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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 8, 2017	2017_655679_0008	001713-17	Resident Quality Inspection

Licensee/Titulaire de permis

VALLEY EAST LONG TERM CARE CENTRE INC.
689 YONGE STREET MIDLAND ON L4R 2E1

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

ELIZABETH CENTRE
2100 Main Street Val Caron ON P3N 1S7

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

MICHELLE BERARDI (679), ALAIN PLANTE (620), JENNIFER LAURICELLA (542), LOVIRIZA CALUZA (687), STEPHANIE DONI (681)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 10-14, and 17-21, 2017.

Additional logs inspected during this RQI included:

-One Follow-Up log, regarding compliance order #001, issued during inspection #2017_638609_0009, regarding s. 20, complying with the homes zero tolerance of abuse and neglect policy;
-Eight Complaints submitted to the Director related to the care of residents;
-Three critical incidents submitted to the Director related to resident falls;
-Four critical incidents submitted to the Director related to concerns regarding administration of medication/medication management system; and
-One critical incident submitted to the Director related to allegations of staff to resident abuse;

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Co-Director(s) of Care, Food Services Manager (FSM), Registered Dietitian (RD), Environmental Services Manager, Physiotherapist, Staffing Coordinator, Falls Prevention and Management Lead, Special Project Nurse (SPN), Restorative Care Lead, Infection Prevention and Control Lead, Life Enrichment Coordinator, Administrative Assistant, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), family members and residents.

The inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, and reviewed numerous licensee policies, procedures, and programs.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
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
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 20. (1)	CO #001	2017_638609_0005	679

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. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (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 has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

Inspector #687 reviewed a Critical Incident (CI) report submitted to the Director. The CI report described that resident #020 had a fall on a particular day that resulted in a significant change, requiring the resident to be admitted to the hospital. The fall resulted in an injury.

A review of the Centric Health Physiotherapy note identified that resident #020 was assessed as being at a particular risk for falls, with a particular score on a specific assessment.

Inspector #687 reviewed the current electronic care plan, which indicated that resident #020 was at a particular risk for falls related to a number of factors.

In an interview with restorative care staff #130, they disclosed to the Inspector that they were not aware of the assessment done on a particular day, nor the change of the fall risk category for resident #020. They further stated that they did not receive any communication from the physiotherapist and did not read the progress notes indicating the change in resident #020's fall risk category.

Inspector #687 interviewed the Special Project Nurse (SPN) #129 with regards to updating care plans for falls prevention.The SPN stated that the staff member conducting the assessment should have revised the care plan. Special Project Nurse #129 also stated that any change in the care plan of any resident is documented under the progress notes. [s. 6. (4) (a)]

2. During a staff interview with Inspector #679, RPN #117 identified that resident #013 sustained an injury after a fall on a particular day.

Inspector #542 completed a health care record review and noted that it was documented in the progress notes that the resident had sustained falls over a number of months, and then again on a particular day, which resulted in an injury.

Inspector #542 reviewed the physiotherapy assessments located on Point Click Care (PCC). An assessment by the Physiotherapy department, indicated that resident #013 scored a particular number on a specific assessment, indicating that the resident was at a particular risk for falls. An additional assessment was completed on a specific date, after resident #013 had sustained an injury. The second assessment indicated that the resident was at a particular risk for falls.

Inspector #679 reviewed the current electronic care plan which indicated that the resident was at a specific risk for falls.

In an interview with Inspector #542, the Fall Prevention lead indicated that the Prevention of Falls Committee included the PT and restorative care team, as well as other members, and that they collaborate to incorporate interventions to prevent residents from falling. They recognized that there was a lack of communication between the team members. They stated that they were unaware that resident #013's fall risk had changed.

Inspector #542 interviewed Physiotherapist (PT) #128 who was responsible for completing the assessments for resident #013. Physiotherapist #128 indicated that they had completed the assessments; however, they did not communicate the change in risk

level to the rest of the Fall Prevention committee team members, nor did they update the care plan to reflect that the resident was changed to a specific risk for falls based on the assessment. [s. 6. (4) (a)]

3. During a record review by Inspector #620, resident #011 was identified as exhibiting altered skin integrity.

Inspector #620 reviewed resident #011's clinical record and determined that the presence of resident #011's altered skin integrity was first identified by staff on a particular day, in a progress note which indicated that the resident was exhibiting altered skin integrity to a specific part of the body. On a particular day, a skin/wound assessment documented in Point Click Care (PCC) indicated that the residents altered skin integrity was on a specific part of their body. Subsequent to the staff's discovery of the wound, on a number of occasions over the course of several months staff assessed the altered skin integrity as being on a particular part of their body, and on a number of occasions staff assessed the wound as being present on a different part of the residents body.

Inspector #620 reviewed a Prescriber's Order Form. The form ordered staff to initiate, "Wound care protocol to a particular body part…". A second Prescriber's Order Form again ordered staff to initiate, "Wound care protocol to the same body part…". A third Prescriber's Order Form , advised staff to continue with the wound care protocol to the same particular part of the resident's body until the Physician assessed the wound.

Inspector #620 reviewed a Physician Medication Review. Under the medication treatment section of the form, resident #011 was designated with having altered skin integrity to a particular body part and a prescribed treatment; the documentation within the treatment section was manually altered to indicate that the altered skin integrity was healed. Adjacent to the designation of the wound and it's treatment, the form advised that the order was to be discontinued.

Inspector #620 reviewed two assessments completed by Co-Director of Care (Co-DOC) #124; the Co-DOC also served as the home's Wound Care Lead. On a particular day Co-DOC #124 competed a wound assessment in PCC using the assessment instrument titled, "Wound Assessment and Treatment". Within the assessment the Co-DOC described the altered skin integrity to a particular part of the residents body. A second assessment documented by the Co-DOC indicated that the resident had altered skin integrity to the same particular part of the body.

A review of resident #011’s plan of care revealed an intervention that advised staff to, “Follow facility protocol/regime for treating altered skin integrity"

Inspector #620 interviewed PSW #142 who indicated that the resident had altered skin integrity on a particular part of their body and that it had always been on that part of their body. They stated that the resident never had altered skin integrity to the alternate part of their body. In an interview with RPN #141 they also revealed that the resident never had the presence of altered skin integrity to a different part of their body.

Inspector #620 interviewed the home’s Co-DOC #124 who indicated that they were the Wound Care Lead for the home. The CO-DOC indicated that the resident never had altered skin integrity to the alternate part of their body. They indicated that the orders for the treatment indicated treatment to a specific part of the residents body; however, the treatment orders should have advised staff to treat another part of the residents body. They indicated that a mistake had been made as it related to the residents altered skin integrity. [s. 6. (4) (a)]

4. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A staff interview by Inspector #679 revealed that resident #013 experienced an injury. A record review by Inspector #542 identified that resident #013 experienced a fall on a particular day that resulted in an injury.

A review of the electronic care plan by Inspector #542, indicated that the resident had specific devices as interventions to prevent falls.

On a particular day, Inspector #542 observed resident #013 in their bed, without the devices in place to prevent falls.

On a separate occasion, Inspector #542 interviewed PSW #120 who indicated that resident #013 had the devices the day prior, but they were "unable to find them today"; therefore, the resident did not have these interventions in place.

Inspector #542 interviewed restorative team member #130 who verified that both of the devices were implemented after resident #013 had sustained an injury and that these interventions were to be in place. Restorative care team member #130 stated that they would ensure that the resident had these devices. [s. 6. (7)]

5. Inspector #687 reviewed a Critical Incident (CI) report submitted to the Director. The CI report outlined that resident #021 sustained a fall, on a particular day, resulting in an injury.

Inspector #687 reviewed resident #012's electronic care plan, in place at the time of the fall. The care plan identified a specific device as an intervention to prevent falls. The device was to be in place when the resident was in their chair.

In an interview with resident #021, they stated to Inspector #687 that they were unable to remember the fall incident.

Inspector #687 spoke to RPN #134 who validated that they were working on that particular day. During an interview with RPN #134, they verified that resident #021 was brought back to their room. RPN #134 verified that resident #021 did not have their device on but that they were uncertain about another device when resident #021 was brought back into their bedroom. [s. 6. (7)]

6. Inspector #679 reviewed a complaint submitted to the Director which alleged that RPN #135 left medications unattended on resident's dressers.

In an interview with the DOC, they identified that this concern was brought forward to them on a particular day, by SPN #129. It was identified that RPN #135 left the medications unattended with resident #032.

In a review of resident #032's electronic Point Click Care record, Inspector #679 identified specific instructions related to the administration of medication.

A review of the policy entitled: "Resident Rights, Care and Services- Medication Management- Administration of Medications", last revised July 20, 2017, identified that "At the time of medication administration, the Registrant will: remain in attendance until the medication is taken".

In an interview with the DOC they identified that RPN #135 received coaching in regards to leaving medications unattended with residents. [s. 6. (7)]

7. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the

resident's care needs changed or care set out in the plan was no longer necessary.

Inspector #620 reviewed a complaint received by the Director. The complainant described concerns about the care that resident #016 received. They also indicated that they were not being kept aware of resident #016's health status.

Inspector #620 reviewed a pain assessment completed on a particular date. The assessment noted that resident #016 exhibited pain related symptoms. The assessment then described the pain. Under the heading of pain site the assessor indicated that the resident was identified as having an altered health condition. The assessment noted that the resident had an altered health condition and that staff were to utilize interventions to keep the resident comfortable.

Inspector #620 reviewed a progress note documented on a particular day, by RN #140. The note stated that an individual requested update on resident's condition from writer. Writer informed the individual that resident had an alteration in their health status, however staff continue to encourage particular interventions. The individual inquired about when the alteration in the residents health status started, informed individual it had been occurring for a number of days. Individual asking if physician has been in to see resident.

A review of resident #016's care plan revealed that there was no focus, goal, or intervention indicating that resident #016 had an altered health condition. There were no interventions indicated in the resident's care plan that identified the resident's altered health status. There was no documented assessment for a particular health concern. On a particular date the care plan was updated to include the altered health condition, and care status; however, interventions were not altered for a particular care area.

Inspector #620 interviewed the DOC who confirmed that the resident had an altered health condition; however, the plan of care had not been reviewed and altered to reflect the residents change in health status. They indicated that it should have been done when they received orders from the Physician on a particular date.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 ensuring that the care set out in the plan of care is provided to the residents #013 and #021 as specified in the plan, and that the plan of care is reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was documented, reviewed and analyzed; that corrective action was taken as necessary; and that a written record was kept.

Inspector #542 reviewed the following four CI reports that were submitted to the Director by the DOC, regarding medication incidents:

- A CI report was submitted on a particular date, due to a medication incident/adverse drug reaction, where resident #022 received an incorrect dosage of a medication.

- A CI report was submitted on a particular date, for improper/incompetent treatment of a resident that resulted in harm or risk to a resident. The CI report outlined that resident #024 was being administered a medication by resident #023. The CI report indicated that no injury was sustained; however, resident #024 did not have physician's order for the medication.

- A CI report was submitted on a particular date, for a missing/unaccounted for controlled substance. The CI report outlined that the home noted that two narcotic tablets were missing during a narcotic count on a particular date. The home's investigation identified that a nurse accidentally spilled water on the tablets, but did not report the incident nor complete the required documentation out of fear.

- A CI report was submitted on a particular date, for a missing/unaccounted for controlled substance. The CI report outlined that it was discovered that four ampuoles of a narcotic medication were found broken and empty; however, there was no documentation to support what had occurred. The home was unable to determine the cause of the broken and empty ampuoles.

Inspector #542 reviewed the home's internal medication incident reports for 2016. Inspector #542 was unable to locate any medication incident reports for any of the above medication incidents.

Inspector #542 interviewed the DOC who indicated that they could not provide a medication incident report for the four mentioned CI reports as they were most likely not completed.

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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 residents in accordance with the directions for use specified by the prescriber.

Inspector #542 reviewed a CI report which was submitted to the Director on a particular date. The CI report indicated that a medication incident/adverse drug reaction had occurred, in which resident #022 received an incorrect dosage of their medication, which resulted in a transfer to the hospital.

Inspector #542 reviewed resident #022's health care record file. The progress notes indicated that on a particular date, the resident sought medical attention due to being administered an incorrect dosage of their medication.

Inspector #542 observed a record within the resident's chart, which identified an order for the medication. The Electronic Medication Administration Record (EMAR) was also reviewed, which confirmed the order for the particular medication.

Inspector #542 interviewed the DOC, who verified that the nurse did not follow the orders as specified by the physician.

2. Inspector #620 reviewed a complaint received by the Director. The complainant alleged that their family member was on a particular medication with an accompanying specified intervention. The complainant also raised concerns about the care being provided to resident #017.

Inspector #620 reviewed a document regarding the protocol for the specified intervention related to the medication, with a revision date of June 2017. The document was signed by the Medical Director and the DOC. The protocol described the parameters for which registered staff were to administer the particular medication. The protocol identified that once this medication was administered, the specific intervention was to be initiated. Inspector #620 confirmed with the DOC that the document had not been altered since this incident occurred.

Inspector #620 reviewed a progress note documented by Registered Nurse (RN) #123. RN #123 indicated that the physicians order for the specific intervention did not get processed, therefore had not been done.

Inspector #620 reviewed an Admission Physical dated a particular date. The document listed the residents medication.

Inspector #620 reviewed resident #017's medication administration record (MAR) and identified that for a number of days over a period of time, the resident received the medication.

A review of the resident's chart revealed that the resident first had the specific intervention completed on a particular day. Resident #017 received their medication for a number of days prior to the staff being aware of the results of the specific intervention.

Inspector #620 interviewed Co-DOC #139 who indicated that if resident #017 was on a particular medication, staff were required to utilize the homes policy regarding the particular intervention. They stated that if a resident was receiving a medication without the specific intervention being completed it would be considered a medication error of omission.

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: 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 :

1. The licensee has failed to ensure that any person who had reasonable grounds to suspect that abuse or neglect of a resident by anyone had occurred, immediately reported the suspicion and the information upon which it was based to the director.

A) Inspector #679 reviewed a complaint submitted to the Director. The complaint alleged that resident #018 reported PSW #132 for being rough with care. The complainant identified that the home was made aware of this concern, but did not act on it.

In an interview with Inspector #679, DOC #126 identified that there was an incident that occurred between PSW #132 and resident #018, that was brought forth to them by a staff member.

A review of a written investigation document dated a particular dated, outlined that a staff member overheard a resident talking about the rough care provided by PSW #132.

B) Inspector #679 reviewed a complaint submitted to the Director on a particular date. The complaint alleged that PSW #133 was abusive towards residents.

In an interview with Inspector #679, DOC #126 identified that there was an incident that occurred between PSW #133 and resident #030, that was brought forth by resident #030 and individuals known to them.

A review of a written investigation documentation identified the concerns outlined by resident #030 about PSW #133.

In an interview with resident #030 on a particular date, they indicated to Inspector #679 that they did recall a staff member being rude, but could not recall the name of the staff member or any specific dates.

A review of the home's abuse and neglect policy entitled "Resident Rights, Care And Services- Abuse-Zero-Tolerance Policy for Resident Abuse and Neglect" last revised June 2, 2017, outlined that "any 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 Ministry of Health and Long Term Care: 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 the resident".

In an interview with the DOC, they identified that they did not submit a critical incident report to the Director related to either incident, but managed the incidents internally.

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 ensuring that any person who has reasonable grounds to suspect that abuse or neglect of a resident by anyone has occurred, immediately reports the suspicion and the information upon which it is based to the director, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(e) is approved by a registered dietitian who is a member of the staff of the home;
O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home’s menu cycle was approved by a registered dietitian who was a member of the staff of the home.

During interviews with Inspector(s) #542, #620 and #679, residents #008, #009, #012, #014, #025, and #026 indicated that they had concerns with their meals.

Inspector #681 reviewed the 2017 Spring/Summer menu and observed that an alternate vegetable choice that would provide one serving of vegetables as per Canada’s Food Guide was missing at lunch on nine out of 21 days.

On July 13, 2017, Inspector #681 requested the RD's review of the Spring/Summer menu; however, the home was unable to provide the documentation which indicated that the Spring/Summer menu was reviewed or approved by the home's RD prior to June 12, 2017, the day the menu was implemented.

In an interview with the home's RD, they indicated to Inspector #681 that they had completed a review of the menu in May, and that the hard copies of the menu review were provided to Food Service Manager #111.

During an interview with the Inspector, Food Service Manager #111 stated that the home did not receive RD #112's review of the Spring/Summer menu until July 13, 2017.

A review of the home’s policy titled “Resident Rights, Care, and Services – Nutrition Care and Hydration Programs – Corporate Menu Change” last updated January 15, 2017, identified that the Registered Dietitian will approve all permanent menu changes.

On July 14, 2017, FSM #111 advised the Inspector that changes to the Spring/Summer menu were being made to ensure that an alternate choice of vegetables was incorporated at both lunch and supper. [s. 71. (1) (e)]

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 ensuring that the home's menu cycle is approved by a registered dietitian who is a member of the staff of the home, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that as part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee ensured that procedures were developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces;

During a tour of the home conducted by Inspector #620 and #687 on July 10, 2017, Inspector #620 identified that the courtyard was unkempt. The Inspectors identified an ashtray that was overflowing with cigarette butts, discarded plastic cups, a large brown tarp, and number of other items of trash on the ground in the courtyard.

On a particular date, Inspector #620 was approached by an individual in the home. The individual asked the Inspector to accompany them to a courtyard. While there, the individual asked the Inspector to take note of how unkempt the courtyard was. The individual pointed out an ashtray column that was observed to be tipped over and its contents (cigarette butts, cups and cigarette cartons) spilled onto the ground. They also pointed out the brown tarp that the Inspector had observed during their initial tour of the home.

On a particular date, the Administrator and the Inspector made an observation of the courtyard and the Administrator indicated that the courtyard should not have been in such a condition and that they would ensure that the trash was removed.

On a separate occasion, the Inspector observed that the courtyard had been cleaned and the trash removed.

Over a one week period, Inspector #620 conducted daily observations of the courtyard. For each observation Inspector #620 observed that there was trash such as cigarette butts, plastic cups, and other discarded trash items on the grounds of the courtyard.

On a particular date, Inspector #620 interviewed the Maintenance Manager who told the Inspector that the home's housekeeping staff were not responsible cleaning the outdoor courtyard because outdoor areas were the responsibility of a subcontractor. They specified that there was not currently a system in place that ensured the trash in the courtyard was tended to, because it was not within the scope of the contractual agreement with the subcontractor.

On a particular date, Inspector #620 interviewed the Administrator who indicated that it was the responsibility of the licensee to ensure that the courtyard was kept clean. They indicated that they recognized that staff were using the area to smoke in; they stated that they needed to take steps to rectify the upkeep of the courtyard. [s. 87. (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 ensuring that as part of the organized program of housekeeping under clause 15 (1) (a) of the Act, procedures are developed and implemented for, the cleaning of common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(b) a sufficient supply of clean linen, face cloths and bath towels are always available in the home for use by residents; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a sufficient supply of clean linen was always available in the home for use by residents.

During the meal service on a particular day, Inspector #681 observed that a number of residents in two dining rooms did not have clothing protectors. Some residents were observed to have towels draped over their clothing while other residents were observed to be spilling food on their clothing.

PSW #118 reported to the Inspector that the particular dining room did not have clothing protectors at breakfast for at least 3 months. RPN #117 stated that staff in the dining room had been using towels or table cloths to protect resident's clothing during meals.

In an interview with the Inspector on a particular date, Environmental Services Manager #113 stated that the last linen audit, completed on a particular date, identified a shortage of clothing protectors. Environmental Services Manager #113 stated that there were 211 clothing protectors in the home on a particular date, and that an optimal number would be 390 as this would be considered a full day supply for the home.

In an interview with the Inspector, the Administrator stated that clothing protectors were ordered on a particular date, by telephone from a particular company. A follow-up email dated almost one month later, indicated that the clothing protectors were on back order and the estimated time of delivery was the end of July or beginning of August.

In an interview with the Inspector, Environmental Service Manager #113 stated that one alternate company, was contacted on a particular date, to see if they could supply a similar clothing protector. However, a response was not received from that company until one month later. A second alternate local supplier was not contacted by the home until one day after receiving the response from the initial alternate company.

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 ensuring that there is a sufficient supply of clean linen available in the home for use by residents, to be implemented voluntarily.

WN #8: 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. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).

s. 107. (5) The licensee shall ensure that the resident's substitute decision-maker, if any, or any person designated by the substitute decision-maker and any other person designated by the resident are promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be so notified. O. Reg. 79/10, s. 107 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that the names of any staff members or other persons who were present at or discovered an incident were included in the report to the Director.

Inspector #687 reviewed three CI report's submitted to the Director related to resident falls. Upon review of the CI reports it was identified that none of the reports included the names of the staff members who responded to the fall incidents.

A review of the home's Critical Incident Policy, last revised on May 5, 2017, identified that the home shall ensure that, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident: a description of the individuals involved in the incident, including, names of any staff members or other persons who were present at or discovered the incident.

2. The licensee has failed to ensure that the resident's substitute decision-maker, if any, or any person designated by the substitute decision-maker and any other person designated by the resident was promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be so notified.

Inspector #620 reviewed a complaint received by the Director. The complainant described concerns about the care that resident #016 received.

Inspector #620 interviewed the complainant who indicated that they had been advised by an individual known to a resident of the home that resident #016 had experienced a change in health status over a period of time. They indicated that when they received the information they asked RPN #116 about resident #016's health status. The complainant indicated that RPN #116 refused to provide any information to them because they were not the Substitute Decision Maker (SDM). The complainant identified that they advised RPN #116 that they were the SDM; however, RPN #116 disagreed and refused to provide any information to them.

A review of resident #016's paper chart identified a document title, "Consent Directives to Sharing Assessment Data." The document required the SDM to provide consent for the sharing of assessment data and the sharing of assessment data with service providers other than the Long-Term Care Home. The SDM named on the document was the complainant and the document was signed and dated by the complainant on a particular date.

A review of resident #016's PCC profile revealed that the complainant was designated as the SDM and to be the first contact for notification of resident #016's health status.

Inspector #620 reviewed a progress note documented by RPN #116 on a particular date which stated that the staff member did not have a chance to call the POA (also known as the SDM) regarding the residents health status. The progress note went onto explain that resident #016's SDM indicated that they had been advised of the residents change in status over a period of time. It was documented that the complainant identified that the SDM designation was not correctly applied in the home's plan of care. RPN #116 documented that they spoke to the Resident and Family Services Coordinator and discovered that the complainant was in fact the SDM.

Inspector #620 interviewed RPN #116 who indicated that they were a full time RPN on the unit in which resident #016 resided. They noted that they were aware that resident #016's health status had changed over a period of time. RPN #116 denied calling the SDM to notify them of the resident's significant change in health status.

Inspector #620 interviewed the Resident and Family Services Coordinator who indicated that they recalled an alteration of the SDM status for resident #106. They provided the Inspector with a progress note that had been documented on a particular date. The progress note stated that all information was to be provided to the complainant.

Inspector #620 interviewed resident #016's initial SDM who indicated that they had been told by the complainant that they were having a difficult time retrieving information related to resident #016's health status. The initial SDM advised that on at a number of occasions they had to call the home to reinforce that the complainant was to receive information related to resident #016's health status as they had been appointed as a SDM.

Inspector #620 interviewed the DOC who indicated that they were unaware that health status information was being withheld from the complainant (SDM). They indicated the change in health status exhibited by resident #016 should have been reported to the complainant/SDM.

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 ensuring that the resident's substitute decision-maker, if any, or any person designated by the substitute decision-maker and any other person designated by the resident is promptly notified of a serious injury or serious illness to the resident, in accordance with any instructions provided by the person or persons who are to be so notified, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home had his or her personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and of acquiring, in the case of new items.

A. During the initial tour of the home, Inspector #620 observed the following:
-In a units tub room: one bottle of body wash and one bottle of shaving cream, both partially consumed and unlabelled;
-In a units spa room: one tube of medicated cream and one bottle of shampoo both used and unlabelled; and
-In a units shower room: two personal washing sponges within the shower stall and one razor, all of which were unlabelled.

B. Inspector #679 observed: one green toothbrush, one electric tooth brush, one purple hairbrush, one bottle of shampoo/conditioner and two deodorant sticks, all used and unlabelled in a shared residents bathroom. Inspector #620 observed two bars of hand soap, two bottles of mouthwash, one tube of toothpaste and one hair brush all used and unlabelled in a shared resident bathroom.

A review of the policy entitled "Resident Rights, Care and Services- Nursing and Personal Support Services- Personal Aids" last revised January 15, 2017 identified that "All resident owned personal care items shall be labelled with the resident's name within 48 hours of admission or when new personal aid items are acquired"

In an interview with Co-DOC #139 they identified that it is the expectation of the home that all personal items are labelled.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were provided with personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

Inspector #681 observed resident #024 receive physical assistance with their meal from resident #023. Resident #024 had their plate removed with less than 25% of their meal consumed. At no point during the meal did resident #024 receive verbal cueing or physical assistance from a staff member.

A review of the electronic care plan for resident #024, indicated that resident #024 required assistance with meals.

In an interview with the Inspector, PSW #107 stated that resident #024 frequently required assistance with their meal. PSW #107 reported that the home area was fully staffed on that particular shift, but they had more residents in the home area who required assistance with their meals.

Inspector reviewed the home's policy titled "Resident Rights, Care, and Services – Nutrition Care and Hydration Programs – Meal Service" last revised April 11, 2017. The policy stated that the PSW's will ensure that they provide encouragement and assistance according to the residents' plan of care and preferences and to promote his or her safety, comfort, independence and dignity in eating and drinking.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that on every shift, symptoms indicating the presence of infection in residents are recorded and that immediate action is taken as required.

Inspector #679 completed a review of resident #004's health care record as they were identified as having an illness through a Minimum Data Set (MDS) assessment. Inspector #679 noted that it was documented in the progress notes for resident #004 that they were exhibiting symptoms for a number of days.

During a review of the electronic progress notes for resident #004, Inspector #679 identified that on a number of shifts, staff did not document resident #004's symptoms.

A review of the home's policy "Operation of Homes- Infection Control- Infection Prevention and Control Program" dated September 16, 2013, identified that registered staff will "On every shift, for those residents with infection or suspected infection, document in the progress notes, using infection note label, regarding the presence or absence of symptoms. Will continue to document for 48 hours after the symptoms of infection have subsided, or until 48 hours after antimicrobial completion."

In an interview with the homes Infection Control Lead they identified that staff were to document the resident's symptoms in Point Click Care on every shift, and that this had not occurred on five shifts during the period in which the resident was exhibiting symptoms.

Issued on this 2nd day of October, 2017

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) :	MICHELLE BERARDI (679), ALAIN PLANTE (620), JENNIFER LAURICELLA (542), LOVIRIZA CALUZA (687), STEPHANIE DONI (681)
Inspection No. / No de l'inspection :	2017_655679_0008
Log No. / No de registre :	001713-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Sep 8, 2017
Licensee / Titulaire de permis :	VALLEY EAST LONG TERM CARE CENTRE INC. 689 YONGE STREET, MIDLAND, ON, L4R-2E1
LTC Home / Foyer de SLD :	ELIZABETH CENTRE 2100 Main Street, Val Caron, ON, P3N-1S7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Chantal Carriere

To VALLEY EAST LONG TERM CARE CENTRE 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)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that the staff and others involved in the different aspects of care collaborate with each other, in both the assessment of the resident and the development and implementation of the plan of care for residents. Specifically ensuring that:

a) The assessments are integrated and consistent for resident's #013 and #020, related to their fall prevention assessments.
b) The assessments are integrated and consistent for resident #011, related to any areas of altered skin integrity.

Grounds / Motifs :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

During a record review by Inspector #620, resident #011 was identified as exhibiting altered skin integrity.

Inspector #620 reviewed resident #011's clinical record and determined that the presence of resident #011's altered skin integrity was first identified by staff on a particular day, in a progress note which indicated that the resident was exhibiting

altered skin integrity to a specific part of the body. On a particular day, a skin/wound assessment documented in Point Click Care (PCC) indicated that the residents altered skin integrity was on a specific part of their body. Subsequent to the staff's discovery of the wound, on a number of occasions over the course of several months staff assessed the altered skin integrity as being on a particular part of their body, and on a number of occasions staff assessed the wound as being present on a different part of the residents body.

Inspector #620 reviewed a Prescriber's Order Form. The form ordered staff to initiate, "Wound care protocol to a particular body part…". A second Prescriber's Order Form again ordered staff to initiate, "Wound care protocol to the same body part…". A third Prescriber's Order Form , advised staff to continue with the wound care protocol to the same particular part of the resident's body until the Physician assessed the wound.

Inspector #620 reviewed a Physician Medication Review. Under the medication treatment section of the form, resident #011 was designated with having altered skin integrity to a particular body part and a prescribed treatment; the documentation within the treatment section was manually altered to indicate that the altered skin integrity was healed. Adjacent to the designation of the wound and it's treatment, the form advised that the order was to be discontinued.

Inspector #620 reviewed two assessments completed by Co-Director of Care (Co-DOC) #124; the Co-DOC also served as the home's Wound Care Lead. On a particular day Co-DOC #124 competed a wound assessment in PCC using the assessment instrument titled, "Wound Assessment and Treatment". Within the assessment the Co-DOC described the altered skin integrity to a particular part of the residents body. A second assessment documented by the Co-DOC indicated that the resident had altered skin integrity to the same particular part of the body.

A review of resident #011's plan of care revealed an intervention that advised staff to, "Follow facility protocol/regime for treating altered skin integrity"

Inspector #620 interviewed PSW #142 who indicated that the resident had altered skin integrity on a particular part of their body and that it had always been on that part of their body. They stated that the resident never had altered skin integrity to the alternate part of their body. In an interview with RPN #141 they also revealed that the resident never had the presence of altered skin

integrity to a different part of their body.

Inspector #620 interviewed the home's Co-DOC #124 who indicated that they were the Wound Care Lead for the home. The CO-DOC indicated that the resident never had altered skin integrity to the alternate part of their body. They indicated that the orders for the treatment indicated treatment to a specific part of the residents body; however, the treatment orders should have advised staff to treat another part of the residents body. They indicated that a mistake had been made as it related to the residents altered skin integrity. (620)

2. During a staff interview with Inspector #679, RPN #117 identified that resident #013 sustained an injury after a fall on a particular day.

Inspector #542 completed a health care record review and noted that it was documented in the progress notes that the resident had sustained falls over a number of months, and then again on a particular day, which resulted in an injury.

Inspector #542 reviewed the physiotherapy assessments located on Point Click Care (PCC). An assessment by the Physiotherapy department, indicated that resident #013 scored a particular number on a specific assessment, indicating that the resident was at a particular risk for falls. An additional assessment was completed on a specific date, after resident #013 had sustained an injury. The second assessment indicated that the resident was at a particular risk for falls on a specific assessment.

Inspector #679 reviewed the current electronic care plan which indicated that the resident was at a specific risk for falls.

In an interview with Inspector #542, the Fall Prevention lead indicated that the Prevention of Falls Committee included the PT and restorative care team, as well as other members, and that they collaborate to incorporate interventions to prevent residents from falling. They recognized that there was a lack of communication between the team members. They stated that they were unaware that resident #013's fall risk had changed.

Inspector #542 interviewed Physiotherapist (PT) #128 who was responsible for completing the assessment for resident #013. Physiotherapist #128 indicated that they had completed the assessments; however, they did not communicate

the change in risk level to the rest of the Fall Prevention committee team members, nor did they update the care plan to reflect that the resident was changed to a specific risk for falls based on the assessment. (542)

3. Inspector #687 reviewed a Critical Incident (CI) report submitted to the Director. The CI report described that resident #020 had a fall on a particular day that resulted in a significant change, requiring the resident to be admitted to the hospital. The fall resulted in an injury.

A review of the Centric Health Physiotherapy note identified that resident #020 was assessed as being at a particular risk for falls, with a particular score on a particular assessment.

Inspector #687 reviewed the current electronic care plan, which indicated that resident #020 was at a particular risk for falls related to a number of factors.

In an interview with restorative care staff #130, they disclosed to the Inspector that they were not aware of the assessment done on a particular day, nor the change of the fall risk category for resident #020. They further stated that they did not receive any communication from the physiotherapist and did not read the progress notes indicating the change in resident #020's fall risk category.

Inspector #687 interviewed the Special Project Nurse (SPN) #129 with regards to updating care plans for falls prevention.The SPN stated that the staff member conducting the assessment should have revised the care plan. Special Project Nurse #129 also stated that any change in the care plan of any resident is documented under the progress notes.

The decision to issue this compliance order was based on the scope, which had the potential to impact a large number of the home's residents, the compliance history which indicated that although non-compliance was not issued under this portion of the legislation, previous non-compliance was issued to the home under a similar portion of the legislation, and the severity, which was determined to be actual harm. (687)

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Sep 29, 2017

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that all medication incidents and drug reactions are documented, reviewed and analyzed; corrective action is taken as necessary, and that a written record is kept of clause a and b.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was documented, reviewed and analyzed; that corrective action was taken as necessary; and that a written record was kept.

Inspector #542 reviewed the following four CI reports that were submitted to the Director by the DOC, regarding medication incidents:

- A CI report was submitted on a particular date, due to a medication incident/adverse drug reaction, where resident #022 received an incorrect dosage of a medication.

- A CI report was submitted on a particular date, for improper/incompetent treatment of a resident that resulted in harm or risk to a resident. The CI report outlined that resident #024 was being administered a medication by resident #023. The CI report indicated that no injury was sustained; however, resident #024 did not have physician's order for the medication.

- A CI report was submitted on a particular date, for a missing/unaccounted for controlled substance. The CI report outlined that the home noted that two narcotic tablets were missing during a narcotic count on a particular date. The home's investigation identified that a nurse accidentally spilled water on the tablets, but did not report the incident nor complete the required documentation out of fear.

- A CI report was submitted on a particular date, for a missing/unaccounted for controlled substance. The CI report outlined that it was discovered that four ampuoles of a narcotic medication were found broken and empty; however, there was no documentation to support what had occurred. The home was unable to determine the cause of the broken and empty ampuoles.

Inspector #542 reviewed the home's internal medication incident reports for 2016. Inspector #542 was unable to locate any medication incident reports for any of the above medication incidents.

Inspector #542 interviewed the DOC who indicated that they could not provide a medication incident report for the four mentioned CI reports as they were most likely not completed.

The decision to issue this compliance order was based on the scope which was determined to be widespread, the severity, which indicated the potential for actual harm, and the compliance history with previous unrelated non-compliance having been issued to the home. (542)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 15, 2017

Order # / Ordre no : 003

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

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

Grounds / Motifs :

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

Inspector #620 reviewed a complaint received by the Director. The complainant alleged that their family member was on a particular medication with an accompanying specified intervention. The complainant also raised concerns about the care being provided to resident #017.

Inspector #620 reviewed a document regarding the protocol for the specified intervention related to the medication, with a revision date of June 2017. The document was signed by the Medical Director and the DOC. The protocol described the parameters for which registered staff were to administer the particular medication. The protocol identified that once this medication was administered, the specific intervention was to be initiated. Inspector #620 confirmed with the DOC that the document had not been altered since this incident occurred.

Inspector #620 reviewed a progress note documented by Registered Nurse (RN) #123. RN #123 indicated that the physicians order for the specific intervention did not get processed, therefore had not been done.

Inspector #620 reviewed an Admission Physical dated a particular date. The document listed the residents medication.

Inspector #620 reviewed resident #017's medication administration record (MAR) and identified that for a number of days over a period of time, the resident received the medication.

A review of the resident's chart revealed that the resident first had the specific intervention completed on a particular day. Resident #017 received their medication for a number of days prior to the staff being aware of the results of the specific intervention.

Inspector #620 interviewed Co-DOC #139 who indicated that if resident #017 was on a particular medication, staff were required to utilize the homes policy regarding the particular intervention. They stated that if a resident was receiving a medication without the specific intervention being completed it would be considered a medication error of omission. (620)

2. Inspector #542 reviewed a CI report which was submitted to the Director on a particular date. The CI report indicated that a medication incident/adverse drug reaction had occurred, in which resident #022 received an incorrect dosage of their medication, which resulted in a transfer to the hospital.

Inspector #542 reviewed resident #022's health care record file. The progress notes indicated that on a particular date, the resident sought medical attention due to being administered an incorrect dosage of their medication.

Inspector #542 observed a record within the resident's chart, which identified an order for the medication. The Electronic Medication Administration Record (EMAR) was also reviewed, which confirmed the order for the particular medication.

Inspector #542 interviewed the DOC, who verified that the nurse did not follow the orders as specified by the physician.

Non-compliance was previously identified under inspection #2015_395613_0009, with a VPC being served in August, 2015.

The decision to issue this compliance order was based on the scope which had the potential to impact one or the fewest number of the affected population that were inspected, the severity, which indicated actual harm, and the compliance

history, which despite previous non-compliance issued, including one VPC, non-compliance continued with this section of the legislation. (542)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 15, 2017

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, commercial courier 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 8th day of September, 2017

Signature of Inspector /
Signature de l'inspecteur :

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

Name of Inspector / Nom de l'inspecteur : Michelle Berardi

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