Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: February 21, 2023	
Inspection Number: 2023_1026_0002	
Inspection Type: Complaint Critical Incident System (CI)	
Licensee: Golden Years Nursing Homes (Cambridge) Inc.	
Long Term Care Home and City: Golden Years Nursing Home, Cambridge	
Lead Inspector Katherine Adamski (#753)	**Inspector Digital Signature** Katherine Adamski Digitally signed by Katherine Adamski Date: 2023.03.03 10:07:32 -05'00'
Additional Inspector(s) Mark Molina (#000684) was also present for this inspection.	

MODIFIED PUBLIC INSPECTION REPORT SUMMARY

This public inspection report has been revised to reflect a change in the title of the report. This Complaint/CI inspection (#2023_1026_0002) was completed on January 3-6, 9-11, 17-20, 23-24, 2023.

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
January 3-6, 9-11, 17-20, 23-24, 2023

The following intake(s) were inspected:
- Intake: #00013840 and #00014848 related to concerns with fall prevention and management, maintenance services, availability of continence care supplies, prevention of abuse and neglect, reporting and complaints
- Intake: #00016147 related to the home's medication management system

The following **Inspection Protocols** were used during this inspection:

Medication Management
Falls Prevention and Management
Housekeeping, Laundry and Maintenance Services
Prevention of Abuse and Neglect
Infection Prevention and Control
Continence Care
Reporting and Complaints

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (10) b

Rationale and Summary
The licensee failed to ensure that resident #001 was reassessed and their plan of care was reviewed and revised when their care needs changed, or the care set out in the plan was no longer necessary.

Resident #001's plan of care included several fall prevention interventions. Two of these interventions were not in place during multiple observations of resident #001.

Direct care staff stated that the resident no longer required the two specific interventions.

Staff acknowledged that resident #001's plan of care was not updated to accurately reflect the care requirements of the resident and took immediate corrective action to do so.

Sources: Observations, resident #001's plan of care including kardex and care plan with revision history, interviews with a Registered Nurse (RN) and other staff.

Date of Remedy: January 23, 2023

WRITTEN NOTIFICATION: PLAN OF CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

Rationale and Summary
The licensee failed to ensure that the care set out in the plan of care for resident #001 was provided to the resident as specified in the plan.

Resident #001 was at high risk of falls with injuries.

Resident #001's plan of care included several fall prevention interventions. Multiple observations of the resident showed that a specific intervention was not in place according to their plan of care. Direct care staff acknowledged that the resident required this specific intervention related to their risk of falls.

During one observation, a specific intervention was observed in place that was not required by the resident and was not documented in their plan of care. Direct care staff acknowledged that this intervention should not have been in place for resident #001.

When resident #001's fall prevention interventions were not applied as per their plan of care, resident #001 remained at risk of falls and injury.

Sources: Observations, resident #001's kardex, care plan with revision history, interviews with direct care staff.

WRITTEN NOTIFICATION: REPORTING CRITICAL INCIDENTS

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.

Rationale and Summary
The licensee failed to ensure that when resident #001 sustained an injury that resulted in a significant change in condition and for which they were taken to the hospital, the Director was informed no later than one business day.

Resident #001 had unwitnessed falls resulting in transfer to hospital.

Resident #001 had a significant change in health assessment shortly after they returned from the hospital. Additionally, resident #001 required changes to their plan of care related to nutrition and hydration as a result of their injuries.

When the Director was not made aware of this incident, they were unable to respond immediately, if required.

Sources: Observations of resident #001, resident #001's plan of care including, census, kardex, care plan with revision history, post fall assessments, Resident Assessment Instrument – Minimum Data Set Ministry of Long Term Care (MLTC) reporting portal, interviews with direct care staff.

WRITTEN NOTIFICATION: REPORTING CERTAIN MATTERS TO THE DIRECTOR

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

Rationale and Summary
The licensee has failed to ensure that suspected abuse of resident #010 was immediately reported to the Director.

Pursuant to s. 154 (3) of the FLTCA, 2021, the licensee is vicariously liable for staff members failing to comply with subsection 28 (1) 2.

Resident #010 reported an incident of alleged abuse by a direct care staff member to two staff of the home.

Neither of the staff reported the incident to management and management acknowledged that they were not aware of the incident.

Staff not reporting the incident of alleged abuse immediately to management, may have put resident #010 at risk of harm due to the home's management team and the Director being unable to respond immediately.

Sources: Interviews with resident #010, direct care staff and the Administrator, MLTC reporting portal.

WRITTEN NOTIFICATION: DUTY TO POTECT

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

Rationale and Summary
The licensee has failed to ensure that resident #010 was protected from verbal abuse by a staff member.

Section 2 (1) of the Ontario Regulation (O. Reg) 246/22 defines verbal abuse as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident’s sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

A staff member made comments of a belittling or degrading nature to resident #010.

Resident #010 was upset by these comments.

Sources: Interviews with resident #010 and direct care staff, MLTC reporting portal.

COMPLIANCE ORDER CO #001 MEDICATION MANAGEMENT SYSTEM

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O.Reg. 246/22, s. 123 (3)(a)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The Licensee has failed to comply with O. Reg. 246/22, s. 123 (3)(a)

The Licensee shall:

1. Develop and implement a written process for conducting daily counts of controlled substances to determine any discrepancies between the physical inventory, perpetual inventory in the Automatic Dispensing Cabinet (ADC), and electronic Medication Administration Record (eMAR) administration history. The process should include follow-up investigation of any discrepancies within 24 hours and documentation of the daily counts.

2. Ensure there is a written process for identifying trends or patterns in discrepancies from the daily count sheets of controlled substances. The process should include documented follow-up to address the identified patterns or trends. The date of the review, the person responsible, and actions taken, if any, must be documented.

3. Ensure the Director of Nursing, pharmacy service provider and the home's Medical Director complete a review of the home's medication management policy in relation to auditing controlled substances. This review must include the date of the review, a description of any revisions made to it and the names of those who participated in it. A record of the review must be maintained in the home.

4. Ensure all Registered Staff are educated on the home’s process for conducting daily counts of controlled substances. Document the education including the date provided, who it was provided by, who attended, and the content of the education.

Grounds

Non-compliance with: O. Reg. 246/22, s. 123 (3)(a)

The licensee has failed to ensure that the home's written medication management system policies and protocols were implemented.

According to O. Reg. 246/22, s. 11. (1)(b), where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure,

strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, is complied with.

O. Reg. 246/22, s. 123 (2) requires the licensee to ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

O. Reg. 246/22, s. 123 (3)(a) requires the written policies and protocols to be implemented.

Rationale and Summary

A Critical Incident (CI) was submitted to the Director related to missing controlled substances.

Resident's #009, #011, and #012 had active physician's orders for a controlled substance.

A) The home's Medication Administration, General Guidelines policy stated medication administration was required to be recorded on a resident's electronic medication administration record (eMAR) directly after the medication was given and no individual was to report off-duty without first recording the administration of any medications.

The home's Controlled Substances and Medication Pass policy stated that controlled substances, including single dose ampules that were removed from the Automated Dispensing Cabinet (ADC), but not administered for any reason were to be placed in the ADC drug disposal bin as wastage.

I) An RPN removed 19 ampules of a controlled substance from the home's ADC under resident #009's profile.

The controlled substances were not documented as administered or wasted according to the home's policies on 15 of these occasions by the RPN.

II) An RPN removed 50 ampules of a controlled substance from the home's ADC under resident #011's profile.

No doses of the controlled substance were administered to resident #011 or wasted by the RPN, resulting in a total of 50 unaccounted for ampules.

III) An RPN removed 74 ampules of a controlled substance from the home's ADC under resident #012's profile.

The controlled substance was not documented as administered or wasted according to the home's policies on approximately 71 of these occasions by the RPN.

When the RPN did not document the administration or waste of all controlled substances that they had removed from the home's ADC, approximately 133 ampules were unaccounted for.

B) The home's Controlled Medication Storage policy stated that an on-site pharmacy representative was to conduct a physical inventory of all controlled substances and compare it to the perpetual inventory in the ADC and the eMAR administration history of the medication. This was to occur once weekly according to section six of the policy.

The Administrator stated that it was the pharmacies responsibility to track all medication transactions.

The Pharmacy was not aware of section six of the Controlled Medication Storage policy that directed pharmacy staff to reconcile the physical and perpetual inventory of all controlled substances, with the eMAR administration history, therefore this was not currently occurring in the home.

The Pharmacy Manager stated that when they conducted their weekly billing audit, which included reviewing as needed medication to ensure a reasonable quantity was removed, everything was in reason and there was nothing flagged as an excessive amount of usage because there was not an audit done against what was administered in the eMAR.

When the inventory of all controlled substances was not reconciled with the eMAR administration history, it was not immediately identified that a certain number of ampules of a controlled substance were unaccounted for.

Sources: the home's internal investigation, resident #009, #011, and #012's census, orders, progress notes, eMAR's, Medication Administration, General Guidelines (#IIA01), Controlled Medication Storage (#IE02), and Controlled Substances and Medication Pass (#IIA03) policies/procedures, Arxium Event Summary Report, interviews with the Administrator, Pharmacy Manager and other staff.

This order must be complied with by
April 14, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the

licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.