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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 20, 2016	2016_381592_0010	008286-16	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

MONTFORT
705 Montreal Road OTTAWA ON K1K 0M9

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

MELANIE SARRAZIN (592), ANGELE ALBERT-RITCHIE (545), JOANNE HENRIE (550), LINDA HARKINS (126), LISA KLUKE (547)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 2, 3, 4, 5, 6, 9, 10, 11, 12, 13 and 16, 2016

During the course of this inspection, the inspector(s) also conducted, two Critical Incidents inspections Log#: 034196-15 (fall resulting in a transfer to hospital), 010112-15 (injury resulting in a transfer to hospital) and six Complaints inspections Log#: 002058-16 (staff to resident abuse), 033760-15 (skin care), 033044-15 (staff to resident abuse), 030727-15, (staff to resident abuse), 013099-16, (care of resident), 013706-16, (care of resident) and follow-up of CO Log#: 000814-16 (Medication Administration).

During the course of the inspection, the inspector(s) spoke with The home's Administrator,The Assistant Administrator, Director of Care (DOC), the Assistant DOC (ADOC), the Clinician Nurse, the Documentation Manager/RAI Coordinator, the Resident/Family Services Coordinator, the Activity Director, Recreational assistants, the Environmental Manager, an Environmental Services Worker, the Registered Dietitian, Food Services Supervisor, Dietary aids, Registered Nurses (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), Office Manager, President of Resident's Council, the President of Family Council, Residents and Family Members.
In addition the inspection team, conducted a tour of the Resident care areas, reviewed Residents' health care records, home policies and procedures, staff work routines, posted menus, observed Resident rooms, observed Resident common areas, reviewed the Admission process and Quality Improvement system, reviewed Residents' Council and Family Council minutes, observed a medication pass, observed several meal services, and observed the delivery of Resident care and services

The following Inspection Protocols were used during this inspection:

Accommodation Services -
Housekeeping Continence Care and
Bowel Management Dignity, Choice and
Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Resident Charges
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **13 WN(s)**
- **5 VPC(s)**
- **1 CO(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 failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have procedures, the licensee was required to ensure that the following policy and procedure was complied with: Management of Concerns/Complaints/Compliments, LP-B-20, revised October 2014. (Log #002058-16)

As per section 21 of the Act, every licensee of a long-term care home shall ensure that there are written procedures that comply with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints.

On page 3 of the home's Management of Concerns/Complaints/Compliments policy and procedure, it was indicated that the Executive Director would ensure that CSR (Client Service Response form: LP-B-20) would be readily available to all staff. Under the section "Verbal Concerns/Complaints it was documented that:

"If concerns cannot be resolved immediately at point-of-service, the individual who is first aware of a concern will initiate the CSR form. A copy of the form as it is initially completed will be forwarded to the Executive Director. The original form will be forwarded to the member of the team who will be responsible for the resolution of the concern" (item 4)

"The CSR form will be completed in full and all actions taken during the investigation will be documented. The CSR is then filed in the complaints management binder" (item 7)

The following complaints were submitted to the Director concerning the care of residents and the operation of the home on a specified unit:

Resident #041's family member reported that on one instance as he/she was walking by resident #044's bedroom, on his/her way to his/her parent's bedroom, heard PSW #123 and PSW #124 screaming and yelling in a dialect from the resident's bedroom, and out of concern for the resident who was crying, the visitor entered the room to check on the situation, then the yelling stopped.

Resident #041's family member reported having observed on one instance, PSW #124 refusing to bring a resident exhibiting anxiety behaviours back to his/her bedroom after supper, and telling the nurse that she would bring the resident back to his/her room, but

only after she had finished cleaning the dining room tables.

Resident #041's family member reported having observed on several instances PSW #123 treating residents on the unit like objects, and being abrupt in her approach with the residents.

The family member indicated that the above complaints had been reported to the nurse in duty and/or the Director of Care.

In a review of the home's Complaints Management Binder, the above complaints were not found.

During an interview with the Director of Care (DOC), she indicated that she was aware of the above complaints as they had been reported by the family members on a specified day in December 2015 and in January 2016. She indicated that investigations of the incidents were conducted by her and documented on progress notes, then filed in the staff member's personal file. She confirmed that it was the home's expectation that a Client Service Response form: LP-B-20 (CSR) be completed for each complaint, including verbal complaints, further added that she had not completed one for the above complaints, as per the home's policy. [s. 8. (1) (b)]

2. The licensee has failed to ensure that Registered Nursing Staff in the home comply with the policy and procedures related to medication administration.

Compliance order #001 was issued on November 30th, 2015 under inspection #2015_286547_0021 for not following their policies regarding Medication Administration, Management of Narcotic and Controlled Drugs and Self-Administration of Medication.

As part of the compliance order, the licensee was required to provide re-education to all registered nursing staff on the home's most current Medication Administration policies and procedures by reviewing the following:

-Medication administration management
-Narcotic and controlled drugs administration management
-Resident self-administration of medication management, and
-The College of Nurses of Ontario Practice Standard related to Medication Administration.

The licensee was also required to develop and implement a process to ensure ongoing monitoring of the management of medication administration, storage of medications and resident self-administration of medications methods, in partnership with the home's pharmacist.

Upon a review of the list of employees who received re-education on the home's most current Medication Administration policies and procedures with the actual number of registered staff employed in the home as of March 31, 2016, Inspector #550 observed that 31 out of 34 registered staff received the education. The Director of Care indicated to the inspector that the 3 staff members who not did not receive the re-education work the night shift and were unable to come during the daytime for the training.

Inspector reviewed the home's audit process in place to ensure ongoing monitoring of the management of medication administration, storage of medications and resident self-administration of medications methods. In their plan of correction, the home indicated different managers and the Regional Manager Clinical Support were to perform four different audits at a set interval: weekly for one month, bi-monthly for one month and then monthly. It was observed by the inspector that the System audit was not carried out as scheduled in March 2016 and the Detailed Medication Administration Audit was not carried out as scheduled in February and March 2016.

It is noted that this area of non-compliance related the not following the home's policy and procedure regarding ''Self-Administration of Medications'' was previously left as a Voluntary plan of correction for the 2014 RQI and a Compliance Order #001 in 2015 RQI. As part of this inspection, three areas of non-compliance were also issued regarding the Medication Management System under written notification #11, #12 and #13. [s. 8. (1) (b)]

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:

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

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; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the care related to nutritional status and eating set out in the plan of care was provided residents #049 and #050 as specified in their plan of care.

Resident #049 was diagnosed with dementia and severe cognitive impairment and according to the most recent assessment, the resident required total assistance of staff with feeding. It was documented that the resident was able to drink thicken fluid independently using a nosey cup to prevent choking. Note that a nosey cup is a glass with a cut out for the nose so a person can drink without tipping the head back or extending the neck.

On May 2, 2016 Inspector #545 conducted a dining observation at lunch time on a specified unit.

The Inspector observed resident #049 being fed by a PSW , while sitting at the table. The PSW fed the fluids to the resident from three small regular plastic glasses observed on the table, one with water, another with milk and a third one with apple juice. There was no nosey cup in view. On May 10, 2016 at breakfast, the Inspector observed resident #049 being fed by PSW #111, who indicated that the nosey cup was used for the thickened apple juice only, and gave the nosey cup to the resident who brought the glass to the mouth and took several sips and finished the entire glass unassisted. The PSW then indicated that she would assist the resident with the milk and water, and that the resident was not required to use the nosey cup for the apple juice.

Resident #050 was diagnosed with Alzheimer's with moderate cognitive impairment and according to the most recent assessment the resident required extensive assistance of one staff with feeding. In a review of the resident's plan of care, it indicated that the resident was intolerant to a specific food , but that it would be acceptable if the food was cooked in a recipe.

On May 2, 2016 at lunch time, Inspector #545 observed a PSW offering resident #050 with two meal options. The resident could not make an option and the meal containing the intolerant food was provided. By 1245, when most residents had left the dining room, the Inspector observed resident #050 sitting at the table with his/her plate untouched. PSW #102 came by, removed the plate and served the resident two toasts with jam.

Dietary Aide #112 confirmed that the meal provided to resident #050 was containing the food which resident #050 plan of care indicated as being intolerant. He indicated that he was not aware of any food restrictions for resident #050. PSW #100 and #102 later indicated that they were not aware of any dietary restrictions to this resident. After reviewing the Kardex in the dining room, the PSW confirmed that it was indicated that the resident was intolerant to that specific food and that the meal containing that food should not have been offered to the resident.

During an interview with the home's Dietitian, she indicated that residents who were prescribed thicken fluids in a nosey cup should be fed all fluids using the nosey cup, including resident #049. She also indicated that resident #050, should not have been offered the meal containing the food which resident #050 was identified as having intolerance on May 2, 2016 at lunch, as the main ingredient was the intolerant food.

As such, resident #049 and #050's care related to nutritional status and eating set out in the plan of care was not provided as specified in their plan of care. [s. 6. (7)]

2. The licensee has failed to ensure that resident #003 was reassessed and the plan of care reviewed and revised when the resident's urinary continence care needs changed and the care set out in the plan was no longer effective to keep the resident dry and clean.

Resident #003 was admitted to the home on a specified date in 2015 with several diagnoses including dementia.

On May 3, 2016 Inspector #545 noted a strong offensives odor of urine from resident

#003 when the resident entered the solarium on a specified unit. Resident #003 was observed to be incontinent of urine several times during the day in his/her bedroom and bathroom floor.

Inspector #547 reviewed resident #003's health care records and noted that a continence assessment was completed last year on a specific date in March 2015 that indicated that the resident was continent, but required total assistance to take the resident to the bathroom every two hours and to provide perineal care. On a specified day in June 2015 the continence assessment indicated that the resident is continent and independent. This assessment was re-evaluated again in September and November 2015 to indicate the resident's continence status was unchanged and that the resident continued to be continent and independent. No continence assessment for 2016 to date was located by RN #101 in the resident's chart.

RN #101 in charge of resident #003's unit regularly indicated to Inspector #547 that resident #003 is able to get to the bathroom on his/her own and that he/she follows his/her own routine. RN #101 indicated that he/she sometimes is incontinent on the floor in the bathroom as part of his/her dementia.

PSW #100 indicated to Inspector #547 that she is one of the resident's primary Psw and that the resident is often incontinent on the floor in his/her room, up to three times a day. PSW #100 indicated that it is almost like the resident cannot hold it any longer, and he/she starts to dribble on his/her way to the bathroom on the floor. PSW #100 has begun to try several options, however not successful for resident #003. The resident's shoes have been identified as having significant urine odor. These shoes are made with leather and urine has been embedded into the resident's shoes when dribbling down the resident's legs and cannot be washed as they are leather.

The ADOC indicated to Inspector #547 that the home expects the registered nursing staff to complete a continence assessment when there is a change in the resident's urinary care needs reported from the PSW's. The ADOC indicated the nursing staff are required to update resident #003's plan of care and implement a toileting program around the resident's patterns and to assess the resident for possible infection when a change from the previous assessment is noted. The ADOC indicated that resident #003 is more than occasionally incontinent and that she was surprised this has not been reassessed and definitely no longer continent or independent. [s. 6. (10)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that care for resident #049, #050 and #003 is provided as specified in their plan of care and review and revised the plan of care when the resident's needs change, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishing and equipment are kept clean.

On May 3, 4 and 12, 2016, Inspector #592 observed several unlabelled urine hat collectors left on the floor and on top of toilet tanks. The bottom of the urine hat collectors were observed with dry yellow/brown matter in shared washrooms in several specified rooms.
A tube of medicated cream was observed left on top of the yellow/brown matter inside of the urine hat collector in a specified room.

On May 12, 2016, in an interview with PSW #108 and #110, they both told Inspector #592 that the urine hat collectors were used to obtain a urine sample from the residents but were not able to identify the urine hat collectors observed in the rooms above as they were not labelled with any resident identifier. They further told Inspector #592 that the urine hat collectors are usually brought back after the urine sample is taken from the residents to the dirty utility room in order for them to be disinfected by the PSW on night shift. PSW #108 and #110 confirmed with Inspector #592 that the urine hat collectors left in residents room were soiled and had to be removed from the resident's washroom as they were not clean to collect urine.

On May 12, 2016, in an interview with the DOC, she told Inspector #592 that the urine hat collectors were send to the dirty utility room to disinfect them, once the urine sample was obtained from the resident. She further told Inspector #592, that it was not sanitary to leave soiled urine hat collectors in resident's washrooms and that there was high chances of having the urine sample contaminated. [s. 15. (2) (a)]

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 urine hat collectors furnished by the home are kept clean, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #002's bed rails were assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

Resident #002 had several medical conditions including Alzheimer's with severe cognitive impairment and requirement total assistance for all activities of daily living, and assessed as high risk for falls.

On May 3, 2016 at 1517, Inspector #545 observed resident #002 lying in bed making spastic movement to lift his/her upper body in a space of approximately 14 inches, between a raised half bed rail placed at the center of the bed and a small three drawer dresser placed against the mattress at the head of the bed. In trying to get up, the resident's head was observed within inches of the corner of the dresser, potentially causing injury. The resident's arm was wedged between the bed rail and the mattress. A fall mat was observed on the floor by the bed as well as a bed alarm pinned to the resident's shirt at the shoulder level. The Inspector activated the call bell immediately and within minutes, PSW #117 entered the room. She immediately moved the small dresser away from the resident's bed, then repositioned the resident using two pillows and indicated that she would get the resident up after staff would be done with the report. PSW #117 indicated that she was surprised that the resident's bed alarm had not been activated when the resident was lifting his/her upper body and his/her head was observed between the gap of the bed rail and the dresser. Five minutes later, the PSW returned to the room with PSW #118 and RPN #119 and they indicated to the Inspector that the small dresser was placed against the bed by the resident's spouse as he/she

feared the resident falling out of bed.

A review of the resident's health record was done by Inspector #545. As per the most recent assessment, it was indicated that full bed rails on all open sides of bed were used daily, as well as half bed rails. In a progress note dated on a specified date in March 2016 it is indicated that the resident was found with his/her left arm stuck between the bars of the bed rail and it was believed that a skin laceration to his/her arm was caused rubbing on the rail, the note indicated that the spouse was notified of the incident. On a specified date in April 2016, a note indicated that the resident's spouse requested that the rails be removed, and a physician's order was received to discontinue the bed rails. On a specified date in April 2016, in a progress note it was documented that a PSW reported that the resident's feet were caught between the bed rail and the mattress, causing a risk of injury. On a specified date in May 2016 a note was documented to indicate that the resident's bed could not be lowered.

In a review of the resident's bed assessment (Arbre decisionnel pour l'utilisation des ridelles de lit et d'équipments de rechange, LTC-K-10 Appendix A), it was documented that resident #002 was last assessed on a specified date in February 2015 and based on that assessment the resident required two half bed rails, a posey alarm and bed at the lowest level.

During interviews with staff members, it was noted that the term "raise" and "lower" was used to describe the status of the bed rails. In the most recent plan of care, it was indicated that both bed rails were to be raised. The physician's order on a specified date in April 2016 indicated to keep the bed rails lowered at the request of the spouse. RN
#101 and RPN #119 indicated that when the bed rails were raised, it meant they were raised towards the head of the bed in a quarter position, therefore not in use, and when lowered, they were in use. They both indicated that the terms "raised" and "lowered" were confusing and that in fact, the bed rails should have been discontinued when ordered by the physician on the specified date in April 2016.

PSW #100 indicated that when the resident's arm was injured, she remembered that the resident's spouse requested that the bed rails be removed. She added that for a short time, the bed rails were not used, then later noticed that the bed rails were in use again, to prevent the resident from falling out of bed.

The Director of Care indicated that the resident's bed system was not re-evaluated post incidents where the resident's left arm and feet were caught in the bed rail and/or

between the bed rail and mattress. She indicated that she would immediately have the bed rails removed and direct staff and family to not move the small dresser against the bed, for the resident's safety. [s. 15. (1) (a)]

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 each resident's bed rails are assessed and the bed system evaluated to minimize the resident's risk, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

A review of the Residents' Council minutes was done by Inspector #545. Residents expresses concerns at several meetings, where there was no evidence of written responses from the licensee.

December 29, 2015 meeting:
-Snacks not being provided to residents and when provided, often done at variable times
-Requesting that their beds be made properly
-Complaining that the call bells at night were too loud and waking residents as staff taking too long to respond
-Chair armrests are soiled

February 16, 2016
-Requesting an IMAX outing
-Requesting purchase of glass display for residents to display their work of arts such as painting, knitting
-Complaining that the call bells at night were too loud and waking residents as staff taking too long to respond, requesting that the DOC attends the next meeting to address these issues
-Requesting that the home's physician have more availability to the residents

March 15, 2016
-Requesting that staff be more quiet during mass, and if a sign could be posted as reminder
-Complain that the chairs were often soiled

During an interview with Assistant to the Residents' Council #127, he indicated that the licensee did not respond in writing to the Council's concerns or recommendations.

The Administrator confirmed during an interview that it was not her practise to respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

This area of non-compliance was previously left as a written notification in the 2015 RQI. [s. 57. (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 to respond within 10 days of receiving Residents' Council advice any related concerns or recommendations, to be implemented voluntarily.

WN #6: 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).

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); 2007, c. 8, s. 85. (4).
(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; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(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 saillants :

1. The licensee has failed to seek the advice of the Family Council in developing the satisfaction survey.

The president of the Family Council indicated during an interview that the Administrator

had informed the council that the survey would be sent out from head office sometime in June 2016. She further indicated that the licensee did not seek their advice in developing this satisfaction survey.

The Administrator indicated during an interview that the home's Satisfaction Survey was developed centrally by Revera and that the advice of the Family Council was not sought out in its development. She further told Inspector #592 that she will contact Revera for further instructions but that there was no plan made between now and June 2016 to seek the family advice in developing the satisfaction survey. [s. 85. (3)]

2. The licensee has failed to seek the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results.

A review of the Residents' Council minutes was done by Inspector #545 and there was no evidence to demonstrate that the licensee had seek advice of the council.

Assistants to the Residents' Council #127 and #128, indicated to Inspector #545 that the licensee did not seek the advice of the Council in developing and carrying out the satisfaction survey, and in acting on its results.

The Administrator indicated during an interview that the home's Satisfaction Survey was developed centrally by Rivera and that the advice of the Residents' Council was not sought out.

This area of non-compliance was previously left in the 2014 RQI as a written notification and as a voluntary plan of correction in the 2015 RQI. [s. 85. (3)]

3. The licensee has failed to make available to the Residents' Council the results of the satisfaction survey in order to seek the advice of the Council about the survey.

Assistants' to the Residents' Council # 127 and # 128 indicated to Inspector #545 that the results of the satisfaction survey was not made available to the Council in order to seek their advice.

The Administrator indicated that the results of the 2015 Satisfaction Survey were posted in the staff room and on the second floor, but the results were not made available to the Council in order to seek their advice.

This area of non-compliance was previously left in the 2015 RQI as a voluntary plan of correction. [s. 85. (4) (a)]

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 Resident and Family Council in developing the satisfaction survey and to make the results of the satisfaction survey available fort he residents, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that they complied with their written policy to promote zero tolerance and neglect of residents.

The home's policy on Prevention of Abuse and Neglect of a Resident titled " Integrite Des residents-Ontario Policy # LP-C-20-ON last revised on September 2014".

This policy stated the following definitions of abuse as:

"Psychologique- tout gestes, acte, comportment, remarque visant a menacer, a insulter, a intimider ou a humilier, y compris l'isolement social impose, l'evitement, le fait d'ignorer, le manque de reconnaissance ou l'infantilisation provenant de toute personne autre qu'un resident". Examples included the following: "le non-respect de la vie privee et l'obstruction au processus de prise de decision".

"Verbal-toute forme de communication verbale visant a menacer ou a intimider ou toute forme de communication verbale visant a diminuer ou a degrader et qui porte atteinte au sentiment de bien-etre, de dignite ou d'estime de soi d'un resident, si la communication est faite par toute personne autre qu'un resident". Examples included the following: " ton de voix inapproprie, commentaires ou gestes brusques".

This policy stated on page 4 of 14 that the mandatory reporting requirements included the following:

-"Tout employe qui a des motifs raisonables de soupconner un cas d'abus ou de negligence envers un resident doit immediatement signaler ce soupcon et l'information s'y rattachant au directeur executif de l'etablissement.
-" Le personnel doit se referer au Algorithme des evenements indesirables graves[LP- C-40-Annexe A] au moment de signaler un incident".
-" Declarations obligatoires en vertu de la Loi sur les foyers de soins de longue duree (Ontario): Article 24(1) de la Loi sur les foyers de soins de longue duree stipule que toute personne ayant un doute raisonable d'un incident de mauvais traitement existant ou possible doit faire un signalement au directeur".

This policy stated on pages 5 and 6 of 14 that the following interventions were required as stated on page 5/14:
- "Il faut premierement prendre les mesures raisonnables necessaires pour assurez la securite, le confort et le bien-etre immediats de toute victime de mauvais traitements et par la suite effectuer des evaluations exhaustives, en determinant les besoins du resident et en etablissant un plan documente afin de repondre a ces besoins".

- "Toute situation ou la securite des residents ou d'autrui n'est pas en peril doit etre signalee suivant les directives du corps de police local, c.-a-d., autre que les services d'urgence 911."

- "Aussitot qu'il a connaissance d'un incident [presume, soupconne ou observe de maltraitance ou de negligence ayant occasione une blessure physique ou de la douleur a un resident, ou un etat de detresse nuisible a la sante ou au bien-etre d'un resident, l' etablissement en informe le decideur substitut du resident (s'il y a)ou toute autre personne nommee par ce dernier".

This policy stated on pages 6 and 7 of 14 that the the following areas for investigation

require:

"- Une enquete immediate et comprehensive sur la declaration ou temoignage de l'abus presume, soupconne ou observer sera entamee par le DE de l'etablissement ou le responsable designe par ce dernier. Certaines ressources (La trousse pour mener une enquete sur une allegation de mauvais traitements et des conseils pour les enquetes effectuees par une tierce partie) peuvent s'averer utiles lors d'une enquete.
- Le resident, son decideur substitut ou toute autre personne nommee par le resident seront informes de la tenue de l'enquete.
- Le resident ou son decideur substitut (s'il y a) seront informes des resultats de l'enquete des sa conclusion".

On May 3, 2016 resident #035 told Inspector #547 during the resident interview, that the last Fall, a Personal Support Worker(PSW) went into his/her room in the middle of the night and approached him/her speaking loudly. Resident #035 indicated he/she remembered he/she was not quite awake at the time and that the PSW asked the resident to get up abruptly in her voice again. Resident #035 indicated that he/she tried to tell the PSW that he/she could not get up on his/her own because his/her legs were sore. Resident #035 then indicated that the PSW took his/her legs abruptly and swung them around and pulled the resident's arm to have him/her stand up. Resident #035 indicated that he/she was afraid at that point and thought he/she better follow the PSW's requests as he/she was not listening to him/her anyway.

Resident #035 then reported this incident to the DOC the next morning as soon as he/she saw her and the resident also told his/her family member who is the home's main contact for the resident. Resident #035 did not know what happened after he/she reported this to the DOC, but it had not occurred again.

Resident #035 was admitted to the home on a specified date in 2015.
Resident's health care records indicated that the resident is alert and oriented to time, place and person.

Inspector #547 interviewed the DOC on May 9, 2016 regarding resident #035 that reported to her that he/she was mistreated by a PSW in the home last Fall. The DOC recalled this conversation with resident #035 and indicated that at the time resident #035 reported this to her, that she understood this to be a need to change the residents plan of care regarding sleep preferences and she did not associate this as abusive. On a specified day in October 2015 during the resident's annual care conference, the resident

and his/her family member mentioned this incident once again to those attending this meeting including the nursing clinician of the home. The nursing clinician then brought this to the DOC's attention after the care conference on a specified day in October 2015 and then she began her investigation with PSW #129.The DOC provided Inspector #547 notes from PSW #129's file that indicated what the DOC recalled from her discussion with resident as the following:

1. The PSW was not listening to him/her when he/she tried to tell the PSW this is not his/her usual routine.

The DOC indicated to inspector #547 that she addressed this with PSW#129 in their meeting on a specified date in October 2015 regarding the importance of listening to resident's verbal requests and to observe non verbal signs with residents regarding their rights and the home's values.

2. The resident stated to the DOC, that he/she felt "Bouscule" as in old movies regarding old age homes where the residents were mistreated.

The DOC indicated to inspector #547 that she addressed this with PSW #129 in their meeting on October 26, 2015 regarding the home's code of conduct and the home's code of ethics that was to be reviewed by PSW #129.

The DOC indicated that she did not think this meant resident #035 was abused however now upon review of her documentation , the DOC indicated that she did not try to clarify with the resident, what his/her thoughts and feelings were related to this incident after it was reported at the resident's care conference. The DOC further indicated that she did not call the resident's family member to clarify this incident as part of her investigation or to any other staff working with PSW #129.

On May 6, 2016 Inspector #547 interviewed the resident's family member on the telephone, who also recalled this incident with PSW #129 as he/she indicated that this incident still bothered the resident to this day. The resident's family member indicated that the resident can recall every detail to this day from that incident as it marked him/her. The resident's family member indicated that he/she did not have any contact with the home after the resident's care conference related to this incident, and hoped that this PSW received added training.

On May 9, 2016 Inspector #547 interviewed the home's nursing clinician who attended

the resident care conference on a specified date in October 2015 and indicated that she recalled this report of suspected abuse of the resident by a staff member, and that she reported it right after the conference to the DOC. The nursing clinician indicated that it was evident that the resident and the resident's family member were upset and concerned about this incident.

The DOC indicated that she did not report this alleged, suspected, reported abuse of resident #035 to the Director.
The DOC indicated that she did not report this incident to any local police force.
The DOC indicated that she did not report this to the resident's family member, who was the main contact for the resident in the home, that the DOC indicated is called at any time there is a change in the resident's care.
The DOC further indicated that she did not have any documentation to assist in reminding her that she had met with resident #035 or any call to the resident's family member regarding the conclusion of her investigation and training that was provided to PSW #129. [s. 20. (1)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that, (a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any. (Log #013706-16)

During an interview, the substitute decision maker for resident #046 indicated to Inspector #550 that he/she has not met with the interdisciplinary team since his/her family member was admitted on a specified date in March 2016. He/she indicated there is a meeting scheduled on a specified date in May 2016 but he/she would have liked to have met the team sooner.

During an interview, the Director of Care confirmed to the inspector that the post admission care conference for resident #046 that is scheduled on a specified date in May 2016 should have been done within 6 weeks of the resident's admission. [s. 27. (1) (a)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis.

On May 3, 5 and 6, 2016, Resident #004 was observed by Inspector #592 and #545 with long facial hairs covering his/her chin.

On May 6, 2016, the Resident's spouse told Inspector #592 that he/she was concern about the facial hairs covering his/her spouse, as his/her spouse was a proud person and would of not tolerate to have long facial hair on his/her face.

The current plan of care for Resident #004 indicated that the resident required total assistance with personal hygiene. The current plan of care further indicates that resident is being provided with a bath twice a week and that resident #004 has received a bath on May 2, 2016.

On May 6, 2016, in an interview with PSW #103 assigned to the resident, she told Inspector #592 that resident #004 was totally depending on staff for personal hygiene (including shaving) and indicated that the home's expectation was to provide shaving to residents on their shower/bath days and as needed on the other regular days. PSW #103 told Inspector #592 that resident was provided a bath this week by one of the assigned bath PSW and that she did not noticed that facial hairs were covering the resident's chin but that she will remove them later this morning.

On May 6, 2016, in an interview with the DOC, she told the Inspector that all the residents are being provided individualized personal care, including shaving and that resident #004 facial hairs should have been removed by PSW's. [s. 32.]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that planned menu items were offered and available at each meal.

The Daily and Weekly menus posted for Tuesday, May 10, 2016 indicated that fruit yoghurt was to be offered to residents.

Inspector #545 observed breakfast on all four units in the home and yoghurt was not offered to any residents. The fridge in all four kitchenette was verified and yoghurt was not found.

During an interview with Dietary Aides #112 and #113 indicated that there was no yoghurt available. They both indicated that the delivery of food items was expected later in the morning. Dietary Aide #112 confirmed that he worked on the weekend and that there was no yoghurt in neither fridges on the first floor.

The Food Services Supervisor indicated that it was the home's expectation that if a food item was not available, an alternative was provided and changes were made to the menu. She indicated that she was not aware that there was no yoghurt available on any of the units and after checking the main kitchen's fridge, confirmed that none was available in the home. [s. 71. (4)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home. O. Reg. 79/10, s. 114 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home. (Log #013706-16)

The family member of resident #046 indicated to Inspector #550 that the resident is receiving a specific medication in the form of a patch that is to be applied in the morning and the old patch is to be removed before the application of the new patch. He/she indicated that during his/her visits, he/she had found two patches on his/her family member on two different occasions (in March and May 2016).

During an interview, the Director of Care indicated that she was made aware that the resident was found with two patches on his/her body on a few occasions. She indicated the resident is often agitated and wont' let staff examine his/her body to remove the old patch. It is her expectation in this situation that staff document the incident in the progress notes and in the medication administration record. Inspector #550 requested to review the home's policy for the administration of medication that are dispensed via patch and after verification with the Corporate office and the pharmacy provider the Director of Care indicated to the inspector that they do not a have a policy for the administration of medication dispensed in the form of a patch.

As evidenced above, the licensee does not have a written policy and protocols in place as part of their medication management system to ensure accurate administration of all drugs in the home.

An order is being issued under s. 8. (1) related to the policy and procedures related to medication administration. [s. 114. (2)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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 O. Reg. 79/10, s. 129 (1).
(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 saillants :

1. The licensee has failed to ensure that drugs are stored in an area or a medication cart,
. 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 (e.. Expiration dates, refrigeration, lighting).

During an observation of resident #032's room, inspector #550 and the DOC observed on top of the resident's night table beside his/her bed, a tube of medication and a jar of prescribed cream. The pharmacy label on the tube of medication was dated April 26, 2016 and indicated the name of the resident with directions for application. The pharmacy label on the jar of prescribed cream was dated April 14, 2016 and indicated the name of the resident with directions for application.

The Director of Care indicated to the inspector the resident is not supposed to keep any medication at bedside as he/she does not have a physician order to support this. All his/her medication are to be kept locked in the medication cart. The DOC removed both medication and gave them to the nurse and indicated to keep the medication in the medication cart.

As evidence above, the licensee did not ensure that the medicated creams for resident #032 were stored in the medication cart or in an area that is secured and locked.

An order is being issued under s. 8. (1) related to the policy and procedures related to medication administration. [s. 129. (1) (a)]

WN #13: 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 are administered to residents in accordance with the directions for use specified by the prescriber.

On May 10, 2016 at 1237, Inspector #550 observed the administration of insulin to resident #040 by RN #122. The resident was sitting in the dining room eating his/her meal and was administered insulin subcutaneous (s/c) in the arm. At the time of the administration, the resident had a few spoonful of Sheppard's pie and coleslaw left to eat; he/she had consumed 90% of his/her meal and was still eating.

Upon a review of the physician order's in the resident's health records, the inspector observed the following order for insulin dated on a specified date in April 2016:

Insulin (identified name and type), give specified units subcutaneous before breakfast, specified units subcutaneous before lunch and specified units subcutaneous before supper.

During an interview, the RN was not aware the physician order indicated to administer the insulin before meals, she indicated she always administer insulin to all residents after they have started eating to make sure they eat.

2. During an interview with RN #122, she told Inspector #550 that resident #032 was self-administering a cream during the evening before bed.
During an interview with resident #032, he/she indicated to the inspector and the DOC that staff will fill the applicator with the cream and give it to him/her so he/she can self-administer.

Inspector reviewed the resident's health care records and observed the following physician order dated on a specified date in January 2016 for the medicated cream:

Medicated cream, apply specified mg at bedtime three times a weeks then two times a week at bedtime. Please administer for the resident.
As such, the insulin for resident #040 and the medicated cream for resident #032 were not administered in accordance with the directions for use specified by the prescriber.

An order is being issued under s. 8. (1) related to the policy and procedures related to medication administration. [s. 131. (2)]

Issued on this 15th day of June, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MELANIE SARRAZIN (592), ANGELE ALBERT-RITCHIE (545), JOANNE HENRIE (550), LINDA HARKINS (126), LISA KLUKE (547)
Inspection No. / No de l'inspection :	2016_381592_0010
Log No. / Registre no:	008286-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	May 20, 2016
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	MONTFORT 705 Montreal Road, OTTAWA, ON, K1K-0M9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Kelly Boisclair

To REVERA LONG TERM CARE INC., 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) (a)

Linked to Existing Order / Lien vers ordre existant: 2015_286547_0021, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee will:
1. Review their medication management system to ensure policies and procedures are developed and/or implemented specifically regarding:
• the application and removal of medications dispensed in the form of a transdermal patch
• the safe storage of drugs, and,
• the administration of drugs to residents in accordance with the directions for use specified by the prescriber

2. Provide education to all registered nursing staff on the policies and/or procedures that will be developed and implemented as listed above.

Furthermore, as specified from the previous order CO #001 issued on November 30th, 2015 under inspection #2015_286547_0021, the licensee will provide education to all registered nursing staff of the following:
• Narcotic and controlled drugs administration management
• Resident self-administration of medications management and,
• The College of Nurses of Ontario Practice Standard related to Medication Administration.

3. Establish a monitoring process to ensure of the newly implemented policies and procedures are applied to achieve compliance through the home.

This monitoring process as specified from the previous order CO #001 issued on November 30th, 2015 under inspection #2015_286547_0021, must be carried out in accordance with the established schedule.

Grounds / Motifs :

1. The licensee has failed to ensure that Registered Nursing Staff in the home comply with the policy and procedures that are put in place.

Compliance order #001 was issued on November 30th, 2015 under inspection #2015_286547_0021 for not following their policies regarding Medication Administration, Management of Narcotic and Controlled Drugs and Self-Administration of Medication.

As part of the compliance order, the licensee was required to provide re-education to all registered nursing staff on the home's most current Medication Administration policies and procedures by reviewing the following:

-Medication administration management
-Narcotic and controlled drugs administration management
-Resident self-administration of medication management, and
-The College of Nurses of Ontario Practice Standard related to Medication Administration.

The licensee was also required to develop and implement a process to ensure ongoing monitoring of the management of medication administration, storage of medications and resident self-administration of medications methods, in partnership with the home's pharmacist.

Upon a review of the list of employees who received re-education on the home's most current Medication Administration policies and procedures with the actual number of registered staff employed in the home as of March 31, 2016, Inspector #550 observed that 31 out of 34 registered staff received the education. The Director of Care indicated to the inspector the 3 staff members who not did not receive the re-education work the night shift and were unable to come during the daytime for the training.

Inspector reviewed the home's audit process in place to ensure ongoing monitoring of the management of medication administration, storage of medications and resident self-administration of medications methods. In their plan of correction, the home indicated different managers and the Regional Manager Clinical Support were to perform four different audits at a set interval: weekly for one month, bi-monthly for one month and then monthly. It was observed by the inspector that the System audit was not carried out as scheduled in March 2016 and the Detailed Medication Administration Audit was not carried out as scheduled in February and March 2016.

It is noted that this area of non-compliance related the not following the home's policy and procedure regarding ''Self-Administration of Medications'' was previously left as a Voluntary plan of correction for the 2014 RQI and a Compliance Order #001 in 2015.

2. The licensee has failed to ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and

disposal of all drugs used in the home. (Log #013706-16)

The Family member of resident #046 indicated to Inspector #550 that the resident is receiving a prescribed medication in the form of a patch that is to be applied in the morning and the old patch is to be removed before the application of the new patch. The family member indicated that during his/her visits, he/she had found two patches on his/her family member on two different occasions (Specified date in March and May 2016).

During an interview, the Director of Care indicated that she was made aware that the resident was found with two patches on his/her body on a few occasions. She indicated the resident is often agitated and wont' let staff examine his/her body to remove the old patch. It is her expectation in this situation that staff document the incident in the progress notes and in the medication administration record. Inspector #550 requested to review the home's policy for the administration of medication that are dispensed via patch and after verification with the Corporate office and the pharmacy provider the Director of Care indicated to the inspector that they do not a have a policy for the administration of medication dispensed in the form of a patch.

As evidenced above, the licensee does not have a written policy and protocols in place as part of their medication management system to ensure accurate administration of all drugs in the home.

3. The licensee has failed to ensure that that 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 (e.g. expiration dates, refrigeration, lighting).

During an observation of resident #032's room, inspector #550 and the DOC observed on top of the resident's night table beside his/her bed, a tube of medicated cream and a jar of prescribed cream. The pharmacy label on the tube of the medicated cream was dated April 26, 2016 and indicated the name of the resident with directions for application. The pharmacy label on the jar of the prescribed cream was dated April 14, 2016 and indicated the name of the

resident with directions for application.

The Director of Care indicated to the inspector the resident is not supposed to keep any medication at bedside as he/she does not have a physician order to support this. All his/her medication are to be kept locked in the medication cart. The DOC removed both medication and gave them to the nurse and indicated to keep the medication in the medication cart.

As evidence above, the licensee did not ensure that the medicated creams for resident #032 were stored in the medication cart or in an area that is secured and locked.

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

On May 10, 2016 at 1237, Inspector #550 observed the administration of insulin to resident #040 by RN #122. The resident was sitting in the dining room eating his/her meal and was administered insulin, subcutaneous (s/c) in the right arm. At the time of the administration, the resident had a few spoonful of sheppard's pie and coleslaw left to eat; he/she had consumed 90% of his/her meal and was still eating.

Upon a review of the physician order's in the resident's health records, the inspector observed the following order for insulin dated April 12, 2016:

Insulin (name and type), give specified units subcutaneous before breakfast, specified units subcutaneous before lunch and specified units subcutaneous before supper.

During an interview, the RN was not aware the physician order indicated to administer the insulin before meals, she indicated she always administer insulin to all residents after they have started eating to make sure they eat.

During an interview with RN #122, she told Inspector #550 that resident #032 was self-administering a prescribed cream during the evening before bed. During an interview with resident #032, he/she indicated to the inspector and the DOC that staff will fill the applicator with the prescribed cream and give it to him/her so he/she can self-administer.

Inspector reviewed the resident's health care records and observed the following physician order dated on a specified date in January 2016 for the medicated cream:

Prescribed cream, apply specified mg at bedtime three times a weeks then two times a week at bedtime. Please administer for the resident.
As such, the insulin for resident #040 and the prescribed cream for resident #032 were not administered in accordance with the directions for use specified by the prescriber.
(550)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 22, 2016

REVIEW/APPEAL INFORMATION

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 Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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 and the Director

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
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.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON M5S-
2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 20th day of May, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Melanie Sarrazin

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