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

Hamilton Service Area Office
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Original Public Report

Report Issue Date July 25, 2022
Inspection Number 2022_1432_0001
Inspection Type
☐ Critical Incident System ☒ Complaint ☒ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other ____________________

Licensee
955464 ON Limited

Long-Term Care Home and City
Millennium Trail Manor, Niagara Falls

Lead Inspector
Cathy Fediash #214

Inspector Digital Signature

Additional Inspector(s)
Angela Finlay #705243
Bernadette Susnik #120
Nishy Francis #740873 was also present during this inspection.
Jonathan Conti #740882 was also present during this inspection.

INSPECTION SUMMARY

The inspection occurred on the following date(s): June 20, 22, 24, 27, 28, 29, 30, July 4, 5, 6, 7, 8, 11, 12, 13, 14, 15, and 18, 2022.

The following intake(s) were inspected:

- #010723-22 (Complaint) related to medication.
- #007623-22 (Complaint) related to maintenance; responsive behaviours; air temperature; care and services; staffing, training and care standards.
- #021052-21 (Complaint) related to pain; care and services.
- #013268-22 (Complaint) related to maintenance.
- #020719-21 (Follow-up) related to pain; prevention of abuse and neglect.
- #020718-21 (Follow-up) related to fall prevention.
- #020600-21 (Follow-up) related to skin and wound.
- #020599-21 (Follow-up) related to medication.
- #020713-21 (Follow-up) related to minimizing of restraining.
- #020714-21 (Follow-up) related to minimizing of restraining.
- #020712-21 (Follow-up) related to minimizing of restraining.
- #020715-21 (Follow-up) related to minimizing of restraining.
- #020716-21 (Follow-up) related to minimizing of restraining.
- #020717-21 (Follow-up) related to minimizing of restraining.

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Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance.

Legislative Reference		Inspection #	Order #	Inspector (ID) who complied the order
O. Reg. 79/10	s. 50 (2) (b) (iv)	2021_575214_0014	001	#214
O. Reg. 79/10	s. 135 (1) (b)	2021_575214_0014	002	#214
LTCHA, 2007	s. 19. (1)	2021_575214_0015	001	#705243
O. Reg. 79/10	s. 49. (2)	2021_575214_0015	002	#705243
O. Reg. 79/10	s. 110 (1) 1	2021_575214_0015	003	#214
O. Reg. 79/10	s. 110 (2) 1	2021_575214_0015	004	#214
O. Reg. 79/10	s. 110 (7) 5	2021_575214_0015	005	#214
O. Reg. 79/10	s. 110 (7) 6	2021_575214_0015	006	#214
O. Reg. 79/10	s. 110 (7) 7	2021_575214_0015	007	#214
O. Reg. 79/10	s. 110 (7) 8	2021_575214_0015	008	#214

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

- Falls Prevention and Management
- Housekeeping, Laundry and Maintenance Services
- Infection Prevention and Control (IPAC)
- Medication Management
- Pain Management
- Prevention of Abuse and Neglect
- Resident Care and Support Services
- Responsive Behaviours
- Restraints/Personal Assistance Services Devices (PASD) Management
- Safe and Secure Home
- Skin and Wound Prevention and Management
- Staffing, Training and Care Standards

INSPECTION RESULTS

During the course of this inspection, the inspector(s) made relevant observations, reviewed records and conducted interviews, as applicable. There were *findings of non-compliance*.

WRITTEN NOTIFICATION [ACCOMODATION SERVICES]

NC#01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021, s. 19 (2) (c)

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The licensee has failed to ensure that the home, furnishings, and equipment were maintained in a safe condition and in a good state of repair.

The inspector toured the home and observed multiple areas where ceiling tiles were either missing or stained with old water marks, drywall ceilings that were patched and unfinished with evidence of new mould growth, walls that had evidence of old water leaks and never repaired, walls newly patched and unfinished. According to personal support workers and nursing staff, the water leaks were continuous and had been occurring for some time.

The observations were made in but not limited to a soiled utility room, shower rooms and shower areas, two tub/shower washrooms, housekeeping closet, dining rooms, main laundry room, basement corridor, unit corridor's, two common resident washrooms, a servery, two staff washrooms, a lounge, five identified ensuite washrooms, and a garbage chute room. It was identified that some of the water damage was from water leaks or flooding associated with clogged toilets and sinks and other leaks had been reported to be due to plugged condensate lines from air conditioning units.

According to a maintenance person, some water may have also penetrated the insulation surrounding exterior air ducting. A tour of the roof revealed that the bitumen product once applied to the insulation surrounding the ducting was cracked, exposing the mesh and insulation layer below. Rain and snow melt can penetrate the insulation where water can travel to the interior areas of the home. The maintenance person was actively re-applying a new sealant at time of inspection.

Actively leaking plumbing was observed in shower rooms, dripping taps in resident ensuite washrooms, dripping water from pipes under a servery sink and dishwasher in main kitchen and leaking water from a pipe in the boiler room. A sink in a lounge did not have any water supplying the hot water tap when turned on and the faucet/taps at a sink in another location were very loose.

Flooring material was cracked, missing sections or split in most of the resident home area corridors, a dining room, servery, tub room, tub/shower areas and a soiled utility room. A staff member identified that new flooring had been purchased and that plans were in place to replace corridor flooring in the fall. No specific plans were provided regarding the rest of the home.

Excessive vegetative growth was observed on the roof (grass and weeds) with a thick layer of composted material which only forms after years of accumulation. The growth was isolated to areas in and around roof top heating and cooling units, where water from condensate lines was seen draining next to the units and underneath ducting. The water was not draining towards the roof drains but ponding into certain areas. The licensee did not have a written procedure related to preventative roof maintenance and no evidence that maintenance staff conducted regular inspections of the roof. According to a staff member, the roof was

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scheduled to be replaced in a few years once new air conditioning units were installed in the fall.

A tub on a home area was out of order and a personal support worker reported that it had been out of order more than once in the past six months. They stated that it was reported to maintenance three weeks prior. The shower wand in a tub room was cracked and water was not spraying out normally.

Cabinet doors at two nurses' station home areas were not easy to open as the doors lodged into the floor. The hinges were either disconnected or very loose. The upright two door cabinet in an identified shower area, was water damaged.

The wood laminate on dining room tables in dining rooms were noted to be cracking and peeling.

Self-closing doors to two laundry chute rooms, a housekeeping closet and a soiled utility room were not closing and latching. All four doors were tested and did not close and latch when released. The doors had to be pulled closed.

Sources: Interviews with PSWs, nursing staff, Director of Environmental Services, Maintenance staff, Administrator, Dietary Manager, direct observation, maintenance procedures.

#120

WRITTEN NOTIFICATION [COMMUNICATION AND RESPONSE SYSTEM]

NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 20 (c)

The licensee has failed to ensure that the resident-staff communication and response system allowed calls to be cancelled only at the point of activation.

The activation station located in a courtyard was cancelled at the nurse's station when tested by the inspector. The nurse's station was equipped with a desk console which sounded and indicated the location of the active station from the courtyard. When the handset was picked up by staff, the audio alert ceased including the flashing dome light in front of the courtyard door in the corridor. The call could therefore be cancelled at a point that was not the point of activation.

In addition, the activation stations located in the courtyard and many balconies did not have an appropriate cancellation button. Only one button was observed which was tested and which activated the alert system. However, it was difficult to determine how to cancel the call or even if a call could be canceled at the station.

Sources: Interviews with the Director of Environmental Services, the Administrator and PSWs, direct observation and testing.

#120

WRITTEN NOTIFICATION [COMMUNICATION AND RESPONSE SYSTEM]

NC#03 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 20 (f)

The licensee has failed to ensure that the resident-staff communication and response system clearly indicated when activated where the signal was coming from.

The home's resident-staff communication and response system (RSCRS) had not been used as designed so that when an activation station was used, it had not clearly indicated where the signal came from. For staff to determine where the signal originated, they had to walk around the home area looking at dome lights (if lit) or walk to the nursing station and look at a desk console display screen to see the room number or exit door location. As the system is not based on an audible component, staff would not have heard any sound and therefore would not have any indication whether someone was requiring assistance or not.

The home's RSCRS was originally designed and approved to work in conjunction with pagers which were to be carried by all direct care staff. This ensured that regardless of where staff were working, they would be alerted to the location of an activated station. During the three-day inspection, multiple personal support workers (PSWs) in different home areas were not wearing a pager. On a specified date, two pagers each were found in three separate home areas in a cabinet or drawer at the nurses' stations. Two were not functional. An inventory of all pagers in the home conducted by the licensee, identified that 50 percent (%) of the pagers were not functional.

Two registered staff members did not have a working portable phone, which was required to be carried by all registered staff so they could respond to activated stations when a PSW cannot respond after a designated period of time. The phones were ordered over a month prior and had not yet been received by the home.

PSWs reported that pagers are inconvenient because they were heavy, required to be carried in flimsy uniform pockets where the pagers could become damaged (leaning over and smashing them onto hard surfaces), or they fall out onto the floor or are accidentally taken home. An alternative solution to ensure the home's RSCRS was functional at all times as designed and that staff can easily adhere to the requirements had not been sought.

Sources: Interviews with PSWs, the Director of Environmental Services, the Administrator, direct observation and testing.

#120

WRITTEN NOTIFICATION [MAINTENANCE SERVICES]

NC#04 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 96 (2) (g)

The licensee failed to ensure that procedures had been implemented to ensure that the temperature of the water serving hand basins used by residents had not exceeded 49 degrees Celsius.

The inspector measured the hot water temperature in several random areas using a calibrated digital probe thermometer. On a specified date, the temperature was 51.2 degrees Celsius (°C) at the hand sink in a dining room and 52°C at the sink in a lounge. The hot water serving the hand sink in another dining room was 53°C and the sink in the lounge of another home area was 53°C. The exceedance was reported to the Administrator after temperatures were taken on this date, who promptly reported the issue to maintenance staff. Four days later, the hot water serving the hand sink in the tub/shower room in a home area was 53.3°C and the sink in a lounge was 55.7°C. The exceedances were reported to the Administrator.

According to the licensee's Water Temperatures Policy, staff were to monitor the water temperatures once per shift in random locations where residents had access to hot water and to record the temperatures. The policy did not indicate where to record the temperatures, but within the licensee's policies, a separate hot water temperature log sheet was located. Staff on a home area were not able to produce the log sheet, but kept temperatures documented in a specified clinical book. The book did not include any temperatures taken outside of any resident ensuite washroom which were all recorded below 48°C. The inspector was not able to verify the accuracy of the digital thermometer that registered staff had available to them to take water temperatures.

The maintenance staff manually adjusted the hot water temperature of the hot water system which took several days to achieve the appropriate temperature. Hot water temperatures were between 45 and 46.5°C on a specified date, when re-measured using the same thermometer in the same areas as previously noted to be over 49°C.

Sources: Interviews with registered staff, PSWs, maintenance staff and Administrator. Water Temperatures Policy, created on April 1, 2007, last reviewed in April 2019, Independent measurements.

#120

WRITTEN NOTIFICATION [HOUSEKEEPING]

NC#05 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s.93 (2) (a)

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The licensee has failed to ensure that as part of the organized program of housekeeping under clause 19 (1) (a) of the Act, that procedures were developed and implemented for cleaning of the home, including floors, wall surfaces, vents, outdoor areas and fixtures.

The sinks located in two nurse's stations had scale and debris build-up behind the taps. Scale build-up also was noted on faucets in resident ensuite washrooms. No descaling procedure was available in the housekeeping services contractor's procedure binder. When discussed with the housekeeping director, no de-scaling activities were included in the housekeeper's routines.

Heavy accumulation of dust on exhaust vents were observed in but not limited to a tub/shower washroom, three garbage chute rooms, two laundry chute rooms, a soiled utility room, and a clean utility room. The housekeeping services contractor's procedures and schedules had not included the cleaning of vents in tub/shower rooms and no procedures for cleaning any garbage or laundry chute rooms or housekeeping closets.

The courtyard and balconies on various home areas were not kept clean of bird droppings and nesting materials. Accumulation of both were observed on two dates, four days apart. According to the Administrator, recreational staff were to ensure that birds did not nest on the balconies, that maintenance staff were responsible for deep cleaning the balconies and that housekeepers were to keep furnishings and sweep the concrete floors. None of these tasks were in writing in any policy and procedure that the licensee or the housekeeping services contractor had available to them.

Sources: Direct observation, review of housekeeping procedures and schedules, interview with the Administrator, Director of Housekeeping contractor and Director of Environmental Services.

#120

WRITTEN NOTIFICATION [FOOD PRODUCTION]

NC#06 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 78 (7) (c)

The licensee has failed to ensure that the home had and that the staff of the home complied with a cleaning schedule for the servery and dishwashing areas.

A daily and weekly cleaning schedule for the serveries and dishwashers was developed, however staff had not complied with the schedules.

All serveries were observed for visible matter on the swing door to the dining rooms, baseboards, and walls. According to the cleaning schedule, only walls were required to be cleaned weekly and no task was assigned for doors and baseboards. Splashes and food

debris may occur daily, and the cleaning schedule failed to ensure that these surfaces were cleaned as necessary to maintain the servery in a clean state.

Accumulated debris and visibly soiled floors noted under fixed equipment such as dishwashers and the steam table in each servery. Floors under steam tables were to be swept and mopped daily. The daily schedule did not include the need to clean underneath other fixed equipment such as dishwashers and shelving units.

The ceramic flooring throughout four serveries, the flooring in a unit and the main kitchen had not been clean in appearance. In particular, the ceramic tiles had black dirt build-up along edges and in the textured grooves of the ceramic tile. A deep cleaning schedule for the flooring was not provided to determine when and how the flooring was cleaned. According to the housekeeping services contractor, a floor machine with a textured pad was available and will be used to deep clean the servery floors going forward.

A dishwasher in a servery had accumulated matter on the top and scale build up on the front along an edge. The main kitchen dishwasher had scale build-up along the front edge. According to the cleaning schedule, de-scaling was to occur weekly on a specified day in each servery and the main kitchen. However, a completed cleaning schedule was only provided for one servery.

Sources: Interview with Administrator, dietary manager, Director of Housekeeping contractor, housekeeper (assigned to floor care), review of floor care procedure (CD-08-07-7), review of cleaning schedules, and observations.

#120

WRITTEN NOTIFICATION [LIGHTING]

NC#07 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 21 2. v.

The licensee has failed to ensure that the lighting had been maintained at a minimum level of 215.28 lux in an identified dining area and resident common washroom.

The level of lighting in the dining room and the resident washroom were measured with a lighting meter to be less than 215.28 lux.

The dining room was missing a ceiling dome light (removed and not replaced) and the dome light next to it had two bulbs that were not functional. The resulting light level was measured by the inspector in the area, with all other lights on, to be 100 to 190 lux.

The common resident washroom did not have a lighting fixture in the middle of the room as other similar washrooms. The light was instead lined up along one wall, near the toilet. The

handwash sink was therefore in semi darkness and the lighting level was measured to be 100 lux.

Sources: Interviews with the Director of Environmental Services, the Administrator, direct observation, and testing.

#120

WRITTEN NOTIFICATION [AVAILABILITY OF SUPPLIES]

NC#08 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 48

The licensee has failed to ensure that supplies, equipment, and devices were readily available at the home to meet the nursing and personal care needs of residents.

According to an inspection conducted in the past few months by the home's lift and transfer equipment contractor, seven mechanical floor lifts and five sit-to-stand lifts were accounted for in the home.

The home has five resident home areas and according to the Administrator, two each were required for two units as neither home area had any ceiling lifts. The other units had ceiling lifts, however five of these lifts on a specific home area were not functional and waiting to be replaced.

PSW staff identified a lack of adequate floor lifts for transferring residents to toilets, as the ceiling lifts were not designed to continue into resident washrooms. Staff indicated they were required to borrow lifts from different home areas due to lift malfunctions and a lack of back-up floor lifts. The Administrator reported that two floor lifts and one sit-to-stand lift were not functional and had been repaired the day prior. According to the contractor's inventory of floor lifts, two were beyond their 10-year life expectancy and one was nine years old.

The lack of adequate lift and transfer equipment had impacted the residents, many of whom required transfers three or four times per day. Staff identified that transfers were delayed, and residents on a specified floor had to wait to be transferred to their toilets or to their wheelchairs from bed.

Sources: Interviews with PSWs, the Administrator, observations, Lift vendor service agreement and preventative maintenance service records.

#120

WRITTEN NOTIFICATION [PLAN OF CARE-DOCUMENTATION]

NC#09 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

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Non-compliance with FLTCA, 2021, s. 6 (9) 1 and LTCHA, 2007, s. 6 (9) 1

The licensee has failed to ensure the provision of care as set out in the plan of care for two resident's was documented.

a) A resident had a history of responsive behaviours towards co-residents and staff. Behavioural Supports Ontario (BSO) was involved in their care.

   The BSO had initiated a document for data collection for a period of five days to help identify the resident's triggers and to help develop strategies to manage their behaviours. BSO initiated the document and indicated to complete fully.

   The document was completed as expected on three of the dates and partially completed on the other two dates.

   Not completing the documentation as intended had the potential to hindered BSO's assessments and prevented them from identifying potential triggers and developing the appropriate strategies or interventions.

b) During a period of time, a resident was experiencing pain. The physician wrote an order for a drug to be administered at certain times during the day, for a period of five days. For the first four days, documentation indicated the resident had received the medication as specified in the order. On the fifth day, documentation was not present for all of the doses prescribed.

   ADOC #107 confirmed that documentation was to be completed for all doses of the prescribed order and had not been.

   When the provision of care is not documented, it is unknown if the resident received the care, as set out in their plan.

Sources: the resident's clinical records; and interviews with RPN #137, ADOC #107, and #108, and other staff.

#705243

WRITTEN NOTIFICATION [PLAN OF CARE-DOCUMENTATION]

NC#010 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007, s. 6 (9) 1. 2. 3.

The licensee has failed to ensure the provision of care, outcome of care, and effectiveness of care as set out in the plan of care for a resident was documented.

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The resident had a diagnosis that required treatment with two different drugs. The physician discontinued one of the drugs and wrote an order for staff to monitor weekly for a specified outcome, for a determined period of time.

There was one instance where the provision of monitoring was not documented, and eight instances where the provision of care was checked off, but the outcome of the monitoring had not been documented.

Registered Practical Nurse (RPN) #116 and Assistant Director of Care (ADOC) #108, indicated the monitoring and documentation was required for this order to ensure the physician was able to determine the effectiveness of the recent drug changes and that by not documenting the outcome, it was assumed it had not been done.

Approximately three months later, the resident sustained an incident related to the same diagnoses. The physician wrote a new order to reduce the dose of the prescribed drug.

The failure to document the provision, outcomes and effectiveness of the prescribed weekly monitoring, potentially delayed the resident's drug change and may have prevented the incident.

Sources: The residents clinical records; and interview with RPN #116 and ADOC #108.

#705243

WRITTEN NOTIFICATION [PAIN MANAGEMENT]

NC#011 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10, s. 52 (2)

The licensee has failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

For a period of two months, the resident experienced an area of pain that resulted in a change of health status.

The home's pain management policy stated that a resident should be assessed for pain when there is a change in condition that causes new pain and that based on this assessment, non-pharmacological and/or pharmacological interventions should be considered to manage and treat the pain.

During the two months the resident exhibited new pain, they had not received any pain assessments.

They had an order for routine and when needed, pain medication. The resident was given their routine pain medication only.

The home not completing pain assessments for the resident resulted in the resident not receiving potential interventions to manage or treat their pain.

Sources: The resident's clinical records; the home's policy, Pain Management Policy, with a last revision date of April 1/19; and interviews with RPN #116 and ADOC #108 and #107.

#705243

WRITTEN NOTIFICATION [RESPONSIVE BEHAVIOURS]

NC#012 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 58 (4) c

The licensee has failed to ensure that when a resident demonstrated responsive behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

Documentation indicated the resident demonstrated several incidents of a responsive behaviour toward other co-residents, over a period of five months.

The home's responsive behaviours policy indicated that for residents with new or increasing responsive behaviours, the circumstances should be reviewed for any potential triggers and any new/revised interventions to prevent re-occurrence and that the care plan would be updated accordingly. The policy identified several alternative interventions, including referrals, heightened monitoring and assessments.

The resident had not received any assessments or referrals. Interventions in their plan of care were to monitor and redirect the resident.

On one occurrence, collection of data occurred and identified the responsive behaviour; however, the home was unable to provide evidence of any actions or follow-up taken as a result and no other interventions had been trialed.

A RPN had stated that the staff did not evaluate or complete any assessments of the resident's behaviours or ability to consent and that the current interventions in place were not effective and that no other follow-up actions had been taken to manage the resident's behaviours.

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The failure of the home to conduct assessments, reassessments and implement further interventions to manage the resident's responsive behaviours presented a risk of potential harm and loss of dignity to this and other residents.

Sources: The resident's clinical record; the home's policy, Responsive Behaviours Management, last revised on April 1, 2022; and interviews with RPN #116 and other staff.

#705243

WRITTEN NOTIFICATION [DUTY TO PROTECT]

NC#013 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to ensure that a resident was protected from abuse by a co-resident.

As per O. Reg. 246/22, s. 2 (1), emotional abuse is defined as any threatening or intimidating gestures, actions, behaviour or remarks by a resident that causes alarm or fear to another resident where the resident performing the gestures, actions, behaviour or remarks understands and appreciates their consequences.

Two residents had been roommates. One of the resident's was observed to have been abusive toward their roommate. Actions were taken by the home. No injuries were noted to the resident; however, it was noted they had required emotional support to feel safe and had verbalized they did not feel safe.

Failing to protect the resident from abuse presented a risk to their feelings of safety.

Sources: The resident's clinical records; and interviews with a resident, PSW #136 and DOC #101.

#705243

WRITTEN NOTIFICATION [REPORTING CERTAIN MATTERS TO DIRECTOR]

NC#014 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021, s.28 (1) 2

The licensee has failed to ensure that when an incident of abuse between two residents had occurred, that it was immediately reported to the Director.

Two residents had been roommates. One of the resident's was observed to have been abusive toward their roommate.

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The home's abuse policy indicated the administrator and/or designate must notify the Ministry of Long-Term Care for an alleged, suspected, or witnessed abuse or neglect that has taken place or is likely to have taken place in accordance with the legislation and the reporting policy.

The home did not report the incident to the Director.

Sources: The resident's clinical records; the home's abuse policy, Abuse- Prevention, Reporting and Elimination of Abuse and Neglect, last revised on April 1, 2022; and interviews with a resident, PSW #136 and DOC #101.

#705243

WRITTEN NOTIFICATION [ADMINISTRATION OF DRUGS]

NC#015 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 140 (2)

The licensee has failed to ensure that drugs were administered to a resident in accordance with directions for use specified by the prescriber.

a) A resident had a diagnosis and had been prescribed a drug to be taken twice daily.

A review of a report indicated the first dose of the drug had been administered hours following the prescribed time frame. The second dose had been administered within close proximity to the first dose and not within the required time frame between doses, as prescribed.

Staff who had administered the second dose, indicated they had not realized this administration occurred within close proximity to the first dose as they had not administered the initial dose. They indicated there was only a place to sign for drugs that had not been administered and they did not believe they were able to see the time for any drugs that had been administered on the documentation system.

Review of the documentation identified that drugs administered were signed as having been administered at their scheduled times. The actual time of administration was only identified when running a report.

Staff involved and the Director of Care (DOC) confirmed the drug had not been administered as prescribed.

b) A resident had a diagnosis and had been prescribed a drug to be taken daily.

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A review of a report indicated the drug had been administered hours following the prescribed time frame.

Staff involved and the DOC confirmed the drug had not been administered as prescribed.

c) A resident had a diagnosis and had been prescribed a drug.

On an identified date, the resident had exhibited an adverse event. A new drug order was written by a prescriber as a result.

It was identified this drug had not been administered as prescribed by the prescriber and the following were identified as contributing factors:

To process drug orders, the home and pharmacy used an online scanning system that was directly linked with each other. Each unit of the home had an individualized scanner with the ability to scan a drug order and see when the order was scanned for the unit; when it was received by pharmacy, and the ability to monitor receipt of the drug from the pharmacy.

The drug order had been scanned to the pharmacy the same day as ordered; however, it was scanned from a different unit than the unit the resident resided on. It was communicated that the scanner on the resident's unit had not been working.

It was indicated orders are usually received at pharmacy within five minutes of scanning. This order was received a little over three hours later. The clinical Pharmacy Consultant indicated the scanner can at times, go idle, and is a program issue with the pharmacy and requires the pharmacy to go into the system and activate an order that is in limbo.

The pharmacy processes same day drug orders and transcribes them onto the electronic Medication Administration Record (eMAR) for orders that are received by a certain time of the day. The pharmacy provides daytime services Monday to Friday and the home uses a satellite pharmacy for any drugs required outside of these days and times. As this order was received after the required time on a Friday afternoon, the order was not processed and not transcribed onto the eMAR, by the pharmacy.

It was confirmed that drug orders were to be processed promptly, including a first and second check conducted. An RPN agency staff who worked this day, indicated they did not know how to send the order to the pharmacy and confirmed they had not first checked the order as they were not aware of how to process orders, using this system. A registered staff who worked regularly at the home, scanned the order to pharmacy.

While it was confirmed the order had not been first checked on the day it was ordered, it was unknown the exact date and time of the first and second order checks as this had not been documented on the order form, as required.

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The physician order form was observed to have had a check mark on the right side of the form that indicated the order had been transcribed onto the eMAR; however, staff who checked the order, indicated they had not checked off this action and could not confirm if they transcribed the order onto the eMAR. Observation of the resident's eMAR and confirmed by the DOC, indicated the order had not been transcribed onto the eMAR.

The clinical Pharmacy Consultant confirmed the drug order was printed by the pharmacy when they re-opened on Monday. As the order for the resident's drug appeared to be the same as an already existing order for the same drug, the pharmacist had not filled the order and had not clarified the order with the prescriber.

The prescriber of the drug confirmed they were not aware the resident had existing orders (different to the one they prescribed), already in place for the same drug, when they wrote their orders. They confirmed when they wrote the order to change the drug, it was meant to implement the order just written.

It was confirmed the drug order had not identified what change to the medication was to take place; had not been processed in a timely and complete manner and had not been filled by the pharmacy as well as no clarification of the order with the prescriber.

As the drug order had not been received and processed by the home and pharmacy as required, including ensuring the drug was entered onto the eMAR, the drug order was unable to be followed up to ensure receipt or the need to access the satellite pharmacy for afterhours service.

The DOC confirmed drugs were not administered to the resident as prescribed for a period of seven days, when new orders for the resident's drug, were implemented in place of this order.

d) A resident demonstrated an abnormal result from a test.

The home had a policy in relation to the test that included an algorithm with interventions to implement based on the test result.

Progress notes indicated an RPN implemented three, non-medicinal interventions. An assessment conducted by the same staff, indicated two non-medicinal interventions had been implemented. The assessment indicated the physician was notified and directions were to follow the medical directive for this test result.

It was confirmed staff were to follow the algorithm, posted in each nursing station. The algorithm specified at the bottom of the second and third intervention, if the attending physician had different directions, these shall prevail.

A review of the resident's paper chart identified they had written medical directives in place for management of this situation. The directions for this specific event indicated to administer a drug, followed by a non-medicinal intervention.

A review of the resident's medical directives on the eMAR, which was the current system registered staff used to identify physician orders in place, and to document orders administered, indicated the only item listed for the resident's medical directives for management of this situation was the drug.

The RPN confirmed they should have administered the drug as ordered for this specific situation. The staff indicated they had not been aware of the paper copy of the medical directives that had been located in the resident's chart as the home only uses the eMAR system in PCC for administration of medications and with exception to the drug, the medical directives on paper, had not been transcribed onto the eMAR.

The DOC indicated the home had moved from a paper system of documentation to an electronic system, in the last year. They indicated not all the medical directives had been moved over from the paper version to the electronic version and confirmed drugs were not administered to the resident as prescribed.

e) Five days following the above incident, the resident demonstrated an abnormal result from the same test.

An RPN implemented two, non-medicinal interventions. An assessment conducted by the same staff, indicated the physician was notified and directions were to follow the medical directive for this test result.

It was confirmed the resident should have been administered a drug, as ordered on the medical directives.

The contributing factors identified in the example above, were the same contributing factors for this example.

When drugs are not administered as directed by the prescriber, there is a potential for risk of harm occurring to the resident as their prescribed therapy to manage outcomes, had not been implemented.

Sources: The resident's progress notes; assessments; physician medical directive orders; eMAR document; the licensee's specified policy and corresponding Algorithm (revised February 28, 2020); and interviews with the DOC; clinical Pharmacy Consultant, RPN #105; agency RPN's #119 and #120; agency RN #122; NP, and other staff.

#214

WRITTEN NOTIFICATION [POLICIES, ETC., TO BE FOLLOWED, AND RECORDS]

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NC#016 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 11 (1) (b)

The licensee has failed to ensure that their policy for Documentation and their policy for care of a resident with a specified diagnosis, was complied with.

Fixing Long-Term Care Act, 2021, s. 11 (1) (b) required an organized program of nursing services for the home to meet the assessed needs of the residents.

Ontario Regulation 246/22, s. 11 (1) (b), required the licensee to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system, was complied with.

Specifically, the licensee had not complied with their Documentation policy.

1. The Documentation policy, indicated the following:

a) Disciplines under the Regulated Health Professions Act (RHPA) were ethically and legally responsible to document.
b) Disciplines under the RHPA were expected to have a thorough understanding and ability to apply the “Documentation Standards” as outlined by their applicable College.
c) All entries are signed with name and status of person documenting. In the case of electronic documentation, the system assigns this based on the log in. Never document under someone else’s login.

A review of the College of Nurses of Ontario (CNO), Documentation Standard, revised 2008, indicated the following:

a) Nurses are required to make and keep records of their professional practice.
b) Nurses meet the documentation standard by:

i) providing a full signature or initials, and professional designation (RPN, RPN(Temp), RN, RN (Temp), or NP, with all documentation.
ii) providing full signature, initials, and designation on a master list when initialling documentation.
iii) clearly identifying the individual performing the assessment and or intervention when documenting.
-iv) advocating at the nurse’s facility for clear documentation policies and procedures that are consistent with the College’s standards.

Review of a resident’s electronic progress notes for identified dates indicated the notes were not signed with the full name of the author of the notes but instead were signed with a generic title, that had not identified who the author was.

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Review of the resident's eMAR for the same identified dates, indicated the initials documented for administration of medications were generic and not the initials of the staff who administered the medications.

During an interview with the DOC and Director of Nursing Operations they were unable to readily identify the authors of the progress notes or the staff that had administered medications on the dates identified.

It was confirmed the home implemented an electronic system of documentation for all staff, including nursing staff, within the last year. The DOC confirmed that every staff member, including agency staff, were to have their own individual log in profile created in the electronic system upon hire and confirmed the licensee's documentation policy had not been complied with.

2. The licensee's policy for care of a resident with a specified diagnoses indicated the following:

   a) If a resident demonstrated this diagnoses, registered staff were to follow a specified Algorithm.
   b) Personal Support Workers would report to Registered staff promptly if residents with this specified diagnosis, had not consumed their snacks.
   c) Registered staff were to complete an assessment, which generated a progress note for any resident who had a test completed with specified results.
   d) Quarterly, a report of these assessments completed in the quarter, was to be taken to the Professional Advisory Committee (PAC) for review of trends, to identify any changes for improvement and review any changes implemented in previous quarters. This is done with the Medical Director, Pharmacy provider, DOC, and the Administrator. The results of the quarterly evaluations and any changes that were implemented are recorded in the minutes. Annually, a report of these assessments completed in the previous year was to be taken to PAC for review.

   The licensee's policy contained an algorithm that directed registered staff to provide specified interventions that were dependant upon the results of a specified test.

A review of a resident's results for this testing were reviewed for a period of approximately one month. There were 13 occasions when their test results required intervention.

a) Eleven of the occasions required the assessment to have been conducted and it was not.

   For three of the occasions, progress notes identified interventions that had been implemented; however, the interventions were either not always what had been specified in the policy or conducted in the time frame, specified in the policy.

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For the remaining eight occasions, it is unknown what interventions were provided of if required retesting had been conducted.

It was confirmed the assessments were required to be completed and had not been. It was confirmed interventions specified in the algorithm had not been implemented as per the policy. It was confirmed for the known times specified retesting had occurred, it had not occurred within the time frames specified in the policy.

b) On two occasions the resident demonstrated results from a specified test. The licensee's policy identified interventions, including administration of a drug, that were to be implemented for these test results.

Review of documentation indicated the assessment had been completed for both occasions.

For the one occasion, the assessment identified non-medicinal interventions had been implemented and specified retesting had been conducted outside of the specified time listed in the policy.

For the second occasion, the assessment had not identified what interventions were implemented or if retesting had been conducted; however, a corresponding progress note had indicated non-medicinal interventions had been provided and no information if required retesting had occurred.

It was confirmed the assessments were required to be completed in entirety, as directed in the assessment.

It was confirmed interventions specified in the algorithm had not been implemented as per the policy which specified if the attending physician had different directions, these were to prevail. It was confirmed that the resident was to have received administration of a specified drug and had not. It was confirmed that required retesting had not been conducted within the time frame specified in the policy for the one occasion and unknown if conducted for the second occasion.

A directive from the Minister of Long-Term Care, in relation to this diagnoses, indicated that every licensee was to ensure that for every incident related to this diagnosis, a report to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider, was made.

Review of the licensee's incident reports that were communicated to the pharmacy, indicated no incident reports for these two incidents had been conducted and while

the assessment had contained an area to document notification to the SDM; the physician and the DOC, the assessment had not contained an area to document that the pharmacy service provider had been informed. It was confirmed the pharmacy service provider had not been informed of the two incidents.

c) A review of a report that showed the completion of the assessments, had been conducted for a period of three consecutive months. The report indicated a total of five assessments had been conducted. Two assessments for one resident; two assessments for a second resident, and one assessment for a third resident.

Review of the PAC meeting minutes that had contained information for the same three consecutive months as well as for the previous year, indicated a review of the assessments conducted for these three residents had not been completed as well as no review of any of these assessments for the previous year. It was confirmed the licensee's policy had not been complied with.

d) A review of the snack task for a period of approximately one month, indicated there had been 15 occasions in which the resident refused their snack.

Records reviewed had not identified that this information had been reported to Registered staff, and no records were located to identify what actions had been taken when the resident had not consumed their snacks. During an interview it was confirmed that a progress note was to have been conducted identifying the resident had not consumed their snack and this had not been conducted. It was unknown what direction should take place following this, as the policy had not contained this.

When the organized program of nursing services in relation to documentation requirements are not complied with, this has the potential risk to result in delay or inability of identifying the nurse(s) responsible for the documentation of the resident's care needs and does not provide the nurse(s) to demonstrate their accountability and professional responsibility, as required.

When the organized program of nursing services in relation to the care of a resident with a specified diagnoses is not complied with, this has the potential for risk of harm to occur to the resident's health and well being and does not allow for any of these trends to be reviewed, any changes for improvement discussed or any review of changes that had been implemented in previous quarters.

Sources: The resident's progress notes; eMAR; test values; the licensee's care of a resident with a specified diagnosis policy and corresponding algorithm (revised February 28, 2020); the licensee's Documentation Policy (revised April 1, 2019); CNO Documentation Standard, revised 2008; PCC reports; PAC minutes; a specified Minister's directive, and interviews with the DOC and other staff.

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WRITTEN NOTIFICATION [PLAN OF CARE]

NC#017 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

The licensee failed to ensure that there was a written plan of care for a resident that set out clear directions to staff and others who provided direct care to the resident.

A resident had a specified diagnoses and received identified testing.

a) The home used an algorithm that directed registered staff to provide specified interventions that were dependant upon the results of a specified test. At the bottom of the algorithm there was direction to staff if the attending physician had different directions, these shall prevail.

   It was confirmed that all resident's had medical directives that provided directions to implement interventions for a resident dependent upon the results of this test.

   It was confirmed that directions in the algorithm were not clear as the algorithm listed initial interventions to be implemented in certain situations and in a different column of the algorithm, at the bottom, directed staff to follow physician directions if different. It was confirmed that all residents had these medical directives, and these directions were not the same as the directions in the algorithm.

b) A resident had paper medical directives in place for the management of their diagnoses, that had been stored in their paper chart. The directives listed several different interventions to implement, including when to implement them.

   A review of the eMAR system, which was the current system registered staff used to identify physician orders in place, and to document orders administered, indicated only one of the medical directives had been listed. This medical directive indicated to administer an identified amount of a drug and provided a general reference of when to administer as well as to refer to the medical directives as needed.

   It was confirmed this medical directive in the eMAR had not provided clear direction to staff as it had not identified specifically when to administer the drug. It was confirmed the eMAR medical directive was not clear when direction to staff was to refer to the medical directives as needed, as these were the medical directives. It was confirmed the eMAR medical directive was also not clear when it had not contained all other non-medicinal directives listed on the paper medical directive.

   It was identified the home had moved from a paper system of documentation to an electronic system in the last year and that not all medical directives had been moved over from the paper version to the electronic version.

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When a written plan of care does not set out clear directions to staff and others who provide direct care, there is a potential risk for the resident to be harmed and not receive care according to their assessed needs.

Sources: The resident's paper and electronic medical directives; progress notes; test values; the licensee's algorithm and an interview with the DOC and other staff.

#214

WRITTEN NOTIFICATION [MEDICATION MANAGEMENT SYSTEM]

NC#018 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 123 (2) (3) (a)

The licensee failed to ensure that written policies and protocols that had been developed for the medication management system to ensure the accurate acquisition and receipt of a resident's drugs, and those that were developed, had been implemented.

The licensee's policy, Medication Procedures, indicated the following:

a) All physician and Nurse Practitioner orders will be processed by Registered staff. Every order will be thoroughly and independently double checked and double noted/verified after being transcribed.
b) All orders are to be processed promptly.
c) If the medication order comes in during pharmacy business hours, the medication order will be transcribed to eMAR by the pharmacy and registered staff have to verify the entry when they log on.
d) After hour orders are entered by Registered staff and verified by a second registered staff. The pharmacy verifies the order the next business day.
e) All orders are scanned to the pharmacy.
f) Registered staff will, when all aspects of the order are fully completed, will sign the order with their signature and date.

The resident had a diagnosis and had been prescribed a drug for therapy.

The resident experienced an adverse event, and a new drug order was written. The order indicated to change a drug and provided specified doses, times to administer and parameters of when to administer the drug.

It was identified that this drug order had not been acquired or received. The following were identified as contributing factors:

i) The prescriber confirmed they were not aware the resident had an existing drug order already in place for the same drug. They confirmed when they wrote the order to change this drug, it was meant to implement the order just written.

ii) The drug order had been scanned to the pharmacy by staff at the home, the same day as ordered; however, it was scanned from a different unit than the unit the resident resided on, resulting in the inability to follow up on drugs ordered from this unit. It was communicated that the scanner on the resident's unit had not been working.

iii) Pharmacy indicated drug orders were usually received at pharmacy within five minutes of the order having been scanned. This order was received a little over three hours after it had been scanned. The clinical Pharmacy Consultant indicated the scanner can at times, go idle, and is a program issue with the pharmacy and requires the pharmacy to go into the system and activate an order that is in limbo.

iv) Pharmacy indicated they process same day drug orders and will transcribe the order onto the eMAR, for orders that are received by a certain time of the day, Monday to Friday. Drug orders that are required outside of these days and times are to be processed through the satellite pharmacy. As this order was received after the specified time on a Friday afternoon, the order was not processed and not transcribed onto the eMAR, by the pharmacy. The satellite pharmacy was not utilized.

v) Drug orders were to be processed promptly and were to include a first and second check of the drug order. An RPN agency staff who was working this day, indicated they had not first checked the order as they were not aware of how to process orders, using this system.

An RPN staff member had conducted the first check of the order and another RPN staff member had conducted the second check of the order. While it was confirmed the order had not been first checked on the day it was ordered, it was unknow the exact date and time of the first and second order checks as this had not been documented on the order form, as required.

The order form was observed to have had a check mark indicating the order had been transcribed onto the eMAR; however, interviews with staff who checked the order, indicated they had not checked off this action and could not confirm if they transcribed the order onto the eMAR. Observation of the resident's eMAR and confirmed by the DOC, indicated the order had not been transcribed onto the eMAR.

Pharmacy confirmed the drug order was printed by the pharmacy on the next business day, which was a Monday. As the order for the resident's drug appeared to be the same as an

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already existing order for the same drug, the pharmacist had not filled the order and had not clarified the order with the prescriber.

It was confirmed the written policy had contained directions for writing drug orders; however, no direction was included to ensure orders were clear and that pharmacological interventions, treatment, or therapy were provided by reviewing the best possible medication history for the client, as identified by the CNO practice standards.

It was confirmed the drug order had not been processed promptly and that the first and second checks had not been dated and the time documented, as identified in the policy.
It was confirmed the drug order had not been transcribed to the eMAR and that the policy had not provided direction regarding actions to take when staff scanned the order before the end of day and pharmacy had not received until after the end of day.

It was confirmed the drug order had not been received and processed by the home and pharmacy as required, including ensuring the drug was entered onto the eMAR so that follow up to ensure receipt or the need to access the satellite pharmacy for afterhours service, could be done.

When written polices and protocols to ensure accurate acquisition and receipts of resident drugs are not fully developed and implemented, this has the potential risk to result in drugs not being received and accounted for; not administered or a delay in administration and prescribed therapy to manage resident outcomes, not being implemented or delayed in implementation.

Sources: The resident’s progress notes; physician order’s; eMAR; the licensee’s Medication Procedures policy (revised February 28, 2020); the CNO Documentation Standard, revised 2008; and interviews with the DOC and other staff.

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