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
Jan 25, 2017	2016_246196_0022	033014-16	Resident Quality Inspection

Licensee/Titulaire de permis

BOARD OF MANAGEMENT OF THE DISTRICT OF KENORA
1220 Valley Drive KENORA ON P9N 2W7

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

PRINCESS COURT
PRINCESS STREET BOX 725 DRYDEN ON P8N 2Z4

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

LAUREN TENHUNEN (196), DEBBIE WARPULA (577), JENNIFER KOSS (616)

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): December 5, 6, 7, 8, 9, 12, 13, 14, 15, 2016

The following intakes were inspected concurrently:

Critical Incident System (CIS): two intakes related to resident falls; four intakes related to staff to resident alleged abuse.

Complaint: one intake related to medication administration and one intake related to resident care concerns.

Follow up: one intake related to a Compliance Order for restraint use; one intake related to a Compliance Order for medication; one intake related to a Compliance Order for restraint training and one intake related to a Compliance Order for infection prevention and control.

During the inspection, the Inspectors conducted a walk-through of resident care areas, observed staff to resident interactions and the provision of care and services to residents, reviewed submitted Critical Incident System (CIS) reports, reviewed various home policies and procedures, several employee files, homes' investigation records and resident health care records.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Resident Assessment Instrument (RAI) Coordinator, Administrative Assistant, Activity Coordinator, Cook and Dietary staff members, Physiotherapist (PT), Physiotherapy Assistant (PTA), residents and family members.

The following Inspection Protocols were used during this inspection:

Admission and Discharge
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care
Trust Accounts

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 110. (1)	CO #001	2015_281542_0017	577
O.Reg 79/10 s. 134.	CO #002	2015_281542_0017	616
O.Reg 79/10 s. 221. (1)	CO #003	2015_281542_0017	577

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. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff participated in the implementation of the infection prevention and control program.

On one day during the inspection, Inspector #616 observed medication administration by Registered Practical Nurse (RPN) #100 in the dining room on one of the units at lunch time. The Inspector observed that the RPN had not performed hand hygiene between medication administration to residents.

In an interview with the RPN, they stated to the Inspector that they should have used hand sanitizer between residents' medication administration, but had not.

A review of the home's Medication Management System Policies and Procedures (Draft), identified that staff were to observe aseptic techniques and principles of infection control in all medication delivery that included hand washing (or use wipes) between resident contacts.

During an interview with the Director of Care (DOC) on a specific date, they stated that the draft policy identified above, was currently in use by the home. In addition, the DOC verified to the Inspector that staff were expected to sanitize (gel) their hands between residents, and if their hands were visibly soiled, they were expected to wash their hands with soap and water. [s. 229. (4)]

2. The licensee has failed to ensure that the following immunization and screening measures were in place: Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded

immunization schedules posted on the Ministry website.

As part of this Follow Up Inspection, the inspectors were following up on outstanding Compliance Order #004, served December 7, 2015, issued during inspection #2015_281542_0017. The licensee was ordered to ensure that each resident admitted to the home was screened for tuberculosis within 14 days of admission unless the resident had already been screened at some time in the 90 days prior to admission and the documented results of this screening were available to the licensee and also offered immunizations against tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. This Compliance Order was due December 31, 2015.

On a specific day during the inspection, Inspector #196 obtained the electronic record of immunization status for three residents admitted to the home within the previous year from the Resident Assessment Instrument (RAI) Coordinator #108. Of the three residents reviewed, resident #010, had been admitted in the summer of 2016, and the electronic record did not identify whether the tetanus and diphtheria (Td) vaccine had been offered, administered or whether there was a history of it being given.

On a specific day during the inspection, Inspector #196 conducted an interview with RN #101 regarding the offering of immunization to residents in the home. They reported that all residents, upon admission to the home, are listed on a document titled "RN Responsibilities for New Admissions". Upon review, RN #101 reported that resident #010 had "no hx. received" recorded on this document under the column of "tetanus" vaccine and the electronic record of immunization status did not note whether the Td vaccine was offered or administered. They confirmed to the Inspector that they were unable to verify the offering of the Td vaccine to resident #010 as there was no documented record it had been offered.

The hard copy of the resident's chart was reviewed by Inspector #196 and RN #101 for any information regarding the tetanus and diphtheria vaccinations. The document titled "District of Kenora Home for the Aged - Princess Court" was located misfiled in the hard copy of the resident's chart. This form outlined the requirements for TB skin testing and Immunization, provided O. Reg.79/10, s.229 information, specific also to "residents must be offered immunizations against pneumococcus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website". This document with resident #010's name on it, had an order from the physician to administer vaccine where there was no previous history available and when the 10 year booster

dose of vaccine was due.

On a specific day during the inspection, Inspector #196 conducted an interview with the DOC. They reported that they were made aware and verified that resident #010 had not being offered a specific type of immunization upon admission to the home, that the specific vaccine was administered when discovered on a specific day during the inspection and reported that it had somehow been missed. [s. 229. (10) 3.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 that ensures all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #2: 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following rights of residents were fully respected and promoted: Every resident had the right to be treated with courtesy and respect and in a way that fully recognized the resident's individuality and respected the resident's dignity.

A Critical Incident System (CIS) report was submitted to the Director. The report outlined an incident of alleged emotional abuse, which resulted in resident #023 becoming upset, which had occurred on a specific date. The report identified a witnessed interaction in which Dietary Aide #102 responded to resident #023 in a particular manner upon a request from the resident.

During the inspection, on a specific day, Inspector #196 conducted an interview with RPN #118 who had witnessed the incident. They stated that they had observed resident #023 and DA #102 and described the occurrence as was outlined in the CIS report.

During the inspection, Inspector #196 conducted an interview with the Administrator regarding the CIS report and investigation. The Administrator reported that the investigation into the incident of alleged emotional abuse had been completed. They further reported that it was determined that Dietary Aide #102 received disciplinary action as a result of the incident. [s. 3. (1) 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 that ensures the following rights of residents are fully respected and promoted: every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, to be implemented voluntarily.

WN #3: 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).

Findings/Faits saillants :

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

During stage one of the inspection, resident #003 was identified as requiring additional inspection regarding bed rails that were in an upright position, functioning as a potential restraint device.

On three specific dates during the inspection, Inspector #196 conducted observations of resident #003's bed and noted two bed rails in an assist position.

The health care records for resident #003 were reviewed by the Inspector for information regarding the use of bed rails. The current care plan, under the focus of "risk of injury from falls", identified the specific details of bed rail use, different was what was observed. The PSW flow sheet document for a particular five day period, identified the use of specific bed rail use different from the care plan and observations, on all three shifts.

During the inspection, Inspector #196 conducted an interview with PSW #103. They reported that approximately a month previous, resident #003's bed was repositioned

differently in their room and the bed rails were in a different position. An interview was conducted with RPN #104, during the inspection, and they reported that, upon observation of the resident's bed, the bed rails were not positioned correctly and that the current care plan was incorrect. [s. 6. (1) (c)]

2. A Critical Incident System (CIS) report was submitted to the Director. The report outlined resident #017's fall with injury.

On two specific dates during the inspection, Inspector #577 conducted observations of resident #017's room and noted two specific types of ambulation aides. During observations throughout the inspection, the Inspector observed resident #017 use a different type of ambulation aide than those previously observed in the resident room, for mobility.

During an interview with PSW #105, they reported that the resident required particular assistance with transferring and required a particular ambulation aide for an activity of daily living. They further reported the resident's family assisted the resident with a different activity of daily living using a specific ambulation aide.

During an interview with RN #107, they reported that staff use one type of ambulation aide and family use a different type of ambulation aide. They further reported that staff are aware that they are not to use the ambulation aide the family uses because it was a different kind of equipment.

Inspector #577 reviewed resident #017's current care plan and the care plan that was in place at time of fall. Neither care plan provided clear directions as to which or when each different ambulation aide was to be used and by whom.

During an interview with the ADOC, they confirmed that resident #017's care plan and the PSW care plan summary did not specify the type of ambulation aides that staff were to use. [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 were integrated and were consistent with and complement each other.

During stage one of the inspection, resident #007 was identified as requiring additional

inspection regarding not receiving the necessary care to maintain their oral health. An interview was conducted with the resident on a specific day during the inspection and they reported that there had been concerns but was not too bad right now.

The health care records for resident #007 were reviewed by Inspector #196. The most recent Minimum Data Set (MDS) assessment under Section L (oral/dental status) had identified that the resident had a specific dental appliance and oral concerns. A skin assessment dated November 15, 2016, identified oral concerns and there was a hand written note that indicated a concern with the dental appliance and oral concerns. The progress notes from these dates of assessments, over an approximate three week period in 2016, were reviewed and did not identify issues with the residents' dental appliance or oral concerns.

During the inspection, Inspector #196 conducted interviews with the direct care staff members that had been assigned to provide care to resident #007 that day shift. According to PSW #114 and PSW #115, when questioned about resident #007's oral status, they reported to the Inspector that they were unaware of any concerns. RPN #109 was interviewed later that morning, and reported that they were unaware of any dental appliance or oral concerns until PSW #114 just reported a specific issue in the resident's mouth after assisting with care.

During the inspection, Inspector #196 conducted an interview with the Resident Assessment Instrument (RAI) Coordinator #108. They confirmed that the progress notes did not contain information regarding oral concerns that had been identified in the assessments conducted and there was no evidence to support the collaboration of these assessments with the direct care staff members. [s. 6. (4) (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 that ensures 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 and 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 be implemented voluntarily.

WN #4: 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 as described in paragraph 3 of subsection 30 (1) only if the restraining of the resident was included in the resident’s plan of care.

During stage one of the inspection, resident #004 was identified as requiring further inspection in regards to bed rails that were observed in the guard position functioning as a potential restraint device.

On a specific day during the inspection, Inspector #196 conducted an interview with the spouse of resident #004. They told the Inspector that both bed rails were to be elevated when their spouse was in bed, for safety and to prevent them from falling out of bed. On another day during the inspection, PSW #103 and RPN #117 both reported to the Inspector that the purpose of the bed rails were to keep resident #004 in bed and to prevent them from voluntarily exiting out of the bed. On another day during the inspection, RN #116 reported that they thought that if both bed rails were elevated to keep a resident in bed then it was considered a restraint.

The health care records for resident #004 were reviewed by Inspector #196. The current care plan under the focus "Physical Restraints - PASD" did not indicate the use of bed rails as a restraint and under the focus of "risk of injury from falls" the intervention of bed rails was identified.

During the inspection, Inspector #196 conducted an interview with the ADOC and the DOC. The ADOC confirmed that the bed rails when elevated for resident #004 were considered to be a restraint device and the DOC confirmed that they had not been obtaining a physician's order for the use of bed rail restraints for residents. In addition, they reported that the home had not been considering the use of two bed rails elevated as a restraint device. [s. 31. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures that a resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) only if the restraining of the resident is included in the resident's plan of care, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 109. Policy to minimize restraining of residents, etc.
Every licensee of a long-term care home shall ensure that the home's written policy under section 29 of the Act deals with,
(a) use of physical devices; O. Reg. 79/10, s. 109.
(b) duties and responsibilities of staff, including,
(i) who has the authority to apply a physical device to restrain a resident or release a resident from a physical device,
(ii) ensuring that all appropriate staff are aware at all times of when a resident is being restrained by use of a physical device; O. Reg. 79/10, s. 109.
(c) restraining under the common law duty pursuant to subsection 36 (1) of the Act when immediate action is necessary to prevent serious bodily harm to the person or others; O. Reg. 79/10, s. 109.
(d) types of physical devices permitted to be used; O. Reg. 79/10, s. 109.
(e) how consent to the use of physical devices as set out in section 31 of the Act and the use of PASDs as set out in section 33 of the Act is to be obtained and documented; O. Reg. 79/10, s. 109.
(f) alternatives to the use of physical devices, including how these alternatives are planned, developed and implemented, using an interdisciplinary approach; and O. Reg. 79/10, s. 109.
(g) how the use of restraining in the home will be evaluated to ensure minimizing of restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation. O. Reg. 79/10, s. 109.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written policy under section 29 of the Act deals with, types of physical devices permitted to be used.

During stage one of the inspection, resident #004 was identified as requiring additional inspection regarding bed rails used as a potential restraint device.

During the inspection, Inspector #196 conducted interviews with PSW #103 and RPN #117 regarding the use of bed rails for resident #004. They both reported that the purpose of the bed rails were to keep the resident in bed and to prevent them from voluntarily exiting out of bed.

Inspector reviewed the licensee's policy titled "Restraint and Personal Assistive Device Minimization NUR 400", last revised September 2015, identified permissable restraints for use which included "seat belts, table trays, thigh restraints and pelvic restraints" but did not include bed rails. The policy titled "Bed Entrapment Prevention Program ADM 470", last revised September 2015, identified "If a bed rail is used to restrain a resident (ie. limit or inhibit a resident's freedom of movement) but not to assist with a routine activity of living, then the device is considered to be a restraint" but this was not reflected in the home's policy to minimize restraints. [s. 109. (d)]

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 that ensures that the home's written policy under section 29 of the Act deals with, types of physical devices permitted to be used, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 126. Every licensee of a long-term care home shall ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. O. Reg. 79/10, s. 126.

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs remained in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed.

Inspector #616 observed the home's medication administration processes on a specific day during the inspection with RPN #109 at 1330hrs. During the unit narcotic and controlled substances count with the RPN, the Inspector noted on the resident's Narcotic Control Record that medications scheduled for administration at 1700hrs had been signed for by the RPN prior to administration for the following three residents:

-resident #007 was ordered a specific narcotic medication, next scheduled at 1700hrs.

-resident #029 was ordered a specific controlled substance, next scheduled at 1700hrs.

-resident #030 was ordered a specific controlled substance, one tablet at bedtime (at 1700hrs).

During an interview with RPN #109, they stated that they had pre-poured medications from the original packaging into plastic medication cups for residents #007, #029, and #030 as a time management strategy for the medication administration pass at the supper hour. They stated that they should not have pre-poured the medications prior to administration to the resident at the scheduled time.

A review of the Medication Management System Policies and Procedures (Draft) identified that medication was to be recorded immediately after given to resident, not before. Further the policy stated that pre-pouring of medications was not acceptable under any circumstances.

During an interview with the DOC on a specific day during the inspection, they stated that draft policy identified above, was currently in use by the home. They stated to the Inspector that registered staff should not have pre-poured medications prior to administration to the resident. [s. 126.]

2. On a specific day during the inspection, at 1700hrs, Inspectors #616 and #196 observed one small plastic medicine cup with yellow liquid at an empty place setting for resident #031 who was not observed in the dining room, and one small plastic medicine

cup with the same yellow liquid on the table in front of resident #027. Registered staff were not observed in the dining room at this time.

In an interview with PSW #110 at the time, they stated to the Inspector that the yellow liquid at the place setting for resident #031 and #027 was a specific type of medication for the residents provided to them by registered staff. The Inspector interviewed RPN #111 who entered the dining room a few minutes later. They verified and stated that they had pre-poured the specific type of medication in anticipation of the heavy medication pass at the supper hour. They further stated that the medication should have been administered to the residents when they could be supervised to take it, not left at the table as had been done for resident #031, and left resident #027 unsupervised. [s. 126.]

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 that ensures drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed, to be implemented voluntarily.

WN #7: 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 controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

Inspector #616 observed the home's medication administration processes on a specific date during the inspection, with RPN #109 on a particular unit at 1330hrs in the medication room. The RPN was observed to open the bottom drawer of the unlocked medication cart, to access the narcotic and controlled substances within two separate locked boxes. The RPN was also observed to access a locked metal box within an unlocked upper cupboard in the medication room for a specific type of medication, also a narcotic. The Inspector also observed two other units in the home and found the narcotic and controlled substances storage areas locked within the unlocked medication carts on both units.

During an interview with RPN #109, at the time of the Inspector's observation on one particular unit, they stated that they had not locked the medication cart when it was stored in the medication room. They further stated that they understood that the narcotic box was locked, and the medication room was locked. The Inspector also interviewed RPN #111 and RPN #104 from the other units on this same day. Both RPNs stated that the narcotic and controlled substances storage areas were locked within the medication cart, however the medication carts were not locked in the locked medication room.

A review of the Medication Management System Policies and Procedures (Draft) identified that controlled substances must be stored in a separate, double-locked stationary cupboard in the locked area or in a separate locked area within a locked medication cart.

During an interview with the DOC during the inspection, they stated to the Inspector that narcotics and controlled substances should have been locked in a separate area within the locked medication carts, or locked storage area, in the locked medication room. [s. 129. (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 that ensures 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, to be implemented voluntarily.

WN #8: 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 has failed to ensure that no drug was used by or administered to a resident in the home unless the drug has been prescribed for the resident.

A complaint was received by the Director related to a medication incident where resident #024 had administered one of their medications to resident #022 in the dining room.

Inspector #616 interviewed the complainant on a specific date. They stated they had been notified that that the registered staff had not supervised resident #024 take their medications due to an issue in the dining room. During this time, resident #024 had administered one of their own pills, reportedly a specific type of medication to resident #022.

During the inspection, the Inspector interviewed RPN #117, the nurse involved. The RPN stated to the Inspector that on this day, they had provided resident #024 their medications in the dining room, and resident #022 had received their medications in their room prior to breakfast. They stated their attention was diverted to another resident when resident #024 informed RPN #117 that they had given one of their pills to resident #022. The RPN stated that they had determined with resident #024 that the medication

given to resident #022 was not prescribed for them.

During the inspection, the Inspector interviewed resident #024 who recalled an incident where they had given one of their pills to co-resident #022 "by mistake". They were unable to recall the specific medication. The Inspector also interviewed the ADOC on this day. They stated although the incident was unwitnessed, the medication given to resident #022 by resident #024 was determined not to be prescribed for them.

The Inspector reviewed the home's internal medication incident report which verified the details of the incident. A progress note in resident #022's electronic health record documented that resident #022 had received another resident's specific type of medication that morning in error and that there had been no adverse reactions.

The home's policy "Medication Management System, Policies and Procedures" (Draft) was reviewed by the Inspector. The policy stated that medications were given only when there was a written/signed physician's order to do so.

In the interview with ADOC, during the inspection, they stated this "draft" policy was in effect at the time of the medication incident and that resident #022 should not have received a medication that they did not have a physician's order for. [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 that ensures 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 #9: 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, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and of acquiring, in the case of new items.

During the inspection, on three occasions, Inspector #577 and #616 observed residents' personal items to be unlabelled and used in the tub rooms. The Inspectors found the following:

a) Tub room on one unit: one unlabelled, used stick deodorant, one unclean white brush covered in grey hair, two used unlabelled tubes of toothpaste, one unclean black comb, two unlabelled, used toothbrushes in the cupboard in a plastic bin; one unclean black comb on a cart by the tub

b) Shower room on another unit: one unlabelled, used stick deodorant and one unclean white brush covered with grey hair on the table in the shower room

c) Tub room on another unit: one unclean black comb on the sink

d) Shower room on another unit: one unlabelled, used stick deodorant, two unclean, unlabelled hair brushes covered in grey hair, one pink unclean hairbrush covered in grey hair, one unclean black comb in cupboard of drawers and one unclean black comb on top of drawers

e) Tub room on another unit: two unlabelled, used deodorant sticks, one used unlabelled tube of toothpaste, two disposable razors with visible hair shavings, one unclean black comb, one unclean white brush covered with grey hair, one unclean hair pic and two unclean electric shavers with hair particles.

During an interview with RPN#104 during the inspection, Inspector #577 showed them the unclean, unlabelled personal items in the tub and shower rooms on the one unit and they reported that all personal items should have been labelled and proceeded to dispose of them.

During an interview with PSW #112 during the inspection, Inspector #577 showed them the unclean, unlabelled personal items in the tub and shower rooms on another unit and they reported that all personal items should have been labelled and disposed of them.

During an interview with PSW #113 during the inspection, Inspector #577 showed them the unclean, unlabelled personal items in the tub and shower rooms on another unit and they reported that all personal items should have been labelled and disposed of them.

A review of the home’s policy titled "Infection Prevention and Control Routine Precautions - OHS 410" revised date September 2015, indicated the following:
-residents personal care supplies (lotions, creams, soaps, razors, hairbrushes, antiperspirants) must be dedicated to one resident, and not shared between residents. All items must be marked with resident ID to prevent unintended use by others. Used unmarked items must be disposed of in the garbage.

During an interview with the DOC and ADOC during the inspection, they confirmed with Inspector #577 that residents' personal belongings, which included brushes, combs, toothpaste and nail clippers, were not to be kept in tub and shower rooms. [s. 37. (1) (a)]

Issued on this 26th day of January, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LAUREN TENHUNEN (196), DEBBIE WARPULA (577), JENNIFER KOSS (616)
Inspection No. / No de l'inspection :	2016_246196_0022
Log No. / Registre no:	033014-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jan 25, 2017
Licensee / Titulaire de permis :	BOARD OF MANAGEMENT OF THE DISTRICT OF KENORA 1220 Valley Drive, KENORA, ON, P9N-2W7
LTC Home / Foyer de SLD :	PRINCESS COURT PRINCESS STREET, BOX 725, DRYDEN, ON, P8N-2Z4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Patrick Berrey

To BOARD OF MANAGEMENT OF THE DISTRICT OF KENORA, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2015_281542_0017, CO #004;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:

1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.
2. Residents must be offered immunization against influenza at the appropriate time each year.
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.
4. Staff is screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
5. There must be a staff immunization program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

O. Reg. 79/10, s. 229 (10).

Order / Ordre :

The licensee is ordered to ensure that the following immunization and screening measures are in place: Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.

The licensee is specifically ordered to:

a) establish a process for registered staff to follow that will ensure all residents are offered tetanus and diphtheria (Td) immunizations in accordance with the publicly funded immunization schedules posted on the Ministry website; and
b) maintain accurate records of the Td immunizations that are offered to residents.

Grounds / Motifs :

1. The licensee has failed to ensure that the following immunization and screening measures were in place: Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.

As part of this Follow Up Inspection, the inspectors were following up on outstanding Compliance Order #004, served December 7, 2015, issued during inspection #2015_281542_0017. The licensee was ordered to ensure that each resident admitted to the home was screened for tuberculosis within 14 days of admission unless the resident had already been screened at some time in the 90 days prior to admission and the documented results of this screening were available to the licensee and also offered immunizations against tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. This Compliance Order was due December 31, 2015.

On a specific day during the inspection, Inspector #196 obtained the electronic record of immunization status for three residents admitted to the home within the previous year from the Resident Assessment Instrument (RAI) Coordinator #108. Of the three residents reviewed, resident #010, had been admitted in the summer of 2016, and the electronic record did not identify whether the tetanus and diphtheria (Td) vaccine had been offered, administered or whether there was a history of it being given.

On a specific day during the inspection, Inspector #196 conducted an interview

with RN #101 regarding the offering of immunization to residents in the home. They reported that all residents, upon admission to the home, are listed on a document titled "RN Responsibilities for New Admissions". Upon review, RN #101 reported that resident #010 had "no hx. received" recorded on this document under the column of "tetanus" vaccine and the electronic record of immunization status did not note whether the Td vaccine was offered or administered. They confirmed to the Inspector that they were unable to verify the offering of the Td vaccine to resident #010 as there was no documented record it had been offered.

The hard copy of the resident's chart was reviewed by Inspector #196 and RN #101 for any information regarding the tetanus and diphtheria vaccinations. The document titled "District of Kenora Home for the Aged - Princess Court" was located misfiled in the hard copy of the resident's chart. This form outlined the requirements for TB skin testing and Immunization, provided O. Reg.79/10, s.229 information, specific also to "residents must be offered immunizations against pneumococcus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website". This document with resident #010's name on it, had an order from the physician to administer vaccine where there was no previous history available and when the 10 year booster dose of vaccine was due.

Previous non-compliance related to this legislation, O.Reg.79/10, s.229.(10) was issued during the following inspections:

December 7, 2015 - Compliance Order from Inspection #2015_281542_0017;
April 28, 2014 - Written Notification/Voluntary Plan of Correction from Inspection #2014_211106_0009.

The decision to re-issue this Compliance Order was based on the scope which was isolated, the severity which indicated minimal harm or potential for actual harm, and the compliance history.

Despite the issuance of one Compliance Order and one Written Notification/Voluntary Plan of Correction in the past three years, the licensee continues to be in non-compliance with s.229.(10).
(196)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 17, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 25th day of January, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lauren Tenhunen

Service Area Office /
Bureau régional de services : Sudbury Service Area Office