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 # / No de registre	Type of Inspection / Genre d'inspection
Nov 16, 2017	2017_659189_0020	023894-17	Resident Quality Inspection

Licensee/Titulaire de permis

City of Toronto
55 JOHN STREET METRO HALL, 11th FLOOR TORONTO ON M5V 3C6

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

KIPLING ACRES
2233 KIPLING AVENUE ETOBICOKE ON M9W 4L3

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

NICOLE RANGER (189), CECILIA FULTON (618)

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): October 17, 18, 19, 20, 23, 24, 25, 26, 2017.

The following critical incident reports were inspected concurrently with the Resident Quality Inspection (RQI):
log #002686-17, related to skin and wound care

The following complaints were inspected concurrently with the RQI:
log #026909-15, related to personal support services, continence care
#010237-17, related to continence care
#010238-17, related to medication
 # 018826-16, related to medications

The following follow up order was inspected concurrently with the RQI:
log #00551-17, related to prevention of abuse and neglect

During the course of the inspection, the inspector(s) spoke with Administrator, Assistant Administrator, Director of Nursing (DON), Nurse Manager (NM), registered nurse (RN), registered practical nurse (RPN), Behavioural Support Ontario Nurse (BSO), personal care assistant (PCA), Resident Council President, Family Council President, private sitter, residents and family members.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **9 WN(s)**
- **3 VPC(s)**
- **0 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. 19. (1)	CO #001	2016_370649_0032	618

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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe and secure environment for its residents.

During the initial tour of the home the inspector observed the following:

On an identified hallway - an unlabeled used jar of medicated cream left in the clean utility cart in the hallway. RPN #120 confirmed the used jar of medicated cream should be labelled and not left in the clean utility cart.

On an identified shower room - three used razors left on top of a half wall in the shower room, a small biohazards container full of used razors left on top of a half wall in the shower room. RN #118 confirmed that the used razors and biohazard container of razors poses a safety risk and should not be left in the shower room. The RN stated that he/she will remove the used razors and biohazard container from the shower room.

The identified registered staff confirmed that the identified safety risk items should not have been left unsupervised and accessible to residents. [s. 5.]

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 home is a safe and secure environment for its residents, 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. (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).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to 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 (b) reported to the resident, the resident's SDM, 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.

During the record review of the home's Medication Incident Summary for an identified period, the inspector selected three medication incidents to review. The medication incident for resident #012 , medication incident for resident #013, and medication incident for resident # 014, revealed that the medication incidents were not reported to the three identified residents' Substitute Decision Makers (SDM).

Interview with the Director of Nursing (DON) and Nurse Manager #116 confirmed that the SDMs were not notified of the residents' medication incidents. [s. 135. (1)]

2. The licensee has failed to 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).

During the record review of the home's Medication Incident Summary for an identified time period, the inspector selected three medication incidents to review. The medication incident for resident #013 revealed that there was no review or analysis conducted for the medication incident.

Interview with the DON confirmed that resident #013 medication incident was not reviewed and and analyzed and that corrective action was not documented. [s. 135. (2)]

3. The licensee has failed to ensure that : (a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, (b) any changes and improvements identified in the review are implemented, and (c) a written record is kept of everything provided for in clause (a) and (b).

During the record review of the home's Medication Incident Summary for an identified time period, the inspector selected three medication incidents to review. The medication incident for resident #012 , medication incident for resident #013, and resident # 014. A review of the Medical Advisory and Pharmacy &Therapeutics Committee meeting minutes for two identified months, failed to reveal that a quarterly review was undertaken of all medication incidents and adverse drug reactions that had occurred in the home since the time of the last review, nor were any changes and improvements identified in

the review implemented.

Interview with the DON confirmed that during the Medical Advisory and Pharmacy &Therapeutics Committee meeting, a review of the quarterly medication incidents in the home are not reviewed or analyzed by the team. [s. 135. (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 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 (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; 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); and that (a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; (b) any changes and improvements identified in the review are implemented; and (c) a written record is kept of everything provided for in clauses (a) and (b), to be implemented voluntarily.

WN #3: 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. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program.

During the initial tour of the home conducted on October 17, 2017, the inspector observed the following:

-An identified shower room – Dirty garbage filled with incontinent products left on the floor in the shower room, shower room not cleaned after use. Interview and observation with RN # 118 confirmed that the dirty garbage should not be left on the floor and the PSW staff are to clean the shower room after use.

Interview with the DOC confirmed that the staff did not participate in the infection prevention and control program. [s. 229. (4)]

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 all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The Licensee has failed to ensure that they fully respected and promoted the resident's right to participate in decision-making.

On an identified date, the MOHLTC received a complaint related to a Substitute Decision Maker (SDM) not provided the opportunity to participate in decision making.

Review of Resident #005's clinical records reveal that they were receiving a medication prior to their admission to the home on an identified date, and that this medication continued when they were admitted.

A Physician progress note written on an identified date, stated that due to the resident exhibiting symptoms they were going to hold this medication. A physician order on an

identified date, put this medication on hold, to be reassessed in 7 days. The order was signed by the physician, and nurses as required. A box on the Physician order form which is to be checked off when POA is notified was not checked off and there were no progress notes indicating that the family had been notified or consulted regarding this change of medication.

A Physician order on an identified date discontinued the medication. The order form was signed by the physician and nurses and the box indicating that the POA had been notified was not checked.

On an identified date and time, there is a progress note written by registered staff # 115 stating that the resident's SDM was visiting and became aware that the medication had been put on hold from an identified date. The progress note revealed that the SDM was upset that this change had been done without their input.

Interview with registered staff #115 confirmed that the process when transcribing new medication or changing existing medication orders is that they are to notify SDM to obtain consent. They became aware during a conversation with the SDM that they had not been made aware that this medication was on hold.

Interview with Nurse Manager (NM)# 116 confirmed that families are to be notified regarding new medications or changes to existing medication orders and that in this situation that notification had not occurred. [s. 3. (1) 9.]

2. The licensee has failed to ensure that they have fully respected and promoted the resident's right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

On an identified date and time, during the medication administration pass with RPN #110, the inspector observed the Medication Administration Record (MAR) book left unattended on two occasions, displaying the residents personal health information. On both occasions, the MAR information was visible to anyone passing by. Interview with RPN #110 revealed that he/she forgot to close the MAR book while administering the medications to the residents.

Interview with Nurse Manager #108 confirmed that the open MAR book observed by the inspector was visible to anyone passing by and did not protect residents' personal health

information. [s. 3. (1) 11. iv.]

WN #5: 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Substitute Decision Maker (SDM) of the resident was provided the opportunity to participate fully in the development and implementation of the resident's plan of care.

Interview with resident #003's SDM, revealed that the home had implemented a treatment that involved the application of medication to an affected area, and that they did not notify or consult SDM in regards to this change in the resident's plan of care.

Review of resident #003's clinical records revealed a physician order written on an identified date, ordering a medicated cream to be applied to the affected area The order was signed by the physician and nurses as required. There was no sign off in the box indicating that the SDM had been notified and there were no progress notes to indicate the SDM had been notified.

Interview with registered staff #105 and 115 revealed that when processing physician orders, including new orders or changes to existing orders for medication and treatment, the registered staff is to contact the SDM, or the resident themselves if capable, to notify them of the change in treatment and to seek consent for the change. Once this communication has been completed the registered staff is to sign off in the box on the order sheet, and also write a progress note detailing the communication.

Interview with Nurse Manager (NM) #108 confirmed the process for notifying SDM's of new medication orders and revealed that the lack of documentation regarding notification of the SDM would indicate it had not occurred. [s. 6. (5)]

2. On an identified date, the MOHLTC received complaint intake #026909-15, related to care received at the home for resident #003. The complainant reported that on an identified date, resident #003 developed skin discoluration to an identified area, however the SDM was not informed about the marks until three days later.

On an identified date, the MOHLTC received complaint intake #010237-17, related to care received at the home for resident #003. The complainant reported that on an identified date, resident #003's urinary device had little output during the day shift, and was eventually changed on the evening shift, however the SDM was not notified during the day of the resident's change in care.

Interview with RPN #110 revealed that he/she was assigned to provide care to the resident on an identified date. RPN #110 reported that resident #003 did develop skin discolouration to the identified area , however he/she confirmed that he did not notify the SDM of the issue.

Interview with RN #107 revealed that he/she was assigned to provide care to the resident on an identified date. RN #107 reported that he/she was informed by resident #003's private sitter of the low urine output, however the private sitter had taken the resident to an activity and the RN #107 states that he/she was unable to assess the resident. Interview with Nurse Manager #108 revealed that the home's process is to assess the resident related to the identified concern, and to notify the SDM's of any new changes to the resident.

Interview with Nurse Manager #108 and Director of Nursing revealed that resident #003's SDM was not notified when resident #003's urinary output decreased and required the urinary device to be changed. [s. 6. (5)]

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

On an identified date, the MOHLTC received complaint intake #026909-15, related to care received at the home for resident #003. The complainant reported that during a visit

to the home on an identified date, the complainant found the resident incontinent, and when requested for assistance from PCA #106, the PCA did not assist the resident with continence care.

Review of the written plan of care revealed resident #003 wears an incontinent product during the day and night and to provide care with each incontinent change.

Interview with PCA #106 revealed that he/she was assigned to provide care to resident #002 on the identified date. PCA #106 reported that he/she was assisting another resident in their room, when resident #003's family approached the room and informed him/her that the resident required to be changed as he/she was incontinent. PCA #106 reported that he/she was busy assisting another resident and will also require the assistance of another PCA who is currently on break. PCA #106 confirmed that he/she did not return back to assist resident #003 with his/her continence care.

A review of PCA #106 disciplinary letter confirmed the PCA did not follow the plan of care related to resident #003 continence care. [s. 6. (7)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system that the licensee was required by the Act or Regulation to have instituted or otherwise put in place was complied with.

O. Reg. 79/10 s.114 (1) - Every licensee of a long term care home shall develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents.

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

A review of the home's policy entitled " Management of Diabetes Medications, Medication Administration, MM-0206-00, published 01-08-2016, indicated to record on MAR sheet the site that was used for the administration of insulin, and the insulin site diagram should be kept in front of the MAR sheet to assist registered staff in the rotation of insulin sites.

On an identified date at time, during the medication administration pass with RPN #110, the inspector observed, RPN #110 administer insulin to an identified area on resident #006. RPN #110 coded on the MAR the insulin site of administration as D. The inspector inquired what the D referred to and requested to see a legend. RPN #110 searched the MAR record book and then stated that there is no diagram on the MAR book which indicates what the letters for the insulin site refers to.

At an identified hour, RPN #110 proceeded to administer insulin to an identified area on resident #011. RPN #110 coded on the MAR the insulin site of administration as B. The inspector inquired how he/she is able to identify which letters correspond with the site of insulin administration when there is no legend in place, RPN #110 reported that he/she is familiar with the insulin site by memory.

A review of the Insulin Administration site diagram (Appendix A in the Management of Diabetes Medications, Medication Administration, MM-0206-00, policy), indicated that the insulin site for the observed area for resident #006 is coded as F, and the insulin site for the observed area for resident #011 is coded as A.

Review of the Insulin Site Diagram and the MAR record for resident #006 and resident #011 with Nurse Manager #108, confirmed that RPN #110, incorrectly coded the insulin site of administration for both residents, and that the insulin site diagram should be left on the MAR book for the registered staff to refer to when administering insulin. The Nurse Manager confirmed that RPN #110 did not follow the home's policy on documentation as it related to the rotation of insulin sites. [s. 8. (1) (b)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was bathed, at a minimum, twice a week by the method of his or her choice.

During stage one of the Resident Quality Inspection, resident #001 identified that he/she does not receive two baths a week always.

Review of the resident #001's bath assessment flow sheet, completed on admission revealed that he/she was assessed as needing one staff assistance to be showered.

Review of the written plan of care identified that resident #001 was to receive showers on two identified evenings.

The Bath/Weigh schedule, identified by PSW #100 and RN #101, as the information source they utilized to identify when and how a resident is to be showered, indicated that resident's shower days had been changed to facilitate work load issues.

Review of the Nursing and Personal Care Record for two identified month revealed that showers were not documented as given on seven identified days

Interview with PSW #100 revealed that if a resident refuses their bath that they re-approach and also have the team lead try to re-approach the resident to take their bath. If the resident does not take their bath, it would be documented as no bath and the information would be given to the team lead.

PSW #100 identified him/herself as the PSW who worked on many of the shifts when the

showers were not signed for. PSW #100 stated that she he/she did provide baths on those dates however it appears he/she did not sign for them.

Interview with RN #101 revealed that when a resident refuses a bath, the PSW would be expected to inform the registered staff and the registered staff would document the refusal and the reason for the refusal in the progress notes.

Review of resident #001's progress notes conducted by the Inspector and RN #101 revealed that there was a progress note written on an identified date which stated shower given and tolerated well. Aside from that note, there are no other notes indicating why shower had not been received on the scheduled bath days.

Interview with Nurse Manager (NM) #116 revealed that the lack of documentation identifying the reason the resident did not receive his/her shower/bath, and the resident's statements, which the NM considered reliable, that he/she had not been receiving two weekly baths, confirmed that resident #001 had not received them. The NM confirmed that it is the home's expectation that residents be offered two showers/baths of their preference a week. [s. 33. (1)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee has failed to ensure that copies of the inspection reports for the past two years were posted in the home.

During the initial tour of the home on October 17, 2017, the inspector observed that the following inspection reports were not posted in the home: 2015_405189_0008 dated July 6, 2015 and 2016_370649_0032 dated February 23, 2017.

During an interview with the Administrator and Assistant Administrator, the missing reports were found in the management office and they posted the inspection report in the home immediately after it was brought to the Administrator's attention. [s. 79. (3) (k)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

During record review of resident #006's Medication Administration Record (MAR) on an identified date, the resident started on an identified medication on an identified date. A required Monitoring Form was initiated on an identified date, and was to be completed every 7 days by the registered staff to document the effectiveness of the medication. The inspector reviewed the form which revealed that the monitoring/documentation was not completed for day 28.

A review of resident #007's (MAR) on an identified date, revealed the resident started on an identified medication on an identified date. A required Monitoring Form was initiated on an identified date, and was to be completed every 7 days by the registered staff to document the effectiveness of the medication. The inspector reviewed the form which revealed that the monitoring/documentation was not completed for day 7 .

A review of the required Monitoring Form with the Nurse Manager #108 confirmed that the monitoring/documentation was not completed for resident #006 and resident #007 on the identified dates. [s. 134. (a)]

Issued on this 29th day of November, 2017

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

Original report signed by the inspector.