Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 31, 2018	2017_627138_0028	024719-17	Resident Quality Inspection

Licensee/Titulaire de permis

ALMONTE GENERAL HOSPITAL
75 SPRING STREET ALMONTE ON K0A 1A0

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

FAIRVIEW MANOR
75 SPRING STREET ALMONTE ON K0A 1A0

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

PAULA MACDONALD (138), ANANDRAJ NATARAJAN (573), RUZICA SUBOTIC-HOWELL (548)

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): November 20 - 24, 2017 and November 27 - December 1, 2017.

The following intakes were inspected as part of this Resident Quality Inspection:
Log 019417-17 relating to alleged abuse of a resident by anyone;
Log 020065-17 relating to alleged improper/incompetent treatment of a resident that results in harm or a risk of harm to a resident; and
Log 025333-17 relating to alleged abuse of a resident by anyone.

During the course of the inspection, the inspector(s) spoke with residents, family members, the President of Residents' Council, a chair of the Family Council, personal support workers (PSWs), housekeeping aides, the Activities Team Leader, the Registered Dietitian, the Food Services Manager, the Executive Assistant to the President and Chief Executive Officer, the Fairview Manor Receptionist/Staffing, registered practical nurses (RPNs), registered nurses (RNs) including the Team Leader, the Director of Resident Care, a pharmacist, and the Infection and Prevention Control Lead (IPAC).

The inspector(s) also conducted a tour of the resident care areas, reviewed residents' health care records, reviewed policies and procedures related to prevention of abuse, falls management, and medication, reviewed Residents' Council meeting minutes, reviewed Family Council meeting minutes, observed a lunch meal service, observed a medication administration pass, review internal investigation documents.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Admission and Discharge
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use safe transferring and positioning techniques when assisting resident #042.

A review of Critical Incident Report indicated that on a day in the summer of 2017, a PSW transported resident #042 in a wheelchair without foot rest in place. During the transportation the resident's foot caught on the floor. The resident was sent to the hospital for further management and was diagnosed with a specific injury.

On November 30, 2017, Inspector #573 reviewed resident #042's written plan of care at the time of incident which indicated that resident #042 uses a wheelchair for all mobility. Further, it identified that when resident #042 was fatigued staff were to mobilize the resident in the wheelchair.

On November 30, 2017, Inspector spoke with RPN #132 who indicated that the day of the incident, while PSW #139 was mobilizing resident #042 in a tilt wheel chair, resident's foot got caught and injured. RPN #132 indicated that the PSW wheeled the resident's wheel chair without the foot rest in place nor positioned the wheel chair in a tilted position so that the resident's foot was in an elevated position.

On December 01, 2017, Inspector #573 spoke with the home's Director of Resident Care, who indicated that she immediately investigated the incident. Further, the Direct of Resident Care indicated that on the day of the incident, PSW #139 failed to follow the safe transferring and positioning techniques when assisting resident #042.
(Log #020065-17) [s. 36.]

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 staff follow and use safe transferring and positioning techniques when assisting with residents in the wheelchair, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with section 49.(2) of the Regulation in that the licensee has failed to ensure that when a resident has fallen, the resident has been assessed and that where the condition and circumstances of the resident require, a post fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Inspector #138 inspected two residents with reported falls in the last 30 days: resident #020 and resident #035.

RPN #140 reported to Inspector #138 that resident #020 had a fall in the last 30 days. The inspector reviewed the resident's health care record and noted that it was documented that the resident had two falls in the last 30 days.

RPN #101 reported to Inspector #138 that resident #035 had a fall in the last several days. The inspector reviewed the resident's health care record and noted that it was documented that the resident had two recent falls.

Inspector #138 further reviewed the health care record for both resident #020 and resident #035 which included the plan of care as defined by the home. The plan of care for each resident outlined that both resident #020 and resident #035 were at a risk for falls and the plan of care included interventions to manage the risk of falls for each resident. The progress notes were further reviewed and it was observed that progress notes outlining some assessment activities were entered for each of the falls identified above. The inspector also located a Post Fall Tracking Tool on the hard copy of the resident's health care record which outlined the date of each fall and changes to interventions aimed at preventing further falls. The inspector was, however, unable to locate a post fall assessment using a clinically appropriate assessment instrument specifically designed for falls for the four falls identified above.

The inspector spoke with RPN #106 regarding the post fall assessment when a resident experiences a fall. The RPN stated that the progress note entered into the resident's health care record after the fall was considered a post fall assessment (though the inspector had noted that the progress notes entered for the four falls provided limited information).

Inspector #138 obtained the home's policy regarding falls prevention and management (Fall Prevention and Management, Policy # V11-G-60.00, revised June 2014) from the Director of Resident Care and reviewed this policy. It was noted by the inspector that the policy for falls prevention and management did indicate that a component of the post fall assessment did include a progress note, however, the policy did not refer to the use of a specific post falls assessment using a clinically appropriate assessment instrument as per the this legislation.

The inspector spoke with the Director of Resident Care regarding the use of a post fall assessment using a clinically appropriate assessment instrument specifically for the falls outlined above for resident #020 and resident #035. The Director of Resident Care demonstrated that each of these specific falls has a Patient Risk Incident Management System (PRIMS) report that had been generated by the registered nursing staff after these falls had occurred. In later conversations, the Director of Resident Care confirmed that this PRIMS report is not accessible by staff nor is it a part of the resident's health care record and, therefore, is considered an incident report rather than a clinically appropriate assessment instrument used for post fall assessments.

As such, the licensee failed to ensure that when resident #020 and #035 fell that a post fall assessment was conducted using a clinically appropriate assessment instrument specifically designed for falls. [s. 49. (2)]

2. The licensee has failed to ensure that when the resident has fallen, the resident has been assessed and, if required, a post-fall assessment has been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Resident #006 was admitted to the home in 2014, with multiple diagnosis. A review of the most recent resident's MDS assessment indicated that resident #006 was at risk for falls.

Inspector #573 reviewed resident #006's progress notes that indicated the resident had

three fall incidents. Most recently, the resident had a fall and prior to that resident #006 had a fall incident with a minor injury. A review of the resident's health care record shows that no post-fall assessment, using a clinically appropriate tool specifically designed for falls, was done for any of the above identified fall incidents.

On November 28, 2017, during an interview with RPN #111 who indicated that when a resident has fallen, registered nursing staff must do a post fall assessment, which is documented in the resident's progress notes, to complete a falls risk assessment and a fall tracking tool. RPN #111 indicated to the inspector that registered nursing staff would complete a fall incident report in the home's electronic incident reporting system (PRIMS). Further, the RPN indicated that she was not aware and completing any clinically appropriate post fall assessment tool that is specifically designed for falls.

On November 28, 2017, Inspector #573 reviewed resident #006's health care record in the presence of RPN #111. Upon review, the Inspector found that there was no completed fall risk assessment and a fall tracking tool for two of resident #006's recent falls.

On November 28, 2017, Inspector #573 spoke with RN #114 who indicated that for resident's post fall the registered nursing staff will assess the resident, document the vitals/ injuries and immediate interventions in the progress notes and will complete a fall tracking tool. The indicated that registered nursing staff will also complete a fall incident report in the PRIMS. Further, RN #114 indicated to the inspector that the PRIMS is an electronic incident report system and that was not considered as a clinical post fall assessment tool. [s. 49. (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 when the resident has fallen, the resident has been assessed and, if required, a post-fall assessment has been conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to seek the advice of Residents' Council in the development of the survey.

The yearly Resident Satisfaction Survey is scheduled to be made available in January 2018. During an interview with the President of Resident Council s/he indicated that the council had not been involved in the development of the current survey. S/he indicated that council would appreciate being involved in its development to measure resident's satisfaction with the home, care, services, programs and goods provided.

Council meeting minutes for 2017 do not indicate that council was involved in the development of the satisfaction survey.

On November 28, 2017 during an interview with Inspector #548 the Director of Resident Care indicated that she has become aware that advisement from council in the development of the satisfaction survey is required. She indicated that the survey is scheduled to be sent out in January to all resident's and, moving forward she indicated that she would open dialogue and engage council in its development. [s. 85. (3)]

2. The licensee has failed to ensure that the licensee seek the advice of the Family Council in developing and carrying out of the annual satisfaction survey.

On November 22, 2017, Inspector #573 spoke with the Family Council Chair who indicated that the Licensee did not seek any advice or input from the Family Council in developing and carrying out the home's annual satisfaction survey for 2017.

On November 28, 2017, Inspector #573 spoke with the home's Director of Resident Care who stated that the home conducts an annual satisfaction survey every year and indicated that she was not sure that the licensee seek the advice of the Family Council in developing and carrying out this survey. Further, the Director of Resident Care stated to the inspector that she does not have any documentation or records to support that the licensee seek advice from the Family Council in developing and carrying out the home's annual satisfaction survey for 2017. [s. 85. (3)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The Licensee failed to report to the Director missing or unaccounted controlled substances no later than one business day after the occurrence.

The last quarter medication incidents reports were provided to Inspector #548. From a review of the eight incidents for the last quarter there are two recorded incidents of missing controlled substances.

A medication incident indicated that a prescribed controlled drug was not administered to a resident and the drug was missing however, a review of the Medication Administration Record (e_MAR) two days previous indicated that the drug was administered.

A second incident involving the same resident where controlled substances were missing and had not been located.

On November 24, 2017 both the Director of Resident Care and Team Leader confirmed during an interview that the three controlled substances had not been located.

Progress note entries by registered nursing staff indicated that there were three separate incidents of the missing controlled drugs for another resident. The resident is prescribed a controlled substance to be administered at specific time intervals. Review of the e_MAR indicated that the drug was administered to the resident on one of the days.

During interviews both the Director of Resident Care and Team Leader indicated to Inspector #548 that they were not aware of the missing controlled substances for this resident. The Team Leader indicated that from her investigation there were three missing and unaccounted for controlled drugs.

The licensee failed to report to the Director five incidents of missing or unaccounted for drugs, as required. [s. 107. (3) 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 the licensee shall report the missing and unaccounted for controlled substances as required, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

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

The licensee has in place a web-based application used for the reporting of medication

incidents. Incidents from the last quarter were provided to Inspector #548. There are six recorded incidents. The Director of Resident Care indicated during an interview with Inspector #548 on November 24, 2017, that immediate actions taken to assess and maintain resident's health would be conducted by the registered practical nurse or the charge registered nurse, post incident. She explained that from her review of the medication incidents from the last quarter that there is no formal process for this assessment including documentation of the nursing actions provided to residents post medication incident.

She further indicated that for those residents that had an incident involving missing controlled substances used for pain management (that required administration at a specific time interval and specific administration method), it was unknown if there were any ill effects to the residents as the there was no documentation of an assessment of the residents conducted post incident.

Progress notes were reviewed. There is documentation of the immediate actions taken to assess and maintain a resident's health when three medication incidents became known.

There is documentation of the immediate actions taken to assess and maintain a second resident's health when the medication incident became known.

There is documentation of the immediate actions taken to assess and maintain a third resident's health when the medication incident and then another medication incident in became known.

There is documentation of the immediate actions taken to assess and maintain a fourth resident's health when the medication incident became known.

There is documentation of the immediate actions taken to assess and maintain a fifth resident's health when the medication incident became known.

There is documentation of the immediate actions taken to assess and maintain a sixth resident's health when the medication incident became known.

There is documentation of the immediate actions taken to assess and maintain a seventh resident's health when the medication incident became known.

The licensee failed to ensure the documentation of the immediate actions to assess and

maintain the health of seven residents.

The licensee failed to report 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, every mediation incident involving a resident and every adverse drug reaction.

The licensee has in place a web-based application used for the reporting of medication incidents. Incidents from the last quarter were provided to Inspector #548. The electronic format is structured for the user to add in information on patient demographics, the date and time of the incident and incident description, the impact and severity of harm and immediate actions taken, who was informed- resident, substitute-decision maker, physician, Power of Attorney, manager/supervisor/nurse/ward clerk. The Director of Resident Care indicated that pharmacy and the Medical Director are informed at the quarterly Pharmaceutical and Therapeutics Meeting of medication incidents at that time.

Once the form is completed, it is forwarded to the Director of Resident Care or designate for review.

Those incidents that involved residents are as follows:
1. There is no documentation that the resident, resident's substitute decision-maker (SDM), if any, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending were notified related to medication incident for the third resident .

2. There is no record that the resident, resident's substitute decision-maker, if any, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class were informed of medication incident for the fourth resident.

On November 24, 2017, during an interview with the Inspector #548 with the Director of Resident Care and Team Lead (incoming Assistant Director of Care) both indicated that it is not usual practice to inform the resident, or SDM of all medication incidents. Both indicated that if the there is an incident involving a high-risk drug then the physician is informed. On November 29, 2017, the pharmacist indicated that the family and physician are notified when there is an incident involving a high-risk medication. [s. 135. (1)]

2. The licensee failed to ensure that all medication incidents and adverse drug reactions are documented, reviewed and analyzed.

The last quarter medication incidents reports were provided to Inspector #548. From a review of the eight incidents for the last quarter there are two recorded incidents of missing pain medication. From the review of progress note entries there are three additional incidents of missing or unaccounted for pain medication. This a total of eleven medication incidents, reported and unreported.

On November 27, 2017, during an interview with the Inspector #548 the Director of Resident Care indicated that medication incidents and adverse drug reactions are discussed at the Pharmacy and Therapeutics meeting. She provided meeting minutes for December 6, 2016, April 19, 2017 and September 20, 2017. She indicated the June 2017 minutes could not be located at the time of the inspection.

The meeting minutes were reviewed. September 20, 2017 notes indicate that all medication incidences will be reported to pharmacy and pharmacy will review and see if any patterns exist. However, there is no analysis of the medication incidents.

On November 28, 2017, during an interview with the Inspector #548 the home's pharmacist indicated that there is discussion of medication incidents and adverse drug reactions at the meeting as a standing agenda item and the analysis of those incidents are discussed amongst the members.

During an interview the Director of Resident Care agreed there was no documentation of the analysis of the medication incidents. [s. 135. (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:
1. that any medication incident or adverse drug reaction is 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,
2. every adverse drug reaction is documented, together with the immediate actions taken to assess and maintain the resident's health and;
3. ensure that all medication incidents and adverse drug reactions are documented, reviewed and analyzed, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On November 20, 2017, during home's initial tour Inspector #573 observed in the resident's spa room of the secured unit, a clear plastic caddy beside the main tub that contained used two deodorant stick, two roll on, two used body mist and one used Aveeno skin cream with no name nor labelled. Inspector #573 also observed a blue plastic caddy beside the shower area that contained used Nivea creams, used shaving foam, one spray hair oil, one small scissor, one nail clipper and one nail nipper with no name nor labelled.

On November 28, 2017, Inspector #573 observed in the resident's spa room of the

secured unit, beside the main tub with one used bar soap, one disposable razor with hair, one steel nail file, one nail clipper, one small scissor and other resident's personnel items with no name nor labelled. Inspector #573 also observed a blue plastic caddy beside the shower area that contained one small scissor, one nail clipper, one nail nipper and other resident's used personnel items with no name nor labelled.

On November 28, 2017, Inspector #573 in the presence PSW #125 observed the unlabelled resident's personnel items and the nail care equipment (scissor, steel nail file, nail clipper) in the spa room. PSW #125 indicated that she was not sure to whom the resident's personnel items belongs to since these items were not labelled. Further, regarding the nail care equipment she indicated that she was not sure that these were the home's nail care equipment that was used in the spa room for residents who do not have their own nail clippers.

Inspector #573 interviewed PSW #126 regarding the nail clippers in the spa room, she indicated PSW staff use home's common nail clippers in the tub room for residents who do not have their own nail clippers and that they would use the tub cleaning solution to clean and disinfect nail clippers between residents. Inspector #573 noted that the tub/shower cleaning solution is not a high level disinfectant solution.

On November 28, 2017, Inspector #573 spoke with RPN #127 who indicated that resident's each personnel items were to be labelled. The RPN indicated that for residents who do not have their own nail clippers, PSW staff will use the home's common nail care equipment. She further indicated that PSW staff would use alcohol wipes for cleaning and disinfecting the home's common nail care equipment.

Inspector #573 reviewed Best Practices for Cleaning, Disinfection and Sterilization of Medical Equipment/Devices in all Health Care Settings from Provincial Infectious Diseases Advisory Committee (PIDAC) which classify fingernail care equipment used on multiple residents as semi critical equipment/devices which requires high-level disinfection between uses and foot care equipment as critical equipment/devices which requires sterilization.

On November 29, 2017, Inspector #573 spoke with the home's Infection Prevention and Control (IPAC) lead staff member regarding the unlabelled resident's personnel items and nail care equipment in the spa room. The IPAC lead indicated that the resident's personnel items including nail clippers should be individualized and labelled with the resident's name and stored in an appropriate manner that avoid any contamination.

Staff members were observed to not participate in the home's infection prevention and control program, specifically related to residents' personal care items including nail care equipment that were not properly labelled and stored in the resident spa room. [s. 229. (4)]

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 staff participate in the implementation of the home's infection prevention and control program, specifically related to residents' personal care items, to be implemented voluntarily.

WN #7: 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 their policy: Medication Incidents, last reviewed January 16, 2017 was complied with related to three medication incidents.

As per O. Reg. 79/10. S. 115 (3) (b) the licensee is to ensure that a pharmacist from the pharmacy service provider reviews reports of any medication incident.

The licensee has in place a web-based application used for the reporting of medication incidents. A paper form MediSystem Mediation Incident Report Form (IR—FRM-CL-003A) is available in the event the electronic is not accessible.
The home's policy 'Medication Incidents', last reviewed: January 16, 2017 clearly states that all identified medication incidents are to be reported via online reporting system by the nursing staff or designate. In addition, to notify the Pharmacy provider and the Manager of Pharmacy Operations or designate will receive notifications either through online medication reporting or by fax that a medication incident occurred.

On November 29, 2017 the pharmacist indicated that he was unaware of the three separate incidents of missing or unaccounted controlled substances.

The licensee has failed to ensure staff, which includes the pharmacist, comply with policies related medication incidents of controlled substances. [s. 8. (1) (b)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee respond in writing within 10 days of receiving Family Council advice related to concerns or recommendations.

On November 22, 2017, Inspector #573 spoke with the Family Council Chair who indicated that the Family Council did not receive any written responses from the licensee within 10 days of them providing with concerns or recommendations about the home.

On November 23, 2017, Inspector #573 reviewed the Family Council meeting minutes of February 2017 that identified concerns regarding the removal of resident's comfortable seating chairs from the corridor and recommendations regarding availability of Wi-Fi in the Fairview Manor LTCH, that were forwarded to management. Upon review, there was no documentation to support that a written response from the licensee regarding the identified concerns and recommendations was communicated within 10 days to the Family Council.

On November 27, 2017, Inspector #573 spoke with home's Director of Resident Care who indicated that a written response with regards to the above concerns and recommendations to the Family Council was not given within 10 days. [s. 60. (2)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (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, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually 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. 116 (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, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

On November 29, 2017 the Team Lead indicated that there are members of the interdisciplinary team that meet on a quarterly basis however, the dietitian is not a member of Pharmaceuticals and Therapeutics committee.

On November 29, 2017 during an interview with Inspector #548 the Dietitian indicated that she has been working at the home for four years and is aware that she is required to meet annually as an interdisciplinary member to evaluate the effectiveness of the medication management system however, she has not been invited to do so. [s. 116. (1)]

Issued on this 31st day of January, 2018

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

Original report signed by the inspector.