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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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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
Feb 5, 2016	2016_330573_0002	001118-16	Resident Quality Inspection

Licensee/Titulaire de permis

THE PERLEY AND RIDEAU VETERANS' HEALTH CENTRE
1750 Russell Road OTTAWA ON K1G 5Z6

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

THE PERLEY AND RIDEAU VETERANS' HEALTH CENTRE
1750 RUSSELL ROAD OTTAWA ON K1G 5Z6

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

ANANDRAJ NATARAJAN (573), AMANDA NIXON (148), KATHLEEN SMID (161), MELANIE SARRAZIN (592), RUZICA SUBOTIC-HOWELL (548)

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): January 18, 19, 20, 21, 22, 25, 26, 27, 28 and 29, 2016

Critical Incident/Complaint Inspection were conducted concurrently and

incorporated in this Resident Quality Inspection Report.

The following (i) Logs :001602-14, 002647-14, 002866-14, 003103-14, 014356-15, 021326-15, 025967-15, 026170-15, 027623-15, 028530-15, 004632-15, 013131-15, 018980-15 and 027659-15 were inspected related to critical incident the home submitted regarding abuse.
(ii) Logs: 007238-15, 020543-15, 021764-15, 023235-15, 023971-15 and 029008-15 were inspected related to critical incident the home submitted regarding resident fall resulting in transfer to hospital.
(iii) Logs: 018514-15 and 029068-15 were inspected related to a critical incident the home submitted regarding administration of medication and unexpected death of a resident.
(iv) Log: 028530-15 was inspected related to a complaint regarding resident plan of care.

During the course of the inspection, the inspector(s) spoke with the Chief Operating Officer, Director of Nursing Operations (DNO), Director of Support Services (DSS), Director of Human Resources, Resident Care Managers, Personal Support Worker Supervisors, Food Service Supervisors, Manager of Support Services, RAI Coordinator, Registered Physiotherapist, Registered Dietitian, Registered Nurses (RN), Registered Practical Nurses (RPN), the home's Psychogeriatric Nurse, the home's Behavioural Support Ontario (BSO) Champion, Personal Support Workers (PSW), Food and Nutrition Aides, Unit Nursing Clerks, Finance Clerk, Housekeeping Aides, Recreational Therapist Coordinator, Physiotherapy Aide, the Chair of the Family and Friends Council, the President of the Community Resident Council and the Veterans Resident Council, Family Members and Residents.

During the course of the inspection, the inspector(s) completed a walk through tour of all resident areas, observed medication storage areas, observed resident care, observed meal services, observed medication administration, reviewed Community and Veteran Resident Councils meeting minutes, reviewed Family and Friends Council meeting minutes, reviewed Resident health records, reviewed home's menu cycle, reviewed relevant home policies, protocol and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

- **8 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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who has reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

According to O.Reg.79/10, s.2.(1) Verbal abuse is defined as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth that is made by anyone other than a resident.

Physical abuse is defined as the use of physical force by anyone other than a resident that causes physical injury or pain.

Emotional abuse is defined any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

On a specific date family member of resident #048 reported in person to the PSW supervisor #109 that they had a video footage of a staff member being verbally inappropriate and perceived as rough during the care provided to resident #048.

The home enquired further on that same day and proceeded to conduct an investigation into the alleged incident. The PSW supervisor #109 reported the incident to the Director of Nursing Operations on the same day. Following the investigation, the home concluded that the PSW staff was rough with care that caused discomfort to the resident. Further the investigation indicated that the PSW staff did not communicate in a respectful manner to the resident by compromising his/her respect and dignity.

The Director, under the LTCHA, was notified of the suspected abuse until 13 days after the incident, through the Critical Incident System. Information pertaining to a suspected abuse was not reported immediately. [Log:018980-15]

2. On a specific date family member of resident #048 reported in person to the PSW Supervisor #109 that resident #048 was being neglected intentionally by a staff member.

The home enquired further on that same day and proceeded to conduct an investigation into the alleged incidents. An email was send to the Manager of Resident Care and to the Director of Nursing Operations on the same day to inform them of the alleged abuse.

Following the investigation, the home concluded that the staff member intentionally did not respond for 90 minutes to the resident call bell by shutting it off, when resident #048 wanted to go to the bathroom.

The Director, under the LTCHA, was notified of the suspected abuse three days after the incident through the Critical Incident System. Information pertaining to a suspected abuse/Neglect was not reported immediately. [Log:013131-15]

3. On a specific date resident #052 reported to a RPN staff member that the staff who got him/her up that morning was unpleasant and that the same staff member took away the resident call bell and pressed his/her hand hard and told him/her not to ring resulting in soreness to his/her hand.

The RPN reported the incident immediately to Supervisor #109 who enquired further on that same day and proceeded to conduct an investigation into the alleged incident. The PSW supervisor #109 reported the incident to the Chief Nursing Officer, the Director of Nursing Operations and the Manager of the Resident Care #121 on the same day. Following the investigation, the home has concluded that abuse and neglect had occurred by forcefully taking away the call bell of resident #052 and delaying resident needs.

The Director, under the LTCHA, was notified of the suspected abuse one day after the incident through the after-hours pager system. Information pertaining to a suspected abuse was not reported immediately. [Log:004632-15] [s. 24. (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 a person who has reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident in the home has his or her personal items cleaned as required.

On January 19, 2016, Inspector #573 observed: In Rideau 2 South unit - resident #001's unclean wheelchair with heavy accumulation of dust and debris on the seat belt and under the wheelchair frame.

In Rideau 1 South unit - resident #004's unclean wheelchair with dust and unidentified debris on the cushion and the wheelchair frame.

On January 19, 2016, Inspector #548 observed: In Gatineau 2 South unit - resident #035's walker to be speckled with white particulate, a dried smear on the right side top of the walker's cushion and thick white particulate in the cushion edges.

In Gatineau 1 South unit - resident #038 wheelchair seat cushion had a dried hard crusted area with a hair particle stuck with it.

On January 22, 2016, Inspector #548 observed - resident #004's wheelchair to be dusty and unclean with dried debris in the cushion and frame.

- Resident #035's walker is observed to be speckled with white particulate and the cushion edges to be dusty in the seams of the cushion and stitching.

- Resident #038's wheelchair seat cushion has a dark dried hard crusted area.

On January 22, 2016, during an interview on Gatineau 1-South PSW supervisor #119 indicated the home's schedules the weekly cleaning of resident personal mobility items. She indicated there is to be spot cleaning, as required. Supervisor #119 indicated that each unit the PSW staff will initialize a form titled: Evening Cleaning form when the cleaning of resident mobility aids was completed. The PSW supervisor #119 indicated that this is the practice in the home.

On January 22, 2016, during an interview on 2 Gatineau South with PSW #117 and #126, both confirmed that there is a scheduled weekly cleaning for resident personal mobility items and PSW are to sign a form when it is completed. Both indicated that spot cleaning is done, as necessary.

Review of Evening Cleaning form for Unit- Gatineau 2 South/East Side and Review of the Unit Gatineau 1 South/West Evening Cleaning form dated for the month of January 2016 was completed.

Review of the Evening Cleaning form for Unit- Gatineau 1 South/ West Side dated January 2016 with PSW supervisor #119 present. It indicated that resident #035 personal mobility item is scheduled for cleaning every Tuesday of the month. It is recorded on January 12 and 19, 2016, that a cleaning was completed. Resident #038 personal mobility items is scheduled for weekly cleaning on every Tuesday of the month. On the form Gatineau 2 South/East Side dated January 2016 it is recorded a cleaning

was completed on January 12, 2016.

Although, there is a schedule to clean resident's personal items the inspector observed resident's #004, #035 and #038 mobility items to be in the same condition. As such, the Licensee failed to ensure each resident in the home has his or her personal mobility items cleaned as required. [s. 37. (1) (a)]

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 each resident of the home has his or her personal mobility items cleaned as required, to be implemented voluntarily.

WN #3: 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 failed to 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.

The MOHLTC received two Critical Incident Reports regarding a significant change in health status for resident #047 as a result of a fall, where the resident was transferred to hospital post fall incident.

The health care record was reviewed.

The resident was identified at risk for falls and had history of falls.

On January 22, 2016, RN #116 indicated that the home has a clinically specific assessment tool designed for falls and a fall assessment that is to be completed for all witnessed and unwitnessed falls. This was confirmed by the Director of Nursing Operations.

On a specific date it was recorded on the Fall Risk Screening Tool that resident #047 was found on the floor in the dining room.

Review of the health record indicated that there were no post fall assessment completed using a clinically specific assessment tool for the fall incident.

Five days latter the resident was found on the floor in the resident bed room by a staff member.

Review of the health record indicated that the next day a completed post fall assessment was done by a RPN.

On January 26, 2016, the Director of Nursing Operations indicated the home completed an internal investigation of the resident #047 fall incident. The Director of Nursing Operations indicated the post fall assessment that was completed on next day by the RPN was not accurate and the home has taken appropriate action with respect to this RPN. This was confirmed by the Director of Human Resources and evidenced in the RPN's personnel file.

As such, the licensee failed to ensure post fall assessments were completed for resident #047 for the two fall incidents. [Log:007238-15] [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 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, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the actions that are taken to respond to the needs of the resident #056 responsive behaviours, including the interventions and the resident's responses to the interventions are documented.

During the course of the inspection, Critical Incident Report (CIR) #C595-000077-15 was inspected related to a physical abuse between resident #056 and resident #058 which occurred on a specified date. It is documented in the CIR that resident #056 has had multiple incidents of physical aggression in the last 180 days towards different residents. Based on the critical incident submitted by the Manager of Resident Care it was noted that disciplinary action to be taken towards a staff member who failed to provide one on one monitoring to resident #056 at the time of the incident.

The written plan of care for resident #056 at the time of the incident identifies resident #056 with several responsive behaviours. The written plan of care indicates that resident #056 may be provided with one on one upon physical responsive behaviour. It further indicates that staff are to ensure that resident #056 is visible to the staff at all times and if not, to seek the resident out.

On January 27, 2016, in an interview with RN #142, who indicated that resident #056 was identified with verbal and aggressive unexpected behaviours. Resident #056 has to be monitored by the staff at a distance so that resident #056 does not feel threatened by the staff members and if other residents come too close to the resident #056, Staff has to remove residents away from the area. RN #142 indicated that on the day of the incident, PSW #143 was assigned to provide one on one to resident #056, and instructions were given to have resident #056 within PSW sight at all times. The RN #142 further indicated the PSW #143 who was assigned to provide one on one brought the resident #056 to the dining room and left resident unattended without any other staff present in the dining room which resulted in resident #056 physical abuse towards resident #058. She further stated to Inspector #592 that resident #056 was to be provided with one on one on days and evening from a specific date, due to resident #056 physical aggression towards a co-resident and that if a staff member was to go on break, someone was to take over.

The RN #142 indicated to Inspector #592 that when a resident is monitored one on one by staff, the registered nursing staff would document the interventions and resident responses to the interventions in the resident progress notes.

On January 27, 2016, in an interview with PSW #143, indicated that on a specified date, she took resident #056 for breakfast and left the resident in the dining room unattended. Further the PSW #143 indicated that she had 10 other residents that were assigned to her on that day and it is impossible for her to do the one on one monitoring of resident #056. In addition, she indicated to Inspector #592 that she was not instructed to provide one on one monitoring to resident #056 and was not communicated to her at the morning report and in the resident plan of care.

The progress notes for resident #056 were reviewed by the inspector and it was documented that resident #056 be monitored closely. Further upon review of the progress notes there was no documentation or any information regarding that staff is providing continuous one on one monitoring intervention to the resident and the resident response to the interventions.

As such for resident #056 responsive behaviours, the interventions including the one on one monitoring and the resident's responses to interventions was not documented. [Log:026170-15] [s. 53. (4) (c)]

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 resident #056 demonstrating physical responsive behaviours, the actions that are taken to respond to the resident needs, including one on one interventions and that the resident's responses to interventions are documented, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(e) is approved by a registered dietitian who is a member of the staff of the home; O. Reg. 79/10, s. 71 (1).

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(f) is reviewed by the Residents' Council for the home; and O. Reg. 79/10, s. 71 (1).

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(g) is reviewed and updated at least annually. O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's menu cycle is approved by a registered dietitian who is a member of the staff of the home, is reviewed by the Residents' Council for the home and is reviewed and updated at least annually.

The home implemented the current menu in 2005, along with changes to the home's food production system. The home's menu is a four week cycle for both meals and snacks and includes minced and puree texture modifications, no added salt, diabetic 1, diabetic 2, modified fat, renal and restricted lactose. As reported to Inspector #148, the 2005 menu, including therapeutics, was approved by Registered Dietitian(s) at the time of its initial implementation.

Over the course of time, the menu has had several changes to individual food items based on resident choice, preference and seasonal or product availability. As it relates to changes of individual food items over the past year, it was reported to Inspector #148, that such changes are reviewed by members of the Residents' Council and the home's Registered Dietitian(s). The review completed is to ensure the food item change is comparable.

After speaking with the Director of Support Services, Food Service Supervisor and the home's Registered Dietitians, it was established that the home's menu, including the available therapeutics for both meals and snacks used in the home, has not been reviewed or updated at least annually. In addition, the home's menu, including the available therapeutics for both meals and snacks used in the home, has not been approved by the home's Registered Dietitian(s).

During interviews by Inspector #573, both President's for the Community and Veterans Residents' Council, indicated no recollection of having reviewed the home's menu. The home's Director of Support Services reported to Inspector #573 that dining/food are a standing agenda item for council meetings, however, could not demonstrate that the home's menu, as described above, was reviewed by both councils. [s. 71. (1) (e)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's menu cycle is approved by a registered dietitian who is a member of the staff of the home, the home's menu cycle reviewed by the Community and Veterans Residents' Council of the home, the home's menu cycle reviewed and updated at least annually, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs are stored in an area or medication cart that is secure and locked.

On January, 19, 2016, Inspector #573 observed:
- In a specific unit for Resident #004 there were prescribed topical creams, gels, nasal cream and sprays on the bedside table.
- In a specific unit common area a basket on top of a cupboard containing prescribed topical creams, pain gels and nasal creams. It was observed no staff members were

present.
- In a specific unit it was observed a basket containing prescription antibiotic ointment, pain gel and a nasal cream on the treatment cart near the resident common area. It was observed no staff members were present. In addition, it was observed there were prescribed creams and a ointment on top of the counter of the nursing station for resident #070. It was observed that no staff members were present.
- In a specific unit for Resident #007 there were prescribed medicated skin creams, pain gel and one inhaler on the bedside table.

On January 19, 2016, in a specific unit at approximately 0930 hours it was observed by Inspector #548 that liquid medication to be on top of the medication cart. During breakfast service it was observed that the RPN #128 prepared and administered medications to several individual residents. With each administration her back was turned towards the cart and the cart was out of her line of sight. During an interview RPN#128 indicated that the home encouraged the practice of leaving the syrup on top of the medication cart for accessibility while preparing medications.

On January 20, 2016, in a specific unit Inspector #573 observed a basket on top of a cupboard containing prescribed medicated skin creams, ointments and a pain gel. It was observed that there were three residents sitting in the vicinity of the basket watching television and no staff members present.

On January 20, 2016, in a specific unit at 0845 hours it was observed by Inspector #548 that the medication cart in the hallway outside the dining room to be left unattended and a container of liquid medication on the top of the cart. It was observed there was no staff member present.

On January 20, 2016 Inspector #548 observed in Resident #022 room a container of prescribed cream on top of the bedside table.

On January 22, 2016, during an interview with the Director of Nursing Operations who indicated to Inspector #548 that all drugs are to be secured and locked and no drugs are to be left unsecured or unlocked in the common areas or medication cart, where residents could access them. [s. 129. (1) (a)]

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 stored in an area or a medication cart that is secure and locked, to be implemented voluntarily.

WN #7: 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. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. The Licensee failed to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident.

As stipulated in Policy titled: Self-Administration of Medications, #5-5, dated January 2014 the home has a process that includes prescriber approval, resident ability to administer their own medications and safe storage of resident drugs for those residents that self-administer their medications. The policy specifies that the resident is to sign a form record titled" Resident Self-Administration of Medication Agreement" that is to be filed in their health care record.

On January 19, 2016, Inspector #573 observed prescribed medications on the resident's bedside table:
- In a specific unit for Resident #004 there were prescribed topical creams, gels, nasal cream and sprays on the bedside table.
- In a specific unit for Resident #007 there were prescribed medicated skin creams, pain gel and one inhaler on the bedside table.

On January 20, 2016, Inspector #548 observed on a specific unit in resident #022 room a

container of prescribed cream on top of the bedside table. During an interview the resident #022 indicated that the cream is left at the resident bedside table so that he/she can apply the cream by self.

On January 22, 2016, resident #007 indicated that she/he administers these medication creams to her/him self however, she/he is not sure how many times to apply the creams and she/he does not use the inhaler anymore.

On January 25, 2016, resident #004 indicated that he/she administers the medication creams, ointments, and Nasal spray, on his/her own accord.

The health record was reviewed for resident #004, #007 and #022.

There is record of prescriber approval on the Physician Medication Review for the self-administration of two medications for resident #004. Review of the health care record did not reveal the signed agreement for the administration of drugs, as per policy.

On January 25, 2016, during an interview both RN #134 and RPN #133 confirmed resident #004 had not had an assessment of his/her capability to self-administer medications.

Upon record review there is no record of prescriber approval for the self- administration of medications for resident #007 and #022 and no assessment of the capability.

On January 25, 2016, during an interview RN #132 indicated that the resident #007 has not been approved nor assessed as capable for the administration of drugs. [s. 131. (5)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee failed to seek the advice of the Residents' Council in developing and carrying out of the home's annual satisfaction survey.

During interviews by Inspector #573, both President's for the Community and Veterans Residents' Council, indicated that the licensee did not seek the advice of the Council regarding the development of home's annual satisfaction survey.

Inspector reviewed the minutes of the both the Residents' Council meetings from January 2015 to December 2015 and this review indicated that the Residents' Council advice has not been requested or consulted in developing of the satisfaction survey.

On January 26, 2016, Inspector #573 spoke with the Director of Support Services (DSS) who indicated that the licensee conducted home's annual satisfaction survey in month of August and September 2015. The DSS further confirmed to the inspector that the licensee did not seek the advice of the Residents' Council in developing and carrying out the home's 2015 annual satisfaction survey. [s. 85. (3)]

Issued on this 5th day of February, 2016

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

Original report signed by the inspector.