Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 13, 2019	2019_749653_0020	003201-18, 016224-18, 025820-18, 027483-18, 027742-18, 030835-18, 000264-19	Complaint

Licensee/Titulaire de permis

Royal Canadian Legion District 'D' Care Centres
59 Lawson Rd TORONTO ON M1C 2J1

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

Tony Stacey Centre for Veterans' Care
59 Lawson Road TORONTO ON M1C 2J1

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

ROMELA VILLASPIR (653), JADY NUGENT (734)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): July 22, 23, 24, 25, 26, 29, 30, 31, and August 1, 2, 6, 7, 8, 2019.

The following complaint intakes were inspected during this inspection:

Log #(s):

003201-18, 016224-18 related to dignity, continence care, personal support services, missing personal records and items;
025820-18, 027742-18 related to medication, mouth care, hydration, recreational and social activities, staffing, allegation of neglect, and the home's complaint procedure;
027483-18 related to medication;
030835-18, 000264-19 related to allegation of staff to resident abuse and the home's infection prevention and control program.

During the course of the inspection, the inspectors conducted observations of resident care provision, staff and resident interactions, reviewed clinical health records, staff training records, staffing schedules, staff employment records, the home's Critical Incidents (CI) and complaint binders, internal investigation records and relevant home policies and procedures.

During the course of the inspection, the inspector(s) spoke with the residents, Substitute Decision-Makers (SDMs), Personal Support Workers (PSWs), PSW Student, Registered Practical Nurses (RPNs), Registered Nurses (RNs), Nurse Managers (NMs), Laundry Staff, Environment Manager (EM), Dietary Aide, Food Service Supervisor (FSS), Recreation Assistant (RA), Office Manager, Associate Director of Care (ADOC), Director of Care (DOC), and the Executive Director (ED).

A Voluntary Plan of Correction related to s. 6 (7) of the Long-Term Care Homes Act, S.O. 2007, identified in concurrent CIS inspection report #2019_749653_0021 will be issued in this complaint inspection report #2019_749653_0020.

A Voluntary Plan of Correction related to r. 101 (2) of the O. Reg. 79/10, identified in concurrent CIS inspection report #2019_749653_0021 will be issued in this complaint inspection report #2019_749653_0020.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Dignity, Choice and Privacy
Falls Prevention
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Sufficient Staffing

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende 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. 6. Plan of care

Specifically failed to comply with the following:

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).

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee had failed to ensure that the care set out in the plan of care was provided to the residents as specified in the plan.

The following evidence was identified under Critical Incident System (CIS) inspection report #2019_749653_0021 (Log #: 002357-19):

The home submitted a Critical Incident Report (CIR) to the Director for an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. The CIR indicated resident #014 had an unwitnessed fall in the tub/ shower room and was sent to the hospital for further assessment.

A review of resident #014's Resident Assessment Instrument-Minimum Data Set (RAI-MDS) annual assessment and written plan of care indicated resident #014 had moderate cognitive impairment and required assistance for an identified Activity of Daily Living (ADL).

An interview with Personal Support Worker (PSW) #106 indicated on an identified date and time, they had transferred resident #014 from their personal assistive device to the toilet with the assistance of another PSW. After the transfer, both PSWs left the resident on the toilet inside the tub/ shower room, and PSW #106 sat down at the nursing station just outside of the tub/ shower room. PSW #106 stated they waited at the nursing station

for the resident to finish their activity in the tub/ shower room, and after some time the PSW heard the resident said they were finished. Upon PSW #106's return, they saw the resident lying on the floor and noted an injury. PSW #106 was aware of the resident's required assistance for toileting, but stated they usually leave the resident by themselves on the toilet and give them time to do their activity, while they waited outside.

A review of Registered Nurse (RN) #107's progress note and an interview with them indicated resident #014 had an unwitnessed fall resulting in an injury, and was sent to the hospital for further assessment. The RN acknowledged care was not provided to resident #014 as specified in the plan when they were left unsupervised.

During an interview, the Director of Care (DOC) acknowledged the above mentioned information from record reviews and staff interviews, and that care was not provided to resident #014 as specified in the plan. The DOC further acknowledged the incident resulted in an injury and the resident was sent to the hospital. [s. 6. (7)]

2. The following evidence was identified under CIS inspection report #2019_749653_0021 (Log #: 002237-19):

The home submitted a CIR to the Director for an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. The CIR indicated resident #007 had an unwitnessed fall and was transferred to the hospital for further assessment. The resident sustained an injury as a result of the fall.

A review of resident #007's written plan of care indicated they required an identified number of staff for assistance with transfers. The written plan of care also indicated that a transfer logo was in place on the wall near the resident's bed.

During the initial observation conducted by Inspector #734 on an identified date, it was noted that resident #007 had a transfer logo posted above their bed which indicated the required number of staff for assistance with transfers, as per their written plan of care. The inspector witnessed PSW #118 transferred resident #007 from the bed to their personal assistive device. During another observation conducted by Inspector #734 on an identified date, it was noted that PSW #102 transferred resident #007 from their personal assistive device to the bed.

During two separate interviews by Inspector #734, Registered Practical Nurses (RPNs)

#109 and #123 both confirmed that the PSWs did not follow the resident's plan of care during the above mentioned observed transfers.

During an interview, the DOC stated that front line staff were expected to follow the transfer interventions within the written plan of care and the transfer logos posted in the resident's room. [s. 6. (7)]

3. The licensee had failed to ensure that the staff and others who provided direct care to resident #001 were kept aware of the contents of the resident's plan of care and had convenient and immediate access to it.

The Ministry of Long-Term Care (MLTC) received a complaint related to resident #001.

Due to lack of clarity amongst staff obtained during staff interviews regarding the interventions for resident #001, Inspector #734 asked PSW #102 if they were able to access resident #001's written plan of care. PSW #102 confirmed that as a PSW they had access to the written plan of care which was kept in a binder in the nursing station. PSW #102 then proceeded to take Inspector #734 into the nursing station to obtain the binder, however they were unable to locate the binder. PSW #102 then proceeded to ask RPN #109 where the binder was now located. RPN #109 was also unable to locate the binder. PSW #102 then asked the DOC if they knew where the care plan binder had been placed. At which time the DOC explained to PSW #102 that the binder had been removed from the nursing station since February 2019, and PSWs were now to access the residents' written plan of care on Point Click Care (PCC).

Inspector #734 then asked PSWs #108 and #112 to demonstrate how they use PCC to access the resident's written plan of care, and both PSWs were unaware of how to use the system, and neither had accessed the system before. The PSWs further indicated the home announced the change and the RAI Co-ordinator provided them with a sheet on how to access the information. However, no formal training had been provided. An interview with PSW #111 also stated they had not been trained on how to access the resident's written plan of care on PCC. [s. 6. (8)]

4. The licensee had failed to ensure that the provision of the care set out in the plan of care had been documented.

The MLTC received a complaint regarding care concerns related to resident #011. The complainant indicated the resident's Substitute Decision-Maker (SDM) had sent a letter

to the home on an identified date, regarding resident #011's care, and one of the concerns was lack of mouth care.

A review of resident #011's nursing and personal care record from the time period the complaint was lodged, identified missing documentation under the ADL "mouth care provided".

A review of the resident assignment sheet indicated PSWs #133 and #134 worked during the identified shifts and was assigned to resident #011's care. Separate interviews with PSWs #133 and #134 indicated mouth care was provided to resident #011 in the morning, at bedtime, and as needed. Both staff acknowledged that the home's expectation was for them to document the care provided to the residents, however, they stated there were times when they were too busy providing care and did not have enough time to document on the nursing and personal care record.

During an interview, the DOC reviewed resident #011's nursing and personal care record and acknowledged that the provision of mouth care set out in the plan of care had not been documented. [s. 6. (9) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure
-that the care set out in the plan of care is provided to the resident as specified in the plan;
-that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it;
-that the provision of the care set out in the plan of care is documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

The MLTC received a complaint related to an allegation of staff to resident abuse. During a follow-up telephone interview by a triage inspector, the complainant indicated on an identified date, PSW #117 was rough and slapped resident #004's hand during care.

The home submitted a CIR on an identified date and time for staff to resident physical abuse. The CIR indicated resident #004 was slapped by a PSW on their left hand because they did not cooperate with the care.

A review of the home's policy titled, "Abuse and Negligence -Document No. 02-06" dated October 2015, indicated that, "whether alleged or actual abuse or neglect by an employee or volunteer they should be removed immediately pending investigation of the incident". Furthermore, the policy stated, "the nurse manager once they have determined the resident is safe will inform the Director of Care and the Executive Director".

A review of progress note indicated that PSW #136 reported PSW #117 had slapped resident #004's arm due to the resident not being compliant during care. The note also stated that at the time of the incident, the resident's vital signs were taken, both staff were spoken to by the Nurse Manager (NM), and the SDM was informed.

Inspector #734 attempted to interview PSW #136, however they were not available.

During an interview, PSW #117 confirmed that they had been the identified staff for the alleged physical abuse towards resident #004. PSW #136 had reported the allegation to the NM at the time of the incident. PSW #117 provided a recount of the incident, in which they explained that after being spoken to by senior staff they continued to work and remained in the home until the completion of their shift on the day of the incident. PSW #117 was called back to the home the next day, at which time they were suspended by the previous Executive Director (ED), pending investigation.

During an interview with the DOC, they confirmed that the home did not follow their Abuse and Negligence policy by allowing PSW #117 to remain in the home on the day of the incident. In addition, the DOC also stated that NM #107 did not inform the previous DOC about the incident until the next day. [s. 20. (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 there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and ensure that the policy is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

s. 31. (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 31 (4).

Findings/Faits saillants :

1. The licensee had failed to ensure that the written staffing plan included a back-up plan

for nursing and personal care staffing that addresses situation when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work.

According to O. Reg. 79/10 s. 31 (2), Every licensee of a long-term care home shall ensure there is a written staffing plan for the programs referred to in clauses (1) (a) and (b).

According to O. Reg. 79/10 s. 31 (3) (d), The staffing plan must include a back-up plan for nursing and personal care staffing that addresses situation when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work.

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

The MLTC received a complaint regarding care concerns related to resident #011. The complainant indicated the resident's SDM had sent a letter to the home regarding resident #011's care.

A review of the resident's SDM's e-mail addressed to the home, indicated insufficient staffing in the home created problems getting residents to the dining room in the morning.

A review of the home's written staffing plan dated August 2016, indicated the following under the back-up plan:
"a) RNs may be used to replace RPNs as required.
b) The Director of Care may be used to replace RNs on off shifts if necessary.
c) Managers can assist in the nursing department provided they are not giving care, but can be utilized to make beds, assist nursing staff at meal time, porter residents, answer call bells, speak with families".

Separate interviews with the unit clerk, NM #131, Associate Director of Care (ADOC), and DOC, indicated the home had a call-in binder with the call-in list for PSWs, RPNs, and RNs, that were used when replacing staff who cannot come to work. If no one was available to take the shift, the home would offer overtime to staff who were already

working in the building on that particular shift. The unit clerk, NM #131, ADOC, and DOC, further indicated agencies were utilized upon the approval of the ADOC or DOC.

During separate interviews, the ADOC and the DOC reviewed the home's written staffing plan and acknowledged that the back-up plan did not comply with the legislative requirement under s. 31 (3) (d) as the back-up plan under the written staffing plan did not address situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work. [s. 31. (3) (d)]

2. The licensee had failed to ensure that the written staffing plan was evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

A review of the home's written staffing plan dated August 2016, indicated the following under evaluation: "At least annually, the program is evaluated and updated in accordance with evidence-based practices and, the relase of the CMI. Evaluation of the program is documented using the annual program evaluation form".

During an interview, the DOC indicated they started as a nurse manager in the home in July 2016, and they had just taken on the DOC position in February 2019. The inspector provided the DOC an opportunity to search for records of previous staffing plan evaluations, but the DOC could not find even one record of evaluation. The DOC further acknowledged that the home failed to demonstrate that the staffing plan was evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. [s. 31. (3) (e)]

3. The licensee had failed to ensure that there was a written record of each annual evaluation of the written staffing plan including the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

A review of the home's written staffing plan dated August 2016, indicated the following under evaluation: "At least annually, the program is evaluated and updated in accordance with evidence-based practices and, the relase of the CMI. Evaluation of the program is documented using the annual program evaluation form".

During an interview, the DOC indicated they started as a nurse manager in the home in July 2016, and they had just taken on the DOC position in February 2019. The inspector

provided the DOC an opportunity to search for written records of previous staffing plan evaluations, but the DOC could not find even one record of evaluation. The DOC further acknowledged that the home failed to ensure that there was a written record of each annual evaluation of the staffing plan including the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. [s. 31. (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 the written staffing plan include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work;
-that the written staffing plan is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices;
-to keep a written record relating to each evaluation under clause (3) (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee had failed to ensure that a documented record was kept in the home that included (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any (e) every date on which any response was provided to the complainant and a description of the response, and (f) any response made by the complainant.

The MLTC received a complaint regarding care concerns related to resident #011. The complainant indicated the resident's SDM had sent a letter to the home regarding resident #011's care.

A review of the resident's SDM's e-mail addressed to the home identified the first line indicated "letter of complaint". The e-mail identified different areas of concerns such as allegation of abuse, neglect, recurrent infection, withholding nutrition, and insufficient staffing.

A review of the previous ED's e-mail response sent to resident #011's SDM indicated acknowledgement of receipt of the letter of complaint. The ED stated given the seriousness of the report, the previous DOC submitted a CIR to the MLTC. The ED further indicated on behalf of the home, they apologized for the care resident #011 received and the staff that provided the care had been re-educated on their duties and responsibilities.

A review of the home's policy titled "Complaint Process" dated October 2015, indicated "Any and all written or verbal complaints made to staff concerning resident care or operation of the home will be dealt with as follows:

A documented record of a complaint using the Internal Complaint Documentation Form will be kept by the Director of Care and will include the following:
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response, and
(f) any response made in turn by the complainant.
(g) the documentation form must be signed by the Executive Director of designate
(h) all managers, and nurse managers have the complaint documentation form".

A review of the home's complaint binder and an interview with the DOC, did not identify an internal complaint documentation form was completed for resident #011's SDM's written complaint. The DOC further indicated an internal complaint documentation form should have been completed and filed for the written complaint that was received by the home. [s. 101. (2)]

2. The following evidence was identified under CIS inspection report #2019_749653_0021 (Log #: 007594-18):

The home submitted a CIR to the Director related to an allegation of improper/ incompetent treatment of resident #005. The CIR indicated on an identified date, the resident informed the DOC and the ED of an incident that happened with PSW #120 three days prior. The resident stated the PSW yelled at them and said inappropriate things during care.

A review of resident #005's progress note indicated the resident was very upset and stated PSW staff was very rude and yelling at them during care. The PSW indicated the incident did not happen and the NM was informed.

Further review of resident #005's progress note and an interview with NM #122 indicated

the resident complained to them during the identified shift, about PSW #120. The NM performed the complaint procedure and continued to follow-up. NM #122 further indicated they completed the complaint paper documentation and slipped it under the previous DOC's office. The NM further indicated they had written all of the details on the complaint form, and the previous DOC investigated on the concern.

A review of the home's complaint binder and an interview with the DOC, did not identify a documented record was kept for resident #005's verbal complaint. The DOC further indicated an internal complaint documentation form should have been filed for resident #005's verbal complaint that was received by the home. [s. 101. (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 a documented record is kept in the home that includes, (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee had failed to ensure that drugs were administered to resident #012 in accordance with the directions for use specified by the prescriber.

The MLTC received a complaint related to resident #012 not receiving their medications.

An interview with the complainant indicated on an identified day, resident #012 did not receive their medication because pharmacy did not send them to the home.

A review of resident #012's PCC census profile indicated they were admitted to the home on an identified date and was discharged eight days later.

A review of resident #012's physician's order form indicated the registered staff received a telephone order on an identified date, from the attending physician confirming the medication orders.

A review of resident #012's August 2018 paper Medication Administration Record (MAR) indicated on an identified date, code #10 which equated to see nurse's notes, was documented on three of the medications.

A review of RPN #100's documentation on PCC indicated on the identified date, there was no blister pack medication and they were unable to give the medications. The RPN left a voice mail message with pharmacy and indicated they were to follow-up.

During an interview, RPN #100 reviewed their above mentioned progress notes and acknowledged the medications did not arrive during their shift and were not administered to resident #012.

During an interview, the DOC reviewed resident #012's paper MAR and progress notes, and acknowledged that on the identified date, drugs were not administered to the resident in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

Additional Required Actions:

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

WN #6: 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 had failed to ensure that appropriate actions were 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.

A review of resident #012's physician's order form indicated the registered staff received a telephone order on an identified date, from the attending physician confirming the medication orders.

A review of resident #012's August 2018 paper MAR indicated on an identified date, code #10 which equated to see nurse's notes, was documented on three of the medications.

A review of RPN #100's documentation on PCC indicated on the identified date, there was no blister pack medication and they were unable to give the medications. The RPN left a voice mail message with pharmacy and indicated they were to follow-up.

During an interview, RPN #100 reviewed their above mentioned progress notes and acknowledged the medications did not arrive during their shift and were not administered to resident #012. The RPN further acknowledged it was considered a medication incident as the resident did not receive their medications, which was classified as omission. When asked by the inspector to demonstrate that appropriate actions were taken in response to the above mentioned medication incident, the RPN acknowledged their documentation could not substantiate that appropriate actions were taken in response to the medication incident involving resident #012.

During an interview, the DOC reviewed resident #012's paper MAR and progress notes, and acknowledged it was a medication incident as the resident did not receive their medications. The DOC further acknowledged that appropriate actions were not taken in response to the medication incident involving resident #012, as the registered staff should have responded step by step by doing an initial assessment of the resident, calling the pharmacy emergency line to obtain the drugs, notifying the attending physician, the resident, the SDM, and filling out the medication incident form, and documenting on the progress notes. [s. 134. (b)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee had failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident, the SDM, and the attending physician.

A review of resident #012's physician's order form indicated the registered staff received a telephone order on an identified date, from the attending physician confirming the medication orders. .

A review of resident #012's August 2018 paper MAR indicated on an identified date, code #10 which equated to see nurse's notes, was documented on three of the medications.

A review of RPN #100's documentation on PCC indicated on the identified date, there was no blister pack medication and they were unable to give the medications. The RPN left a voice mail message with pharmacy and indicated they were to follow-up.

During an interview, RPN #100 reviewed their above mentioned progress notes and acknowledged the medications did not arrive during their shift and were not administered to resident #012. The RPN further acknowledged it was considered a medication incident as the resident did not receive their medications, which was classified as omission. The RPN indicated they notified their nurse manager, and the pharmacy, but they did not notify the attending physician, the resident, and the SDM.

During an interview, the DOC reviewed resident #012's paper MAR and progress notes, and acknowledged it was a medication incident as the resident did not receive their medications. The DOC further acknowledged that the medication incident was not reported to the resident, the SDM, and the attending physician as required. [s. 135. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every medication incident involving a resident and every adverse drug reaction is 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, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 232. Every licensee of a long-term care home shall ensure that the records of the residents of the home are kept at the home. O. Reg. 79/10, s. 232.

Findings/Faits saillants :

1. The licensee had failed to ensure that the records of the residents of the home were kept at the home.

The MLTC received a complaint related to resident #001's missing medical chart.

A review of resident #001's progress note indicated NM #131 had spoken to the resident's family member regarding their chart. The NM explained the situation and indicated the family member would be kept informed.

During an interview, the DOC acknowledged that the home had lost one year's worth of resident #001's physical chart. The home informed resident #001's SDM of the missing chart. Furthermore, the DOC provided Inspector #734 with documentation that contained a response letter from the Information and Privacy Commissioner of Ontario (IPC) addressing the concern of the missing chart. The information provided also contained the home's letter to the IPC and the completed electronic submission report.

To date the home has still been unable to locate the resident's chart and is unable to determine how the chart went missing.

The licensee had failed to ensure that the resident's records were kept in the home. [s. 232.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 233. Retention of resident records

Specifically failed to comply with the following:

s. 233. (1) Every licensee of a long-term care home shall ensure that the record of every former resident of the home is retained by the licensee for at least 10 years after the resident is discharged from the home. O. Reg. 79/10, s. 233 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that the record of every former resident of the home was retained by the licensee for at least 10 years after the resident was discharged from the home.

The MLTC received a complaint related to resident #012 not receiving their medications.

An interview with the complainant indicated on an identified date, resident #012 did not receive their medication because pharmacy did not send them to the home.

A review of resident #012's PCC census profile indicated they were admitted to the home on an identified date and was discharged eight days later.

During the course of the inspection, Inspector #653 reviewed resident #012's clinical health records, and noted the original physician's order form and the record of the resident's list of medications confirmed with the attending physician upon admission, were missing. The inspector provided the home an opportunity to search for the above mentioned records, however, the records were not found.

During an interview, the DOC acknowledged the home was not in compliance with s. 233 (1) of the O. Reg. 79/10, as the above mentioned original clinical health records could not be found. [s. 233. (1)]

Issued on this 13th day of September, 2019

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

Original report signed by the inspector.