Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 27, 2017	2017_627138_0017	008938-17	Resident Quality Inspection

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE WEST END VILLA
2179 ELMIRA DRIVE OTTAWA ON K2C 3S1

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

PAULA MACDONALD (138), MELANIE SARRAZIN (592), RUZICA SUBOTIC-HOWELL (548)

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): June 5, 6, 7, 8, 9, 12, 13, 14, 15, 16, 19, 20, 21, 22, and 23, 2017.

The following inspections were conducted as part of the RQI:

Critical Incident Inspection Log #009820-17, CIS #2709-000010-17 relating to alleged resident abuse,

Critical Incident Inspection Log #010313-17, CIS #2709-000011-17 relating to alleged resident abuse,
Critical Incident Inspection Log #011258-17, CIS #2709-000012-17 relating to an injury to a resident for which the resident is taken to hospital and which results in a significant change in the resident's health status,
Complaint Inspection Log #007787-17 relating to resident care concerns,
Complaint Inspection Log #009305-17 relating to resident care concerns,
Complaint Inspection Log #009324-17 relating to funding and staff qualifications,
Complaint Inspection Log #009973-17 relating to alleged resident to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Food Service Manager, the Food Service Supervisor, the Program Manager, the Clinical Coordinator, the Medical Director, the Registered Dietitian, an Information Officer at the Ontario College of Social Workers and Social Service Workers (OCOSWSSW), the Office Manager, the Front Receptionist, the RAI Coordinator, the Behavioural Therapist from the Royal Ottawa Hospital, the Geriatric Psychiatric Nurse from the Royal Ottawa Hospital, a Behavioural Support Ontario (BSO) worker, the President of the Family Council, the President of the Resident's Council, the Wound Care Champion, food service workers, housekeeping aides, maintenance, recreation aides, personal support workers (PSW), registered practical nurses (RPN), registered nurses (RN), pharmacists, a social work employee, and a detective from the Ottawa Police.

While in the home the inspectors toured residential areas, observed staff to resident interactions, observed a meal service, observed a medication pass, reviewed resident health care records, reviewed medication incident documentation, reviewed internal investigation notes, reviewed staff qualifications, reviewed home policies, reviewed pest control documents, and reviewed maintenance logs.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to comply with section 9.(1)2. of the Regulation in that the licensee failed to ensure that all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

On June 5, 2017, Inspector #548 observed the fifth floor south electrical room was unlocked and accessible to the inspector. Inside the room was a wall of electrical boxes and there was no resident-staff communication response system (call bell) and no staff present.

On the fourth floor Inspector #548 observed the south storage room to be open and accessible. The inspector continued on the unit and observed the north storage room to be open. The north storage room supplies included incontinent products, O2 tanks, and resident laundry. Both rooms were not equipped with a call bell nor supervised by staff.

The inspector was on the third floor unit the same day and observed the south storage room was unlocked and easily opened. Inside the room was an opened panel door exposing pipes and insulation. On the same floor the eyewash station room was opened fully and on the counter was the Lab specimen fridge and a Resident fridge. On the unit, RPN #100 indicated that the Eyewash station room is not a designated resident area however, family and visitors of residents use the room to wash their hands. All three rooms on the third floor were not equipped with a call bell.

On June 7, 2017, Inspector #592 observed the eye wash station door located on the third floor to be open with no staff supervision and was accessible to residents.

On June 8, 2017, Inspector #548 toured all resident living areas in the building and noted the third floor, as well as the second floor, eyewash station rooms to be open.

On June 9, 2017, during an interview with Inspector #548 both the Administrator and Director of Care indicated that these rooms mentioned above are not resident accessible rooms and that they would follow up regarding these doors. [s. 9. (1)]

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 doors to non-residential areas are to be closed and locked when not being supervised by staff, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to comply with section 36. of the Regulation in that the licensee failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

A Critical Incident Report (CIR #2709-009820-17) was submitted on May 18, 2017, to the Director under the LTCHA, 2007 of alleged staff to resident physical abuse. The report was amended on May 29, 2017 and June 6, 2017, respective of the home's investigation.

The incident was reported to activity aide #149 by a resident of a physical and verbal incident by PSW #148 in May 2017. The resident described being forced out of bed and yanked (by the arms) causing an injury to the resident. The resident reported that the PSW #148 was also verbally abusive.

The resident requires extensive assistance with some activities of daily living and uses a wheelchair as a means to mobilize on the unit. As recommended by physiotherapy, a two person transfer from bed to wheelchair is specified in the care plan due to the resident's decreased mobility.

Review of the Administrator's notes indicated that PSW #148 indicated during an interview that she forced the resident to transfer out of bed, although the resident refused and had completed the transfer by self own with no assistance.

On June 8, 2017, during an interview with Inspector #548, the Administrator indicated that she had the resident demonstrate to her the manner in how the resident had been transferred by PSW #148. The resident was able to demonstrated the motion to the Administrator. The Administrator indicated that the resident had no injury prior to the incident and she concluded that the injury sustained was a result of the one-person transfer carried out by PSW #148.

On June 9, 2017, the resident recalled the incident of being forced out of bed and transferred from bed to the wheelchair by PSW #148. On observation, the Inspector #548 noted that the resident still suffered the specific injury.

Safe transferring was not performed as required for the resident and the resident sustained a physical injury.

(Log #009820-17) [s. 36.]

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 staff use safe transferring techniques as assessed by the physiotherapist when transferring resident #038, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 63. Every licensee of a long-term care home shall ensure that social workers or social service workers who provide services in the home are registered under the Social Work and Social Service Work Act, 1998. O. Reg. 79/10, s. 63.

Findings/Faits saillants :

1. The licensee failed to comply with section 63. of the Regulation in that the licensee failed to ensure that the social workers who provide services in the home are registered under the Social Work and Social Service Act, 1998.

Inspector #138 spoke with the Administrator regarding employee #143. The Administrator stated that employee #143 was hired in May 2016 to replace the social worker who was planning to retire. The Administrator acknowledged that employee #143 was hired as a social worker without the required registration but stated that condition of continued employment was based on fulfilling this requirement.

Inspector #138 consulted the Ontario College of Social Workers and Social Service Workers' (OCSWSSW) on line register. The OCSWSSW is the regulatory body under authority of the Social Work and Social Service Act, 1998, whose mandate is to regulate the practice of social work and to govern its members. The on line register did not recognize employee #143 as a social worker.

Inspector #138 obtained and reviewed employee #143's letter of hire dated April 27, 2016. It was noted by the inspector that the letter of hire outlined that the employee was being offered a position of social worker commencing May 3, 2016, but the letter of hire also provided employee #143 until November 3, 2017, to become a registered social worker.

The inspector spoke with employee #143 who confirmed that he was hired in May 2016 as a social worker. Employee #143 stated that he was not registered as a social worker with OCSWSSW when he was hired but added that he had submitted his application to OCSWSSW in March 2017, and is waiting for confirmation of registration as a social worker.

As such, employee #143 was hired as a social worker on May 3, 2016, without being registered under the Social Work and Social Service Act, 1998.

(log # 009324-17) [s. 63.]

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 employee #143 is registered with Ontario College of Social Workers and Social Service Workers while working in the home in a social worker position, to be implemented voluntarily.

WN #4: 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:
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee failed to comply with section 73.(1)8. of the Regulation in that the licensee failed to ensure course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.

Inspector #138 observed the lunch meal service in the second floor dining room on June 5, 2017. The inspector observed the following:

- Resident #044 was seated with the entrée portion of the meal waiting for staff assistance to be fed. The dessert portion of the meal was provided to the resident before assistance was provided with the entrée portion of the meal.

- Resident #051 was feeding self the entrée portion of the meal. It was observed that a

nursing staff member approached the resident and began to feed the resident the dessert portion of the meal in between bites of the entrée that the resident was feeding self.

- Resident #047 was being fed the soup portion of the meal by staff when the entrée and, minutes later, the dessert portion of the meal was delivered to the resident. The resident continue to eat the soup and was not ready for the entrée or the dessert.

- Resident # 045 and resident #046 were assisted by nursing staff with the entree portion of their meal. The dessert portion of the meal was provided to these residents as they were eating, before the two residents were even halfway through the entrée portion of their meal.

Inspector #138 did not observe the residents above to request any deviation from course by course service. The inspector also reviewed the plans of care for the above residents and noted that there was no indication on any of the plans of care to indicate a meal service other than course by course.

As such, the licensee failed to ensure a course by course service of meals for resident #044, resident #045, resident #046, resident #047, and resident #51 at lunch on the second floor on June 5, 2017. [s. 73. (1) 8.]

2. The licensee failed to comply with section 73.(2)(b) of the Regulation in that the licensee failed to ensure that no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident.

Inspector #138 observed the lunch meal service in the second floor dining room on June 5, 2017. The inspector observed resident #042, resident #043, resident #044, and resident #049, all seated at the same table, each were provided their meal by nursing staff at 1246 hours. A PSW sat at the table and immediately assisted resident #042 and resident #049 with their meal. The other two residents, resident #043 and resident #044, were not provided assistance with their meal until 1310 hours, twenty five minutes after their meal was served. The plans of care for these four residents confirmed that each resident required complete feeding assistance.

As such, resident #043 and resident #044 who require assistance with eating and drinking were provided a meal before someone was available to provide the assistance

required by each of these two residents. [s. 73. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure residents in the second floor dining room receive course by course service of their meals unless indicated by the resident or assessed otherwise, to be implemented voluntarily.

WN #5: 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,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to comply with section 87. (2) (d) of the Regulation in that the licensee failed to ensure that procedures are implemented for addressing incidents of lingering offensive odours.

On June 7, 2017, Inspector #548 observed a strong urine odour upon entering a specific resident room on the second floor. During an interview with Inspector #548, a resident who resides in this room indicated that the room had a strong odour as a result of a roommate's constant incontinence.

Inspector #548 spoke with housekeeper #122 who stated that she is aware of the lingering odour of urine in this specific second floor room for over a month and has not reported the information to the Administrator.

On June 6, 2017, Inspector #592 also observed in a specific room on fourth floor a lingering odour of urine in the shared bathroom. During an interview with Inspector #548, a resident who resides in this room indicated that there has been a constant odour of

urine in the bathroom since the resident's admission to the room several months prior and the odour only slightly diminishes when housekeeping cleans the area. The resident became teary-eyed and explained that the resident is not able to have visitors in the room due to the odour. The resident also stated that a family member had reported to the resident that the odour was profound. The resident had made a request to move rooms as a result of the odour. The resident indicated that the odourizing gel in the bathroom was not working.

The inspector observed that four residents share the bathroom of this specific room on the fourth floor. On a shelf was a container of Odor Gel.

Inspector #548 spoke with housekeeper #121 regarding the bathroom in the specific room on the fourth floor. The housekeeper indicated that she is aware of the bathroom's odour and is cleaning the bathroom up to four times a day. She indicated that there is an odour gel in the bathroom and, should it be required, she is to inform the janitor to deodorize the area. She indicated that she has not done so as the issue of the odour was related to resident's incontinence.

This specific room on fourth floor was identified in last year's Resident Quality Inspection report, May 9, 2016, #2016_287548_0008 as having lingering offensive odours. A Voluntary Plan of Correction was issued as the licensee failed to ensure procedures were implemented to address incidents of lingering offensive odours for two consecutive years.

Inspector #548 spoke with the Administrator regarding the strong urine odour in both rooms, one on the second floor and one on the fourth floor. The Administrator indicated that procedures are to be implemented to address lingering offensive odours such as deodorizing of the area by the janitor. She indicated that she has recently become aware that procedures were not implemented to address the strong urine odour in these rooms. [s. 87. (2) (d)]

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 procedures are implemented to address offensive lingering odours in two rooms, one of the second floor and the other on the fourth floor, to be implemented voluntarily.

WN #6: 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. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 114 (3).
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Findings/Faits saillants :

1. The licensee failed to comply with section 114.(3)(a) of the Regulation in that the licensee failed to ensure that the medication management system's written policies and protocols are developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, specifically related to resident self administration of medications.

The medication management system's written policy: Self-Administration of Medications, policy 5-5, dated January 2014, specifies that residents are permitted to self-administer medications in the home with prescriber and nursing team assessment of the resident's capability and understanding to self administer medications. This assessment is to be recorded on the 'Self-Administration Assessment Form', a component of the Medication Administration Record (MAR). Assessments are to be conducted quarterly or with a change in resident health status. As well, the resident is to sign a form 'Resident Self-Administration of Medication Agreement' of their understanding of prescriber

specifications.

On June 7, 2017 Inspector #138 observed prior to lunch at 1215 hours in resident #023's room several medicated creams, a gel, and drops to be on the bedside table.

On June 13, 2017, during an interview with Inspector #548, resident #023 indicated that the pain relieving medicate gel is self administered when required. When asked where the other medicated cream would be used for what area the resident could not give clear directions to the inspector.

On review of the Physician orders, resident #023 has been prescribed to self apply the pain relieving medicated gel in the evening. There was no order to self administer other medicated cream.

On the same day, during an interview with Inspector #548, RPN #110 indicated prescriptions are to be administered by registered nursing staff. She explained that resident #023 will at times resist the application of the creams by staff and staff assist the resident to apply them in the presence of staff. The RPN indicated that, to her recollection, there was no assessment conducted for the self administration of medications for resident #023.

On June 7, 2017, on resident's #005 bedside table, Inspector #592 observed prescribed drops and a tube of pain relieving medicated gel. The same was observed by Inspector #548 on June 14, 2017.

On June 14, 2017, during an interview with Inspector #548, resident #005 indicated that both medications are self administered as necessary. The resident explained that the pain relieving medicated gel is applied by the resident when needed but did not provide an explanation for the drops.

On the same day, during an interview with Inspector #548, RPN #117 indicated that there is no record that resident #005 was assessed to be capable to self administer these medications.

On June 8, 2017, Inspector #548 observed several labelled inhaled medications with resident #008 in a clear plastic bag. Resident #008 indicated that the resident requires these inhaled medications to manage symptoms of a specific disease. Resident #008 further explained that the resident keeps the inhaled medications nearby and will self

administered when needed.

On June 13, 2017, during an interview with Inspector #548, RPN #137 indicated that the resident has been self administering inhaled medications since admission. The resident was admitted to the home several months ago. The RPN further added that there is no assessment conducted so that the resident may self-administer these medications.

The Clinical Consultant Pharmacist Quarterly Report dated May 2017, was presented to the Professional Advisory Committee by the clinical pharmacist. A risk was identified and communicated to the members regarding self administration of medications. The report specified that physicians were not to order any medications to be self-administered or at the bedside until all aspects of the policy are met including the assessment of resident competence and safety.

The licensee failed to ensure that the written policy, Self-Administration of Medications, policy 5.5, was implemented for resident #005, resident #008 and resident #023. [s. 114. (3) (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 written policy, Self-Administration of Medications, is implemented for resident #005, resident #008, and resident #023, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (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 comply with section 135.(2) of the Regulation in that the licensee has failed to ensure that all medication incidents are reviewed and analyzed.

Over the course of the inspection, the process for medication incident reporting was reviewed by Inspector #548 with the Director of Care (DOC). According to the DOC, medication incident reporting may be conducted by the registered nursing staff, pharmacist, DOC, and pharmacy provider through an electronic reporting system. The DOC indicated that she reviews each incident (MEDINIC) and is responsible to respond to those medication incident involving residents.

The Inspector #548 reviewed medication incidents for a three month period: March, April, and May 2017.

During an interview on June 15, 2017, with Inspector #548, the DOC indicated that the medication incidents are reviewed and evaluated. Review of the Medication Quarterly Evaluation in the presence of the DOC it was noted that the quarterly report provided information on the types of medication incidents during a specific period of time in March, April, and May 2017. The quarterly report provided to the Inspector #548 categorized medication incidents. The DOC explained that the information is shared with the interdisciplinary Professional Advisory Committee for information purposes. The DOC further explained that the new reporting system did not offer the benefits of conducting analysis of medication incidents in the home. The DOC concluded that improvements were conducted individually based on the risk and severity of the incident however, no analysis was being conducted at the present time. The DOC could not produce documentation of the individual improvements made, at the time of the inspection.

On June 19, 2017, during an interview with Inspector #548, the Medical Director indicated that analysis was not being conducted related to medication incidents and was unaware of the requirement to do so. This was confirmed on June 20, 2017, with the clinical pharmacist at the home who indicated that although medication incidents are discussed at the committee level with the review of the incident category and severity level as well as, those corrective actions implemented. The clinical pharmacist agreed that analysis of medication incidents would be beneficial.

Inspector #548 reviewed the Professional Advisory Committee meeting minutes for the period of March, April, and May 2017, and noted there was no record of analysis of the medication incidents during that period of time. [s. 135. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that medication incidents are analyzed and this analysis is documented, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to comply with section 17.(1)(g) of the Regulation in that the licensee failed to ensure that the home is equipped with a resident-staff communication and response system that, in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff.

In this report the resident-staff communication and response system is commonly referred to as the call bell system.

The home uses a call bell system that, when activated, makes an intermittent sound, displays location on an display panel with a light indicator above the room.

On June 06, 2017, Inspector #592 activated the call bell in room #465 and room #455 located on the fourth floor south area and observed that the sound of the call bell system was audible only near the nursing station and the sound became less audible towards the ends of the hallways. PSW #106 and PSW #119 reported to Inspector #592 that they were not able to hear the call bell sound unless they were close to the nursing station, therefore they were relying on the light indicators above resident rooms to monitor for calls bells that may be activated as the call bells are not always audible and that the display system was not visible from the hallway. PSW #106 and PSW #119 further indicated that when they are unable to monitor lights when they are in a resident's room, they rely on other staff to communicate if a call bell has been activated.

On June 07, 2017, Inspector #592 activated the call bell in room #366 on the third floor south area and observed that the sound of the call bell system was audible only near the nursing station and the sound became less audible towards the end of the hallways. PSW #118 reported to Inspector #592 that she was unable to hear the call bells unless she was closer to the nursing station. She further indicated that she was relying on the light indicators above resident rooms and on the display panel which at the time of the interview was not visible from the hallway. PSW #118 further indicated that the staff will communicate to her if a call bell was activated and that often she will come out of a resident's room to monitor if a call bell was activated.

On June 08, 2017, in an interview with RPN #117, she indicated to the inspector that when a call bell is activated, there will be a display on the display panel located at the nurses station and that a light indicator outside of the room will illuminate. She further indicated that a sound will be heard once and then every several seconds or minutes the sound will continue until the call bell is cancelled. RPN #117 further indicated that the call bell sound was not audible down the corridors but often staff members will go in and out the resident's room and will be able to monitor if a call bell had been activated.

On June 08, 2017, in an interview with the Administrator, she indicated to the inspector that an outside company came five to six months ago to fix the call bell display system and it was not reported to her that the call bell sound was not audible down the third and fourth floor south corridor. She further indicated that she would contact the company to do a follow-up with them in regards to the level of sounds and the last visit done to the home.

On the same day, the Administrator informed Inspector #592 that the outside company came on site following the discussion with the inspector and that the call bell system sound was re-calibrated. [s. 17. (1) (g)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee has failed to comply with section 33.(3) of the Act in that the licensee failed to ensure that the PASD described in subsection (1) that is used to assist a resident with a routine activity of living is included in the resident's plan of care.

On June 06, 2017, a resident was observed by Inspector #138 with two quarter rails in the up position while the resident was in bed.

On June 13, 2017, Inspector #592 also observed the two quarter rails in the up position while this resident was sitting beside the bed.

On June 13, 2017, in an interview with the resident, the resident indicated the use of both quarter rails to help with bed mobility.

On June 13, 2017, in an interview with PSW #130 assigned full time to the resident, she indicated that the purpose of the rails was for the resident to use on a daily basis when she was assisting the resident in bed. The PSW further indicated that the resident will grab the quarter rail when being repositioned.

On June 13, 2017, in an interview with RN #135, she indicated to Inspector #592 that she did not know the resident well, but that when rails were used it was identified in the resident’s plan of care under the mobility section, especially if they were used in a routine activity of living. Inspector #592 reviewed the resident's health records with the presence of RN #135 and observed that there was no documentation found for the use of the rails in the resident's plan of care. RN #135 further indicated that she would do the follow-up as it was the home’s expectation that when rails are used to assist resident with activity of daily living that it is included in the resident’s plan of care. [s. 33. (3)]

Issued on this 27th day of June, 2017

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

Original report signed by the inspector.