Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Aug 15-18-19-23-25-29 2011 ~~Aug~~ 9, 10, 11, 16, 17, 24, 26, 30, 31, 2011	2011_034117_0020	Resident Quality Inspection (RQI) ~~Annual~~

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

LYNE DUCHESNE (117), CAROLE BARIL (150), COLETTE ASSELIN (134)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct an Annual inspection.

During the course of the inspection, the inspector(s) spoke with to the home's Director of Care (DOC), Assistant Director of Care (ADOC), to the home's Quality Improvement Manager, to several Registered Nurses (RN), to several Registered Practical Nurses (RPN), to several Personal Support Workers (PSW), to the Food Service Supervisor, to several Dietary Aides, to a Physiotherapy Assistant, to several Housekeepers, to the Environmental Services Manager, to several residents, to several resident family members as well as to the Presidents of the Resident and Family Councils.

During the course of the inspection, the inspector(s) observed several residents care and services, observed the lunch time meal services of August 10 2011, examined several resident rooms, spa rooms, resident care equipment, resident unit medication rooms, reviewed several resident health care records, reviewed the home's admission process, reviewed several of the home's policies, protocols and procedures.

The following Inspection Protocols were used in part or in whole during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Laundry

Accommodation Services - Maintenance

Admission Process

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Hospitalization and Death

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Quality Improvement

Recreation and Social Activities

Resident Charges

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES	
Definitions WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Définitions 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. 131. Administration of drugs

Specifically failed to comply with the following subsections:

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 sayants :

1. The following findings show the licensee did not comply with section 131 (1) and section 131 (2) of the O.Regulation 79/10 as it relates to the prescription and administration of drugs.

The home's policy, dated January 2007 and titled Drug Administration Times # V1-J-10.26, specifies that routine times are scheduled for the administration of medication. Medication given:

Daily to be given at 10:00 or 19:00
BID 10:00 and 19:00
TID 10:00, 14:00 and 19:00
QID 08:00, 12:00, 16:00 and 20:00.

It is also a well established practice that the medication can be administered 1 hour prior to or 1 hour after from the directions specified by the prescriber. It is also noted that the home does not have an HS (bedtime) medication policy.

• On August 15, 2011, at 12:00 the inspector # 134 observed an identified resident, receive his/her anxiolitic medication. This medication is ordered TID, to be given at 10:00, 14:00 and 19:00. As per the Medication Administration Record (MAR) sheet, the medication was administered at 10:00 and 12:00 on the day shift. Since the medication was given at 12:00 instead of 14:00, it was not given as per prescriber order.

• On August 15, 2011, a resident was ordered medication drops QID. This treatment was administered at 10:00, 12:00, 17:00 and 19:00. The order for the medication drops was not administered as per home's policy of QID times of 8:00-12:00-16:00-20:00 in line with prescriber directions.

• A resident's order for ophtalmic medication is ordered to be instilled TID. The MARS was reviewed and the medication is being administered at 10:00, 12:00 and 17:00 instead of 10:00-14:00-19:00 as per home's policy related to TID times.

• A Resident has an order for a neuroleptic/anti-psychotic medication every am, supper and qHS. The resident is receiving his/her medication at 10:00, 17:00 and 19:00. The 19:00 hour dose is being given 2 hours after the supper dose, raising concerns regarding HS / bedtime medication. Interviewed evening charge RN stated to inspectors that HS means bedtime and is typically given between 20:00-22:00.

• A new resident has an order for a cardiac medication QID. The MARs indicates he/she is to be administered the medication at 10:00, 12:00, 17:00 and 19:00. The resident is not receiving his/her medication according to home's routine QID time schedule of 8:00-12:00-16:00-20:00.

• A resident has an order for a narcotic medication TID. The MARs indicates he/she is to receive the narcotic medication at 8:00, 14:00 and 19:00. The Resident has received his/her medication at 12:00 on August 20 and at 12:10 on August 21 instead of at the prescribed time of 14:00 because he/she was complaining of hip pain.

• A resident is ordered to have an analgesic medication TID. The MAR indicates the administration times as being 10:00-12:00-19:00. The analgesic medications were not administered as per home's policy related to TID times which are 10:00-14:00-19:00.

• A resident is ordered to have an anxiolitic medication TID and antidepressant medication at supper and at bedtime time. The resident's MAR indicated that the anxiolitic medication is being given at 10:00 - 17:00 -19:00 ¸ which is not administered as per home's policy related to TID times of 10:00-14:00-19:00. The antidepressant medication is documented as being given at 17:00 and 19:00 but not at bedtime as prescribed. The 19:00 hour dose is being given 2 hours after the supper dose, raising concerns regarding HS / bedtime medication

• A resident is ordered to have neuroleptic/anti-psychotic medication in morning and lunch and at bedtime. The MAR indicates that the administration times were changed manually, original pharmacy hours on MAR were noted as being 10:00-12:00-19:00. The time was changed manually to 10:00-14:00-19:00 and then back to 10:00-12:00-19:00. Interviewed RPN told inspector #117 that she does not know why administration times were changed.

• A resident is ordered a medication OD to be given at 10:00 as well as another medication BID to be given at 10:00 and 19:00.

Unit RPN reports to the inspector #117 that they do not give the medications as ordered. The RPN states that he/she gives one of the above medication at 08:00 and the other at 10:00 but signs both as being given at 10:00.

• A resident is ordered medication and a laxative medication OD. The MAR administration time was changed for both of these medications from 10:00 to 08:00. There is no documented reason for the change of administration time and it is not being administered as per the home's policy for OD administration time.

The home's policy "Self Administration of Medication", # VI-J-20.00, dated January 2007 indicates the following: "If a physician deems it appropriate, he/she will ensure that there is a written physician's order on the resident's chart indicating the med to be self administered the amount of the med to be given to the resident and any special instructions."

• A resident has a medical order, dated January 12, 2011, indicating that the resident can self administer his/her HS medication. The medical order does not specify which medication is to be self administered.

• A review of the resident's health care record indicates that the resident does not have any identified HS medication.

• Two RPNs stated to the inspector #117 that the resident has six (6) medications prescribed to be given at 19:00. The RPNs stated that they leave two out of six prescribed medications to be self administered at HS. The other four are given at 19:00. The resident's Medication Administration Record (MAR) indicates that all six medications are signed as being given at 19:00.

• On May 27 2011, an RPN noted that the identified resident had 4 tablets of one medication and 2 tablets of another in his/her locked bedside drawer. These had been signed in the MAR as being given.

• A former resident was diagnosed as having ongoing constipation issues. The resident's bowel management interventions included daily laxative medications. The home's bowel management protocol was used when the former resident did not have bowel movements for several days.

• The former resident's health care record documents that he/she received a non prescribed medication as a bowel management intervention on November 27 and 28 2010, on December 2, 4 and 9 2010. The resident did not have a medical order for this non prescribed medication.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following subsections:

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

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

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits sayants :

1. The licensee has failed to comply with section s.6 (10) (c) of the LTCHA 2007 (the Act), in that a former resident's bowel management interventions were not reassessed when the care set out in the plan has not been effective.

• The identified former resident was diagnosed as having ongoing constipation issues. The resident's bowel management interventions included daily laxative medications. The home's Medical Directive related to bowel management protocol was used when the resident did not have bowel movements for several days.

• The former resident's health care record documents that he/she did not have a bowel movement for 9 days even though he/she was administered laxatives and enemas as per the Medical Directive for bowel management interventions on November 27 and 28 2010, on December 2, 4 and 9, 2010. There is no documentation in the resident's health care record as to the effectiveness of the interventions.

• The plan of care was not reassessed when these interventions were not effective and the plan of care was not reviewed and revised.

2. The licensee has failed to comply with section s.6 (1) (c), of the Act, in that the plan of care for an identified resident did not provide clear direction to staff as it relates to an identified resident's mouth care. The licensee also failed to comply with section 6 (4) (a) of the Act, in that the staff did not collaborate with each other in the assessment of the above resident's mouth care needs.

• An identified resident reported to the inspector #134 that he/she had lost his/her lower denture over one month ago, around July 16, 2011. The resident said his/her lower gums were sore because he/she continues to eat regular food without his/her lower plates and this is irritating his/her lower gums. The resident indicated he/she developed cold sores as a result of not wearing his/her lower denture.

• Staff and management are aware that the identified resident's lower denture has been missing but no interventions were implemented until August 19, 2011, to ensure clinical assessment of new dietary needs, to notify denturologist for new plates or to follow-up with the resident to assess oral mucosa.

• There are no clear interventions for staff in plan of care as it relates to the resident's change in condition and needs, following the loss of the lower denture.

• The resident's clinical needs and conditions were not assessed until August 19 2011, one month after the loss of his/her dentures.

3. The licensee has failed to comply with section s.6 (10) (c) of the Act, in that the plan of care for an identified resident does not set out clear directions to staff regarding his/her continence care needs.

• The identified residents plan of care is dated November 12, 2010 and does not reflect the resident's current continence care needs interventions as reported by the resident and PSW staff.

• Plan of Care specifies that the identified resident is on a scheduled toileting plan, that he/she wears white liners in underwear, to check and change pads as needed, and to monitor the resident as he/she removes underwear when incontinent.

• The resident was observed by inspector #134 to be wearing pull-up incontinence briefs. The PSW reported that the resident no long removes his/her underwear when incontinent as he/she is now wearing pull-up incontinence briefs and that the resident toilets himself /herself at will.

• The plan of care specifies not to leave the identified resident on toilet, that the resident requires one person assistance for toileting when in fact the resident self toilets without staff knowledge or assistance.

• The identified resident's plan of care indicates that he/she is at risk of falling. The plan of care does not specify clear interventions to prevent resident from falling during toileting.

4. The licensee has failed to comply with section s.6 (1) (c) of the Act, in that the plan of care for an identified resident did not

provide clear direction to staff as it relates to the resident's mobility needs.

• An identified resident uses a self propelled wheelchair to mobilize. His/her plan of care indicates that the resident is independently mobile with the aid of a walker.

• Inspection #150 observed the identified resident to mobilize with his/her wheelchair on the resident care unit.

• The unit RPN reported that the resident no longer uses his/her walker and uses the wheelchair due to increased left knee pain.

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 in regards to residents plan of care being reviewed and revised when there is a change in resident care condition when the care set out in the plan of care is no longer effective; that the plan of care is developed based on collaborative assessments and that the plan of care gives clear directions to staff, to be implemented voluntarily.

WN #3: 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 subsections:

s. 78. (2) The package of information shall include, at a minimum,
(a) the Residents' Bill of Rights;
(b) the long-term care home's mission statement;
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents;
(d) an explanation of the duty under section 24 to make mandatory reports;
(e) the long-term care home's procedure for initiating complaints to the licensee;
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints;
(g) notification of the long-term care home's policy to minimize the restraining of residents and how a copy of the policy can be obtained;
(h) the name and telephone number of the licensee;
(i) a statement of the maximum amount that a resident can be charged under paragraph 1 or 2 of subsection 91 (1) for each type of accommodation offered in the long-term care home;
(j) a statement of the reductions, available under the regulations, in the amount that qualified residents can be charged for each type of accommodation offered in the long-term care home;
(k) information about what is paid for by funding under this Act or the Local Health System Integration Act, 2006 or the payments that residents make for accommodation and for which residents do not have to pay additional charges;
(l) a list of what is available in the long-term care home for an extra charge, and the amount of the extra charge;
(m) a statement that residents are not required to purchase care, services, programs or goods from the licensee and may purchase such things from other providers, subject to any restrictions by the licensee, under the regulations, with respect to the supply of drugs;
(n) a disclosure of any non-arm's length relationships that exist between the licensee and other providers who may offer care, services, programs or goods to residents;
(o) information about the Residents' Council, including any information that may be provided by the Residents' Council for inclusion in the package;
(p) information about the Family Council, if any, including any information that may be provided by the Family Council for inclusion in the package, or, if there is no Family Council, any information provided for in the regulations;
(q) an explanation of the protections afforded by section 26; and
(r) any other information provided for in the regulations. 2007, c. 8, s. 78 (2)

Findings/Faits sayants :

1. The licensee failed to comply with section 78 (2) of the Act in that the Resident Admission package does not include the following information:

- the long-term care home's policy to promote zero tolerance of abuse and neglect of resident's [section 78 (2)(c)]

- an explanation of the duty under section 24 of the LTCHA, Reporting Certain Matters to the Director, to make mandatory reports [section 78 (2)(d)]

- notification of the long-term care home's policy to minimize the restraining of residents and how a copy of the policy can be obtained [section 78 (2)(g)]

- an explanation of the protections afforded by section 26 of the LTC Homes Act regarding Whistle-blowing protection [section 78 (2)(q)]

- the home's DOC reported to inspector # 117, that she and other team members have not communicated to residents or their families/ legal substitute decision makers, the legislated requirements listed above

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WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following subsections:

s. 79. (1) Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations. 2007, c. 8, s. 79. (1).

s. 79. (2) Every licensee of a long-term care home shall ensure that the required information is communicated, in a manner that complies with any requirements that may be provided for in the regulations, to residents who cannot read the information. 2007, c. 8, s. 79. (2).

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights;
(b) the long-term care home's mission statement;
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents;
(d) an explanation of the duty under section 24 to make mandatory reports;
(e) the long-term care home's procedure for initiating complaints to the licensee;
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints;
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained;
(h) the name and telephone number of the licensee;
(i) an explanation of the measures to be taken in case of fire;
(j) an explanation of evacuation procedures;
(k) copies of the inspection reports from the past two years for the long-term care home;
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years;
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years;
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council;
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council;
(p) an explanation of the protections afforded under section 26; and
(q) any other information provided for in the regulations. 2007, c. 8, ss. 79 (3)

Findings/Faits sayants :

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1. The licensee failed to comply with section 79 (1)(2) and (3)(c)(g)(n)(p) of the Act in that information required to be posted was not posted in the home nor were they communicated to residents who cannot read the information. These are:

- the long-term care home's policy to promote zero tolerance of abuse and neglect of resident's

- an explanation of the duty under section 24 of the LTC Homes Act, Reporting Certain Matters to the Director, to make mandatory reports

- notification of the long-term care home's policy to minimize the restraining of residents and how a copy of the policy can be obtained

- an explanation of the protections afforded by section 26 of the LTC Homes Act regarding Whistle-blowing protection

- the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council

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WN #5: 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 subsections:

s. 85. (1) Every licensee of a long-term care home shall ensure that, at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home. 2007, c. 8, s. 85. (1).

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).

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3);
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any;
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits sayants :

1. The licensee failed to comply with section 85 (1)(2) and (4)(a) of the Act in that the home did not conduct a yearly satisfaction survey, past satisfaction survey results were not communicated to the Resident Council and that the Resident and Family Councils have not been consulted as to the development of the satisfaction survey.

- The DOC and Quality Improvement Manager reported to inspection #150 that the home's Family and Resident surveys are ready to be sent in September 2011. They report that the Residents and Family Councils were not consulted for their advice in the development and the carrying out process for this year's survey.

- The DOC reported to inspector #150 that the home did not conduct a yearly Resident and Family Satisfaction Survey in 2010 due to floor repairs and moving of residents to another location during those floor repairs.

- The President of the Residents Council, reported to inspection #134, that he is not aware that the home is planning on conducting a Satisfaction Survey this September 2011. He also states that the home did not seek advice from the Resident Council in developing the survey or how to carry out the 2011 survey.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following subsections:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions.
2. The physical device is well maintained.
3. The physical device is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits sayants :

1. The licensee failed to comply with section 110 (1)(2) of the O. Regulation 79/10 in that a physical device was not well maintained as it was missing a security clip.

2. An identified resident self mobilizes with a wheelchair. The resident is identified as being at high risk for falls and has a back clip lap belt ordered as a physical restraint.

3. The resident's back clip lap belt restraint was noted to be loose on August 11 2011 at 11:20am and again on August 24 2011 at 11:25. Resident's health care record indicates that on July 27 2011, the resident's family expressed concerns with the resident's back clip lap belt restraint being loose.

4. Based on an interview with the home's physiotherapy assistant (PTA), the PTA evaluated the resident's back clip lap belt restraint on July 28 2011, and no issues were noted. On August 11th, the PTA assessed the resident's back clip lap belt restraint and noted that the security clip was missing from the lap belt restraint. Immediately, the PTA applied a security clip. On August 24th, the lap belt restraint was re-evaluated by the PTA after the inspector #117 noted that the lap belt restraint was loose. The assessment revealed that the security clip had not been applied properly by the PTA on August 11 2011.

5. The completed restraint monitoring records for July 27, August 11 and 24 did not indicate that the back clip lap belt restraint was loose.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following subsections:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits sayants :

1. The licensee failed to comply with section 137 (1)(b) of the O.Regulation 79/10 as it relates to the cleaning of a resident's personal equipment.

- The home's policies Personal Support Worker #V11 C 10.05 and policy #V11 C 30.03 relate to the cleaning and storage of nursing equipment.

- The home's wheelchair cleaning schedule indicates that an identified resident's wheelchair was scheduled for cleaning on August 12, 2011. The records indicate that it had been cleaned during the early morning hours of August 12th, during the night shift. The Inspector #150 observed during the morning of August 12, 2011, that the identified resident's wheelchair was encrusted with dirt on the chassis. The wheelchair's seat cushion was stained as well as his front seat belt restraint.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 117. Medical directives and orders — drugs
Every licensee of a long-term care home shall ensure that,
(a) all medical directives or orders for the administration of a drug to a resident are reviewed at any time when the resident's condition is assessed or reassessed in developing or revising the resident's plan of care as required under section 6 of the Act; and
(b) no medical directive or order for the administration of a drug to a resident is used unless it is individualized to the resident's condition and needs. O. Reg. 79/10, s. 117.

Findings/Faits sayants :

1. The licensee failed to comply with section 117 (b) of the O. Regulation 79/10 in that no medical directive or order for the administration of a drug to a resident is used unless it is individualized to the resident's condition and needs.

2. The home has a Medical Directive that has been approved by the home's Medical Advisory Committee. The Medical Directive is kept with the medication carts on each resident care units.

3. Several Registered Nurses and Registered Practical Nurses reported to the inspector #117 that the Medical Directive is followed as needed for every resident in the home. It is not resident specific and not individualized.

4. The home's Director of Care reported to the inspector #134 on August 24, 2011 that the generic Medical Directive is used at this time, in the home.

5. In December 2010, a former resident was diagnosed as having ongoing constipation issues. The home's Medical Directive related to bowel management protocol was used when the resident did not have bowel movements for several days. The resident's health care record documents that he/she was administered Milk of Magnesia and Fleet enemas as per the Medical Directives for bowel management interventions. The interventions were not individualized to the resident's condition or needs.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 123. Emergency drug supply
Every licensee of a long-term care home who maintains an emergency drug supply for the home shall ensure,
(a) that only drugs approved for this purpose by the Medical Director in collaboration with the pharmacy service provider, the Director of Nursing and Personal Care and the Administrator are kept;
(b) that a written policy is in place to address the location of the supply, procedures and timing for reordering drugs, access to the supply, use of drugs in the supply and tracking and documentation with respect to the drugs maintained in the supply;
(c) that, at least annually, there is an evaluation done by the persons referred to in clause (a) of the utilization of drugs kept in the emergency drug supply in order to determine the need for the drugs; and
(d) that any recommended changes resulting from the evaluation are implemented. O. Reg. 79/10, s. 123.

Findings/Faits sayants :

1. The licensee failed to comply with section 123 (a) of the O. Regulation 79/10 in that only drugs approved by the Medical Director in collaboration with the pharmacy service provider, the Director of Nursing and Personal Care and the Administrator are kept in the emergency drug supply.

2. August 16 2011, inspector #134 examined the home's Garden Walk unit medication room. It was noted that 38 blister pack cards of residents discontinued antibiotics were being kept for emergency drug supplies.

3. The home's emergency drug supply list was reviewed. It was noted that the discontinued antibiotic medication were not on the approved emergency drug list.

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 in regards to the home's emergency drug supply, and to ensure that only drugs approved for this purpose by the Medical Director in collaboration with the pharmacy service provider are kept in the emergency drug supply, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following subsections:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits sayants :

1. The licensee failed to comply with section 129 (1)(a)(ii) of the O. Regulation 79/10 in that medication cart were not kept locked at all times and has failed to comply with section 129 (1)(b) in that the controlled substances are not stored in a separate locked area within the locked medication cart.

The licensee failed to comply with section 129 (1)(a) of the O. Regulation 79/10 in that medication cart were not kept locked at all times and has failed to comply with section 129 (1)(b) in that the controlled substances are not stored in a separate locked area within the locked medication cart.

• On August 16 at 11:30, on the Garden Walk unit, inspector #134 observed the RPN walk away from his/her medication cart on three occasions while he/she went to administer medication to three different residents without locking the medication cart. The medication cart was not in the RPN's eyesight at these times.

• On August 17 at 11:50, on the Heritage House unit, inspector #117 observed the RPN walk away from his/her medication cart on three occasions while he/she went to administer medication to three different residents without locking the medication cart. The medication cart was not in the RPN's eyesight at these times.

• On August 23 2011 at 14:30, inspector #117 noted that Oxazepam, a controlled substance, for an identified resident, is kept in a blister pack in a drawer of the medication cart and was not double locked.

• On August 16 2011, on Heritage House unit, inspector #117 observed 8 blister packs of Lorazepam, a controlled substance, for 8 different residents kept in the medication cart, in a drawer, and were not double locked.

• On August 16, 2011, at 14:55 inspector #150 observed SDZ-Lorazepam 4mg/ml 8 vials, a controlled substance, was stored in the non locked medication fridge in the medication room on Old Mill Place unit.

• On August 16, 2011 at 14:55, on Old Mill unit, inspector #150 observed 2 blister packs of Lorazepam, a controlled substance, for one resident kept in the medication cart, in a drawer, and were not double locked.

• On August 16, 2011 at 11:30h and 13:30h on Garden Walk unit, inspector #134 observed two blister packs of Lorazepam, a controlled substance, for two residents kept in the medication cart, in a regular drawer, and were not double locked.

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 in regards to ensuring that drugs are stored in a medication cart that is secured and locked; and that controlled substances are stored in separate locked area within the locked medication cart, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following subsections:

s. 136. (2) The drug destruction and disposal policy must also provide for the following:
1. That drugs that are to be destroyed and disposed of shall be stored safely and securely within the home, separate from drugs that are available for administration to a resident, until the destruction and disposal occurs.
2. That any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs.
3. That drugs are destroyed and disposed of in a safe and environmentally appropriate manner in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
4. That drugs that are to be destroyed are destroyed in accordance with subsection (3). O. Reg. 79/10, s. 136 (2).

Findings/Faits sayants :

1. The licensee failed to comply with section 136(2) (1 and 2)of the O.Regulation 79/10 as it relates to the storage of controlled substances to be destroyed.

2. Two blister pack cards of discontinued controlled substance medications, awaiting destruction, were observed to be in an open basket, on the counter of the Garden Walk medication room. These controlled substances were not double locked.

3. On August 16, 2011, 38 blister pack cards holding discontinued antibiotics, prescribed for different residetns, were not destroyed once the residents' treatments were discontinued.The discontinued medications were instead placed in the emergency drug cupboards for future use.

4. The 38 blister pack cards were observed to have the residents names and prescriptions on them. These were crossed out and were labeled "stock".

Issued on this 31st day of August, 2011

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

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LYNE DUCHESNE (117), CAROLE BARIL (150), COLETTE ASSELIN (134)
Inspection No. / No de l'inspection :	2011_034117_0020
Type of Inspection / Genre d'inspection:	~~Annual~~ Resident Quality Inspection (RQI)
Date of Inspection / Date de l'inspection :	Aug 9, 10, 11, 16, 17, 24, 26, 30, 31, 2011 + Aug 15-18-19-23-25-29 2011
Licensee / Titulaire de permis :	ALMONTE GENERAL HOSPITAL 75 SPRING STREET, ALMONTE, ON, K0A-1A0
LTC Home / Foyer de SLD :	FAIRVIEW MANOR 75 SPRING STREET, ALMONTE, ON, K0A-1A0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	~~RAY TIMMONS~~

To ALMONTE GENERAL HOSPITAL, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, 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). and S.131 (2) → see WN #1 in Report.

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance with s. 131 (1) and 131 (2) to ensure that no drug is administered to a resident without a prescription and that drugs are administered to residents in accordance with the direction for use specified by the prescriber. In particular, this plan shall address the review and revision of the home's Drug Administration policies in relation to the non compliance noted above, with a particular focus on clarifying medication administration times.

Further, the plan shall include regulated nursing staff training to ensure medication policies and procedures as well as drug documentation standards are followed. Finally the plan must include quality improvement activities to ensure these changes are monitored and implemented successfully within the set deadline.

This plan must be submitted in writing to inspector Lyne Duchesne at 347 Preston St, 4th Floor, Ottawa, ON, K1S 3J4 or by fax at (613) 569-9670 on or before the 16th of September, 2011. Full compliance with this order shall be by December 2, 2011.

Grounds / Motifs :

1. 1. The following findings show the licensee did not comply with section 131 (1) and section 131 (2) of the O.Regulation 79/10 as it relates to the prescription and administration of drugs.

The home's policy, dated January 2007 and titled Drug Administration Times # V1-J-10.26, specifies that routine times are scheduled for the administration of medication. Medication given:

Daily to be given at 10:00 or 19:00
BID 10:00 and 19:00
TID 10:00, 14:00 and 19:00
QID 08:00, 12:00, 16:00 and 20:00.

It is also a well established practice that the medication can be administered 1 hour prior to or 1 hour after from the directions specified by the prescriber. It is also noted that the home does not have an HS (bedtime) medication policy.

• On August 15, 2011, at 12:00 the inspector # 134 observed an identified resident, receive his/her anxiolitic medication. This medication is ordered TID, to be given at 10:00, 14:00 and 19:00. As per the Medication Administration Record (MAR) sheet, the medication was administered at 10:00 and 12:00 on the day shift. Since the medication was given at 12:00 instead of 14:00, it was not given as per prescriber order.

• On August 15, 2011, a resident was ordered medication drops QID. This treatment was administered at 10:00, 12:00, 17:00 and 19:00. The order for the medication drops was not administered as per home's policy of QID times of 8:00-12:00-16:00-20:00 in line with prescriber directions.

• A resident's order for ophtalmic medication is ordered to be instilled TID. The MARS was reviewed and the medication is being administered at 10:00, 12:00 and 17:00 instead of 10:00-14:00-19:00 as per home's policy related to TID times.

• A Resident has an order for a neuroleptic/anti-psychotic medication every am, supper and qHS. The resident is receiving his/her medication at 10:00, 17:00 and 19:00. The 19:00 hour dose is being given 2 hours after the supper dose, raising concerns regarding HS / bedtime medication. Interviewed evening charge RN stated to inspectors that HS means bedtime and is typically given between 20:00-22:00.

• A new resident has an order for a cardiac medication QID. The MARs indicates he/she is to be administered the medication at 10:00, 12:00, 17:00 and 19:00. The resident is not receiving his/her medication according to home's routine QID time schedule of 8:00-12:00-16:00-20:00.

• A resident has an order for a narcotic medication TID. The MARs indicates he/she is to receive the narcotic medication at 8:00, 14:00 and 19:00. The Resident has received his/her medication at 12:00 on August 20 and at 12:10 on August 21 instead of at the prescribed time of 14:00 because he/she was complaining of hip pain.

• A resident is ordered to have an analgesic medication TID. The MAR indicates the administration times as being 10:00-12:00-19:00. The analgesic medications were not administered as per home's policy related to TID times which are 10:00-14:00-19:00.

• A resident is ordered to have an anxiolitic medication TID and antidepressant medication at supper and at bedtime time. The resident's MAR indicated that the anxiolitic medication is being given at 10:00 - 17:00 -19:00 , which is not administered as per home's policy related to TID times of 10:00-14:00-19:00. The antidepressant medication is documented as being given at 17:00 and 19:00 but not at bedtime as prescribed. The 19:00 hour dose is being given 2 hours after the supper dose, raising concerns regarding HS / bedtime medication

• A resident is ordered to have neuroleptic/anti-psychotic medication in morning and lunch and at bedtime. The MAR indicates that the administration times were changed manually, original pharmacy hours on MAR were noted as being 10:00-12:00-19:00. The time was changed manually to 10:00-14:00-19:00 and then back to

10:00-12:00-19:00. Interviewed RPN told inspector #117 that she does not know why administration times were changed.

• A resident is ordered a medication OD to be given at 10:00 as well as another medication BID to be given at 10:00 and 19:00. Unit RPN reports to the inspector #117 that they do not give the medications as ordered. The RPN states that he/she gives one of the above medication at 08:00 and the other at 10:00 but signs both as being given at 10:00.

• A resident is ordered medication and a laxative medication OD. The MAR administration time was changed for both of these medications from 10:00 to 08:00. There is no documented reason for the change of administration time and it is not being administered as per the home's policy for OD administration time.

The home's policy "Self Administration of Medication", # VI-J-20.00, dated January 2007 indicates the following: "If a physician deems it appropriate, he/she will ensure that there is a written physician's order on the resident's chart indicating the med to be self administered the amount of the med to be given to the resident and any special instructions."

• A resident has a medical order, dated January 12, 2011, indicating that the resident can self administer his/her HS medication. The medical order does not specify which medication is to be self administered.

• A review of the resident's health care record indicates that the resident does not have any identified HS medication.

• Two RPNs stated to the inspector #117 that the resident has six (6) medications prescribed to be given at 19:00. The RPNs stated that they leave two out of six prescribed medications to be self administered at HS. The other four are given at 19:00. The resident's Medication Administration Record (MAR) indicates that all six medications are signed as being given at 19:00.

• On May 27 2011, an RPN noted that the identified resident had 4 tablets of one medication and 2 tablets of another in his/her locked bedside drawer. These had been signed in the MAR as being given.

• A former resident was diagnosed as having ongoing constipation issues. The resident's bowel management interventions included daily laxative medications. The home's bowel management protocol was used when the former resident did not have bowel movements for several days.

• The former resident's health care record documents that he/she received a non prescribed medication as a bowel management intervention on November 27 and 28 2010, on December 2, 4 and 9 2010. The resident did not have a medical order for this non prescribed medication.

(117)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 02, 2011

REVIEW/APPEAL INFORMATION / RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Ave. West
Suite 800, 8th floor
Toronto, ON M4V 2Y2
Fax: 416-327-760

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

and the

Director

c/o Appeals Clerk
Performance Improvement and Compliance Branch
55 St. Clair Avenue, West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2

Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

Issued on this 31st day of August, 2011

Signature of Inspector / Signature de l'inspecteur : Lyne Duchesne Carole Baril

Name of Inspector / Nom de l'inspecteur : LYNE DUCHESNE - Carole Baril - Colette Asselin

Service Area Office / Bureau régional de services : Ottawa Service Area Office