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
Mar 19, 2018	2018_674610_0002	034022-16, 006189-17, 017613-17, 017732-17, 026650-17, 026687-17, 027239-17, 000200-18, 001575-18, 002945-18	Critical Incident System

Licensee/Titulaire de permis

peopleCare Inc.
650 Riverbend Drive Suite D KITCHENER ON N2K 3S2

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

peopleCare Oakcrossing London
1242 Oakcrossing Road LONDON ON N6H 0G2

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

NATALIE MORONEY (610)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): February 2, 5, 6, 7, and 8, 2018.

The following Critical Incident System (CIS) report inspections were conducted concurrently

during this inspection:

CIS #2980-000037-17/Log #000200-18 related to falls prevention and management
CIS #2980-000016-17/Log #016123-17 related to falls prevention and management
CIS #2980-000035-16/Log #029260-16 related to falls prevention and management
CIS #2980-000017-17/Log #017613-17 related to falls prevention and management
CIS #2980-000016-17/Log #016123-17 related to falls prevention and management
CIS #2980-000035-16/Log #029260-16 related to falls prevention and management

CIS #2980-000029-17/Log #026650-17 related to allegations of resident to resident sexual abuse
CIS #2980-000032-17/Log #027239-17 related to allegation of resident to resident physical abuse
CIS #2980-000044-16/Log #034022-16 related to allegation of resident to resident physical abuse
CIS #2980-000037-16/Log #029262-16 related to allegations of resident to resident physical abuse
CIS #2980-000030-17/Log #026650-17 related to allegations of resident to resident physical abuse
CIS #2980-000006-17/Log #006189-17 related to allegations of resident to resident physical abuse
CIS #2980-000039-17/Log #031809-16 related to allegations of resident to resident physical abuse

CIS #2980-000018-17/Log #017732-17 related to medication incidents
CIS #2980-000004-18/Log #002945-18 related to medication incidents
CIS #2980-000002-18/Log #001575-18 related to medication incidents

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Resident Care, Assistant Director of Care, Registered Nurses, Office Manager, Registered Practical Nurses, Personal Support Workers, Environmental Service Manager, Practical Nursing Students, Housekeeper, Clinical and Leadership Nurse, and residents.

Inspector also observed medication rooms, resident care provision, resident and staff interactions, medication administration, medication storage areas, reviewed relevant resident clinical records, relevant policies and procedures, meeting

minutes, and observed general maintenance and cleanliness of the home.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **6 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 LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. 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. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

The licensee has failed to ensure that any person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director; Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

The home submitted a Critical Incident System (CIS) reports to the Ministry of Health and Long Term Care (MOHLTC): regarding an allegations of abuse from one resident to another resident that resulted in one of the resident having a significant change in status.

Another CIS report was sent regarding an incident from a resident to another resident for allegations of abuse. Review of documentation showed one resident received an injury as a result of the incident.

The licensee policy Mandatory Reporting reference #003400.00 stated in part to immediately initiate the online mandatory Critical Incident System (MCIS)/phone the after hours pager upon becoming aware of abuse of a resident by anyone.

During an interview, the DOC stated that they were aware of the incidents but had not reported the incidents off alleged abuse immediately.

The licensee has failed to ensure that any person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

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 any person who has reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director; Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm, to be implemented voluntarily.

WN #2: 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. (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 :

The licensee has failed to ensure that all staff have received retraining annually related to the following:
The Residents' Bill of Rights, home's policy to promote zero tolerance of abuse and neglect of residents, duty to make mandatory reports under section 24 and the whistle-blowing protections.

The home's policy Abuse and Suspected Abuse/Neglect or a Resident Reference #005010.00 stated in part that staff training on zero tolerance of abuse and neglect will take place during orientation and be reviewed annually.

During an interview with the DOC, a review of the staff annual mandatory education for prevention of abuse and neglect for 2017, showed that not all of the nursing staff received the education.

A staff member stated they had not received Prevention of Abuse and Neglect training since 2016 and was not able to tell the inspector the different types of abuse and definitions.

During a telephone interview, the Environmental Service Manager said that staff training for Prevention of Abuse and Neglect was last completed in 2016 and that none of their staff had received the annual mandatory education for 2017.

The Administrator stated that it was the home's expectation that all staff would receive retraining annually related to Prevention of abuse and neglect and this was not completed in 2017.

The licensee has failed to ensure that all staff have receive retraining annually related to the Resident's Bill of Rights, home's policy to promote zero tolerance of abuse and neglect of residents, duty to make mandatory reports under section 24 and the whistle-blowing protections. [s. 76. (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 all staff have receive retraining annually related to Residents' Bill of Rights, home's policy to promote zero tolerance of abuse and neglect of residents, duty to make mandatory reports under section 24 and the whistle-blowing protections, to be implemented voluntarily.

WN #3: 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 has failed to 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.

Documentation was completed for a resident that showed a resident had not been receiving medication as prescribed as the medication for the controlled substance was unaccounted for.

The homes policy Medication Incident Reporting Reference #011110.00stated in part that immediate action was to be taken in the event of a medication incident and events were to be recorded and analyzed.

The DOC acknowledged that they were made aware of a missing controlled substance for a specific resident but did not report the incident of the missing controlled substance immediately to the MOHLTC.

Inspector reviewed a specific resident's documentation and noted two further medication incidents were identified related to a missing controlled substance for that specific resident.

The DOC stated that they were not aware of these two incidents and that medication incident reporting had not been completed.

The licensee has failed to 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) for a missing or unaccounted for controlled substance. [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 to 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, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 126. Every licensee of a long-term care home shall ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. O. Reg. 79/10, s. 126.

Findings/Faits saillants :

The licensee has failed to ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed.

The Inspector had observed medication carts in the home and noted that there was medication without a pharmacy label and it was not possible to identify which resident the medication was prescribed to.

The nursing staff said that they were responsible for labelling the medication, when removing them from the labelled pharmacy box, and before being placed into the medication cart and that nursing staff were not following this procedure and that the labels were not provided by the pharmacy.

The ADOC observed the medication and told the inspector that the pharmacy was to send the labels for the medication pens and the labels would be placed in the plastic sleeve in the medication rooms for the nursing staff to apply. The ADOC agreed that the pharmacy had not sent the labels and that the medication were not being labelled with the client identifiers.

The Administrator acknowledged that medication would be individually labelled, and was working with the pharmacy to have the medication labelled individually before being delivered to the home.

The licensee has failed to ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. [s. 126.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A) A specified resident was provided a medication that had been placed on hold by the prescriber, was not receiving a medication as prescribed as the medication was unaccounted for, and received a medication that was not prescribed and another that had been expired.

The homes policy Medication Incident Reporting Reference #011110.00 stated in part that immediate action was to be taken in the event of a medication incident and events were to be recorded and analyzed.

The DOC acknowledged that they were made aware, of a missing controlled substance for the specified resident and that they were not aware of the other medication incidents and that medication incident reports had not been completed.

B) CIS report was submitted to the MOHLTC by the home, related to a medication incident that occurred to a specific resident that was administered medications that were not prescribed.

The specific resident had a change in condition and was transferred out of the home for an assessment.

The specific resident was admitted back to the home, following an adverse reaction to a medication.

The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber for resident #001 and #004. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 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. (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 has failed to ensure that every medication incident involving a resident and every adverse drug reaction was documented, together with a record of the

immediate actions taken to assess and maintain the resident's health; and 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. In addition, the licensee failed to ensure that all medication incidents and adverse drug reactions were documented, reviewed and analyzed; corrective action was taken as necessary and to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that had occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, any changes and improvements identified in the review are implemented, and a written record was kept of everything provided.

Documentation was completed for a specific resident regarding a medication that was not being provided as prescribed. The home submitted a CIS report for the missing controlled substance ten days after the incident had occurred.

The DOC acknowledged that they were made aware of the missing controlled substance and they had not taken immediate action.

Further review of the specific resident’s documentation showed two further medication incidents and a missing controlled substance.

The homes policy Medication Incident Reporting Reference #011110.00 stated in part that immediate action was to be taken in the event of a medication incident and the events were to be recorded and analyzed.

The DOC said that there was no completed medication incident report in risk management or appropriate documentation that the Director of Nursing and Personal Care, the Medical Director, or the pharmacy service provider had been immediately notified or notified at all.

The DOC verified that the professional advisory committee (PAC) meeting was held and they did not review the medication incidents that occurred in the home from October to December 2017. [s. 135. (1)]

2. The licensee has failed to ensure 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, any changes and improvements identified in the review are implemented, and a written record is kept of everything provided.

The homes policy Medication Incident Reporting Reference #011110.00 stated in part that all medication incidents and adverse drug reactions are documented reviewed and analyzed and corrective action was to taken and that the pharmacy provider, the Long Term Care Home and physician was to be involved with the review and analysis.

The Inspector completed observations of the medication rooms, medication carts, medication administration, and medication incident reporting on controlled substance, and documentation for medication administration on the electronic medication administration record (eMAR).

A review of the homes Professional Advisory Committee (PAC) meeting minute's documentation showed that the quarterly medication incidents were not reviewed as they could not "pull the incidents" and that they had an increase in number of "medication errors" and "possibly in reporting".

The Pharmacy services provide pharmacy report for the quarter review showed that from October to December, 2017, medication incidents had not been reviewed as the report was pending. The medication incidents were not reviewed and analyzed.

The homes policy Medication Incident and Reporting Reference #011110.00 showed that the "data regarding medication incidents were reviewed at the medication safety meetings quarterly or prior if required at the discretion of the Director of Care" and "data regarding medication adverse consequences and errors will be complied and presented at the PAC by the Clinical Pharmacist on a quarterly basis".

The licensee could not provide a statement that the management team supports the effective medication management program in the home at the time of inspection.

The DOC stated that they had a meeting but did not review the medication incidents for the quarter.

The Clinical Lead Nurse (CLN) stated they are working on a plan to ensure that a quarterly review was undertaken of all medication incidents that have occurred in the home in order to reduce and prevent medication incidents and adverse drug reactions, as well as trending and analysis as an interdisciplinary team.

The licensee has failed to ensure 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, any changes and improvements identified in the review are implemented, and a written record was kept of everything provided for in clause and failed to ensure that every medication incident involving a resident and every adverse drug reaction was documented with a record of the immediate actions taken to assess and maintain the resident's health and that incidents were not reported to the appropriate persons as described in O.Reg. 79/10, s. 135. [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 and every adverse drug reaction was documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and 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. In addition, the licensee failed to ensure that all medication incidents and adverse drug reactions were documented, reviewed and analyzed; corrective action was taken as necessary, to be implemented voluntarily.

Issued on this 10th day of April, 2018

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

Original report signed by the inspector.