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

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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
May 31, 2016	2016_284545_0013	012457-16	Resident Quality Inspection

Licensee/Titulaire de permis

CITY OF OTTAWA
Long Term Care Branch 275 Perrier Avenue OTTAWA ON K1L 5C6

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

PETER D. CLARK CENTRE
9 MERIDIAN PLACE OTTAWA ON K2G 6P8

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

ANGELE ALBERT-RITCHIE (545), ANANDRAJ NATARAJAN (573), JOELLE TAILLEFER (211), KATHLEEN SMID (161), PAULA MACDONALD (138)

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): May 16, 17, 18, 19, 20, 24, 25, 26 and 27, 2016

Two Complaints and ten Critical Incidents Inspections were completed as part of the Resident Quality Inspection:

Complaints submitted by family members

• Log #: 001196-16, related to an unexplained injury to a resident
• Log #: 014941-16, related to concerns about a resident's care and operation of the home

Critical Incidents submitted by the home
• Log #: 033686-15 and Log #: 031137-15 related to two resident's attempting to self-harm
• Log #: 028918-15, Log #: 025553-15, Log #: 024476-15, Log #: 017676-15, Log #: 002046-16 related to allegations of abuse to residents
• Log #: 022195-15 related to an unexpected death of a resident
• Log #: 000225-16 related to an unexplained injury to a resident
• Log #: 015341-16 related to an injury to a resident

During the course of the inspection, the inspector(s) spoke with the Administrator, Manager of Personal Care, Manager of Resident Care, Manager of Hospitality Services, a Food Services Supervisor (FSS), Manager of Recreation/Leisure/Volunteer Services, RAI-MDS Coordinator, Administrative Assistant, Staffing Coordinator, a Geriatric Psychiatry Outreach Nurse, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Care Workers (PSW), a Housekeeping staff, a Physiotherapy Assistant (PTA), Presidents of the Residents' Council and Family Council, family members and residents.

The inspectors also conducted a tour of all resident care areas, observed residents' rooms, observed resident common areas, observed a medication administration pass, including a Narcotic and Controlled Substances storage area, observed meal services, reviewed resident health records, reviewed staff schedules, reviewed several of the home's policies and procedures related to abuse, complaints, restraints, medication administration system, infection control and cleaning of mobility equipment, reviewed the home's Admission Package, meeting minutes of the Residents' & Family Councils and observed delivery of resident care and services.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **13 WN(s)**
- **3 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 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 compliance with any protocol required by the Act or this Regulation, such as the "Protocol: Screening and Management of a specified antibiotic resistant infection, P & P No: 850-01" put in place by the home.

In accordance with section 86(1) of the Act, every licensee of a long-term care home shall ensure that there is an infection prevention and control program for the home.

The home's policy: "Protocol: Screening and Management of a specified antibiotic resistant infection, P & P No: 850-01, last revised February 2016", indicated that:
-Staff and resident safety shall be ensured when caring for residents identified with the specified antibiotic resistant infection and the risk of transmission reduced.
-Contact precautions shall be set up for all residents with the specified antibiotic resistant infection
-The nurse initiates the specified antibiotic resistant infection contact precautions promptly and immediately notifies the physician, the Infection Control Delegate and Power of Attorney/Substitute Decision Maker.

On May 16, 2016 Inspector #573 observed a Droplet Contact Precaution sign posted on resident #040's bedroom door which directed staff to wear gloves, mask and gown when entering the resident's room, however Protective Personal Equipment (PPE) was not found in or nearby the bedroom. The signage also directed the resident to wear a mask when leaving the bedroom. The following day, Inspector #138 observed resident #040 sitting in the lounge with other residents watching TV; it was noted by the Inspector that the resident was not wearing a mask.

On May 25, 2016 Inspector #545 observed a Droplet Contact Precaution sign posted on resident's #040's bedroom door, again there was no PPE cart in or nearby the bedroom.

Upon review of resident #040's health record, documentation of the specified antibiotic resistant infection culture received on a specified date in March 2016, indicated that the specified antibiotic resistant infection bacteria was isolated in the culture. In the home's electronic health record, under the Alert tab, it was documented that the resident had tested positive for a specified antibiotic resistant infection in a specified body part. There was no documentation in the written plan of care to indicate that the resident was positive for a specified antibiotic resistant infection and that Contact Precautions were required. As well there was no documentation to indicate that the POA/SDM and the Infection

Control Delegate were notified of the test results. Two months later, in a progress note of a specified date in May 2016 it was documented that the resident was on precautionary isolation (Droplet Contact Precaution) due to a productive cough and a runny nose.

PSW #130 indicated to the Inspector that resident #040 did not have any infection, that PPE was not required and was unable to explain why a Droplet Contact Precaution signage was posted on the resident's bedroom door.

During an interview with RN #117, she indicated that the resident did not have any infection and she could not explain why a Droplet Contact Precaution sign was posted on the resident’s bedroom door. She further indicated that the resident had been hospitalized a few months before for a lung infection and was diagnosed with a pulmonary condition, and immediately removed the sign from the resident's bedroom door. Later, RN #117 confirmed that the resident had tested positive for a specified antibiotic resistant infection in March 2016 upon return from hospital, and the registered staff should have updated the written plan of care, posted a Contact Precaution signage on the resident's bedroom door immediately upon receiving results of positive to a specified antibiotic resistant infection and ensured that PPE (gloves and gowns) be available outside of the resident's bedroom and instructed staff to use PPE when providing care to the resident.

The Infection Prevention & Control Lead, indicated to the Inspector that it was the home’s expectation that staff immediately setup contact precautions for all residents with a specified antibiotic resistant infection, as per Provincial Infectious Diseases Advisory Committee (PIDAC) best practice, and in this situation, contact precautions were not set up, the written plan of care was not updated to include positive to a specified antibiotic resistant infection and instructions to direct staff in using PPE when providing care to this resident was not provided, as per the home's "Protocol: Screening and Management of a specified antibiotic resistant infection". [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 the home implements their Infection Control policy related to the screening and management of a specified antibiotic resistant infection, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 114 (3).
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written policies and protocols related to the medication management system to ensure accurate dispensing, storage, administration and destruction and disposal of all drugs used in the home, were implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The home's Medication Policies were provided by the Manager of Resident Care and was reviewed by Inspector #545. The Manager confirmed that the home uses a manual medication pass system, where registered staff document on a paper medication administration record (MAR) all administered medications and treatments.

(A) The Medication Pass - Procedure, Index Number 04-02-20 last revised on June 23, 2014 indicated the following:

Medication Pass, items:
9. Administer medications to the resident ensuing that oral medications have been swallowed. Do not leave medications at bedside unless there is a physician's written order to do so. Do not ask someone else to administer the medication; medication administration is a continuous process.

Multi-dose Strip Medication System Specific, items:
1. Select the correct package in the chronological order for the specific resident and pass time
2. Check the package information against the MAR sheet for accuracy, using the "Rights of Medication Administration"
3. Visually check the medications for accuracy according to nursing practice
4. Check for and administer any medications which are not found in the medications strips (i.e. liquids, inhalers, etc), but are scheduled
5. Administer the medications and initial the MAR sheet with administration

(B) The Medication Pass - MAR/TAR Sheets, Index Number 04-02-10, last revised June 23, 2014 indicated the following, under the section "Signing on the MAR and TAR Sheets, under item:
1. that whenever a medication was administered, the nurse or care provider must initial in the box opposite that medication for the date and the time given.

(C) The Narcotic and Controlled Substances Administration Record, Index Number 04-07 -10, last reviewed June 23, 2014 indicated under Procedure that:
2. When a page of the Narcotic and Controlled Substance Administration Record is completed, the nurse responsible for the last entry on the page must transfer the count to the following page, line 1. The nurse must also transfer all the information received from the pharmacy to the subsequent page, including the original quantity of drug dispensed.
4. All entries must be made at the time the drug is removed from the container.

(D) The Medication Disposal Non Controlled/Controlled , AP & OP No: 345.02, last revised July 2014 indicated under Administrative Practice that: "Medication that is deemed surplus, discontinued, expired or presents with an illegible or damaged package will be disposed of in a safe manner. Until time of removal and complete destruction, the medication will be kept in a secure area, separate from those medications that are available for administration to residents".

During a medication pass observation on May 20, 2016 from 0735 to 0816 hours

conducted by RPN #107 on a specified unit, Inspector #545 observed this registered staff signing each medication as administered prior to entering the resident's room to administer the medications. After removing a benzodiazepine from a multi-dose blister pack which was locked in the Narcotic and Controlled Substance storage area within the medication cart, RPN #107 signed for the administration in the Medication Administration Record (MAR). The nurse entered the resident's room holding a small paper cup which contained all the prepoured medications, including the benzodiazepine and told the resident she was leaving the medications in the paper cup by the resident's bed, on the night table, then left the room. Later, during an interview, RPN #107 indicated to the Inspector that it was her practice to sign for administration while she was verifying each medication. She further indicated that she would sign for the administration of the benzodiazepine in the Narcotic and Controlled Substance Administration Record only after she had completely finished passing medications for all residents on the unit, which would occur around 0945 hours. She added that resident #052 was capable of making his/her own decisions, therefore it was acceptable to leave the medications at the resident's bedside for self-administration at a later time.

In a review of resident #052's health record, the inspector was unable to locate an order for medication self-administration.

In a review of the Narcotic & Controlled Substances storage area on May 20, 2016 with RN #108, hand-written information was noted to be entered incorrectly on the following Narcotic & Controlled Substances Administration Records when compared to the narcotic and controlled substances packaging for the following residents:
-Resident #058: at the top of the Administration Record, the dosage of a specified benzodiazepine incorrectly documented;
-Resident #016: at the top of the Administration Record, RX number for a specified narcotic incorrectly documented; and
-Resident #059: at the top of the Administration Record, the dose for a specified narcotic was documented as 1/2 tablet; while the instructions on the blister pack indicated to administer 1/4 tablet

During the same observation of the Narcotic & Controlled Substances storage area on May 20, 2016, the Inspector observed:
- 21 tablets of a specified narcotic, part of a blister pack for resident #060, with an expiry date of March 2016, close to two months passed the expiry date.

During an interview with the Manager of Resident Care, he indicated that it was the

home's expectation that registered staff adhere to Medication Management policy and procedure, and that all medications should be signed for only after administration in the MAR sheet, that any narcotic and controlled substance administered should be signed for in the MAR and the Narcotic and Controlled Substances Administration Record immediately following administration. He further indicated that medications should never be left at the bedside unless there was a order for self-administration. The Manager added that it was the responsibility for all registered staff to transfer all information from a Narcotic & Controlled Substance Administration Record to a new sheet when one was filled up or if a new order was received, and to ensure that all information was entered correctly. [s. 114. (3) (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 home's written policies and protocols related to the medication management system to ensure accurate dispensing, storage, administration and destruction and disposal of all drugs used in the home, is implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices., to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

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 drugs were administered to resident #052 in

accordance with the directions for use specified by the prescriber.

Resident #052 was diagnosed with several medical conditions including anxiety, depression, vision loss, and one sided weakness secondary to a stroke with mild cognitive impairment. According to the most recent assessment, the resident required extensive assistance of one staff with activities of daily living such as dressing, toilet use and personal hygiene.

On May 20, 2016, Inspector #545 observed RPN #107 enter resident #052's room while PSW #104 was assisting the resident with care. The nurse left 11 different medications, including one antidepressant tablet in a medication paper cup on the night table of Resident #052; applesauce was not used.

On the same day at 1430 hours, resident #052 indicated to the Inspector that he/she had dropped the medication paper cup on the floor when tried to self-administer the medications that had been left on the night table by the nurse earlier in the day. The resident further indicated that a small white pill was still on the floor as he/she was unable to access it. The resident further indicated that he/she was unable to identify the white pill on the floor.

The Inspector checked the room, and found a small white pill on the floor between the bed and the lazy-boy chair in the resident's bedroom.

RPN #113 confirmed that the white pill was a specified antidepressant.

In a review of the resident's Medication Administration Record (MAR), it was documented that all medications should be mixed whole in applesauce.

As such, the specified antidepressant medication was not administered to resident #052 in accordance with the directions for use specified by the prescriber: in applesauce at 0800 hours on May 20, 2016. [s. 131. (2)]

2. The licensee has failed to ensure that no resident administered a drug to him/herself unless the administration had been approved by the prescriber in consultation with resident #052.

Resident #052 was diagnosed with several medical conditions including anxiety, depression, vision loss, one sided weakness secondary to a stroke with mild cognitive

impairment. According to the most recent assessment, the resident required extensive assistance of one staff with activities of daily living such as dressing, toilet use and personal hygiene.

On May 20, 2016, during an observation of a medication pass with RPN #107, Inspector #545 observed the nurse prepare and prepour 11 different medications in a small paper cup, including one controlled substance medication.

RPN #107 then entered resident #052's bedroom and put the small paper cup with all the medications by the resident's bed on the night table and left the room, reminding the resident that the medications were by the bedside. Upon leaving the room, the RPN indicated to the Inspector that it was OK to leave the medications at the bedside because resident #052 was able to make own decisions and the doctor had approved self-administration of medications for this resident.

Upon review of the resident's health record, an order for self-administration was not found.

Later that day, resident #052 indicated to Inspector #545 that he/she was surprised that the nurse had left the medications in his/her bedroom as other nurses always gave him/her all medications while the resident was having breakfast in the dining room. The resident further indicated that he/she had dropped the small paper cup when tried to self-administer the medications as his/her arm was too shaky.

In an interview with RPN #113, he confirmed that there was no order for self-administration for resident #052, and medications should not be left at the resident's bedside. [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 drugs are administered in accordance with the directions for use specified by the prescriber and 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 #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that dental care set out in the plan of care was provided to resident #015 as specified in the plan.

Resident #015 had several medical conditions including dementia, anxiety disorder and heart disease. According to the most recent assessment, the resident required total assistance of one staff for personal hygiene, including oral/dental care. It was also documented that the resident had decaying, carious teeth with tartar coating, as well as broken teeth.

In a review of the health record, it was documented that resident #015 had been seen by the dentist on a specified day in April 2016 for regular care, it was noted that the resident's main problem was thick accumulation of tartar.

In the resident's most recent written plan of care it was documented that staff were required to brush the resident's teeth and do oral hygiene in the morning, after each meal, at bedtime and when required.

PSW #104 assigned to resident #015's care indicated to the Inspector that the resident's morning care was done by the night staff, that he didn't know if the resident had own teeth or dentures, as he didn't provide oral/dental care after breakfast and/or lunch. [s. 6. (7)]

2. The licensee has failed to ensure that care set out in the plan of care such as application of compression stockings, was provided to resident #019 as specified in the plan.

Resident #019 had several medical conditions including diabetes, a circulation disorder and cognitive impairment with responsive behaviours, such as anxiety, and calling out. According to the most recent assessment, the resident required assistance of one staff for dressing.

On May 24, 2016, Inspector #545 observed resident #019 in the lounge waiting for lunch, the resident had blue and white stripe socks with sandals on his/her feet; and some swelling was observed when the resident lifted the pants to show the inspector the scarred legs. Later, the Inspector observed one pair of compression stockings in a plastic basket in the resident's bathroom with other personal items. The resident was unable to explain to the Inspector why the compression stockings were not applied.

In a review of the resident's health record, in the quarterly medication review signed by the physician on a specified day in May 2016 it was documented that resident #019 should have thromboembolic disease (TED) stockings applied in the morning and off at bedtime related to venous insufficiency.

On May 24, 2016, PSW #119 indicated that night staff had gotten resident #019 up in the morning, and the TED stockings had not been applied. She further indicated that she did not apply them to the resident, as she had not seen instructions for her to do so.

During an interview with RPN #120, she indicated to Inspector #545 that there was an order from the physician to apply TED stockings daily to resident #019's legs for swelling due to a circulation disorder. She further indicated that the resident had been removing compression stockings and that might have been the reason why they were no longer being applied as prescribed.

The Manager of Personal Care indicated that it was the home's expectation that staff provide care as set out in the written plan of care, such as application of compression

stockings. She added that if the resident removed the stockings, staff should have notified the physician for a reassessment. [s. 6. (7)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents' mobility equipment were kept clean and sanitary.

Between May 16, 17, and 25, 2016 the following mobility equipment were observed unclean:
-Resident #004's wheelchair: the seatbelt and frame were soiled
-Resident #024's gerichair: red hardened matter on the left footrest, as well as an area on the backrest with dried white matter
-Resident #021's gerichair: dried brown matter on the edge of the table top, as well as a large area of dried white matter on both footrests, and several areas of orange colour dried debris

Housekeeping Aide #122 indicated to the inspector that it was the responsibility of the PSW on night shift to clean all mobility equipment.

PSW #126 indicated that it was the responsibility of day/evening staff to wipe off any visible dirt, debris or matter on the resident's mobility equipment when observed, and that a deep clean was scheduled to be done by PSW on night shifts.

RN #123 indicated that the Rehab Assistant coordinated the cleaning of the ambulation equipment on all units in the home and provided each unit with a cleaning schedule, whereby each mobility equipment was cleaned every two weeks on the night shift by the PSW. She further indicated that staff were expected to clean the mobility aid using a disinfectant such as "Accel" wipes or "Virex" spray, and that cushions were removed and washed in the machine on the units and hanged to dry until the next day.

RN #117 indicated to the Inspector that on a specified unit, a new method of cleaning was being piloted, whereby a steam cleaner was used to clean the frame, the backrest, the seat cushion with the cover on, the seatbelt and all other parts. She further indicated that one PSW was able to clean 20 mobility aids in less than 30 minutes.

In a review of the Cleaning of Mobility and Therapy Related Equipment May 2016 schedule, the following mobility equipment were scheduled to be cleaned on the following dates:
-Resident #004's wheelchair: signed as cleaned Saturday May 14, next cleaning scheduled for Saturday May 28
-Resident #024's gerichair: signed as cleaned Sunday May 15, next cleaning scheduled for Sunday, May 29
-Resident #021's gerichair: was scheduled for cleaning on Thursday May 19, no signature of staff found to indicate that cleaning was completed

The Manager of Personal Care indicated that it was the responsibility of the staff to clean any visible unclean area on resident's mobility equipment and inform night staff if deep cleaning was required prior to the cleaning schedule. After looking at resident #004's seatbelt, and residents #024 and #021's gerichairs, she confirmed that the mobility equipments were unclean and unsanitary. She further indicated that a tool would be required to ensure the cleaning of the seatbelt, as staff were unable to clean the debris wedged in the creases of the seatbelt with the use of the steam cleaner. [s. 15. (2) (a)]

WN #6: 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 failed to comply with section 24.(1)2. of the Act in that the licensee failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or a risk of harm to the resident shall immediately report the suspicion and the information upon which it is based to the Director.

Inspector #138 reviewed a Critical Incident Report (CIR) which outlined resident to resident physical abuse with injury that occurred on a specific date in September 2015. The CIR is a method used by the homes to inform the Director of incidences of abuse. It was noted that the report date on the CIR indicated that the Director was not immediately informed but was informed eight days after the incident occurred.

Specifically, the above CIR outlined a physical altercation between resident #046 and resident #047 that resulted in resident #046 suffering an injury. The Inspector reviewed the health care record for resident #046 and noted that the incident progress note dated approximately two hours after the incident occurred outlined that resident #046 reported being grabbed by resident #047 resulting in an injury. The incident progress note further outlined that resident #046 was assessed by RPN #131 and found to exhibit signs of an injury. An additional progress note later that same evening outlined that resident #046 had complaints of soreness to the area with bruising and increasing signs of an injury. A progress note was also entered into the resident's health care record by the night charge RN who had also reassessed the resident and also found signs of an injury. Eight days after the incident, the resident was diagnosed with a specific injury following a diagnostic test.

The Inspector spoke with RPN #131 regarding the reporting of this incident. RPN #131 stated that the evening charge RN was verbally made aware of the incident, the night charge RN was made aware of the incident through shift report, and that management was made aware as the incident progress made approximately two hours after the incident would automatically and immediately be sent electronically to the appropriate manager. The Inspector spoke with the Manager, Personal Care regarding the reporting of the above incident. The Manager, Personal Care stated that the appropriate manager will receive the incident progress notes electronically for review. She was unable to explain the rationale for the delay in reporting of this specific incident. (Log#: 025553-15)

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident may be restrained by a physical device if the restraining of the resident was included in the resident's plan of care.

On May 18 and 19, 2016, resident #004 was observed seated in a wheelchair with a front closing lap belt. On both days, when Inspector #573 requested resident #004 to undo the front closing wheelchair lap belt, resident #004 could not undo the lap belt.

Upon review of resident #004's health record, it was indicated that no restraints were in use for resident #004 at the last assessment completed on a specified day in May 2016. The written plan of care in effect was reviewed by the Inspector and it identified the use of wheelchair lap belt for the resident's safety. Further, the plan of care indicated that resident #004 was physically capable to undo the wheelchair lap belt.

On May 19, 2016, during an interview, PSW #114 and PSW #115 stated that staff applied the wheelchair lap belt for resident #004's safety to prevent from falls. Further, both PSWs indicated to the inspector that resident #004 was not physically capable of releasing the wheelchair lap belt. Inspector #573 observed resident #004 in the presence of PSW #114 that resident was unable to remove the wheelchair lap belt when PSW #114 requested to undo the lap belt.

In an interview on May 19, 2016, RPN #116 stated to Inspector #573 that the wheelchair lap belt was used for resident #004's safety to prevent from any falls. RPN #116 indicated to the inspector that she was not aware that resident #004 was physically incapable of removing the wheelchair lap belt. Further RPN #116 indicated to the inspector that if resident #004 was unable to undo the wheelchair lap belt on her own, the device would be considered a restraint. [s. 31. (1)]

WN #8: 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 has failed to ensure that each resident of the home had his or her personal items, labelled within 48 hours of admission and of acquiring, in the case of new items.

On May 16, 2016, during a tour of the home's common tub rooms, Inspector #573 observed the following personal items unlabeled in four different units:
-one used disposable razor
-one used hair brush (white)
-one used hair brush (white), two used, roll type deodorant
-one used hair brush (white), one used long nail clipper

On May 26, 2016, Inspector #545 conducted an observation in the common tub rooms and observed the following personal items unlabeled in two different units:
-one used black plastic comb on the bench by the shower
-one used hair brush (white) on the bench by the tub

PSW #130 and RPN #125 indicated that it was the home's expectation that all residents' personal items be labeled and kept in a plastic basket in the resident's bedroom, for sanitary reasons.

The Manager of Personal Care indicated that it was the PSWs responsibility to label all residents' personal items upon admission and when new items were acquired, and no unlabeled personal items should be left in the common tub/shower rooms on the units. [s. 37. (1) (a)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee failed to respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

On May 18, 2016, Inspector #573 spoke with the President of the Residents' Council (RC) who indicated that the licensee did not respond in writing within 10 days with regards to any advice related to the concerns or recommendations from the Residents' Council. Further the president stated that the licensee gave a verbal response at the meeting or it would be discussed at the next Residents' Council meeting.

Inspector reviewed the minutes of the Residents' Council meetings from April 2015 to April 2016.

- For April 2016, RC meeting minutes - Concerns regarding resident doors on a specified unit being left open by staff during night;
- For November 2015, RC meeting minutes - Concerns regarding banisters and metal parts that support the railing to be checked for safety reasons; and
- For October 2015, RC meeting minutes - Concerns regarding water not draining properly in a specified unit's shower room.

There was no written evidence to support that a response from the licensee regarding the identified concerns was communicated to the Residents' Council.

On May 25, 2016, Inspector #573 spoke with the Manager for Recreation, Leisure and Volunteer Services, who indicated that any concerns or recommendations from the Residents' Council the licensee usually, gave a verbal response at the RC meeting or it would be discussed at the next RC meeting. The Manager of Recreation indicated to the inspector that currently they did not have a process to respond in writing. Further she indicated that the home was in the process of implementing the written response within 10 days to the Residents' Council concerns or recommendations. [s. 57. (2)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (1) Every licensee of a long-term care home shall ensure that the required

information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations. 2007, c. 8, s. 79. (1).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's policy to promote zero tolerance of abuse and neglect, and the explanation of the whistle blowing protections afforded under section 26 was posted in a conspicuous and easily accessible location of the home.

On May 16, 2016, Inspectors #573 and #138 conducted an initial tour of the home and did not observe the required posting of information related to the home's policy to promote zero tolerance of abuse and neglect, and the explanation of the whistle blowing protections under section 26 of the legislation.

In an interview on May 19, 2016, the Home's Administrative Assistant (AA) stated to Inspector #573 that copies of the home's policies were kept inside a plastic document sleeve near the home's main reception area.

Inspector #573 observed in the presence of the AA that the home's policy to promote zero tolerance of abuse and neglect, and the explanation of the whistle blowing protections that were kept inside in the plastic document sleeve titled "City of Ottawa Long Term Care Branch Mission, Vision, Values and Strategic Directions 2014 -2017". There was no communication posted directing residents, visitors and staff member that the plastic document sleeve contained the copies of the home's policies.

Inspector #573 spoke with the AA, who agreed with the Inspector that the home's policy to promote zero tolerance of abuse and neglect, and the explanation of the whistle blowing protections were not visibly seen, unless someone requested at the reception for the location of the home's policies. [s. 79. (1)]

2. The licensee has failed to ensure that required information, as described by 79(3) of the Regulation, was posted in the home.

Upon the initial tour of the home, Inspectors #573 and #138 were unable to locate the required posting of information related to the long-term care home's procedure for initiating complaints to the licensee and the notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy could be obtained.

On November May 19, 2016, in the presence of the home's Administrative Assistant, Inspector #573 looked for the required posting of information, such as the long term care

home's procedure for initiating complaints to the licensee and the notification of the long term care home's policy to minimize restraining of residents and how a copy of the policy could be obtained, and the AA confirmed that the information was not posted anywhere in the home. [s. 79. (3)]

WN #11: 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 has failed to comply with section 85. (3) of the Act in that the licensee failed to seek the advice of the Residents' Council in developing and carrying out the satisfaction survey.

Inspector #573 spoke with the President of the Residents' Council who indicated that the licensee did not seek the advice of the Residents' Council regarding the development of the home's annual satisfaction survey.

Inspector reviewed the minutes of the Residents' Council Meetings from April 2015 to April 2016 and the minutes had no documentation to support that the licensee sought the advice of the Residents' Council regarding the development of the home's annual satisfaction survey.

On May 25, 2016, Inspector #573 spoke with the Manager for Recreation, Leisure and Volunteer Services who stated that the home conducted an annual satisfaction survey for 2016 but did not seek the advice of the Residents' Council in developing and carrying out the annual satisfaction survey for 2016. [s. 85. (3)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the restraint documentation included every release of the lap belt restraint and repositioning of resident #015.

Resident #015 was diagnosed with several medical conditions including dementia, anxiety disorder and heart disease, and according to the most recent RAI-MDS assessment, a trunk restraint was applied daily.

Inspector #545 observed resident #015 in a tilt wheelchair with a front closure lap belt on May 17 and 19, 2016. The resident was cognitively and physically unable to release the lap belt when asked.

In the resident's most recent written plan of care it was documented that the resident was at high risk for falls, that a lap belt was required when in a tilt wheelchair for safety, and that staff were expected to monitor hourly and reposition the resident.

In a review of the May 2016 Restraint/PASD Monitoring Form for resident #015, 11 out of 38 shifts (day/evening) revealed no documentation of release and repositioning.

During an interview with PSW #104, he indicated that staff got resident #015 up around 0600 and was put in the tilt wheelchair with a lap belt for safety. He indicated that the resident was repositioned every two hours and that it was the home's expectation that all release and repositioning be documented hourly on the Restraint/PASD Monitoring Form.

The Manager of Personal Care indicated that it was the home's expectation that documentation of every release and repositioning be completed hourly on the Restraint/PASD Monitoring Form. [s. 110. (7) 7.]

WN #13: 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 has failed to ensure that drugs were stored in an area or a medication, that was secure and locked.

On May 20, 2016 at 0735, Inspector #545 observed a medication cart unlocked and unattended in the hallway on a specified unit by room #150. Five minutes later, RPN #107 came out of room #150 and prepared medications for another resident. She then left the medication cart unlocked and unattended and with medications in a small cup, entered room #158, across the hall to administer medications to the resident.

Later during an interview, RPN #107 indicated to the Inspector that she was aware that the medication cart needed to be kept secure and locked, when not in use, or in view.

The Manager of Resident Care confirmed that it was the home's expectation that all registered staff were responsible in keeping the medication cart secure and locked, when they registered staff were unable to monitor the medication cart, including when entering residents' room to administer medications, and leaving the cart in the hallways. [s. 129. (1) (a)]

Issued on this 2nd day of June, 2016

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

Original report signed by the inspector.