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
Feb 15, 2018	2018_520622_0004	020964-17, 021064-17, 025863-17, 026611-17	Complaint

Licensee/Titulaire de permis

THE GLEBE CENTRE INCORPORATED
950 BANK STREET OTTAWA ON K1S 5G6

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

GLEBE CENTRE
950 BANK STREET OTTAWA ON K1S 5G6

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

HEATH HEFFERNAN (622)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): February 6, 7, 8, 9, 12, 13, 2018

The following logs were included in this inspection: Log 026611-17, Log 025836-17, 021064-17 (complaints related to resident care), Log 020964-17 (complaint related to alleged staff to resident abuse and resident care).

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Human Resources, the Director of Care, the Manager of Nursing Care Operations, the Physician, the Dietician, Registered Practical Nurses, Personal Support Workers, resident family and the residents.

The inspector conducted a tour of the home, reviewed a resident's health records, home policies and procedures related to Medication Administration # 9-06 dated revised 2008 and Resident abuse and Neglect #RC 08.03.02 dated reviewed January 2018, reviewed observed the delivery of resident care and services, including resident-staff interactions.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Dining Observation
Hospitalization and Change in Condition
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

O. Reg. 79/10, s. 114 (1) indicates that every licensee of a long-term care home shall develop an interdisciplinary medication management system that provides safe medication management for residents.
O. Reg. 79/10, s. 114 (2) indicates that the licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate administration of all drugs used in the home.

A review of the complaint intake log #026611-17 indicated that during a visit on a specified date, resident #001 had complained the soup was bitter. The complainant had observed resident #001's medication had been placed in their soup instead of being administering to them by the Registered Practical Nurse (RPN) in applesauce. The complainant indicated resident #001 was not being assisted with their food by staff which included the medication.

A review of the homes policy and procedure titled; Medication Administration - the medication pass; Number # 9-06 and dated revised 2008 indicated on page 2 of 2 the following;

- Give medications to the resident yourself, watch carefully to make sure he/she swallows them.
- Never leave the resident's side until you are sure the medication has been taken.

On February 2, 2018 during an interview with inspector #622, the complainant indicated during their last visit on a specified date, resident #001's soup was on their table and there were no staff assisting the resident. The complainant indicated that resident #001 complained that the soup was bitter. Furthermore, the complainant indicated they tasted the soup, agreed it was bitter and asked the Registered Practical Nurse (RPN) about the bitterness of the soup. The complainant indicated the RPN informed them that resident #001's medication had been added to the resident's bowl of soup.

On February 6, 2018 inspector #622 observed RPN #101 leaving the medication room with a plastic pouch used for crushing medications containing a crushed medication. RPN #101 approach the serving table and added the medication from the plastic pouch to a cup of fluid. RPN #101 delivered the cup of fluid to resident #002 leaving it on the table in front of the resident in the dining room. PSW #100 approached the resident #002 approximately ten minutes later to assist them with their meal. PSW #100 reported to RPN #101 that resident #002 had finished the fluid with the medication in it.

On February 7, 2018, inspector #622 observed RPN #102 administering medications and noted the following:

- RPN #102 delivered resident #003's medication which included two medication cups; one with pills and a second with a liquid to resident #003 at the dining room table. After leaving the medication at resident #003's table, RPN #102 left the area as resident #003 was taking their pills. Resident #003's liquid medication remained on the table while two co-residents entered the room and sat at the same table. The RPN returned to the dining room approximately 3 minutes later.
- RPN #102 was observed to pour 1 cup of resource; a prescribed nutritional supplement and placed the cup at a table setting where resident #004 was absent. Another resident #005 was sitting at the same table within access of the cup. RPN #102 continued to administer medications throughout the dining room and entered the charting room for a short period of time, out of eye sight of the resource.

- RPN #102 was observed taking two separate medication cups from the medication cart. RPN #102 approached a table with two residents and placed one cup of medication at the table in front of resident #006 and placed the second cup in front of resident #007 at a separate table. RPN #102 returned to the medication cart and started pouring other residents medications. Resident #007 was noted to get up from the table and go into

another room briefly, the medication was still on the table within reach of two other residents during resident #007’s absence. RPN #102 did not monitor or ensure that the resident's had taken their medication.

During an interview with inspector #622 on February 6, 2018, RPN # 101 indicated that that she crushes resident #002’s medication, adding it to the resident’s drink. RPN #101 indicated she leaves the drink with concealed medication at the resident’s table and PSW staff monitor and report to her whether or not resident #002 had consumed the drink with the medication concealed.

During an interview with inspector #622 on February 7, 2018, RPN #102 indicated it was fine to leave medication unattended on a resident’s dining room table if the resident was cognitively well. RPN #102 also indicated that when residents are of a particular ethnic background, they may prefer to take their medications after their meal so the medication would be left on the table. RPN #102 further indicated that resident #007 was cognitively well, their medications are left on the table for them. RPN #102 indicated she was aware that resident #007 may leave the dining room while the medications are left on the table. RPN #102 also indicated she was aware that there are other cognitively unwell residents in that dining room and that she should have witnessed the medications being taken by each of the residents.

During an interview with inspector #622 on February 07, 2018, Director of Care (DOC) #106 indicated that medication should never be left with the resident unattended, there are a lot of residents who are cognitively unwell who could pick the medication up. DOC #106 further indicated the medications in the above mentioned observations should not have been left with the residents, it does not fit with the homes policy. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where the Act or 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 related to Medication Management, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, is complied with, to be implemented voluntarily.

Issued on this 15th day of February, 2018

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

Original report signed by the inspector.