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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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
Oct 1, 2018	2018_702197_0020	021523-18	Resident Quality Inspection

Licensee/Titulaire de permis

ManorCare Partners II.
6257 Main Street Stouffville ON L4A 4J3

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

Friendly Manor Nursing Home
9756 County Road, #2 P.O. Box 305 DESERONTO ON K0K 1X0

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

JESSICA PATTISON (197), CATHI KERR (641)

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): September 6, 7, 10-13, 2018

The following log was completed with the Resident Quality Inspection: 024479-18 - a complaint related to staffing and fall prevention measures

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care, the Assistant Director of Care, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Life Enrichment staff, an Administrative Assistant, the Residents' Council President, residents and their family members.

The inspectors also observed resident care, medication administration and storage areas and reviewed policies/procedures related to falls prevention and staffing

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Residents' Council
Sufficient Staffing

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that at least one registered nurse who was both an

employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times, except as provided for in the regulations.

In accordance with s. 8(3) of the Long-Term Care Homes Act (LTCHA), the licensee is required to ensure that there is at least one registered nurse on duty and present in the home at all times, except in the case of an emergency.

The Long-Term Care Home is a 60 bed home. According to section 45 of Regulation 79/10, for homes with a licensed bed capacity of 64 beds or fewer, in the case of an emergency where the back-up plan referred to in clause 31 (3) (d) of this Regulation fails to ensure that the requirement under subsection 8 (3) of the Act is met,

- a registered nurse who works at the home pursuant to a contract or agreement between the licensee and an employment agency or other third party may be used if the Director of Nursing and Personal Care or a registered nurse who is both an employee of the licensee and a member of the regular nursing staff is available by telephone, or

- a registered practical nurse who is a member of the regular nursing staff may be used if the Director of Nursing and Personal Care or a registered nurse who is both an employee of the licensee and a member of the regular nursing staff is available by telephone.

In this section, "emergency" means an unforeseen situation of a serious nature that prevents a registered nurse from getting to the long-term care home.

Inspector #197 reviewed the licensee's Registered Nurse (RN) staffing schedule for a specified period. There were a total of 11 eight hour shifts when there wasn't an RN present in the home. Five of the eleven shifts were determined to be emergency situations.

The other six were as follows:

1. Specified day RN shift – RN called in sick early in the morning for that day and the next day.
2. Specified evening RN shifts – the RN that was scheduled to work these shifts resigned after their orientation shift, but was scheduled for later evening shifts
3. Specified day RN shift – RN called in sick early in the morning on for that day and the next day.
4. Specified night RN shift – RN scheduled for nights called in sick.

5. Specified day RN shift – RN that was scheduled for day shift had covered other shifts earlier in the week and was pulled from this scheduled shift.
6. Specified day RN shift – RN scheduled for days informed the home the day before that they would not be in the following day.

The home did not ensure that at least one registered nurse was on duty and present in the home at all times for the shifts listed above. [s. 8. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times, except as provided for in the regulations, to be implemented voluntarily.

WN #2: 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 failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Resident #021 had a physician's order for a specified medication, three times per week. A medication incident was reported that indicated that resident #021 had not received this medication on a specified date, as was prescribed. The medication incident report indicated that the medication had been found still in the strip package for resident #021, but that the medication had been signed off as having been given by Registered Nurse (RN) #107. At the time that the incident was noted, the resident had been assessed with no noted ill effect. The Doctor and the resident's SDM had been notified, as well as the pharmacy and the Assistant Director of Care (ADOC).

During an interview with Inspector #641, the ADOC indicated that RN #107 had been interviewed about resident #021 not receiving the medication and stated that RN thought that the medication had been given and was surprised that it was still in the resident's bin.

The licensee failed to ensure that drugs were administered to resident #021 in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs are stored in an area or a medication cart that is secure and locked.

On a specified date, Inspector #641 observed a small bin with multiple prescription creams in it, to be located on a linen cart with a black netting over it, on the side A hallway. RN #104 advised that the creams were there for the Personal Support Workers (PSW) who applied these creams daily to the residents. The RN lifted the netting and removed the creams demonstrating the easy accessibility of the creams for the PSW's and therefore anyone walking in the hallway.

During an interview with Inspector #641, the Administrator / Director of Care (Admin/DOC) advised that the prescription treatment creams that the PSW's applied on the residents were available on the linen cart because the PSWs needed to have access to them. The Admin/DOC indicated being aware that a prescription cream should be secured so as not to be accessible to the residents.

The licensee failed to ensure that treatment creams were stored in an area that was secure and locked. [s. 129. (1) (a)]

Issued on this 1st day of October, 2018

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

Original report signed by the inspector.