get resident #002's labelled nutritional supplement; however, it was not found in the unit dining room. At a later specified time, RPN #115 informed the inspector that resident #002's nutritional supplement was not brought up from the kitchen for the meal service and was told by FSM #113 that the home did not have any more of the nutritional supplement and new inventory was ordered. RPN #115 stated that they had changed the eMAR to show that they did not administer the nutritional supplement on Day 3.

In an interview on January 20, 2020, at 1310 hours, FSM #113 stated the home has two DAs that apply the labels for the ordered snacks for the residents and then take the snacks to the unit. The FSM was aware that resident #002's plan of care included a labeled snack of the specified nutritional supplement at a specified mealtime. They stated that the resident's nutritional supplement was not sent to the unit at the specified mealtime as the home had run out. During the interview, the FSM spoke to a DA who showed them two unlabelled nutritional supplement servings in the refrigerator, which were observed by Inspector #665. The FSM acknowledged that the labeled nutritional

supplement was not provided to the unit for resident #002 at the specified mealtime on Day 3.

The evidence was reviewed with the ADOC #103 and acting DOC #119 and they both acknowledged in separate interviews that resident #002 was not provided their labeled nutritional supplement on the three identified days as specified in the plan of care.

The resident sample was expanded to determine the scope of the non-compliance under LTCHA 2007, s. 6 (7), and similar non-compliance was identified for resident #006. A review of resident #006's current plan of care showed it was revised by RD #120 on a specified date for the resident to be provided a specified quantity of an identified beverage at all meals and snacks.

During observations conducted on a specified date, resident #006's labelled beverage was observed on the nourishment cart at a specified time; however, PSW #125 was observed to provide the resident with a glass of water, rather than the labelled beverage.

In an interview, PSW #125 indicated they were aware that resident #006's plan of care included the specified beverage at snack time. They stated that they had not provided the resident their labelled beverage on the specified date because the resident's family member did not want the resident to be provided with specified types of beverages. The PSW indicated they were not aware that the labelled beverage was appropriate according to the resident's plan of care, and acknowledged they did not provide resident #006's labelled beverage as per the plan of care on the specified date.

ADOC #103 reviewed resident #006's plan of care and progress notes and stated during an interview that PSW #125 should have followed up with the registered staff on the unit to make sure that the resident's labeled beverage at snack time was to be provided to the resident. ADOC #103 acknowledged that resident #006 was not provided their labelled beverage on the identified date as specified in the plan of care.

The licensee failed to complete items 1) and 2) specified in CO #001 for residents #002 and #006 related to nutrition and hydration.

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 complies with every order made under the LTCH Act, 2007, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that where an incident occurred that caused an injury to resident #003 for which the resident was taken to hospital, and the licensee was unable to determine within one business day whether the injury resulted in a significant change in the resident's health condition, that the Director was informed of the incident no later than three business days after the occurrence of the incident and follow with the report required under subsection (4).

A CIS report was submitted to the MLTC for a fall resident #003 had on a specified date which resulted in a significant change in the resident's health condition. The CIS report documented that the resident had a fall and was transferred to hospital to assess the resident's specified injuries. The resident returned to the home on a specified date with identified treatments for their injuries.

In an interview, ADOC #102 indicated that resident #003 sustained an injury that resulted in a significant change in their health condition as a result of the fall on the specified date. The ADOC acknowledged that the CIS report was not submitted within three business days as per legislative requirements.

In an interview, acting DOC #119 also acknowledged that the CIS report was not submitted to the Director within three business days when there was a significant change in resident #003's health condition as a result of the injury they sustained when they fell on the specified date.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4), to be implemented voluntarily.

WN #6: 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 there was, at least quarterly, a documented reassessment of each resident's drug regime.

During a follow up inspection for CO #003, issued November 1, 2019, for inspection #2019_767643_0027, related to O.Reg 79/10, s. 131. (2), Inspector #665 reviewed resident #005's quarterly medication reviews to determine the resident's prescribed medications.

Review of the physician's orders in resident #005's chart on a specified date had a quarterly medication review for the period of October 1 to December 31, 2019. RN #112 informed the inspector that quarterly medication reviews that required a physician's reassessment were in a binder. Review of the binder had resident #005's quarterly medication review for the period of January 1 to March 31, 2020, which was not reassessed and signed by the physician. The binder had quarterly medication reviews belonging to 12 other residents (residents #009, #016, #017, #018, #019, #020, #021, #022, #023, #024, #025 and #026) which were not reassessed and signed by the physician for the period of January 1 to March 31, 2020.

In an interview, RN #112 stated that it was the home's process for the quarterly medication reviews to be reassessed and signed by the physician before the start of the next quarter. The RN indicated that the quarterly medication reviews for resident #005, and the other 12 residents, had not been completed prior to the start of the next quarter.

In separate interviews with ADOC #103 and acting DOC #119, they both indicated that it was the home's expectation that residents' quarterly medication reviews were to be reassessed and signed by the physician and completed prior to the next quarter. The home failed to ensure that resident #005, as well as 12 other residents noted, had a documented reassessment of their drug regime at least quarterly.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is, at least quarterly, a documented reassessment of each resident's drug regime, to be implemented voluntarily.

Issued on this 28th day of February, 2020

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

Original report signed by the inspector.