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 # / Registre no	Type of Inspection / Genre d'inspection
Apr 21, 2017	2017_535557_0003	004851-17	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

OAK TERRACE
291 MISSISSAGA STREET WEST ORILLIA ON L3V 3B9

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

VALERIE PIMENTEL (557), DIANE BROWN (110), JOVAIRIA AWAN (648)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): March 1, 2, 3, 6, 7, 8, 9, 10, 13, 14, 15 and 16, 2017.

The following Critical Incidents were inspected concurrently:
Log #034144-16 and Log #031857-16 related to a fall.
The following complaints were inspected concurrently:
Log #003440-17 related to falls, nutrition and hydration, not reporting to the Director and neglect, and
Log #005367-17 related to falls, nutrition and hydration, not reporting to the Director and medication.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Recreation Manager (RM), Nutrition Manager (NM), Registered Dietitian (RD), Staff Education Lead (SEL), RAI/MDS Coordinator (RAIC), Nurse Practitioner (NP), Registered Nurse(s) (RN), Registered Practical Nurse(s) (RPN), Agency Nurse, Personal Support Workers (PSW), Para-medic, Resident(s) and Substitute Decision Maker (SDM).

During the course of the inspection, the inspectors conducted observations of residents and home areas, staff and resident interactions, provision of care, medication administration, infection control prevention and practice, reviewed clinical health records, staffing schedules/assignments, minutes of Residents' Council meetings, minutes of relevant committee meetings and relevant policy and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rights of residents were fully respected and promoted: Every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

On an identified date in 2016, on an identified floor, inspector #557 observed the electronic Medication Administration Record (eMAR) screen on the medication cart open and unsupervised, with a resident's personal medication administration record visible to the public and other residents.

The inspector observed residents wandering about the immediate vicinity of the medication cart. Interview with an identified staff member stated that he/she had left the screen open and unattended. He/she further commented he/she did not maintain privacy and confidentiality with regards to the residents' personal health information when he/she had left the screen open and unattended on the medication cart.

During a previous resident quality inspection (RQI) in September 2016, inspection number 2016_298557_0011 / 028412-16, inspector #557 observed the eMAR screen on the medication cart open and unsupervised during the identified inspection.

Interview with the director of care (DOC) indicated he/she was surprised that this had occurred again, as this had previously happened during the RQI last fall. He/she further indicated that two inspectors had previously observed the eMAR screen on a medication cart open and unsupervised. The educator had reviewed this with the registered staff recently. He/she further confirmed that it is the home's expectation that residents' personal health information to be kept confidential, and for staff to maintain privacy and confidentiality. [s. 3. (1) 11. iv.]

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 following rights of residents are fully respected and promoted: Every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and that the electronic medication administration screen be kept closed when not in use or supervised, to be implemented voluntarily.

WN #2: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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. (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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

A complaint was received by the Ministry of Health and Long Term Care (MOHLTC) on an identified day in 2017, with a concern that an identified resident had a change in his/her medical condition.

Review of the written plan of care for the resident identified the following:
The goal for the resident was to receive an identified amount of fluids per 24 hours from fluid and food intake.
The interventions identified the resident was to receive a specific quantity of fluid per 24 hours.

Review of the resident's food and fluid intake for a three week period identified two weeks prior to the identified complaint, the resident was not consuming all his/her food at meals.

On two specific days in an identified month in 2017, record review of the Physician/Nurse Practitioner progress notes identified the resident displayed a change in fluid consumption and directed staff to give more fluids.

Interview with an identified staff worker, confirmed the staff were to give more fluids and identified the resident's normal intake but could not identify how much more fluids the resident should receive.

Interview with a registered staff nurse identified the resident was to have extra fluids but confirmed there was not clear directions documented in the resident's care plan or kardex as both identified the resident was to receive a specified amount of fluid per day. He/she further stated the goal was to receive a specified amount of fluid per day through food and fluid, but did not know how much fluid was contained in food. Review of the resident's food intake did not show the resident eating 100 per cent of his/her food. The registered staff nurse could not clearly identify how much more fluids the resident should receive in the 24 hour period.

Interview with the NP confirmed he/she left an order to increase fluid consumption and that this was not clearly identified in the plan of care.

Interview with the nutrition manager (NM) confirmed the written care plan did not give clear direction to the staff on how much extra fluids the identified resident should receive per day.
[s. 6. (1) (c)]

2. A complaint was received by the MOHLTC on an identified day in 2017, with a concern that an identified resident was sent to the hospital on an identified day in 2017, the hospital identified the resident having a change in medical condition.

Record review of the written plan of care revealed the resident required an identified feeding method. The kardex identified the resident received a regular diet with a regular texture and to cut up food finely.

Staff interviews with identified staff workers and a registered staff member confirmed that the resident did not use an identified feeding method.

The identified staff worker when asked where he/she would obtain information about the residents they indicated from the care plan and kardex. He/she further indicated that the resident required assistance and supervision for eating and drinking and he/she received regular food.

The registered staff member further indicated that he/she had assessed the resident incorrectly and the resident required the assistance of one staff for feeding. He/she suggested that he/she had wrote a generic statement in the plan of care identifying the resident required identified feeding method.

An interview with the DOC confirmed the plan of care did not provide clear direction to direct care providers in regards to providing food to the identified resident. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.

A complaint was received by the MOHLTC on an identified day in 2017, the complainant identified the resident displayed changes in his/her medical condtion.

Record review of the progress notes for a 14 day period in 2017, identified the following for the identified resident:
The NP assessed the resident and documented his/her findings. He/she identified to push fluids and to obtain a laboratory sample.
The physician ordered a laboratory test for a specific screen and to hold an identified medication for 3 days.

The registered dietitian (RD) observed and assessed the resident's meal and identified he/she did well. The registered nursing staff identified later on the same day, the resident's health had changed.

The staff workers documented the food and fluid intake and identified the consumption.

The registered staff member identified in the progress notes the identified resident's condition and that they had contacted the physician for orders and obtained an order.

An interview with the NP identified there was a change in the resident however, he/she did not refer the resident to the RD.

An interview with registered staff member confirmed the resident's intake of both food and fluids was not consistent and could lead to a change in medical condition.

An interview with the RD identified he/she did assess the resident during a meal and that he/she was unaware the NP identified the resident as having a change in condtion.

The NP and RD confirmed they did not collaborate with each other in the assessment of the identified resident, so that their assessments were integrated and were consistent with and complemented each other in respect to the resident's change in condition. [s. 6. (4) (a)]

4. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

A complaint was received by the MOHLTC on an identified day in 2017, with a concern that an identified resident was sent to the hospital on an identified day in 2017, after being observed lying on the floor. The hospital identified the resident as having a specific medical condition. The complainant had identified specific general concerns about their loved one.

Review of the plan of care for the identified resident revealed the following:
The resident was admitted on an identified day in 2017.
Laboratory results indicated lab values with in normal range.
History and Physical exam report from the hospital identified a specific diagnosis.
The written plan of care identified the following:
Nutritional risk was identified and a food and fluid plan was identified.
Review of food and fluid intake was reviewed for a 27 day time frame in 2017.
During this same time frame the resident's average fluids intake from beverages was calculated.

The RD was unable to confirm and estimated 387 mls of fluid would be absorbed if all food items are consumed.

An interview with a staff worker described signs of poor food and fluid intake. He/she identified that the resident ate and drank well for them.

An interview with an identified registered staff member confirmed the resident did not receive the total amount of fluids from food and beverages as identified in the plan of care. He/she further identified the resident had been lethargic and that the staff workers

had not communicated verbally that the resident’s intake had declined. He/she had not collaborated with the dietary department.

An interview with the DOC confirmed that nursing and the dietary department did not collaborate with each other in the development and implementation of the plan of care for the identified resident. [s. 6. (4) (b)]

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

A critical incident (CI) was submitted to the MOHLTC reporting a resident had an unwitnessed fall on an identified day in 2016, and was found lying on the floor in his/her room near the door. The resident was sent to hospital and diagnosed with an identified injury and returned to the home.

The CI revealed that the resident had a history of multiple falls over a four month time period with no significant injury prior to his/her fall on an identified day in 2016.

Record review confirmed the resident had multiple falls over this identified period. Interview with an identified staff worker stated the resident would display behaviors, would want to get up and self-transfer while in his/her adaptive device. The identified staff worker revealed awareness of a time when the resident was in the lounge tried to stand up out of his/her adaptive device and fell. Two staff workers were unable to confirm that hourly monitoring was completed.

Record review of the resident's plan of care revealed staff were to check the resident every hour for safety. This intervention was initiated on an identified day in 2016.

A review of the tasks in the point of care (POC) failed to identify the monitoring of resident on an hourly basis.

Interview with the DOC stated that the hourly monitoring for safety checks would be expected to be monitored under tasks in POC and that the plan of care was not followed if there was no evidence of monitoring. [s. 6. (7)]

6. The licensee has failed to ensure that the following is documented: The provision of the care set out in the plan of care.

A complaint was received by the MOHLTC on an identified day in 2017, with a concern that an identified resident was sent to the hospital on an identified day 2017, after a fall from bed. The complainant had requested an identified piece of equipment be placed on the floor beside the resident's bed and this had not happened and indicated that other alternatives had not been implemented.

A review of the identified resident's clinical records identified that the resident fell on an identified day in 2017, and had been sent to hospital for further assessment on the same day.
A review of the written plan of care for the resident revealed that on an identified day in 2017, the plan had directed PSW staff to document every hour and every shift for registered staff ensuring the resident's safety.
Record review of task documentation by PSW's revealed the following:
-resident safety monitoring every hour documentation was observed to be incomplete by the PSW's on five identified days in 2017, and
-resident safety review every shift documentation was observed to be incomplete by the registered staff on five identified days in 2017.

An interview with an identified support worker confirmed that he/she would document hourly safety checks in POC. Record review of POC for an identified day in 2017, revealed the documentation was missing. The support worker confirmed he/she had checked the resident but had not documented in POC.

An interview with an identified registered staff member confirmed he/she did not document that he/she checked the resident, but did. He/she further stated that this is part of the registered staff routine to check all residents for safety throughout their shift and that they do check the residents.

An interview with an identified registered staff member and DOC confirmed the PSW's and registered staff did not complete their documentation to ensure the care is provided as directed in the plan of care to the resident. [s. 6. (9) 1.]

7. The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the care set out in the plan has not been effective.

A complaint was received by the MOHLTC on an identified day in 2017, with a concern that an identified resident was sent to the hospital on an identified day in 2017, after

being found lying on the floor at his/her bedside. The complainant had requested an adaptive device be placed on the floor beside the resident's bed and this had not happened and indicated that other alternatives had not been implemented.

A review of the identified resident's clinical records indicated that on an identified day in 2017, he/she had a fall.
The written plan of care directed staff to:
-complete post fall huddles,
-to ensure call bell and light cord are within reach,
-assist to rise from sitting to standing slowly,
-assist to sit down if a change in the resident's condition and to notify the nurse, and
-to keep bed at appropriate height.
The records indicated that the resident had multiple falls in an identified month and the majority of these falls were in his/her room. After the last fall the resident was sent to hospital for assessment.
The chart review revealed the plan of care had not been reviewed or revised after the above noted falls.

An interview with the substitute decision maker (SDM) identified he/she had spoken with an identified registered staff member and was unable to identify which staff member this was. The SDM indicated a registered staff member confirmed he/she would place an adaptive piece of equipment on the floor beside the bed, the SDM stated this did not happen until the resident returned from hospital.

An interview with an identified registered staff member confirmed the interventions that were identified on a specific day in 2017, were not effective as the resident had six additional falls. He/she confirmed the SDM had spoken to him/her at some point in time but could not remember when about adaptive equipment. He/she indicated the post fall huddles were done, however, the plan of care had not be revised until the resident returned from the hospital. The registered staff member indicated that the adaptive equipment would help protect the resident when he/she fell out of his/her bed.

An interview with the DOC confirmed that the resident should have been reassessed and the plan of care reviewed and revised at any time when the care set out in the plan has not been effective. [s. 6. (10) (b)]

8. The critical incident system (CIS) was submitted to the MOHLTC identifying a resident was found lying on the floor in his/her room in a compromised manner. The resident was

transferred to hospital after being assessed.

Upon initiating this inspection, it was identified that the resident had passed away on an identified day in 2017. The inspection was completed through record review and staff interviews.

Record review of the home's policy, Assessment and Care Planning, Index Care1-P10, reviewed July 31, 2016, identified that interdisciplinary assessments and plan of care updates are required when there is a change of a resident's condition and when a resident returns from hospital. The policy further identified the interdisciplinary team will ensure that the plan of care is accurate and reflective of the resident's current status.

Record review of the identified resident's clinical records identified he/she had returned from hospital on an identified day in 2016, following treatment related to an unwitnessed fall on an identified day in 2016. Review of safety assessment lifts and transfer record (SALT-2016), dated January 4, 2017, for the resident identified the resident was unable to demonstrate consistent physical strength and required an adaptive device with two staff members for transfers. Review of written plan of care did not identify the use of an adaptive device nor the use of two staff members for transfers.

Interview with two identified staff workers revealed they used an adaptive device to transfer the resident in and out of bed following his/her return from hospital. The further identified the resident had a change in his/her transfer status and the use of an adaptive device as a transfer intervention would be found in the written plan of care.

Interview with a registered staff member identified the SALT-2016 assessment completed on an identified day in 2017, noted the use of an adaptive device for the resident. The staff member confirmed the resident was using an adaptive device. Review of the written plan of care with the registered staff member did not identify this intervention had been documented as reported, and that it had not been updated to reflect the care the resident was being provided.

Interview with the RAI/MDS Coordinator (RAI) and the DOC revealed registered staff are to update a resident's plan of care if the resident had a change in their care. [s. 6. (10) (b)]

9. The licensee has failed to ensure that if the resident is being reassessed and the plan of care is being revised because care set out in the plan has not been effective, have

different approaches been considered in the revision of the plan of care.

A CI report submitted to the MOHLTC, reported that an identified resident had an unwitnessed fall on an identified day in 2016, and was found lying on the floor in his/her room near the door. The resident was sent to hospital and diagnosed with a fracture and returned to the home following an intervention.

The CI revealed that the resident had a history of multiple falls during a four month period in 2016, with no significant injury prior to his/her fall on an identified day in 2016.

Interview with an identified staff worker stated the resident would display behaviors, would want to get up and self-transfer while sitting in his/her adaptive device. The identified staff worker revealed awareness of a time when the resident was in the lounge tried to stand up out of his/her adaptive device and fell.

Record review of the resident's health record confirmed the resident had multiple falls over this identified period and that the resident fell on multiple occasions in the identified time period in 2016.
The written plan of care included documentation that the care plan was reviewed on a specific identified occasions in this time frame in 2016, by way of adding the identified fall dates to the care plan focus and identified the resident was a medium to high risk for falls. Changes were not identified to the written plan of care related to resident's attempts to be independent.

Interviews with two registered staff members confirmed that different approaches were not considered in the revision of the plan of care when the resident continued to fall on the identified dates in 2016, prior to resident's fall with injury on the identified day in 2016.

Interview with the DOC identified that registered staff did not document a post fall huddle which determines what happened, how it happened, why did it happen and if anything could be done differently to prevent further falls. The DOC revealed that there was no evidence that alternatives were considered when the resident continued to fall on and after an identified day in 2016. [s. 6. (11) (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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident,
-to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other,
-to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other,
-to ensure that the care set out in the plan of care provided to the resident as specified in the plan,
-to ensure that the following is documented: The provision of the care set out in the plan of care,
-to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the care set out in the plan has not been effective, and
-to ensure that if the resident is being reassessed and the plan of care is being revised because care set out in the plan has not been effective, have different approaches been considered in the revision of the plan of care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put is complied with.

A CI submitted to the MOHLTC, reported an identified resident had an unwitnessed fall on an identified day in 2016, and was found lying on the floor in his/her room near the door. The resident was sent to hospital and diagnosed with an identified injury and returned to the home following an intervention.

Record review of the home's policy entitled Fall Prevention and Injury Reduction, Index # CARE5.O10.02, reviewed July 31, 2016, revealed that the post fall management included the following step:
-A post-fall huddle is completed to determine the root cause of the fall. Current plan of care is reviewed and updated according to current needs.
Review of Resident Care and Safety Huddle-High risk for Falls/Falls Follow-up form-Revera Appendix G- dated December 2013, included the following:
s-situation: what is the resident experience or issue that has happened. Be specific
b-background: what do you think the problem is? What is concerning the resident, family and/or care staff?
a-assessment: explain the circumstances leading up to this care experience or care and safety issue/situation.
r- recommendation: what changes in care approach is needed to meet the resident care and safety needs? What resources are required to do so?

The CI revealed that the resident had a history of falls including multiple falls in a four month time period in 2016, with no significant injury prior to his/her fall on the identified date in 2016, when he/she was sent to the hospital.

Record review confirmed the resident had multiple falls and further confirmed the lack of post-fall huddle documentation for any of the above mentioned falls over a four month period.

Interviews with two registered staff members confirmed awareness of the need to complete a post fall huddle and that staff were now initiating the process. Staff revealed that a post fall huddle had not been completed for the identified resident over the course of his/her four month fall history in 2016, and prior to resident’s fall with injury on the identified day in 2016.

The DOC acknowledged that staff had not completed a post-fall huddle for the identified resident his/her four month fall history in 2016, and the fall that sent the resident to hospital in 2016 and that the home's policy had not been followed. [s. 8. (1) (a),s. 8. (1) (b)]

2. The CI report was submitted to the MOHLTC identifying a resident was found lying on the floor in his/her room in a comprised manner. The resident was transferred to hospital after being assessed.

Upon initiating this inspection, it was identified that the resident had passed away on an identified day in 2017. The inspection was completed through record review and staff interviews.

Review of the resident’s clinical records revealed progress notes dated in 2016, identified the resident had a fall at his/her bedside. Subsequent progress notes for an identified day in 2016, identified the resident had been admitted to hospital for treatment.

Record review of the home's policy, Fall Prevention and Injury Reduction, Index # CARE5.O10.02, reviewed July 31, 2016, indicated that upon discovering a resident who has fallen non-registered staff will not move the resident, they are to call for the nurse immediately, and stay with the resident to provide comfort until the nurse arrives.

Interview with support worker revealed he/she discovered the resident on the floor of the resident’s room during the night shift in an identified manner. He/she reported that he/she informed the charge nurse immediately and proceeded to assist the resident. The worker stated he/she was aware of the protocol not to touch the resident but that he/she had been directed by the registered staff member to assist the resident prior to

assessment by registered staff.

Interview with the registered staff member revealed he/she was informed of the fall and proceeded to go to the resident immediately upon being informed and discovered the staff were cleaning the resident. The registered staff member denied she had provided direction to staff to clean the resident prior to assessment.

Interview with the registered staff member revealed he/she was also present with the other registered staff member when the resident had fallen. This second registered staff member acknowledged the support workers should not have cleaned the resident prior to registered staff assessment.

Interview with the DOC revealed support staff are expected to stay with the resident without moving or touching them prior to being assessed by registered staff. The DOC acknowledged support staff would not be able to assess injury for a fallen resident. The DOC acknowledged the identified support worker should not have started assisting the resident prior to being assessed by registered staff, and that the home's policy was not followed. [s. 8. (1) (a),s. 8. (1) (b)]

3. 1.The MediSystem Pharmacy policy, Subject: Narcotic and Controlled Substances Administration Record (NaCSAR), last review date of January 17, 2017, identified that when the last entry on the NaCSAR page is entered the nurse responsible must also transfer all the information received from the pharmacy to the subsequent page, including the original quantity of drug dispensed, resident room number, health card number, facility name, date issued, received by and prescription number.

Record review of the NaCSAR revealed the following information was not transferred according the home's policy for the three identified residents: quantity of drug dispensed, resident room number, health card number, facility name, date issued, received by and prescription number.

An interview with an identified registered staff member confirmed that the last nurse to make the entry on the NaCSAR page did not transfer the above noted information onto the subsequent page for the identified resident's and did not follow the home's policy.

An interview with the DOC confirmed the registered staff member did not follow the homes policies for transferring all required information to the subsequent page and it is an expectation that the registered staff follow the policy.

2. Revera Care Manual, section: Medication, Description: LTC-Narcotics and Controlled Drugs Management ON, index: CARE13-020.20, review date July 31, 2016, identifies that narcotics and controlled drugs are documented on the Narcotic and Controlled Drug Administration record (NaCDAR) at the time of administration.

During the medication observation and record review of narcotic and controlled substance storage, the inspector observed the count on Individual Resident's Narcotic Administration record (IRNAR) and the quantity of medication that remained in the blister pack did not match as follows:
Resident one: an identified medication, the count on the NaCDAR identified 12 tablets remaining, the blister pack containing the identified medication had 11 tablets remaining. The count was off by one tablet.
Resident two: an identified medication, the count on the NaCDAR identified 12 tablets remaining, the blister pack containing the identified medication, had 11 tablets remaining. The count was off by one tablet.
Resident three: an identified medication, the count on the NaCDAR identified 9 tablets remaining, the blister pack containing the identified medication had 8 tablets remaining. The count was off by one tablet.

An interview with an identified registered staff member confirmed that he/she did not document on the NaCDAR at the time of administering the above mentioned medications to the identified resident's.

An interview with the DOC confirmed the identified registered staff member did not follow the homes policies for medication administration and it is an expectation that the registered staff sign the NaCDAR at the time of the administration of the medication. [s. 8. (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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident has fallen, the resident has been assessed and, if required, a post-fall assessment conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

The CI report was submitted to the MOHLTC reporting an identified resident had an unwitnessed fall on an identified date in 2016, and was found lying on the floor in his/her room near the door. The resident was sent to hospital and diagnosed with an identified injury and returned to the home.

The CI revealed that the resident had a history of multiple falls over a four month period in 2016, with no significant injury prior to his/her fall on an identified date in 2016 when the resident sustained an injury.

Record review of the resident's fall history, over a specific quarterly time frame in 2016, failed to reveal a post fall assessment of resident's fall on three occasions in 2016.

Interviews with two registered staff members confirmed that the home's process included the completion of a post fall assessment, using a designed assessment instrument when a resident fall was reported. The DOC acknowledged the post-fall assessment had not been completed for the resident on the three above noted occasions when the resident fell. [s. 49. (2)]

2. The CI report was submitted to the MOHLTC identifying a resident was found lying on the floor in his/her room in a compromised manner. The resident was sent to hospital.

Review of the resident’s clinical records identified he/she was found in his/her room on the floor by his/her bedside.

Review of the home's policy for Fall Prevention and Injury Reduction, Index # CARE5.O10.02, Reviewed July 31, 2016, identified that for all falls, a clinical assessment is completed and documented.

Interviews with identified registered staff member confirmed they were both present in the home at the time of this reported fall. They reported that all falls require a post fall assessment to be on the homes computer system. During the staff interview an identified registered staff member was unable to demonstrate this assessment for the documented fall on an identified date in 2016, had been completed for the resident.

Interview with the DOC confirmed the homes process included the completion of a post fall assessment when a resident fall is reported. The DOC acknowledged the post-fall assessment had not been completed for the resident for the documented fall on an identified day in 2016. [s. 49. (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 when the resident has fallen, the resident has been assessed and, if required, a post-fall assessment conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps are taken to ensure the security of the drug supply, including the following: All areas where drugs are stored shall be kept locked at all times, when not in use.

On an identified date in 2017, during stage two of the RQI, the inspector observed the top drawer of the medication cart on an identified floor unlocked. The inspector opened the drawer and observed stock medication in the drawer, as well as, pre-poured medication for an identified resident. At this point in time there were two residents observed in the area of the medication cart.

An interview with the identified registered staff member confirmed he/she had not locked the medication cart properly when he/she walked away from the cart and stated the remaining drawers on the cart are locked and indicated he/she had not pushed the top drawer in tightly therefore it did not lock and confirmed the cart must be locked at all times when not in use.

An interview with the DOC confirmed that any area where drugs are stored are to be locked at all times and it is an expectation that the registered staff ensure they are locked when not in use. [s. 130. 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 steps are taken to ensure the security of the drug supply, including the following: All areas where drugs are stored shall be kept locked at all times, when not in use, to be implemented voluntarily.

WN #6: 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. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

The home submitted a CI dated in 2017, reporting an identified resident received two medications that were not ordered for him/her.

Record review of the eMAR for an identified date in 2017, indicated that the resident had been prescribed and had received two prescribed medication at an identified time. In addition the resident received another identified resident's three medications ten minutes later.

A review of the resident's progress notes identified only one entry confirming the medication error had occurred was made on the following day in 2017.

An interview with an identified registered staff member indicated that he/she was mentoring a nursing student and the nursing student gave another resident's medication to the identified resident by accident. The registered staff member indicated he/she was not present at the time the student nurse administered the medication to the resident. He/she further indicated that the resident spoke to him/her about receiving crushed medication and asked what it was for. The identified registered staff member indicated that he/she was surprised the resident even took the crushed medication from the student nurse as the resident is aware of his/her medication. The progress notes identified the resident had a fall one hour after the wrong medication was administered to the resident, there was a change in the resident's vital signs.

Interview with the DOC confirmed that no drug is to be administered to a resident in the home unless the drug has been prescribed. [s. 131. (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 no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee has failed to ensure that 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.

The home submitted a CI dated in 2017, reporting that an identified resident had received two medications that was not prescribed for him/her. One hour and ten minutes after the administration of the above noted medication the resident fell with no injury.

The home's policy in Care Manual, section: Medication, description: LTC, Medication Incidents, index: CARE13-030.01, review date: July 31, 2016, identifies for all resident related medication incidents there will be a brief factual description of the incident,

treatment and interventions documented in the progress notes. The home will monitor the resident's condition and document for 24 hrs or as per physician order.

Record review of the plan of care for the resident identified the following:
-On an identified date in 2017, an entry was made identifying the resident fell backwards and did not hit his/her head. The first entry made identifying a medication error had occurred was on the following day in the afternoon with an assessment of vital signs.
-Review of the Medication Incident Report identified vital signs were taken at the time of the medication incident and at the time of the fall.

The Medication Incident report further revealed the amount of medication that the resident received. The incident report identified the physician was contacted and ordered to push fluids and for resident to stay in bed. This information was not recorded in the progress notes and there was no telephone order of the conversation between the physician and the nurse documented.
-Review of the physician's orders and physician progress notes did not identify any notation of the medication error.

Interviews with the two identified registered staff members involved with the incident were interviewed. One identified registered staff members identified it was a student nurse who administered the wrong medication to the identified resident. He/she further commented he/she thought the other registered staff member was going to document the incident as he/she completed the medication incident report. This staff member identified it was his/her colleagues responsibility to document the information into the progress notes. Both identified registered staff members confirmed that neither of them followed the home's policy and did not document a description of the incident, treatment and or interventions initiated for the resident.

An interview the DOC confirmed it is the home's expectation that when there is a medication incident involving a resident the registered staff are to take appropriate actions and assess the resident as directed. [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 #8: 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. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed 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.

A complaint was received by the MOHLTC on an identified date in 2017, about an identified resident by his/her SDM. The SDM revealed to the inspector that he/she had spoken with the DOC about the use of a medication. The DOC confirmed he/she had spoken to the SDM and had investigated the use of the identified medication. The inspector requested the home's complaint log records. No record of the complaint made by the SDM was found.

An interview with the SDM indicated that he/she had spoken to the DOC in regards to resident's medication at some time and could not recall the date.

An interview with the DOC confirmed he/she recalled talking to the SDM in regards to the resident receiving too much of the identified medication. The DOC could not recall when this was and had no records of the complaint and indicated he/she did not get very far with the in home investigation and further stated the staff disposed of the medication containers and there were no records.

The DOC confirmed that he/she did not ensure that a documented record of the verbal complaint was kept, which would include the following: the nature of the complaint, date complaint was received, action taken to resolve complaint, final resolution, any responses including date to the complainant. [s. 101. (1) 2.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital.

A complaint was received by the MOHLTC on an identified date in 2017, the complainant identified a resident was transported to the hospital after a fall and had sustained an identified injury.

Record review of the identified resident's progress notes confirmed on an identified date in 2017, at a specific time, the resident was found lying on the floor in his/her room. The registered staff member identified the resident had sustained an injury. The NP's note identified the resident was transferred to the hospital after a fall for a suspected injury as per the registered staff.

An interview with the Executive Director (ED) confirmed the home did not submit a Critical Incident to the Director. [s. 107. (3) 4.]

2. A complaint was received by the MOHLTC on an identified date in 2017, the complainant identified the resident was transported to the hospital after a fall.

Record review of resident's progress notes confirmed on an identified date in 2017, at an identified time, the resident was found lying on the floor on his/her side beside his bed and the resident had sustained an injury.

An interview with the DOC confirmed the home did not submit a Critical Incident to the Director. [s. 107. (3) 4.]

WN #10: 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 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.

Review of the home's annual evaluation of the medication management system dated April 14, 2016, was reviewed for the year of 2015. The period of review was March 2014, to March 2015. The report identified the following members who participated in the review as: the executive director, interim DOC, office manager, staff educator/quality manager and RAI/MDS staff member.

An interview with the DOC confirmed that the medication management system is reviewed annually. When asked who the members of the committee were he/she indicated that he/she was unsure but it should be the members as identified above. When asked if the registered dietitian (RD), medical director and pharmacist participated in the review he/she confirmed that those members of the team did not participate.

The DOC confirmed all members of the interdisciplinary team did not meet annually to review the medication management system. [s. 116. (1)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 117. Medical directives and orders — drugs
Every licensee of a long-term care home shall ensure that,
(a) all medical directives or orders for the administration of a drug to a resident are reviewed at any time when the resident's condition is assessed or reassessed in developing or revising the resident's plan of care as required under section 6 of the Act; and
(b) no medical directive or order for the administration of a drug to a resident is used unless it is individualized to the resident's condition and needs. O. Reg. 79/10, s. 117.

Findings/Faits saillants :

1. The licensee has failed to ensure that no medical directive or order for the administration of a drug to a resident is used unless it is individualized to the residents condition and needs.

A complaint was received by the MOHLTC on an identified date in 2017, the complainant identified issues with medication administration.

Record review of the plan of care for the resident identified the following:
-On an identified date in 2017, the Medication Reconciliation and Admission Order Form identified a medication to be given by mouth when necessary. There were no directions for the reason to administer or frequency identified for the administration of this medication.
-The electronic medication administration record (eMAR) for an identified date in 2017, identified the same medication to be administered by mouth when necessary. The pharmacy identified prescriber to specify directions and frequency.
The identified medication was administered on two identified occasions without directions.
When the resident returned from hospital on an identified date in 2017, the Re-Admission Order Form identified the same medication to be administered by mouth when necessary. There were no directions for the reason to administer or frequency identified for the administration of the identified medication.

An interview with two identified registered staff members confirmed there were no directions for the administration or frequency for the identified medication in the physician orders or on the eMAR individualized to the resident's needs.

An interview with the DOC confirmed the order for the administration the medication to the resident was not individualized to the resident's condition and needs. [s. 117. (b)]

Issued on this 25th day of April, 2017

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

Original report signed by the inspector.