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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Feb 11, 2019	2018_597655_0018 (A1)	028337-18	Resident Quality Inspection

Licensee/Titulaire de permis

Kemptville District Hospital
2675 Concession Road P.O. Bag 2007 KEMPTVILLE ON K0G 1J0

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

Kemptville District Hospital
2675 Concession Road P.O. Bag 2007 KEMPTVILLE ON K0G 1J0

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

Amended by MICHELLE EDWARDS (655) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Ontario

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Written Notification (WN) #9, issued under s. 78 of the LTCHA, 2007, was amended after further review.

Issued on this 11st day of February, 2019 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Amended by MICHELLE EDWARDS (655) - (A1)

Amended Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 23, 24, 25, 26, 29, 30, 31, and November 1, and 2, 2018, on-site. The inspection was conducted off-site on the following dates: November 5, 6, 7, 8, and 13, 2018.

During the course of the inspection, the inspector(s) spoke with residents and family members, Patient Care Aides (PCA's), Registered Practical Nurses (RPNs), Pharmacists and the Consultant Pharmacist, the Registered Dietician (RD), Environmental Services Staff, Environmental Services Supervisor (ESS), Activation staff, a Human Resources representative, the Team Lead, the Nurse Manager, and the Vice President of Nursing and Clinical Services.

During the inspection, the inspector also observed the provision of care and services to residents, reviewed resident health care records, relevant policies and procedures, meeting minutes, internal medication incident reports, and staff training records.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Skin and Wound Care

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

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

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

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #004 as specified in the plan.

Inspector #655 reviewed the health care record belonging to resident #004. According to the health care record, resident #004 experienced a change in body weight during a specified month. This was later confirmed by RD #117.

In a progress note entered on a specified date, RD #117 wrote that resident #004 was already receiving a particular dietary intervention; but, that in response to the change in resident #004's body weight, that intervention would be discontinued and replaced by a different intervention.

Inspector #655 reviewed resident #004's Medication Administration Record (MAR) for the same month in which resident #004 experienced a change in body weight. According to the MAR, resident #004 was to receive the dietary intervention in place at the time twice daily. According to the MAR, this intervention had been in place starting early on in the specified month. On review of the MAR, Inspector #655 found that there was no indication on the MAR that the intervention had been given or offered to the resident during a specified period of 7 days; and no record of the intervention having been refused by the resident, or held for any reason.

During an interview, PCA #116 indicated to Inspector #655 that resident #004's plan of care included a particular dietary intervention. PCA #116 indicated to Inspector #655 that the intervention may be given by the PCA or a nurse; and, that resident #004 normally accepted it when offered. At the same time, PCA #116 indicated to Inspector #655 that they would document if the resident had taken the intervention on a specific record used by PCAs, but they were unsure where the nurse would record that the resident had received the intervention.

Inspector #655 reviewed the record referred to by PCA #116 above for the same month in which resident #004 experienced a change in weight. Inspector #655 was unable to determine whether the resident had received, or been offered, the required intervention based on the documentation on this form.

During an interview, RPN #115 indicated to Inspector #655 that when a resident is prescribed such a dietary intervention, the kitchen staff supplies it, and either the PCA or the RPN will give it to the resident. At the same time, RPN #115 indicated

to Inspector #655 that when the intervention is given, it is recorded on the resident's MAR by the RPN, regardless of who administered it. According to RPN #115, if it is the PCA who has given the supplement to the resident, the RPN is to check with the PCA to confirm that it was given before documenting on the MAR.

During an interview, Team Lead #102 confirmed that when such a dietary intervention is provided to a resident, it is documented on the resident's MAR. Team Lead #102 indicated to Inspector #655 that if the intervention had not been given to or had not been received by the resident for any reason, this should also be recorded on the resident's MAR using one of the available "code" options. On the same day, Team Lead #102 reviewed resident #004's MAR for the specified month in which the resident experienced a change in body weight; and, also reviewed the record described by the PCA for the same month. Team Lead #102 was unable to verify that resident #004 had received, or been offered, the prescribed intervention over the specified period of seven days.

The licensee was unable to demonstrate that the plan of care was implemented – specifically, a prescribed dietary intervention, at a time when resident #004 experienced a change in body weight.

As such, the licensee has failed to ensure that the care set out in the plan of care was provided to resident #004 as specified in the plan. [s. 6. (7)]

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 care set out in the plan of care is provided to residents as specified in the plan, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have a policy, that policy is complied with.

Pursuant to section 30 (1) (1) of Ontario Regulation 79/10, every licensee of a long-term care home shall ensure that with respect of each of the interdisciplinary programs required under section 48, there is a written description of the program that includes its relevant policies. As per section 48 of Ontario Regulation 79/10, the licensee was required to develop and implement an interdisciplinary skin and wound care program.

Specifically, the licensee failed to ensure that the policy titled "Wound Care" (#AN-2), dated January, 2016, was complied with.

Inspector #655 reviewed the policy titled "Wound Care" (#AN-2), dated January, 2016. According to the policy, the nurse or wound care champion is to complete a referral to the Registered Dietician for all residents exhibiting altered skin integrity. According to the policy, the "Treatment Observation Record (TOR) - Initial Wound Assessment" is to be initiated when a resident has any open area or wound (one for each open area/wound); and, then the "Treatment Observation Record (TOR) - Ongoing Wound Assessment" is to be completed with every dressing change, but at a minimum, every seven days.

On review of resident #003's health care record, Inspector #655 located a "Treatment Observation Record - Initial Wound Assessment" which had been completed for resident #003 on a specified date and was related to an alteration in the resident's skin integrity, located on a particular area of the resident's body.

Attached to the initial assessment was a "Wound Care Record" on which it was indicated that the record was to be used for the same alteration in resident #003's skin integrity.

According to instructions written on the top of the form, an intervention was to be provided related to resident #003's alteration in skin integrity at a specified frequency. The "Wound Care Record" included sections to record information about the characteristics of the skin issue. However, all sections were blank when the record was reviewed by the inspector. The "Wound Care Record" had not been completed at a frequency that was consistent with the directions; nor had it been completed any other time over a period of seven days.

Inspector #655 reviewed resident #003's "Twice Weekly Skin Checklist" (skin checklist) for a specified month. According to the documentation on the skin checklist completed for resident #003, resident #003 was identified by PCA staff as having several skin conditions, some starting in the first week of the specified month, before the above-described skin issue had occurred.

Inspector #655 reviewed resident #003's progress notes for a five week period. In the progress notes, resident #003 was described as having several skin conditions, each involving an alteration in the resident's skin integrity over the five week period.

Inspector #655 was unable to locate any record of an "Initial Wound Assessment - Ongoing Wound Assessment" or "Wound Care Record" having been completed for the skin issues described in the resident's progress notes; or for any of the issues that were identified starting in the first week of a specified month, according to the above-described skin checklist.

During interviews, staff (PSW #111 and RPN #110) described resident #003 as being at risk for altered skin integrity.

During an interview, RPN #110 indicated to Inspector #655 that resident #003's skin was not currently being assessed using a specific tool because the resident did not currently have any open areas. During the same interview, RPN #110 indicated to Inspector #655 that residents are routinely referred to the Dietician immediately upon admission to the home; but that otherwise, "we don't usually do Dietician referrals". At the same time, RPN #110 indicated to Inspector #655 that they were not aware of any guidelines in place that would provide direction related

to the referral of a resident to the Dietician. There was no indication that an alteration in a resident's skin integrity would prompt a referral to the Dietician.

During an interview, RD #117 indicated to Inspector #655 that a resident is expected to be referred to the Dietician any time there is a new skin issue of a particular type, including the type exhibited by resident #003. RD #117 indicated to Inspector #655 that they are "sometimes" notified when a resident has a skin issue; but, otherwise they will find out another way. RD #117 indicated to Inspector #655 specifically that they could not recall receiving a referral for resident #003.

During an interview, Team Lead #102 reviewed the expectations related to skin assessments in the home: specifically, that a "Wound Care Record" was to be used whenever a resident had exhibited an alteration in skin integrity with a specific characteristic, when it is first identified, and then with each dressing change thereafter, or in accordance with specified direction.

During an interview, Team Lead #102 indicated to Inspector #655 that they had reviewed resident #003's health care records and were also unable to locate the skin assessments that were expected to be completed for this resident given the resident's skin condition (s). At the same time, Team Lead #102 indicated to Inspector #655 that for any skin issue of a particular type, the resident is to be referred to the Dietician.

The licensee failed to ensure that the policy titled "Wound Care" (#AN-2), dated January, 2016, was complied with when resident #003 exhibited alterations in skin integrity, over a two month period, at which time the resident was not assessed using the skin assessment tools identified in the policy and was not referred to a Registered Dietician. Resident #003 was also not assessed using the tool identified by Team Lead #102 as a practice expectation.

2. The licensee has failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have a policy, that policy is complied with.

In accordance with s. 114 (2), the licensee shall ensure that written policies are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs in the home.

The licensee failed to ensure that policies related to the medication management system were complied with:

i. Specifically, the licensee failed to ensure that the policy titled "Medication Pass – Procedure" (#04 -02-20), last reviewed June 23, 2014, was complied with; and failed to ensure that the policy titled "Safe Medication Practices" (#VII-8), revised February, 2016, was complied with.

Inspector #655 reviewed the policy titled "Medication Pass – Procedure" (#04-02-20), last reviewed June 23, 2014.

According to the policy, medication administration is considered to be a "continuous process" and is to be completed for a specific resident before moving onto another resident. In the policy, the procedural steps are outlined from step 1 to step 15. Among the steps outlined are:

- Step 8: the nurse who prepares the medication must administer it,
- Step 9: when the medication is administered, the nurse is to ensure that oral medications have been swallowed; and, is not to leave medications at the bedside; and,
- Step 10: the nurse is to initial the resident's MAR sheet for each medication, and make appropriate notations or "reason code" for medications which could not be given.

Inspector #655 reviewed the policy titled "Safe Medication Practices" (#VII-8), revised February, 2016. According to the policy, a resident is to take an oral medication in the presence of the health care provider.

During the inspection, RPN #104 was observed to administer medications to resident #007 during a medication pass. During the medication pass, resident #007 was given four different medications in tablet form. During the observation period, RPN #104 was observed to sign each of the four medications off as having been administered to resident #007 as they were poured into the medication cup at the medication cart, prior to resident #007 receiving them. Immediately following the observation period, RPN #104 confirmed the same.

In addition to the above-described observation, Inspector #655 reviewed three medication incident reports (MIRs) during the inspection. In two of the three

incidents reviewed, medications had been signed off in a resident's MAR as having been administered before they were received by the resident:

a) One MIR was related to an incident in which resident #010's medication had been left at the bedside, but was not taken by the resident. In the staff meeting minutes where this incident was discussed, it was indicated that the dose had been signed off in the MAR as having been administered to the resident, though it was not.

b) Another was related to a medication incident in which resident #009's medications had been found in the resident's bin at a specified time. Over the course of the inspection, Nurse Manager #101 confirmed that the medications that had been found in the resident's medication had been signed off in the MAR as having been administered, although they were not.

Over the course of the inspection, both Team Lead #102 and Nurse Manager #101 indicated that the above-described practice of documenting that a resident's medication had been administered before the resident had taken them was not consistent with practice expectations. Nurse Manager #101 confirmed that registered nursing staff are expected to sign medications off on a resident's MAR as having being administered only after it has been confirmed that the resident has taken the medication.

The licensee failed to ensure that medications were signed off as having been administered to a resident only after a resident had taken the medication. As such, the licensee has failed to ensure that the policy titled "Medication Pass-Procedure" (#04-02-20), last reviewed June 23, 2014, was complied with; and, failed to ensure that the policy titled "Safe Medication Practices" (#VII-8), revised February, 2016, was complied with.

ii. In addition to the above-described findings, the licensee failed to ensure that the following policies related to the medication management system were complied with:

- "Disposal of Discontinued Medications" (#02-06-20), last updated on June 23, 2014,
- "Inventory Management - Drug Disposal" (#05-02-20), last reviewed July 25, 2014; and
- "Narcotic and Controlled Substances Administration Record" (#04-07-10), last

updated June 23, 2014.

Inspector #655 reviewed the policy titled "Disposal of Discontinued Medications" (#02-06-20), last updated on June 23, 2014; and, the policy titled "Inventory Management - Drug Disposal" (#05-02- 20), last reviewed July 25, 2014.

According to the above-noted policies, narcotic and controlled substances to be destroyed are to be stored in a double locked storage area within the facility, separate from any narcotic and controlled substance available for administration to a resident. Specifically, it is indicated in the latter policy that discontinued narcotics and controlled substances are to be removed from the medication cart.

Inspector #655 also reviewed the policy titled "Narcotic and Controlled Substances Administration Record" (#04-07-10), last updated June 23, 2014. According to the policy, entries for wasted doses must be filled in completely with an explanation and the signature of a witness on the "Narcotic and Controlled Substances Administration Record".

During the inspection, Inspector #655 conducted an observation of a medication storage area (a medication cart), accompanied by RPN #110. During the observation period, RPN #110 demonstrated to Inspector #655 that controlled substances were kept in a double-locked storage container in the medication cart. At the same time, RPN #110 indicated to Inspector #655 that controlled substances which are no longer needed for a resident (surplus supplies) and are to be disposed of are also kept in the medication cart until the pharmacist is available to assist with destruction and disposal.

During an interview, RPN #104 indicated to Inspector #655 that surplus controlled substances, no longer needed by a resident in the home, are stored in a double-locked storage area; but that they are not stored separately from the controlled substances that are available for administration to a resident. At the time of the interview, RPN #104 indicated to Inspector #655 that there was currently a supply of surplus controlled substances being stored that way. According to RPN #104, medications for a resident who actually did not reside in the home had recently been received from the pharmacy service provider, and this supply would remain in the medication cart as surplus until pharmacy was available to assist with the destruction and disposal. RPN #104 indicated to Inspector #655 that the surplus supply was counted daily by two members of registered nursing staff in order to monitor the supply. At the same time, RPN #104 provided Inspector #655 with the

"Narcotic and Controlled Substances Administration Record" for the above-described surplus supply belonging to an individual who did not reside in the home.

On the same day, Inspector #655 reviewed the above-noted "Narcotic and Controlled Substances Administration Record" (the form) with RPN #104. The form was in use for a surplus supply of a particular controlled substance. According to the documentation on the form, 30 tablets of this controlled substance had been received from the pharmacy service provider on a specified date. A hand-written note on the form read: "not a patient here… sent by mistake". On review of the form, Inspector #655 noted that, although the individual to which the supply belonged to did not reside in the long-term care home, the count had decreased in quantity, from 30 tablets to 29 tablets on a specified date, one week after the supply had initially been received. There was no indication on the form that a tablet from the surplus supply had been administered to another resident, or that a tablet had been wasted for any reason.

At that time, RPN #104 indicated to Inspector #655 that none of the tablets were taken for use by a resident; but that one tablet had fallen out of the medication package and had been wasted for that reason. RPN #104 recalled conducting the count, finding that the count had decreased by one; and subsequently searching within the medication cart where it was found to be loose within the secure storage area. RPN #104 indicated to Inspector #655 that they should have documented this as having been wasted, and had it signed as such; but, didn't.

During an interview, Nurse Manager #101 was unable to speak to the practice expectations with regards to the storage of surplus controlled substances and wasting of controlled substances. Nurse Manager #101 referred Inspector #655 to Team Lead #102.

During an interview, Team Lead #102 indicated to Inspector #655 that surplus controlled substances are stored in the same location as those that are available for administration to a resident because, according to Team Lead #102 that would be the only way to ensure that they were double-locked until the pharmacist is available for their destruction and disposal. At the same time, Team Lead #102 indicated to Inspector #655 that if a controlled substance was wasted, the amount wasted would be documented under the column on the "Narcotic and Controlled Substances Administration Record" titled "amount wasted". In addition, Team Lead #102 indicated to Inspector #655 that it is expected that a witness to the

waste be identified on the same form, including the staff member's signature, as required by the licensee's policies. Team Lead #102 indicated to Inspector #655 that they had not been notified of the above described surplus supply of a controlled substance that had been received from the pharmacy on the specified date; nor that there was a discrepancy on the corresponding count sheet.

The licensee failed to ensure that a surplus supply of controlled substances was kept in a double-locked storage area, separate from controlled substances that are available for administration to a resident; and, failed to ensure that when a tablet of that controlled substance had been wasted, it was witnessed and signed as such.

As such, the licensee failed to ensure that the following policies related to the medication management system were complied with:

- "Disposal of Discontinued Medications" (#02-06-20), last updated on June 23, 2014,
- "Inventory Management - Drug Disposal" (#05-02-20), last reviewed July 25, 2014; and
- "Narcotic and Controlled Substances Administration Record" (#04-07-10), last updated June 23, 2014. [s. 8. (1) (b)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

As per s. 24 (1) of the LTCHA, 2007, a person who has reasonable grounds to suspect that certain matters have or may occur must immediately report the suspicion and the information upon which it is based to the Director under the LTCHA, 2007. Matters to be reported to the Director under s. 24 of the LTCHA, 2007, include: the improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident; abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident; unlawful conduct that resulted in harm or a risk of harm to a resident; misuse or misappropriation of a resident's money; and, misuse or misappropriation of funding provided to a licensee under the Act or the Local Health System Integration Act.

Pursuant to s. 152 (2) of the LTCHA, 2007, the licensee is vicariously liable if a staff member has not complied with the duty to report certain matters to the Director under the LTCHA, 2007, as per s 24 (1).

Inspector #655 was provided with the policy titled "Prevention and Management of Interim Long Term Care Resident Abuse and Neglect" (Policy #VII-6B), dated March, 2015.

Inspector #655 reviewed the above-noted policy. In the policy, reference is made to mandatory reporting to the Ministry of Health and Long-term Care (MOHLTC), and the use of Decision Trees to guide the reporting procedure to the MOHLTC by the licensee. The policy outlines that any health care provider is responsible to report any violations of the policy to the manager or delegate of the Interim Long Term Care unit using RIMs – there was no direction related to the procedure for reporting to the Director of the MOHTLC, under the LTCHA, 2007, by health care providers or other staff working in the home. In the policy, the information that must be included when making a report by the Director was outlined; and, according to the policy is to be completed specifically by the VP of Clinical Services or delegate.

On review of the above-noted policy, Inspector #655 found that there was no explanation of the duty – specifically, of any person other than the licensee themselves (such as a staff member) - to make a mandatory report to the Director under the LTCHA, 2007, with regards to the previously identified matters.

The policy was provided to Inspector #655 by Nurse Manager #101 who confirmed that nursing staff who work in the long-term care home area are currently trained on the above-noted policy. [s. 20. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the written policy to promote zero tolerance of abuse and neglect of residents contained an explanation of the under s. 24 to make mandatory reports, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 59. Family Council

Specifically failed to comply with the following:

s. 59. (7) If there is no Family Council, the licensee shall,
(a) on an ongoing basis advise residents' families and persons of importance to residents of the right to establish a Family Council; and 2007, c. 8, s. 59. (7).
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council. 2007, c. 8, s. 59. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that semi-annual meetings were convened to advise resident's families and persons of importance to resident's of their right to establish a Family Council.

During the inspection, Activation Staff #118 was identified as having a role with Resident and Family Councils.

Over the course of the inspection, it was confirmed that at the time of the inspection, there was no Family Council established in the home.

During an interview, Activation Staff #118 indicated to Inspector #655 that they were not sure what efforts were made by the licensee to advise families and persons of importance to residents of their right to establish a Family Council.

During an interview, Team Lead #102 indicated to Inspector #655 that no meetings had been held specifically for the purpose of advising families and persons of importance to resident's of their right to establish a Family Council.

The licensee has failed to ensure that semi-annual meetings were convened to advise resident's families and persons of importance to resident's of their right to establish a Family Council. [s. 59. (7) (b)]

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 that semi-annual meetings are convened to advise resident's families and persons of importance to resident's of their right to establish a Family Council, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 115. Quarterly evaluation

Specifically failed to comply with the following:

s. 115. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 115 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

As described in WN #7, Inspector #655 found, as a result of the inspection, that there had been no quarterly review of the medication incidents referred to in s. 135 (2) of Ontario Regulation 79/10, as required by s. 115 (3); and, that there had otherwise been no meeting of the interdisciplinary team on a quarterly basis:

During the inspection, Inspector #655 was provided with the meeting minutes for the most recent Professional Advisory Committee (PAC) meeting. On review of the meeting minutes, they were found to include sections titled "Medication Utilization" and "Medication Incidents, Adverse Drug Reactions, and Restraints" - elements that must be included in the quarterly evaluation of the medication management system, as per s. 115 (3). According to the meeting minutes, the following individuals had participated in the meeting: Team Lead #102, Consultant Pharmacist #107, and the Medical Director. There was no indication that the Administrator had attended. Attached to the meeting minutes were tables and graphs depicting drug utilization trends and patterns in the home for the three month period, or quarter, of May, 2017 - July, 2017. The meeting minutes were dated August 23, 2017 - over one year ago.

Over the course of the inspection, both Team Lead #102 and Consultant

Pharmacist #107 confirmed that, normally, Team Lead #102 and Consultant Pharmacist #107 participate in PAC meetings, along with the Medical Director. There was no indication from either the Team Lead or the Consultant Pharmacist that the Administrator had attended PAC meetings. Consultant Pharmacist #107 indicated to Inspector #655 that PAC meetings normally take place on a quarterly basis; while Team Lead #102 indicated to Inspector #655 that PAC meetings normally take place twice a year. Both Team Lead #102 and Consultant Pharmacist #107 confirmed, however, that the most recent PAC meeting was held in August 23, 2017 - over one year ago.

Over the course of the inspection, there was no indication that that an interdisciplinary team had otherwise met at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. (Refer to WN #7 for additional information).

The licensee failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. [s. 115. (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 an interdisciplinary team which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and recommend any changes necessary to improve the system, to be implemented voluntarily.

WN #6: 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. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

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

Findings/Faits saillants :

1. The licensee failed to ensure that no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident.

During the inspection, Inspector #655 was provided with a Medication Incident Report (MIR) related to an incident which occurred on a specified date, involving resident #008 which had been reported by RPN #100 the same day.

According to the written description of the incident on the MIR, resident #008 had been prescribed a specific drug of a particular class of medications, in a specified dose and formula. However, on the day of the incident, the medication was not received from pharmacy; and for that reason, the nurse retrieved the medication from a hospital unit. According to the written description on the MIR, when the nurse retrieved the medication from the other unit, they retrieved a different drug from the same particular class of medications and in the same dose and formula. According to the MIR, on the date of the incident, resident #008 was given the incorrect drug. According to the MIR, there was no harm to the resident as a result of the administration error.

Inspector #655 reviewed resident #008's progress notes for the day of the incident. In the resident's progress notes, the incident was described as above.

Over the course of the inspection, Nurse Manager #101 confirmed that on the specified date of the above-described incident, resident #008 had received a specific drug in error, instead of the one that had been prescribed.

The licensee failed to ensure that no drug was used by or administered to resident #008 unless the drug had been prescribed for the resident. [s. 131. (1)]

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

During the inspection, Inspector #655 was provided with a Medication Incident Report (MIR)) related to an incident which occurred on a specified date, involving resident #009 which had been reported by RPN #105 on the same day.

According to the written description of the incident on the MIR, the nurse found resident #009's medications in their "bin" at specific time. According to the MIR, the incident involved three medications.

On review of resident #009's progress notes, Inspector #655 was unable to locate any documentation related to the incident.

During the inspection, Nurse Manager #101 indicated to Inspector #655 that the above-identified medications which had been found in the resident's medication bin had been "signed off" by the day shift nurse and then the evening nurse found them. Nurse Manager #101 further indicated to Inspector #655 that the nurse who discovered the medications was unable to recall the incident clearly; but believed that they would have given resident #009 one of the three medications whenever the medications were discovered to be remaining in the resident's medication bin after the day shift. However, according to Nurse Manager #101, the nurse indicated that they would not have given resident #009 the other two specified medications at that time.

According to the MIR, there was no harm to the resident as a result of the above described omission error.

The licensee failed to ensure that drugs were administered to resident #009 in accordance with the directions for use specified by the prescriber when resident #009 was not given at least two prescribed medications on a specified date. [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 no drug is used by or administered to a resident in the home unless the drug had been prescribed for the resident; and, to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #7: 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).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident involving a resident was documented, together with a record of the immediate actions taken to assess and maintain the resident's health.

Over the course of the inspection, Inspector #655 reviewed three Medication Incident Reports (MIRs). On two out of the three MIRs reviewed, there was no record of the immediate actions taken to assess and maintain the resident's

health:

i. In the first MIR, a medication incident related to an omission error involving resident #009 was described. According to the MIR, resident #009's medications were found to be remaining in the resident's medication bin by a nurse. According to Nurse Manager #101, the medications that were found had already been signed off as having been administered by the day shift nurse on the particular day of the incident. Three specified medications were involved.

Inspector #655 reviewed the MIR and found no record of any of the immediate actions taken to assess and maintain resident #009's health when the incident was discovered.

There were no additional notes or records attached to the MIR.

ii. In the second MIR, a medication incident involving resident #010 was described. According to the MIR, resident #010 did not receive a certain dose of a specified medication, which was found to be in a medication cup on the resident's bed side table at specific time on the day of the incident.

Inspector #655 reviewed the MIR and found no record of any of the immediate actions taken to assess and maintain resident #010's health when the incident was discovered.

There were no additional notes or records attached to the MIR.

During an interview, Nurse Manager #101 indicated to Inspector #655 that any immediate actions taken to assess and maintain a resident's health following a medication incident would be documented in the nursing notes, not on the MIR which was completed using the hospital's electronic Risk Incident Management System (RIMs). According to Nurse Manager #101, nursing care is not documented in RIMs. At the same time, Nurse Manager #101 confirmed that the record of the immediate actions taken to assess and maintain the resident's health from the resident's health care record (nursing or progress notes) was not being kept together with the documented MIR.

Over the course of the inspection, Inspector #655 reviewed the progress notes for resident #009 and for resident #010 on the day of the respective medication incidents, outlined above. There was no record of the medication incident

involving resident #009 in the resident's progress notes; and specifically, no record of the immediate actions taken to assess and maintain the residents health.

There was a brief description of the medication incident involving resident #010 in the resident's health care record; however, no record of the immediate actions taken to assess and maintain the resident's health when the incident was discovered.

The licensee failed to ensure that every medication incident involving a resident was documented, together with a record of the immediate actions taken to assess and maintain the resident's health.

b) The licensee failed to ensure that every medication incident involving a resident was reported to the Medical Director and the pharmacy service provider.

Over the course of the inspection, Inspector #655 reviewed three MIRs. Each MIR was related to a medication incident which involved a resident (resident #010, resident #009, and resident #008, respectively). These incidents are described above, and/or in WN #6.

On review of each of the above-listed MIRs, Inspector #655 was unable to locate any information that would indicate that the Medical Director had been notified of any of the incidents. On the MIRs, there was a section titled "Recipient List". On each of the MIRs, Pharmacist #106 was listed under the "Recipient List".

During the inspection, however, Pharmacist #108 indicated to Inspector #655 that there was no record that the pharmacy service provider had been notified of the above-noted medication incident related to an administration error involving a specific type of medication for resident #008 (See WN #6).

According to Pharmacist #108, the long-term home would normally obtain the type of medication required by resident #008 from an alternate pharmacy, and for that reason may not have notified them of the incident involving resident #008.

During an interview, Consultant Pharmacist #107 indicated to Inspector #655 that they were the consultant pharmacist for this long-term care home, and that they visited the home at least once a month. Consultant Pharmacist #107 indicated to Inspector #655 that the pharmacy service provider is to be notified of all

medication incidents in the home; and, specifically of those that are of a pharmacy-origin. Consultant Pharmacist #107 indicated to Inspector #655 that they would expect to have been notified of the medication incident involving resident #008, in which the resident was given the wrong medication of a specified type.

During an interview, Team Lead #102 indicated to Inspector #655 that the Medical Director would be notified of a medication incident only if it was "critical" - resulting in a severe, negative outcome. At the same time, Team Lead #102 indicated to Inspector #655 that the Medical Director would not have been notified of the three medication incidents identified above, each involving a resident.

Team Lead #102 further indicated to Inspector #655 that the Medical Director does attend Professional Advisory Committee (PAC) meetings at which some medication incidents would be reviewed. However, according to Team Lead #102, only those of a pharmacy origin would be discussed at the PAC meeting (which was last held over a year ago). During the same interview, Team Lead #102 indicated to Inspector #655 that medication incidents of a nursing-origin would not be reported to the pharmacy service provider, as the pharmacy service provider in that case would not be responsible for the follow-up.

During an interview on the same day, Nurse Manager #101 indicated to Inspector #655 that none of the three medication incidents that were reviewed by the Inspector during the inspection would have been reported to the pharmacy service provider because the incidents were related to an "employee issue" (errors of a nursing-origin). Nurse Manager #101 clarified that all MIRs are automatically sent to the hospital-based Pharmacist (Pharmacist #106, identified on the MIRs under the "Recipient List") via the electronic RIMs system. However, according to Nurse Manager #101, the hospital-based Pharmacist does not have a role in dealing with medication incidents which have occurred in the long-term care home; and as such, the hospital-based Pharmacist would not action it when a MIR from the long-term care area is received.

Medication incidents involving a resident were only reported to the pharmacy service provider if the incident was of a pharmacy-origin. In addition, there was no process in place through which the Medical Director would be notified of a medication incident involving a resident, unless the incident was considered to be "critical".

The licensee failed to ensure that every medication incident involving a resident was reported to the Medical Director and the pharmacy service provider. [s. 135. (1)]

2. The licensee failed to ensure that a written record was kept of the review and analysis of every medication incident.

Over the course of the inspection, Inspector #655 was provided with the following policies:

"Patient/Visitor Safety Incident Reporting (RIMs)" (Policy # I-A-12), last revised in September, 2017;
and,
- "Medication Incidents/Adverse Drug Reactions" (Policy # I-A-10), last revised in August, 2016.

Inspector #655 reviewed the policies in order to clarify the licensee's expectations related to the review and analysis of medication incidents.

According to the above-noted policies, medication incidents are to be reported using the internal "Risk Incident Management System" (RIMs). On review of the licensee's policies, it was determined that the process of a medication "incident review" is to include an evaluation of the circumstances surrounding the event; and, various levels of investigation, depending on the incident category.

According to the licensee's policies, this review process is also to include interviews of the staff member(s) involved. According to the licensee's policies, the individual conducting the review, would be prompted to ask specific questions during the "incident review" in order to determine whether there was a departure from protocols or procedures, evidence of inappropriate risk, issues of supervision or training, or other concerns outlined in the policies. As per the licensee's policies, this process must be completed within one month of the incident having been reported.

In accordance with s. 135 (2) of Ontario Regulation 79/10, a written record of the incident review and analysis must be kept.

During an interview, Team Lead #102 described their role in dealing with medication incidents. Team Lead #102 described being involved in the initial

investigation related to a reported medication incident, explaining that they would find out what happened and speak with those involved in the incident, including residents or staff. According to Team Lead #102, they would record this information on the MIR so that Nurse Manager #101 would have a "full picture" of the incident in order to determine whether any action at the "systems" level was required to reduce the likelihood of a similar incident from occurring.

In addition to the above, Nurse Manager #101 indicated to Inspector #655 over the course of the inspection, that the medication incident reports that were completed in RIMs included a diagram meant to guide the "analysis" of the incident. The diagram included prompts to consider potential contributing factors of different categories, such as: organizational service factors, staff factors, work environment factors, external factors, and patient factors.

Over the course of the inspection, Inspector #655 reviewed three MIRs. Each MIR was related to a medication incident which involved a resident. None of the MIRs included a record of all of the information that was gathered when the Manager and/or delegate completed the required review and analysis of the incident:

On two of the three MIRs reviewed, the above-described diagram meant to guide the "analysis" was not found on the MIR. In addition, no contributing factors were identified.

Over the course of the inspection, Inspector #655 reviewed the above-noted MIRs with Team Lead #102 and Nurse Manager #101; neither of whom were able to recall the details of the incidents. Among the details that could not be recalled: which nurse had been involved in the medication incident, whether the resident involved received the omitted medications at a later time when an incident of omission was discovered, what the MAR documentation showed when there was an omission or non-administered dispensed medication found. This information was not documented or kept with the MIR.

Nurse Manager #101 indicated to Inspector #655 that they could only go by what had been written on the MIR, and further indicated to Inspector #655 that no other records were kept related medication incidents other than the MIR that was completed through RIMS.

During the inspection, Nurse Manager #101 indicated to Inspector #655 and that they were "assuming" that Team Lead #102 would have addressed these details

at the time of the incident, though there was no record of this.

Over the course of the inspection, Team Lead #102 indicated that on two of the above-listed MIRs, there was no indication that they had made any notes related to the incident on the MIR themselves; and therefore were unsure whether they had been involved in the review process.

The licensee failed to ensure that a written record was kept of the complete review and analysis of each of three medication incidents reviewed during the inspection. [s. 135. (2)]

3. The licensee failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions.

Pursuant to Ontario Regulation 79/10, s. 115 (1) and (3), every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home.

The quarterly evaluation of the medication management system must include a review of the reports of any medication incidents and adverse drug reactions referred to in subsections 135 (2).

During an interview, Nurse Manager #101 indicated to Inspector #655 that each medication incident that is reported through the internal electronic reporting system - the Risk Incident Management System (RIMs) is reviewed during monthly staff meetings for the long-term care/convalescent care areas.

Over the course of the inspection, Inspector #655 was provided with staff meeting minutes which were related to the MIRs that had been reviewed by the inspector during the inspection.

i. Inspector #655 reviewed the "CCP/LTC Staff Meeting" minutes in which the first one of the MIRs is referred to (see WN #6 for additional information related to this incident). In the meeting minutes, under a section titled "RIMs from [a specified month]" it states: "medications found in pts room". There was no additional

information found in the meeting minutes related to a review of this medication incident, or the medication incident report. In addition, there was no reference to any other medication incidents that had occurred in the home during the same quarter (i.e. the second MIR, described below). That is, there was no evidence of a "quarterly review" of all medication incidents and adverse drug reactions.

ii. Inspector #655 reviewed the "CCP/LTC Staff Meeting" minutes in which the second MIR is referred to (see WN #6 for additional information related to this incident). In the meeting minutes, under a section titled "Incident Reporting", a written description of the medication incident is recorded - the same written description from the initial MIR, submitted by RPN #100 through RIMs on a specified date. It further states "nurse notified of incident, recognized mistake and completed all of the right procedures. Incident has created awareness for [them] to follow the rights of medication". There was no additional information found in the meeting minutes related to a review of this medication incident, or the medication incident report. In addition, there was no reference to any other medication incidents that had occurred in the home during the same quarter (i.e. the first MIR, described above). That is, there was no evidence of a "quarterly review" of all medication incidents and adverse drug reactions.

During an interview, Nurse Manager #101 was unable to speak to a process through which a quarterly review was undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions.

On the same day, VP of Nursing and Clinical Services #103 indicated that they had spoken with Consultant Pharmacist # 107 who had indicated to them that there was a process through which a quarterly review process was completed, and that there was additional documentation to reflect this.

Over the course of the inspection, it was determined that the quarterly review process referred to by VP of Nursing and Clinical Services #103 and Consultant Pharmacist #107 was a process that was completed by the Professional Advisory Committee (PAC). According to Nurse Manager #101, Team Lead #102 normally attends the PAC meetings.

Inspector #655 was provided with the most recent PAC meeting minutes. Attached to the meeting minutes was a report related to drug utilization patterns in

the home for a three month period (a quarter): May, 2017 - July, 2017; but, no information related to medication incidents or adverse drug reactions. According to the meeting minutes, there had been no medication incidents or adverse drug reactions reported at the time. The meeting minutes were dated August 23, 2017 - over one year ago, and before all three of the medication incidents that were reviewed during the inspection had occurred.

During an interview, Inspector #655 spoke with Consultant Pharmacist #107 about the quarterly review process related to medication incidents. Consultant Pharmacist #107 indicated to Inspector #655 that a review of medication incidents is part of the "standing agenda" at quarterly meetings (PAC meetings); "but we haven't had one in a while". Consultant Pharmacist #107 indicated to Inspector #655 that the medication incidents that are reviewed at PAC meetings are the incidents that have been reported to Team Lead #102. Consultant Pharmacist #107 indicated that they believed that they would be given information related to all incidents that had been reported to Team Lead #102 during PAC meetings. Consultant Pharmacist #107 confirmed that the last PAC meeting took place on August 23, 2017. At the same time, Consultant Pharmacist #107 indicated to Inspector #655 that they could not recall the last time that there had been a medication incident in the home.

During an interview, Team Lead #102 reviewed the processes in place for the review of medication incidents, including monthly staff meetings and PAC meetings. According to Team Lead #102, each MIR submitted through RIMs is reviewed at monthly (not quarterly) staff meetings. Team Lead #102 indicated to Inspector #655 that they attend the monthly staff meetings, along with Nurse Manager #101, the infection prevention and control nurse, and nursing staff. At the same time, Team Lead #102 indicated to Inspector #655 that some medication incidents are reviewed at PAC meetings. According to Team Lead #102, they normally attend the PAC meetings as well, along with the Medical Director, and Consultant Pharmacist #107. Team Lead #102 indicated to Inspector #655 that the PAC meetings normally take place twice a year (not quarterly); but that they had "slipped" this year. Team Lead #102 confirmed that the most recent PAC meeting took place on August 23, 2017.

During the interview, Inspector #655 and Team Lead #102 reviewed the most recent PAC meeting minutes, dated August, 23, 2017, together. According to Team Lead #102, where it is stated in the meeting minutes that there had been no medication incidents or adverse drug reactions at that time, this was indicative

that there had been no incidents of a pharmacy-origin only; it did not speak to the incidence of medication incidents of a nursing origin, according to the team lead. Team Lead #102 further indicated to Inspector #655 that only medication incidents that are of a pharmacy origin would be reviewed at PAC meetings.

Over the course of the inspection, Inspector #655 found no evidence that would demonstrate that a quarterly review was undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions by an interdisciplinary team, or otherwise. The interdisciplinary team (PAC) had not met since August 23, 2017 - over a year ago, and prior to the three medication incidents that were reviewed as part of the inspection. In addition, only medication incidents of a pharmacy origin were being reviewed by the interdisciplinary team. The monthly staff meetings (which are not attended by the pharmacy service provider, Medical Director, or Administrator) included a brief discussion of individual medication incidents; but, did not include a review of all incidents occurring within the quarter or since the time of the last review.

The licensee failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions. [s. 135. (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 every medication incident involving a resident is documented, together with a record of the immediate actions taken to assess and maintain the resident's health; to ensure that all medication incidents involving a resident are reported to the Medical Director and the pharmacy service provider; to ensure that a written record is kept of the review and analysis of all medication incidents; and, to ensure that that a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions., to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

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

Findings/Faits saillants :

1. The licensee failed to ensure that no person mentioned in subsection (1) performed their responsibilities before receiving training on: the home's policy to promote zero tolerance of abuse and neglect, the duty under section 24 to make mandatory reports, and, the protections afforded by section 26; and, subsequently failed to ensure that training in the areas identified under s. 76 (4) was provided annually to environmental services staff.

Over the course of the inspection, Inspector #655 spoke to staff members (PCA #111, RPN #110, and Environmental Services Staff #112) working in the home about the training provided by the licensee with regards to abuse. During interviews, neither PCA #111 nor Environmental Services Staff #112 could recall

having received training related to the requirements of mandatory reporting - or, the duty to report under s. 24 of the LTCHA, 2007. PCA #111 was also unable to recall what other topics related to abuse had been addressed during their training, or when they had last received the training. There was also no indication that the Environmental Services Staff #112 had received training related to the protections afforded by section 26 (or, "whistle-blower protection").

During an interview, Nurse Manager #101 was unable to speak to what training was provided to staff working in the home related to abuse. Specifically, Nurse Manager #101 indicated that they would have to review training records in order to determine if staff had received the required training.

Inspector #655 was provided with the "Surge" training records for PCA #111, RPN #110, and Environmental Services Staff #112 (who performed housekeeping duties), by Nurse Manager #101.

On review of the training records, Inspector #655 found that, according to the records, both PCA #111 and RPN #110 had completed several modules related to abuse. The topics covered included: different types of abuse and neglect, the licensee's policy to promote zero tolerance of abuse and neglect, categories and timelines for reporting, mandatory reporting, and whistleblower protection; and, the Resident Bill of Rights.

However, on review of the training records for Environmental Services Staff #112, Inspector #655 found no records that would demonstrate that they had completed any of the above-described modules related to abuse and the Resident Bill of Rights which had been completed by PCA #111 and RPN #110.

During an interview, Nurse Manager #101 indicated to Inspector #655 that Environmental Services staff were not their employee, and as such they could not speak to what type of training they had received related to abuse. According to Nurse Manager #101, Environmental Services Supervisor (ESS) #113 oversees the environmental staff.

During an interview, Inspector #655 reviewed the above-described training record of Environmental Services Staff #112 with ESS #113. ESS #113 was unable to confirm whether or not Environmental Services Staff #112 had ever completed the above-listed modules related to abuse, and referred the inspector to a Human Resources representative.

During an interview, Human Resources representative #114 indicated to Inspector #655 that staff, including Environmental Services Staff #113 are to review the following policies which are available to all staff members through the internal intranet system as part of their training:

- Policy #V-40, related to managing abuse,
- Policy #I-41, related to whistleblower protection; and,
- Policy #I-20, related to patient and resident rights.

According to Human Resources Representative #114, the above-listed policies were not part of the "Surge" training program for environmental staff. Inspector #655 reviewed the three policies identified by Human Resources Representative #114 as being part of environmental staff training (Policy #V-40, #I-41, and #I-20) and found that the information contained within the identified policies was not consistent with the training requirements outlined in the LTCHA, 2007:

- the definitions of abuse were not consistent with the definitions of abuse as set out in Ontario Regulation 79/10,
- there was no reference to the specific duty to make mandatory reports under s. 24 of the LTCHA, 2007,
- the specific protections afforded under s. 26 of the LTCHA, 2007, were not outlined. Specifically, there was no explanation related to the protections afforded to those who disclose anything to a Long-term Care Homes Inspector, or to the Director under the LTCHA, 2007,
- there was no information related to the meaning of "no retaliation against residents" as outlined in s. 26 of the LTCHA, 2007; and,
- the Resident Bill of Rights as outlined in the LTCHA, 2007, (which includes 27 rights for resident's who reside in Long-term Care Homes) was not outlined.

During an interview, ESS #113 indicated to Inspector #655 that Environmental Services Staff #112 who provided housekeeping services, had been working at the facility for more than ten years. ESS #113 indicated to Inspector #655 that the same staff member would work in the long-term care area intermittently, on a rotational basis; as would all of the other environmental services staff who perform housekeeping. At the same time, ESS #113 indicated to Inspector #655 that all environmental services staff who perform housekeeping would receive the same type of training; and to their knowledge, their training would have only been enhanced (with additional content) over the years- no content would have been

removed from their training schedule.

There was no indication that environmental services staff, including Environmental Services Staff #112, had received training on the home's policy to promote zero tolerance of abuse and neglect, the Resident Bill of Rights as outlined in the LTCHA, 2007, their duty under section 24 of the LTCHA, 2007, to make mandatory reports, or the protections afforded by section 26 of the LTCHA, 2007, before they had performed their responsibilities in the long-term care home area of the facility, or at any other time.

The licensee failed to ensure that no person mentioned in subsection (1) performed their responsibilities before receiving training on: the home's policy to promote zero tolerance of abuse and neglect, the duty under section 24 to make mandatory reports; and, the protections afforded by section 26; and subsequently failed to ensure that training in the areas identified under s. 76 (4) was provided annually, to environmental services staff. [s. 76. (2) 3.]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 78. Information for residents, etc.

Specifically failed to comply with the following:

s. 78. (1) Every licensee of a long-term care home shall ensure that,
(a) a package of information that complies with this section is given to every resident and to the substitute decision-maker of the resident, if any, at the time that the resident is admitted; 2007, c. 8, s. 78. (1).
(b) the package of information is made available to family members of residents and persons of importance to residents; 2007, c. 8, s. 78. (1).
(c) the package of information is revised as necessary; 2007, c. 8, s. 78. (1).
(d) any material revisions to the package of information are provided to any person who has received the original package and who is still a resident or substitute decision-maker of a resident; 2007, c. 8, s. 78. (1).
(e) the contents of the package and of the revisions are explained to the person receiving them. 2007, c. 8, s. 78. (1).

Findings/Faits saillants :

(A1)
1. The licensee failed to ensure that a package of information that complied with the Act and Regulations was given to every resident and to the substitute decision-maker of the resident, if any, at the time that the resident was admitted.

Pursuant to s. 78. (1) (a) of the LTCHA, 2007, every licensee of a long-term care home shall ensure that, a package of information that complies with this section is given to every resident and to the substitute decision-maker of the resident, if any, at the time that the resident is admitted. In addition, the package of information must contain any other information provided for in the regulations.

Pursuant to s. 224 (1) 1 and 7 of Ontario Regulation 79/10, the package of information provided for in section 78 of the Act includes information about:

- The resident's ability to have money deposited in a trust account under section 241 of this Regulation.

During the inspection, VP of Nursing and Clinical Services #103 completed a "LTCH Licensee Confirmation Checklist" related to the admission process. On this form, the requirements under s. 78 of the LTCHA, 2007; and under s. 224 (1) of Ontario Regulation 79/10 are identified; and, the licensee is asked to self-report whether the package of information that is provided to resident's in their home includes each of the required items.

On October 23, 2018, the completed checklist, described above, was returned to Inspector #655. On review of the completed checklist, Inspector #655 noted that one response provided by VP of Nursing and Clinical Services #103 on the checklist was indicative that the package of information that was being provided to residents on admission to the home did not include information related to the trust account.

In this home, residents were being admitted to one of two programs: Interim Long-term Care (ITLC) or the Convalescent Care Program (CCP). For each program, there was a separate admission package.

During the inspection, Inspector #655 was provided with each of the admission packages. There was no information related to the trust account found in the CCP admission package.

On October 25, 2018, Inspector #655 reviewed the above-described checklist and responses with Nurse Manager #101. At the same time, Nurse Manager #101 reviewed the package of information that was being provided to resident's who were admitted to the home under both of the above-noted programs. At that time, Nurse Manager #101 confirmed that there was no information related to the trust account contained in the package of information that was being provided to residents' admitted to the CCP.

The licensee failed to ensure that a package of information that complied with the Act and Regulations was given to every resident (including CPP and ITLC residents), and to the substitute decision-maker of the resident, if any, at the time that the resident was admitted. [s. 78. (1)]

Issued on this 11st day of February, 2019 (A1)

[redacted]

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

Original report signed by the inspector.