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
Jan 4, 2018	2017_566669_0027	023169-17	Resident Quality Inspection

Licensee/Titulaire de permis

THE CORPORATION OF THE COUNTY OF LAMBTON
789 Broadway Street WYOMING ON N0N 1T0

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

LAMBTON MEADOWVIEW VILLA
3958 PETROLIA LINE R. R. #4 PETROLIA ON N0N 1R0

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

ANDREA DIMENNA (669), ALICIA MARLATT (590), DEBRA CHURCHER (670)

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 10, 11, 12, 13, 16 and 17, 2017.

A follow-up inspection (log #034996-16) for a Compliance Order related to bed rails was completed with this inspection.

During the course of the inspection, the inspector(s) spoke with residents, a representative of Family Council, a representative of Residents' Council, Acting Administrator, Director of Nursing and Personal Care (DONPC), Social Worker, Resident Assessment Instrument (RAI) Coordinator, Recreation and Leisure Supervisor, Confidential Support Services Clerk, Environmental Services Supervisor, Ward Clerk, two Registered Nurses (RNs), five Registered Practical Nurses (RPNs), one Housekeeper, and 12 Personal Support Workers (PSWs).

During the course of the inspection, the Inspectors conducted a tour of the home and made observations of residents, activities and care. Relevant policies and procedures, as well as clinical records and plans of care for identified residents, were reviewed. Inspectors observed medication administration and drug storage areas, resident/staff interactions, infection prevention and control practices, the posting of Ministry information and inspection reports and the general maintenance, cleanliness and condition of the home.

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

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

11 WN(s)
5 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
O.Reg 79/10 s. 15. (1)	CO #001	2016_303563_0040	669

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. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Section 48 (1) of Ontario Regulation 79/10, states "The licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: a skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions."

The home's policy, Skin and Wound Care (No. 3-5-19-6), last reviewed June 2017, stated, "Residents with Skin Impairments. Record weekly in the Skin/Wound note including Type and Location, Observations-Size [centimetres] (cm) including undermining (depth, width, length), drainage, Wound bed, Level of Pain (0-10), treatment, Evaluation/Changes Since Last Assessment."

Review of an identified resident's clinical record stated that the resident had weekly skin assessments completed and signed for on the Treatment Administration Record (TAR) on five identified dates. Out of these five weekly skin assessments, all five were missing specific information related to the altered skin integrity and one was missing information related to the resident's pain level.

The Director of Nursing and Personal Care (DONPC) acknowledged that the aforementioned skin assessments were incomplete. The DONPC stated that it was the expectation that skin assessments followed the home's policy.

The licensee has failed to ensure that any actions taken with respect to a resident under a skin and wound program, including assessments and reassessments, were documented.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was isolated during the course of this inspection. The home was issued non-compliance for this section of legislation as a Voluntary Plan of Correction during a Complaint Inspection on March 2, 2016. [s. 30. (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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) the restraining of the resident was included in the resident's plan of care.

The Inspector observed the identified resident with the physical device in use with a potential restraining quality on three separate occasions during the home's Resident Quality Inspection (RQI). During one observation, the resident was observed attempting to release themselves from the device.

The inspector was unable to locate a physician's order, consent, assessment or documentation in the resident's clinical record and care plan related to the physical device with a potentially restraining quality.

The home's policy, Restraints/Personal Assistance Service Devices (PASDs) (No. 3-5-18 -04), last reviewed August 9, 2016, stated, "A physician or Registered Nurse Extended Class (RNEC) in collaboration with the interdisciplinary team may prescribe a physical restraint. The prescribing clinician should ensure that alternatives have been considered,

and informed consent is obtained for the treatment from the resident and/or the substitute decision maker. 1) Assess resident for condition, circumstances or clinical indicators that potentially require treatment interventions in collaboration with the team. Complete Restraint Assessment in Point Click Care. 2) Include in the written order what device is being ordered and instructions relating to the order. 3) Discuss with the Resident/SDM: goals such as elimination of the restraint, reduction of the severity, duration and/or frequency of use, measureable objectives, period of day when the restraint is required, frequency that resident will be checked, frequency of position change, frequency of range of motion exercises and ambulation, frequency of evaluation of the side effects of restraints on resident behavior, deadline date for re-evaluation of the need for restraint. 4) Obtain and record informed consent including that the risks and benefits of alternative treatment options and risks and benefits related to use of the restraint have been outlined to the resident/SDM. Care Plan, Registered Nursing Staff: 1) Establish resident focused goals including reduction of severity frequency, duration or elimination of the restraint."

A RPN stated that the resident was a fall risk and they used the physical device for restraining purposes and fall prevention, and that the device was also used for positioning purposes but it would be considered a restraint as the resident could not release themselves from the device.

The DONPC stated that the use of the identified physical device for this resident constituted a restraint. The DONPC reviewed the resident's clinical record and care plan with the Inspector and acknowledged that there was no documentation related to the device and that the expectation was that there would be a physician's order, consent, assessment, care plan and regular documentation related to the restraint use.

The licensee has failed to ensure that the restraining of the resident was included in the plan of care.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was isolated during the course of this inspection. The home did not have a history of non-compliance in this section of the legislation. [s. 31. (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 when a resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1), the restraining of the resident is included in the resident's plan of care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 133. Drug record (ordering and receiving)
Every licensee of a long-term care home shall ensure that a drug record is established, maintained and kept in the home for at least two years, in which is recorded the following information, in respect of every drug that is ordered and received in the home:
1. The date the drug is ordered.
2. The signature of the person placing the order.
3. The name, strength and quantity of the drug.
4. The name of the place from which the drug is ordered.
5. The name of the resident for whom the drug is prescribed, where applicable.
6. The prescription number, where applicable.
7. The date the drug is received in the home.
8. The signature of the person acknowledging receipt of the drug on behalf of the home.
9. Where applicable, the information required under subsection 136 (4). O. Reg. 79/10, s. 133.

Findings/Faits saillants :

1. The licensee has failed to ensure that a drug record was established, maintained and kept in the home for at least two years, in which the following information was recorded in respect of every drug that was ordered and received in the home:
1. The date the drug was ordered
2. The signature of the person placing the order

3. The name, strength and quantity of the drug
4. The name of the place from which the drug was ordered
5. The name of the resident for whom the drug was prescribed, where applicable
6. The prescription number, where applicable
7. The date the drug was received in the home
8. The signature of the person acknowledging receipt of the drug on behalf of the home
9. Where a controlled substance was destroyed, including documentation as per section 136 (4).

This inspection protocol was initiated as a mandatory part of this RQI.

In an interview with the DONPC, they shared that the pharmacy completed Medication Management Audit Reports and this helped the home identify areas that needed improvement related to the medication management system. They shared that drug ordering was an area that was identified as needing improvement.

Review of the Medication Re-order/Drug Record Sheets for the time period of October 16 to 20, 2017, showed that there was a total of 48 drugs ordered. Of these 48 drugs:
- 11 orders did not document the date the medications were ordered, or who ordered the medications
- 25 orders did not document the date the drug was received, the quantity of medication received, prescription number, or signatures of the person receiving the drugs.

The home's policy, Receiving Non-Controlled Medications (No. 6.7), last revised March 1, 2016, was reviewed and stated that:
"2. Pharmacy delivers all medications to the designated area of the Home to a registered staff member. The medications arrive in a sealed delivery bag/bin. Registered staff sign to indicate receipt of the Pharmacy delivery."
"3. Automatically shipped weekly dispensed medications are checked off against the shipping report provided by the Pharmacy. Discrepancies must be reported to Pharmacy immediately.
All shipping reports that accompany medications that are delivered by the pharmacy automatically each week are also signed and dated by the staff member receiving the medication and are filed in the Drug Record Book or similar binder for such purposes."
"5. Non-pouched medication is reconciled against the Medication Re-order/Drug Record Sheet (See Form 10.13) to ensure all medications ordered have been received and the sheet is signed and dated by the registered staff member. Any discrepancy must be reported to the Pharmacy immediately."

In an interview with the DONPC, they shared that the drug ordering sheets did not document the identified required information as outlined by the Long-Term Care Homes Act.

The licensee has failed to ensure that a drug record was established, maintained and kept in the home for at least two years, in which the date medication was ordered, the date the drug was received, the quantity of medication received, the prescription number, who ordered the medications, and signatures of the person receiving the drug were all recorded in respect to every drug that was ordered and received in the home.

The severity was determined to be a level one as there was minimum risk. The scope of this issue was widespread during the course of this inspection. The home did not have a history of non-compliance in this section of the legislation. [s. 133.]

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 a drug record is established, maintained and kept in the home for at least two years, in which the following information is recorded in respect of every drug that is ordered and received in the home:
1. The date the drug is ordered;
2. The signature of the person placing the order;
3. The name, strength and quantity of the drug;
4. The name of the place from which the drug is ordered;
5. The name of the resident for whom the drug is prescribed, where applicable;
6. The prescription number, where applicable;
7. The date the drug is received in the home;
8. The signature of the person acknowledging receipt of the drug on behalf of the home;
9. Where a controlled substance is destroyed, including documentation as per section 136(4), to be implemented voluntarily.

WN #4: 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 was:
(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 (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.

As part of the Resident Quality Inspection (RQI), medication incidents were reviewed for a specified time period, during which the home reported a total of 11 incidents.

The home's Medication Incident Policy (No. 4.15), last revised on March 1, 2016, was reviewed and stated:
2. "If the incident has resulted in an adverse effect, seek immediate appropriate medical assistance. Consultation with the Pharmacist is also recommended.”
4. "Notify the Prescriber, if appropriate, of the incident.”
5. "Notify the Resident or POA [Power of Attorney] (family representative) for any incidents reaching the resident and any follow-up actions taken"
6. "Fax the incident report to the Pharmacy; forward to Director of Care for investigation.”

Review of a Medication Incident/Near Miss Report, not dated, involving an identified resident missing multiple doses of a medication, showed that the area to document the date and time when the pharmacy was notified and if the pharmacy was notified of the incident, was empty. Review of this resident's progress notes showed that there was no mention of the medication incident. The Report included a comment that there were no effects on the resident at that time, and there was no further documentation to suggest that the incident negatively affected the resident.

Review of a second Medication Incident/Near Miss Report, with a specified date, involving an identified resident missing part of their dose of a medication, showed that the area to document notifications was empty. There was no documentation on the form to support that the resident or their POA if applicable, pharmacy, Director of Care, or Prescriber were notified of the medication incident. Review of this resident's progress notes showed that there was no mention of the medication incident. There was no documentation to suggest that the incident negatively affected the resident.

In an interview with an RPN, they shared that it was part of the home's process to notify the resident or POA of medication errors, and that the nurse who made the error should be notifying the resident or their POA.

In an interview with the DONPC, they agreed that the documentation on the Medication Incident/Near Miss Reports was not completed. They stated that if there was no documentation on the Medication Incident form and no documentation in the resident's

progress notes that someone was notified of the incident, then the resident/POA was not notified.

The licensee has failed to ensure that the medication incidents involving two identified residents were reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the prescriber of the drug, and the pharmacy service provider. [s. 135. (1)]

2. The licensee has failed to ensure that:
(a) all medication incidents and adverse drug reactions were documented, reviewed and analyzed
(b) corrective action was taken as necessary, and
(c) a written record was kept of everything required under clauses (a) and (b).

The home's Medication Incident Policy (No. 4.15), last revised on March 1, 2016, was reviewed and said that when a medication incident occurred, staff were to:
"Initiate a Remedy’s RX Medication Incident/Near Miss Report documenting:
- Resident name
- Date and time of incident
- Indicate type of incident and circle specific example
- Description of incident
- Medication involved
- Effect on resident
- Follow-up actions taken
- Attach a copy of MAR/eMAR report and any other supporting documentation
- Attach a copy of Medication pouch/copy of Medication Label if applicable.”

Review of Medication Incident/Near Miss Report involving an identified resident showed that areas to document the type of incident, factors that contributed to the incident and the corrective action taken to prevent similar occurrences in the future, was empty.

Review of a second Medication Incident/Near Miss Report involving an identified resident showed that areas to document the date and time of the incident, factors that contributed to the incident and the corrective action taken to prevent similar occurrences in the future, was empty.

Review of a third Medication Incident/Near Miss Report involving an identified resident showed that areas to document the effect on the resident and description of effect, if it

was a high risk medication, factors that contributed to the incident and the corrective action taken to prevent similar occurrences in the future, was empty.

In an interview with the DONPC, they agreed that documentation on the Medication Incident/Near Miss Reports was incomplete, and that corrective actions were not taken. the DONPC further said that the documentation on the form should be completed as directed by their policies and the Pharmacy.

The licensee has failed to ensure that corrective actions were taken as necessary, and a written record was kept of the corrective actions for the medication incidents involving three identified residents. [s. 135. (2)]

3. The licensee has failed to ensure that:
(a) a quarterly review was undertaken of all medication incidents and adverse drug reactions that 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 were implemented, and
(c) a written record was kept of everything provided for in clause (a) and (b).

The policy, Professional Advisory Committee (PAC) (No. 9.1), last revised on March 1, 2016, was reviewed and stated:
- "The PAC also promotes safety and minimizes risks for residents around medications including the implementation of a comprehensive medication incident reporting program that reviews medication incidents, examines trends and looks at root causes to recommend system changes and reduce risk."
- "In the Quarterly Evaluation of the Medication Management System the Professional Advisory Committee:
- Evaluates the risk of medication incidents and adverse drug reaction in the Home and keeps a written record of each evaluation. The committee reviews Adverse Drug Reaction Reports and Medication Incident/Near Incident Reports, recommending changes to prevent or reduce the likelihood of recurrence."

The home's Medication Incident/Near Miss Reports were reviewed and showed that incidents occurred in a specified month, involving three identified residents.

Review of Remedy'sRx Summary of Reported Incidents, for a specified time period, did not include the medication incidents for the three identified residents.

Review of the home's PAC meetings minutes from two specified dates, showed that the minutes did not reflect a review of resident-specific medication incidents which occurred in the past quarter.

In an interview with the DONPC, they shared that medication incidents were reviewed at the PAC meetings. The DONPC stated that even if there was no documentation on a Medication Incident/Near Miss Report to indicate that the pharmacy had been notified, that the resident-specific incidents would be reviewed at the PAC meetings. The DONPC was unable to provide documentation to support that the home reviewed the medication incidents for the three identified residents in their quarterly evaluation.

The licensee has failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that occurred in the home since the time of the last review and that a written record was kept.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was a pattern during the course of this inspection. The home did not have a history of non-compliance in this section of the legislation. [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:
1) 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 (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;
2) (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);
3) (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), to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that for the purposes of paragraph 6 of subsection 76 (7) of the Act, the following was an area in which training was provided to all staff who provided direct care to residents: skin and wound care.

During an interview, a PSW stated that they had never received any training on skin and wound care from the home.

An RPN was also interviewed and stated that the home had never offered any skin and wound care education to the staff.

When the Inspector requested copies of the education provided to staff related to skin and wound care, the DONPC stated that they had not provided any skin and wound care education to staff.

The licensee has failed to ensure that training related to skin and wound care was provided to all staff who provided direct care to residents.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was widespread during the course of this inspection. The home did not have a history of non-compliance in this section of the legislation. [s. 221. (1) 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 for the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents: skin and wound care, to be implemented voluntarily.

WN #6: 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:
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).

Findings/Faits saillants :

1. The licensee failed to ensure that the following rules were complied with: 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.

During the home's RQI, a tour of the home revealed multiple unlocked doors to housekeeping and supply rooms.

During the initial tour of the home on October 10, 2017, the following doors were unlocked:
- Room S97 on second floor: a supply room that contained a hydrocollator, another piece of equipment that was very hot to touch, and personal hygiene products such as hairspray and shampoo. A PSW acknowledged that the door should have been locked and proceeded to lock the door. No residents were present.
- Room S87 on second floor: a housekeeping closet that contained multiple cleaning products including disinfectant wipes, steel polish, and Virex. An RPN acknowledged that the door should have been locked, but was unable to lock the door and called maintenance. The Inspector waited for a maintenance staff member to arrive, who locked the door. No residents were present.
- Room T84 on third floor: an equipment supply room that contained assistive devices, extension cords, and a bottle of 100% acetone. A Housekeeper acknowledged that the door should have been locked and proceeded to lock the door. No residents were present.
- Room T96 on third floor: a supply room that contained various cleaning agents such as toilet bowl cleaner and Virox. A PSW acknowledged that the door should have been locked and proceeded to lock the door. No residents were present.

On October 12, 2017, the Inspector checked the doors to rooms S97 and S87 while accompanied by the DONPC. The Inspector observed that Room S87 was locked, but the door to Room S97 was unlocked. The DONPC acknowledged that Room S97 was unlocked and stated that both Rooms S87 and S97, along with all rooms containing chemicals and items that may pose a safety risk to residents, should be locked at all times.

The licensee failed to ensure that doors for non-residential areas were kept closed and locked when they were not being supervised by staff.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was isolated during the course of this inspection. The home did not have a history of non-compliance in this section of the legislation. [s. 9. (1) 2.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

During the home's RQI, it was identified from the census record review and staff interview that an identified resident had an area of altered skin integrity.

The home's policy, Skin and Wound Care (Index No. 3-5-19-6), last reviewed June 2017, stated that registered staff must complete a comprehensive skin assessment in Point Click Care (PCC) if a resident had been identified as having a new an area of altered skin integrity.

The identified resident's Treatment Administration Record (TAR) showed that the resident

had multiple skin integrity issues.

The identified resident's progress notes were reviewed and one of the resident's identified area of altered skin integrity was first documented on a specified date.

Assessments in PCC were reviewed for the identified resident and there was no Comprehensive Skin Assessment for the resident's identified area of altered skin integrity.

The identified resident was interviewed and stated the identified area of altered skin integrity had developed after their admission into the home, and that treatment was provided.

Two RPNs were interviewed and stated that a comprehensive skin assessment was completed for new areas of altered skin integrity. One of the RPNs said that the identified resident was at very high risk for skin issues and that the resident's identified area of altered skin integrity had worsened significantly.

The Resident Assessment Instrument (RAI) Coordinator was interviewed and explained that when a resident had a new area of altered skin integrity, a comprehensive skin assessment in PCC should be completed. The RAI Coordinator reviewed the identified resident's assessments and progress notes, and was unable to find an initial skin assessment for the resident's identified area of altered skin integrity. The RAI Coordinator acknowledged that the resident should have had an initial assessment for their identified area of altered skin integrity.

The DONPC was interviewed and stated that a comprehensive skin assessment should be completed for every new area of altered skin integrity.

The licensee has failed to ensure that the identified resident received a skin assessment for their identified area of altered skin integrity by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that any resident who was dependent on staff for repositioning was repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident should only be repositioned while asleep if clinically indicated.

During the home’s RQI, it was identified from the census record review and staff interview that an identified resident had an area of altered skin integrity.

The home's policy, Skin and Wound Care (Index No. 3-5-19-6), last reviewed June 2017, stated that for the prevention of pressure ulcers, dependent residents must be repositioned a minimum of every two hours, including chair positioning.

The identified resident’s TAR showed that the resident had multiple skin integrity issues, including the identified area of altered skin integrity.

The identified resident’s progress notes were reviewed and one of the resident's identified areas of altered skin integrity was first documented on a specified date, and included specified treatment.

Point of Care (POC) Tasks for the resident were reviewed and none were related to repositioning.

The identified resident's care plan for impaired skin integrity was reviewed and included the intervention to turn, reposition, and provide skin care at least every two hours, and more often as needed or requested.

The identified resident was interviewed and explained that they were not able to reposition themselves, and that staff did not offer to reposition them during the day.

Two PSWs were interviewed and stated that the identified resident was unable to reposition themselves but that the resident called staff when they needed to be adjusted or repositioned.

A RPN was interviewed and stated that the resident was at very high risk for skin issues and that the resident’s identified area of altered skin integrity had worsened, despite interventions.

The RAI Coordinator was interviewed and said they were unsure if the identified resident was able to reposition themselves. The RAI Coordinator reviewed the resident’s care plan and acknowledged that on a specified date, an intervention was entered under the skin integrity focus stating that the resident should be turned or repositioned at least every two hours and more often as needed or requested. The RAI Coordinator

acknowledged that the resident care plan showed that staff should be repositioning the resident every two hours.

The DONPC was interviewed said that residents who were dependent on staff for repositioning should be repositioned at least every two hours. The DONPC acknowledged that the identified resident was independent but stated that staff should still offer to reposition the resident every two hours as an intervention for altered skin integrity.

The licensee has failed to ensure that the identified resident, who was dependent on staff for repositioning, was repositioned every two hours or more frequently as required.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was a pattern during the course of this inspection. The home did not have a history of non-compliance in this section of the legislation. [s. 50. (2) (d)]

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 failed to ensure that the required information was posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations. The required information for the purposes of subsections (1) and (2) included copies of the inspection reports from the past two years for the long-term care home.

During the home's RQI, a tour of the home revealed that not all inspection reports from the past two years were posted.

During the initial tour of the home on October 10, 2017, the home's previous inspection reports were observed to be posted on a bulletin board near the reception desk. The last inspection report posted was from June 2016, with no other reports from 2016, or 2015.

The home's compliance history showed that nine inspections were completed in the past year, including inspections on January 20, 26, 28, and March 2, 2016, as well as on November 2, 2015.

The Acting Administrator was interviewed and stated that the home was required to post inspection reports from the past two years, and acknowledged that there were inspection reports missing from those that were posted.

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

The severity was determined to be a level one as there was minimum risk. The scope of this issue was a pattern during the course of this inspection. The home did not have a history of non-compliance in this section of the legislation. [s. 79. (3) (k)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 113. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes or improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared. O. Reg. 79/10, s. 113.

Findings/Faits saillants :

1. The licensee has failed to ensure that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements were required to minimize restraining and to ensure that any restraining that was necessary was done in accordance with the Act and this Regulation; (c) that the results of the analysis undertaken under clause (a) were considered in the evaluation; (d) that the changes or improvements under clause (b) were promptly implemented; and (e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented was promptly prepared.

The Inspector was unable to locate an evaluation of the home's restraint program within the last calendar year.

The DONPC stated that they had not completed a yearly evaluation of the restraint program, but that restraints should be analyzed monthly and documented in PCC. The DONPC acknowledged that if there was no documentation in PCC, the analysis was not completed.

The licensee has failed to ensure that at least once in every calendar year, an evaluation was made to determine the effectiveness of the restraint policy.

The severity was determined to be a level one as there was minimum risk. The scope of this issue was isolated during the course of this inspection. The home did not have a history of non-compliance in this section of the legislation. [s. 113. (b)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 115. Quarterly evaluation

Specifically failed to comply with the following:

s. 115. (4) The licensee shall ensure that the changes identified in the quarterly evaluation are implemented. O. Reg. 79/10, s. 115 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the changes identified in the quarterly evaluation

were implemented.

This inspection protocol was initiated as a mandatory part of this RQI.

In an interview with The DONPC, they shared that the home completed audits of their medication management system to identify areas that need improvement and the audits were reviewed at the quarterly PAC meetings where they reviewed the results of the completed audits and suggestions were made for improvement that were usually implemented.

The policy, Professional Advisory Committee (PAC) (No.9.1), last revised on March 1, 2016, stated:
"In the Quarterly Evaluation of the Medication Management System the Professional Advisory Committee: Implements and assesses Risk Management and Quality Improvement Activities with continuous process improvement surrounding medication management to better serve the staff and residents of the Home. Quarterly Medication Management System/Audit/eAudits are reviewed; audit tools and follow-up Audit/eAudit reports are developed for the Director of Care; and discussion around best practice initiatives and quality improvement initiatives are in place. Quality Indicators for the Home may be developed by the interdisciplinary team with the common goal of improving therapeutic outcomes for the resident."

Review of two Medication Management Audit Reports, one from the third floor, dated June 12, 2017, and one from the first floor, dated September 25, 2017, showed that an area of concern identified was related to inconsistent documentation of received medication from the pharmacy.

Review of Remedy'sRx Medication Re-order/Drug Record Sheets for the time period of October 16 to 20, 2017, showed that there was a total of 48 drugs ordered. Of these 48 drugs:
- 11 orders did not document the date the medications were ordered, or who ordered the medications
- 25 orders did not document the date the drug was received, the quantity of medication received, prescription number, or signatures of the person receiving the drugs.

In an interview with the DONPC, they stated that changes had been implemented related to the documentation of ordered drugs and documentation in this area had improved lately, but agreed that the changes implemented had been ineffective as evidenced by

the consistent incomplete documentation in multiple quarters.

The licensee has failed to ensure that the changes identified in the quarterly evaluation were implemented.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was isolated during the course of this inspection. The home did not have a history of non-compliance in this section of the legislation. [s. 115. (4)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 116 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that an interdisciplinary team, which included the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who was a member of the staff of the home, met annually to evaluate the effectiveness of the medication management system in the home and recommended any changes necessary to improve the system.

The policy, Professional Advisory Committee (PAC) (No.9.1), last revised on March 1, 2016, stated:
"In the Annual Evaluation the Professional Advisory Committee: Meets annually for an evaluation of the effectiveness of the Medication Management System in the Home. Under the Ontario LTC Act, annual evaluation of the medication management system must take place. This committee is identical in membership to the PAC Committee and must also include a registered dietitian who is a staff member of the Home. Included in the annual evaluation is:
- A review of the quarterly evaluations in the previous year;
- A comprehensive review of the medication management system using the ISMP-Medication Safety Self-Assessment (MSSA) instrument or a similar assessment instrument that is designed specifically to reflect the medication best practices in LTC;
- Identification of changes that improve the medication management system; and
- The Director of Care ensures that a written record is kept of the annual evaluation and any changes that were implemented."

In an interview with the DONPC, they said that they had not completed an annual evaluation of their medication management system and had no documentation to provide to the Inspector to support that an evaluation had been completed.

The licensee has failed to ensure that an annual evaluation of their medication management system was completed.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was isolated during the course of this inspection. The home did not have a history of non-compliance in this section of the legislation. [s. 116. (1)]

Issued on this 9th day of January, 2018

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

Original report signed by the inspector.