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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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
Jul 24, 2015	2015_413500_0005	T-1701-15	Resident Quality Inspection

Licensee/Titulaire de permis

2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP
302 Town Centre Blvd., Suite #200 TORONTO ON L3R 0E8

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

LEISUREWORLD CAREGIVING CENTRE - VAUGHAN
5400 Steeles Avenue West Woodbridge ON L4L 9S1

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

NITAL SHETH (500), JOELLE TAILLEFER (211), THERESA BERDOE-YOUNG (596)

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): April 8, 9, 10, 13, 14, 15, 16, 17, and 20, 2015.

The following complaint inspection intakes were inspected during this RQI: T-1156-14, T-2233-15, T-1893-15, and T-1939-15.
The following critical incident intakes were inspected during this RQI: T-968-14, and T-1171-14.

During the course of the inspection, the inspector(s) spoke with executive director (ED), director of care (DOC), assistant director of care (ADOC), director of environmental services, director of dietary services, resident relation coordinator, resident assessment instrument (RAI) coordinator, director of programs, pharmacist, pharmacy operations manager, physician, nurse managers, registered nursing staff, personal support workers (PSWs), dietary aide (DA), cook, residents and family members.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Reporting and Complaints
Residents' Council
Skin and Wound Care

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

11 WN(s)
7 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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is a safe and secure environment for its residents.

On April 8, 2015, the inspector observed that the doors equipped with a numbered key pad upon entry were unlocked in the following areas:
- the clean utility room in the Pine Valley unit on the third floor where a cabinet drawer contained an expired prescribed cream dated May 7, 2014, and
- the clean utility room in the Morning Star unit on the fourth floor where a cabinet drawer contained an unlabelled dirty pair of scissors.

Interview with PSWs #153 and #136 revealed that the numbered key pad system should lock automatically when the door is closed and PSWs were not aware that the lock was not functioning properly.

Interview with RPN #132 from the Pine Valley unit revealed that the prescribed cream should not be kept in the clean utility room and the numbered key pad system lock was not functioning properly.

Interview with PSW #136 from the Morning Star unit revealed that the unlabelled pair of dirty scissors should not be kept in the utility room.

Interview with the Director of environmental services confirmed that the spring inside the numbered key pad system of the above mentioned doors required repair and would be repaired immediately.

On April 14, 2015, the inspector observed that the numbered key pads of the above mentioned doors were locked and repaired. [s. 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 the home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #2: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

Review of resident #1's Minimum Data Set (MDS) record completed on an identified day indicated that the resident had impaired vision and did not have visual appliances.

On a specified day, the inspector observed the resident walking in the hallway without visual appliances.

Interview with PSW #124 revealed that the resident did not wear visual appliances.

Review of the written plan of care of an identified day, and interview with registered nursing staff #112 revealed that the written plan of care did not address the resident's impaired vision.

Interviews with the Resident Assessment Instrument (RAI) co-ordinator and the DOC confirmed that the written plan of care did not address the resident's impaired vision and did not provide clear directions to the staff that provide direct care to the resident. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.

Review of the physician's order made on a specified day, indicated to administer an identified medication. Review of another physician's order on several days later indicated to hold the above mentioned medication and to have the medication reassessed.

Review of the Medication Administration Record (MAR) indicated that the resident started receiving the above mentioned medication on an identified day.
Review of the MediSystem pharmacy note sent along with medications on an identified day indicated that there was a potential drug interaction. The pharmacy note also indicated to monitor and consider holding the interacting agents while the resident was on the identified medication and to have the medical doctor (MD) to assess this situation and determine the next action.

Interview with the pharmacist from MediSystem pharmacy revealed that the above mentioned medication was sent in a bag with a note indicating the potential interaction between the two other pre-existing medications to the home.

Interview with an identified nurse manager confirmed that the physician was informed of the potential interaction after the medication was started on an identified day.

Interview with resident #11's family member indicated that he/she was not informed of the possible medication interaction.

Interview with the nurse manager and the DOC confirmed that the physician and the family should have been informed immediately of the potential drug interactions prior the administration of the medication. [s. 6. (4) (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 staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other and there is a written plan of care for each resident that sets out,
clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #3: 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 has failed to ensure that the home has a dining and snack service that includes, at a minimum, proper techniques to assist residents with eating, who require assistance.

Observation conducted on an identified date in an identified dining room, revealed that an identified care giver was feeding resident #31 using a tablespoon.

A review of the home's policy # V9-305, entitled Meal Service- Eating Assistance protocol for residents requiring total assistance at meals and a snack, revised February 2013, indicates "A teaspoon ONLY should be used to feed the residents all food items".

Interview with RPN #101 confirmed that as per the above mentioned policy staff are required to use a teaspoon when assisting with feeding of residents and confirmed that feeding with a tablespoon is not a safe feeding technique.

Interview with Director of dietary services #104 confirmed that the private care giver was required to use a teaspoon to provide feeding assistance to the above mentioned resident. [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 home the home has a dining and snack service that includes, at a minimum, proper techniques to assist residents with eating, who require assistance, to be implemented voluntarily.

WN #4: 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.

A review of the home's 2014 residents' and family satisfaction surveys revealed that there were no questions to measure the satisfaction of programs provided in the home such as: physiotherapy, skin and wound care, falls, Occupational Therapy (OT), and restraints.

Interview with the ED confirmed that questions to measure the satisfaction with the above mentioned services and programs provided in the home were not included in the 2014 residents' and family satisfaction surveys. [s. 85. (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, 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, to be implemented voluntarily.

WN #5: 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.

Record review of Critical Incident #2945-000039-14, the home's medication incident reports, and MAR revealed that there were medication errors involving 13 identified residents who did not receive a total of 18 identified prescribed medications on an identified date in 2014.

Interview with the DOC confirmed that on an identified date in 2014, the above mentioned residents were not given a total of 18 prescribed medications, by RPN #177 on the above mentioned dates during the day shift. [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 #6: The Licensee has failed to comply with O.Reg 79/10, s. 219. Retraining

Specifically failed to comply with the following:

s. 219. (1) The intervals for the purposes of subsection 76 (4) of the Act are annual intervals. O. Reg. 79/10, s. 219 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff at the home have received annual retraining in infection prevention and control.

A review of the staff training attendance record for infection prevention and control revealed that ten per cent of all staff at the home were not provided retraining in infection prevention and control (IPAC) in 2014.

Interview with the ADOC confirmed that not all staff were provided retraining in IPAC in 2014. [s. 219. (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 all staff at the home has received annual retraining in infection prevention and control, to be implemented voluntarily.

WN #7: 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. (3) The licensee shall designate a staff member to co-ordinate the program who has education and experience in infection prevention and control practices, including,
(a) infectious diseases; O. Reg. 79/10, s. 229 (3).
(b) cleaning and disinfection; O. Reg. 79/10, s. 229 (3).
(c) data collection and trend analysis; O. Reg. 79/10, s. 229 (3).
(d) reporting protocols; and O. Reg. 79/10, s. 229 (3).
(e) outbreak management. O. Reg. 79/10, s. 229 (3).

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

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the designated staff member who co-ordinates the infection prevention and control program has education in infection prevention and control practices.

Interview with the IPAC lead who co-ordinates the IPAC program indicated that he/she was assigned to the role since March 2015 and did not have any education in IPAC practices including: infectious disease, cleaning and disinfection, data collection and trend analysis, reporting protocols and outbreak management.

Interview with the DOC confirmed that the IPAC lead who co-ordinates the IPAC program did not receive any education in IPAC practices. [s. 229. (3)]

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

Observation on an identified day revealed that resident #14's door had signage indicating

that the resident was on identified isolation precautions.

Interview with RPN #150 revealed that the resident was isolated for a specific type of infection and the precaution signage on the door was incorrect.

Observation on an identified day, and interview with RPN #155 revealed that nine identified residents on the first floor were isolated for specific types of infection.

RPN #155 confirmed that three of the nine were isolated due to a specified infection had incorrect signage posted on their doors.

Observation and interview with RPN #115 indicated that resident's #15, #16, and #17 were isolated for specific types of infection however the signage on their doors were incorrect.

Observation on an identified day revealed that resident #13's door had an identified isolation precaution signage. Physician #154, RPN #149 and the resident's family members were in the resident's room and were not wearing personal protective equipment (PPE).

Interview with physician #154 and RPN #149 confirmed that the resident had a specific type of infection and PPE should be put on before entering the resident's room.

On an identified day, the inspector observed that resident #18's door had an identified isolation precaution signage. Physician #148 was found coming out of the resident's room wearing a PPE mask and threw the PPE mask into the nursing station's garbage.

Interview with physician #148 confirmed that on exiting the above mentioned resident's room he/she should have removed the mask.

Interview with RPN #149 confirmed that he/she also observed physician #148 exiting the resident's room and walk to the nursing station wearing the PPE mask.

Interview with the IPAC program lead confirmed incorrect posting of the isolation signage on the above mentioned resident's doors, and confirmed that everyone entering an isolation room must wear correct PPE on entering and remove the PPE before exiting the isolation room. [s. 229. (4)]

3. The licensee has failed to ensure that residents are offered immunization against tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.

Interview with the IPAC lead revealed that not all residents admitted prior to January 2015 have been offered immunization against tetanus and diphtheria. However, all new residents admitted to the home after January 2015 has been offered immunization against tetanus and diphtheria.

A random record review of the document titled "Consent to Administration of Immunization Agents, Mantoux, and Anti-viral" for three residents admitted prior to January 2015 and three residents admitted in 2015, revealed that the home did not offer immunization against tetanus and diphtheria (Td) to one resident.

Interview with the DOC confirmed that not all residents in the home had been offered immunization against tetanus and diphtheria prior to January 2015. [s. 229. (10) 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 designated staff member who co-ordinates the infection prevention and control program has education in infection prevention and control practices, to be implemented voluntarily.

WN #8: 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the following resident right is fully respected and promoted: Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

Observation on an identified day, in a specified dining room, revealed that resident #32 left the dining room without having a main course. The resident had soup and then left to walk around and returned for the main course after a while. RPN #101 offered the resident the choice of two show plates. The resident selected the fish plate. Dietary aide #103 communicated that the fish plate was not available and he/she would need to get it from the other floor. The above mentioned resident was served a dessert but staff did not ensure that the resident was offered a main course.

RPN #101 who offered show plates to the resident confirmed that he/she did not communicate to the resident that the fish was not available, nor did he/she offer another choice to the resident.

The inspector also observed two other residents who received tray services were not offered alternative choices, as the fish was no longer available.

The inspector observed resident #33 was provided a plastic spoon for dessert.

Interview with dietary aide #103 confirmed that resident #32 should have been offered an alternate choice for the main course and resident #33 should have not been provided a

plastic spoon for the dessert.

Interview with RPN #101 confirmed that resident #32 left the dining room without having a main course and two other residents who received tray services should have received alternate choice for the main course. RPN #101 confirmed that resident #33 should have received a silver teaspoon for the dessert and the above mentioned residents as a result were not treated with respect and dignity.

Interview with Director of dietary services #104 confirmed that staff should have offered two choices of the main course meal and silver cutlery to the above mentioned residents. [s. 3. (1) 1.]

2. The licensee has failed to ensure that the residents' right to have his or her participation in decision-making fully respected and promoted.

Interview with resident #11's substitute decision-maker (SDM) indicated that the resident started taking an identified medication on a specified day, and he/she was not informed of the possible interaction between the antibiotic and the other medications until the resident had already started the medication.

Review of a note sent by the MediSystem pharmacy along with medications on an identified day, indicated that there could be a drug interaction between the newly prescribed above mentioned medication and the resident's pre-existing medications. The pharmacy note also indicated to monitor and consider holding the interacting agents and to have the medical doctor (MD) reassess.

Record review of the resident's progress notes indicated that the SDM was informed that the above mentioned medication was prescribed for the resident on an identified day, but did not indicate he/she was informed of the potential drug interaction.

Interview with the DOC confirmed that the SDM was not informed of the potential drug interaction. [s. 3. (1) 9.]

WN #9: 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 has failed to ensure that copies of the inspection reports from the past two years for the long-term care home are posted.

Observation of on April 8, 2015, during the initial tour and record review of the home's Ministry of Health and Long Term Care Inspection report binder revealed that the following inspection report #2013_102116_0063 was not posted.

The above observation was confirmed by the ED. [s. 79. (3) (k)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.

Interview with resident #34's identified family member indicated that he/she verbally raised a concern to one of the registered staff in the home on an identified day, about the resident's missing identified personal item. The identified family member completed lost/missing items form as suggested by the staff.

A review of the resident's plan of care indicated that the ED had documented investigation notes about the home's efforts to locate the resident's missing identified personal item. Record review of progress notes indicated conversation between the complainant and the ED about the missing personal item and the ongoing investigation. There was no documentation located to indicate the licensee provided acknowledgement of receipt of the complaint.

Interview with the resident's family member revealed that during the last conversation with the ED on a specified day, the ED requested information related to the missing personal item, which the family explained could not be provided.

Interview with the ED confirmed that acknowledgement of receipt of the complaint was not provided to the complainant. [s. 101. (1) 2.]

WN #11: 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).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction is reported to the pharmacy service provider.

Record review of Critical Incident #2945-000039-14, reporting improper/incompetent treatment of a resident that results in harm or risk to a resident, and the homes medication incident forms for 13 identified residents involved in the medication administration errors revealed that the date faxed to pharmacy and required sections to be filled in by pharmacy manager of the forms were not completed.

Record review of the home's policy entitled "Medication Incident- Reporting" #V3-960 revised April 2013, directed the DOC to fax the medication incident forms to the pharmacy.

Interviews with the DOC, the home's consultant pharmacist and pharmacy operations manager confirmed that the medication errors involving the above mentioned residents on an identified day in 2014 were not reported to the pharmacy. [s. 135. (1)]

2. The licensee has failed to ensure that all medication incidents and adverse drug reactions are documented, reviewed and analyzed and a written record is kept of everything required under clauses (a) and (b).

Record review of medication incident reports for medication errors involving 13 identified residents on an identified date revealed that on an identified day, RPN #177 did not administer a total of 18 prescribed medications, but signed off on the Medication Administration Records (MAR) that the ordered medications had been administered to the above mentioned residents.

Record review of the home's policy entitled "Medication Incident- Reporting" #V3-960 revised April 2013, indicated the DOC to report the incidents, causes, trends and ways to prevent reoccurrence quarterly to the home's Quarterly Professional Advisory Committee.

Review of the home’s Professional Advisory Committee (PAC) meeting minutes for an identified date in 2014, revealed that the above mentioned incidents were not reviewed and analyzed. The minutes did not include the above mentioned medication errors that had occurred on an identified date in 2014.

Interview with the DOC and consultant pharmacist confirmed that the above mentioned medication incidents were not reviewed and analyzed at above mentioned PAC meetings. [s. 135. (2)]

Issued on this 17th day of August, 2015

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

Original report signed by the inspector.