Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 19, 2016	2016_381592_0005	002439-16	Resident Quality Inspection

Licensee/Titulaire de permis

RELIGIOUS HOSPITALERS OF ST. JOSEPH OF CORNWALL, ONTARIO
14 York St CORNWALL ON K6J 5T2

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

ST JOSEPH'S CONTINUING CARE CENTRE
14 YORK STREET CORNWALL ON K6J 5T2

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

MELANIE SARRAZIN (592), AMANDA NIXON (148), ANGELE ALBERT-RITCHIE (545)

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): February 1, 2, 3,4 ,5, 8, 9, 10, 11 and 12, 2016

Three Complaints were reviewed during this inspection: Log# O-001520-15, O-001228-14, O-001672-15 and one Critical Incident Log# O-002215-15

During the course of the inspection, the inspector(s) spoke with the home's Executive Director, the Program Support Coordinator, the Director of Care (DOC), the Personal Support Worker Supervisor, the Resident Relations Advisor, the Director of Support Services, the Environmental Services Supervisor, the Dietary Supervisor, Occupational Therapists, Physiotherapy Assistants, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeeping Aids, residents and family members.
In addition, the inspectors reviewed resident health care records including plans of care, assessment and monitoring data, along with nursing staffing patterns, and programs such as the home's fall, medication, prevention of abuse, complaint and skin programs. Inspectors also observed meal service, resident care, staff/resident interaction and resident areas for cleanliness and repair.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care set out clear directions to staff and others who provide direct care to resident #044. (Log # O-001228-14)

On February 11, 2016, during breakfast time, resident #044 was observed with contractures to both hands.

In an interview with PSW #128, she told inspector #592 that the resident is to have a splint applied on each hand but she was unable to apply the splints prior to breakfast, due to resident #044 being resistive to care by crying and yelling upon the application of the splints. She further told inspector #592 that she had reported to the charge nurse (RPN #129) that the splints were not in place.

On that same day, in an interview with PSW #124, she told inspector #592 that resident #044 has palm Posey splints to both hands to wear daily and to be removed when resident goes to bed.

In an interview with RPN #129, she told inspector #592 that she was not familiar with resident #044 personal care as she was new on this unit. She further told inspector #592 that if resident #044 was to have splints in place to both hands, she had not been made aware that resident #044 splints were not applied. Upon a review of the plan of care for resident #044, with inspector #592, RPN #129 was unable to find any directions and instructions for the use of splints for resident #044.

Upon review of the Occupational Therapist progress notes, it indicates that on a specified date in December 2014, a follow-up was done with resident #044 right hand as the splint was not fitting anymore and was replaced by a palm Posey grip to prevent sores to palms.

Further review of the Occupational Therapist progress notes, indicates that on a specified date in March 2015, resident #044 was referred for contracture to left hand and at that time, the instructions were to apply a palm Posey grip to the left hand while resident was in bed and as tolerated.

The last documentation found from the Occupational Therapist progress notes, indicates that on a specified date in October 2015, resident #044 was referred for worsening of contractures to right hand related to staff being unable to apply the palm Posey grip. It is documented that the occupational therapist had recommended to staff, to try a rolled up gauze to resident #044 right hand by gently rubbing his/her hand with warm wash cloth and gently stretching digits prior to application.

On that same day, in an interview with the occupational therapist #125, she told inspector #592 that resident #044 was to have a palm Posey grip applied to his/her left hand and a rolled gauze to his/her right hand at all time. She further told inspector #592 that following a recommendation of equipment or any type of interventions for a resident, she would instruct registered staff, who would update the resident plan of care and communicate the instructions to the PSW staff members. She further told inspector #592 that a specific note would also be left at the resident bedside with the specific instructions and confirmed with inspector #592 that there was no note left in the resident's #044 room. She further told inspector #592 that the process had not been put in place for this resident due to no clear directions received to staff members who are providing the care to the resident. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the written plan of care for resident #011, set out clear directions to staff and others who provide the care to the resident.

Resident #011 was admitted to the home on a specified date in February 2015 with several medical condition including dementia, heart problems, osteoarthritis and partial blindness. According to the most recent assessment (January 2016), the resident required extensive assistance with personal hygiene, including brushing of teeth.

During an interview, resident #011, indicated that some staff rinsed his/her denture at

night and then gave it back to him/her as he/she liked to sleep with it.

Upon review of the most recent plan of care, it indicated under the section Activities of Daily Living (ADL) Function that the resident had an upper denture and was able to clean them by himself/herself. In the Daily Flow sheet completed by the PSW, it was documented that the resident received extensive assistance of one staff for personal hygiene, including brushing of teeth.

During an interview with PSW #137 on February 9, 2016, she indicated that she had provided total care to resident #011 that morning, added that she had given the resident a toothette and directed the resident to swab his/her mouth which he/she did, with encouragement. She further indicated that the resident was not independent with oral care and required extensive assistance.

During an interview with PSW #106, she told inspector #545 that resident #011 had his/her own teeth. She indicated that when set up at the sink with a toothbrush & toothpaste, the resident was able to brush his/her teeth. After checking the plan of care, PSW #106 indicated that she was not aware the resident had dentures, as she had never seen the resident remove it, and had never seen the dentures soaking in a denture cup in the bathroom in the morning.

During an interview with RPN #117, she indicated to the inspector that resident #011 required extensive assistance with all aspects of activities of daily living, including oral care. She indicated that if not provided assistance, she believed the resident would not brush his/her upper denture and teeth. She confirmed that the plan of care was not providing clear directions to staff members who are providing the care to the resident. [s. 6. (1) (c)]

3. The licensee failed to ensure that the care set out in the plan of care was based on an assessment of resident #045 and the needs and preferences of that resident.

On a specified date in May 2015, at a specified time, resident #045 exited the secure unit of the home on the first floor by following a visitor and proceeded to exit out the home as a visitor was entering through the same doors. The resident was seen by a co-resident to leave, at which time the co-resident reported the incident to staff. At the time staff were notified, the resident was out of site from the main exit doors. The home initiated a response and the resident was found by the police force and brought back to the home approximately one hour and 45 minutes later.

Resident #045 has a diagnosis of dementia and has responsive behaviours including wandering, resistance to care, exit seeking and poor sleep patterns.

A review of the progress notes on a specified date in May 2015 indicate seven instances whereby the resident was exit seeking and five instances were recorded in April 2015. Staff members including PSW #131 and RPN #132, indicate that the resident was known to wander the unit and exit seek prior to the day of elopement. RPN #132 confirmed that the resident had been moved from his/her unit to the home's secure unit in January 2015 due to exit seeking.

The plan of care effective on a specified date in April 2015, based on the MDS Assessment of the same date, indicates a behavioural plan of care related to wandering and resistance to care. Interventions included instructions for staff to use a gentle approach when the resident was attempting to leave the unit; for staff to monitor for symptoms of urinary tract infections and delirium that may increase incidents of negative behaviours; and for staff to monitor whereabouts and offer support diversionary tactics. Further discussion with RPN #132, PSW #131 and PSW #133, indicate that there were no formal monitoring procedures in place at the time of the incident, nor were any put in place post incident. PSW #131 indicated that primarily the resident's exit seeking was managed by living on the secure unit and offering activities to provide distraction, although the resident was known at times to refuse participation in activities.

On the day after the incident of elopement, the resident was provided a roam alert bracelet that was applied to the resident's right wrist. A subsequent progress note, on the same date, indicates that the roam alert bracelet was placed on the resident's walker, where it remains as of a specified date in February 2015. Both staff members #131 and #132 indicated that the resident does not always remember to bring his/her walker when wandering the unit and or in other instances may have a co-resident's walker due to his/her state of confusion. Although staff correct the resident when it is observed, there are times whereby the resident is without his/her walker.

The resident was known to exit seek, prior to the incident of elopement on a specified date in May 2015, and the health care record supports that the resident continued to exit seek as evidenced by twelve progress notes describing the resident's exit seeking in June 2015. The plan of care of as it relates to the monitoring of the resident and the use of a roam alert bracelet were not based on the resident needs. [s. 6. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written plan of care for each resident providing clear directions to staff members and that the plan of care is being revised because care set out in the plan has not been effective, to be implemented voluntarily.

WN #2: 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 failed to comply with O. Reg. 79/10 s.8 (1)(b) 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 to be complied with, in that the home failed to ensure compliance with the following policy.

As per O.Reg79/10, r. 114(2), The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

The home uses an electronic Medication Administration Record called Catalyst OneMAR to verify and document medication administration to the residents.

In the home's Medication Administration by Registered Nurse (RN) and Registered Practical Nurse (RPN), policy number 14-a-25, dated June 18, 2014, it was indicated under item 1.

The RN and RPN was accountable for administering medications according to the College of Nurses of Ontario Practice Standards: Medication (2014). And according to the standards: A nurse meets the standard by:

a) documenting in a timely manner and completing documentation during, or as soon as possible after, the care or event;
b) documenting the date and time that care was provided and when it was recorded

In a review of the home's Catalyst oneMAR Quick Reference Guide, provided by RPN #120, under the section Scan to Administer (Doses=100%)

1. After logging in, scan a barcode and you will be taken to the Daily MAR with the medication(s) you just scanned highlighted in green. If there are more medications for that dosing time you can scan them at this point.
2. After administering medications click Sign Off
3. The Daily MAR will now show those doses as 100% given with your electronic initials.
4. Once you are finished with one resident just simply scan the next resident's barcode and the system will direct you the the next resident's Daily MAR; repeat steps above.

During an observation of the 0800 Medication Pass on February 9, 2016 on McNeil House, Inspector #545 observed RPN #117 clicking the button "Sign Off" before administering medications to residents #016, #042, #009, #046, #047, #048, #049 and #050. In the case of resident #016 who refused to take a specific medication with his/her other medications at 0741, the medication was observed administered to the resident at breakfast at 0811. The eMAR recorded this medication as administered at 0741. In the case of resident #042 who was absent in his/her room and was not available to take all 10 prepoured medications at 0743, the medications were observed being administered to the resident at breakfast at 0800. The eMAR recorded all 10 medications as administered at 0743.

During an interview with RPN #117, she indicated that she should be documenting administration of medication only after the medication was administered.

During an interview with the Director of Care, she indicated that registered staffs were expected to document administration of medication only after the drugs were administered. [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 written policies and protocols are implemented when administrating medications to residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Resident #019 was diagnosed with several medical conditions including a neurological disorder and peripheral vascular disease. According to the most recent assessment, the resident required extensive assistance to total care for all activities of daily living, including change of incontinent product for incontinence of urine and bowel, and daily application of ointments for skin alterations.

In a progress note dated on a specified date in September 2015, it was documented that the resident's family member had reported altered skin integrity while changing the resident's continent product. In the note, the nurse documented observing a large red excoriated area covering inside of both thighs, under the scrotum and on the lower abdomen, as well as small open areas on the navel. The nurse applied a specific Barrier cream mixed with a medicated ointment and requested the physician to assess. On the day after, another note indicated that the medicated ointment had been applied to the deep scratches on the resident's abdomen and a request from the nurse practitioner had been done. Later, on the same day, the nurse practitioner prescribed another medicated cream mixted with a medicated powder for application twice daily for 14 days to groin and skin folds and to allow to absorb, then apply a specific spray, and to apply each spray with each toileting, following good skin care.

During an interview with RPN #120, she indicated that the home's expectation was for registered staff to complete a skin assessment using the Skin Assessment Record, policy number 11-a148, Appendix B, upon admission, quarterly, upon return from hospital and anytime altered skin integrity was observed on a resident. After reviewing the resident's health record, the RPN indicated that Resident #019 had not received a skin assessment on a specified day of September 2015 when the resident had altered skin integrity to the groin, scrotum and abdomen.

The RN #100 indicated to the Inspector that it was the expectation of the home that a Skin Assessment Record be completed by registered staff upon observation of altered skin integrity; and she was unable to find evidence that one was completed on a specified day of September 2015, when resident #019 exhibited altered skin integrity, including skin breakdown. [s. 50. (2) (b) (i)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any resident exhibiting altered skin integrity, receives a skin assessment using a clinically appropriate instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that for each resident demonstrating responsive behaviours, actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the residents responses to interventions are documented for Residents #030 and #019.

Resident #030 was admitted to the home on a specified date on September 2015. The resident has a diagnosis of dementia and during admission assessments, behaviours such as repetitive comments and spitting on the floor were identified.

Progress notes dated on a specified date on September 2015, indicate that the shared toilet between resident #030 and resident #027 was not functioning properly. When

assessed by maintenance staff it was discovered the foreign objects such as clothes and plastic medication cups were being flushed down the toilet. Resident #027 does not ambulate independently and does not use the toilet.

In response to resident #030's behaviour to inappropriately dispose of items in the toilet, and to assist in maintaining the resident's toileting, the home covered the toilet with a black garbage back and placed a commode over top of the seat of the toilet, rendering the toilet inaccessible but the commode available for toileting.

On February 5, 2016, Inspector #148 spoke with PSW #101 and Charge RN #100, both are regular staff on the unit and were familiar with the resident. Both staff members confirmed that the garbage bag and commode were placed on the toilet due to Resident #030, flushing foreign objects down the toilet. Neither staff member could recall the resident attempting to put any objects in the commode, noting that since the intervention was put in place the behaviour has been non-existent.

Upon review of the resident's health care record there was no documentation of any reassessment of the intervention or the resident's responses to the intervention. There was no indication of this intervention in the resident's plan of care or most recent Minimum Data Set (MDS) Assessment. [s. 53. (4) (c)]

2. Resident #019 was admitted to the home on a specified date in November 2011. The resident is diagnosed with several medical conditions. Assessments of physical, verbal and behaviours such as outbursts due to hearing problem and inability to communicate his/her needs were identified starting with the assessment dated on a specified date in February 2012. According to PSW #135, RPN #120, the instruction from PSW supervisor to help manage sleep pattern was to not wake the resident at night during rounds for change of incontinent product, as he/she would not resettle.

Inspector #545 observed resident #019 on February 3, 5, 8 to 11 2016 - he/she presented as calm, quiet and cooperative with staff while listening to music in the TV room, being fed in the dining room by staff and read to by sitters. No responsive behaviours were observed by the inspector at this time.

In an interview with PSW #135, he told inspector #545 that on night shift the resident was checked and his/her incontinent product was changed. He further told inspector #545 that the resident no longer exhibited behaviours and quickly resettled back to sleep. The PSW further added that prior to the resident's teeth being removed about one year ago,

he/she had many outbursts such as screaming, flipping chairs, slapping himself/herself, and that night staff were told not to wake the resident at night, as he/she would not resettle. He further indicated that staff were directed to change the continent product at night following an incident on September 29, 2015 when the resident exhibited altered skin integrity.

During an interview with the Director of Care on February 12, 2016, she indicated that she was aware that the resident was not woken up at night for change of incontinent product when first admitted as part of behaviour management. She further added that she was not aware that this practice continued until a specified date in September 2015 when it was brought to her attention that the resident had exhibited altered skin integrity in the groin, abdomen and buttock areas. She indicated that she immediately requested that staff start checking and changing the resident's continent product on night shift.

Upon review of the resident's health care record there was no documentation of any reassessment of the intervention or the resident's responses to the intervention. [s. 53. (4) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure to respond to the needs of resident demonstrating responsive behaviours, including assessment, reassessments and interventions, with the resident's responses to the interventions documented, to be implemented voluntarily.

WN #5: 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 has failed to ensure that when the Residents' Council has advised the licensee of concerns or recommendations, the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council.

The minutes of the Residents' Council were reviewed for the months of September, October, November 2015 and January 2016. The following concerns were identified by the Council:

October 13, 2015 - Plates are being removed too quickly during the meal times on various floors.

November 10, 2015 - The kitchen is too loud on a specific unit (McNeil House). The minutes further indicated that PSW Superviser would be notified to remind staff to provide a pleasurable dining experience.

Inspector #148 spoke with the PSW Supervisor who indicated that she was aware of both issues. As it relates to the loudness in the dining room, she indicates that after being notified (as per email of November 11, 2015), she discussed it with the staff on that unit. As it relates to plates being removed too quickly she indicated that she was not directed to take action on this matter. She indicated she would not be responsible for a response to the Residents' Council.

The Inspector then spoke with the homes Resident Relations Advisor, who liasons with the Residents' Council. After review of the two issues it was determined that at the time of the Council meeting residents were informed that the issues would go forward to the PSW Supervisor for action. After review of her calender, she indicated that it was likely on November 27, 2015 when she met with the Residents' Council president and provided a response related to the outcome from the November concern. A response to the Council related to the concern identified from the October meeting, could not be demonstrated.

The licensee has not ensured that a response is provided to the Residents' Council within 10 days of receiving concerns or recommendations related to the operation of the home. [s. 57. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the licensee will respond to any concerns or recommendations from the Resident's Council within 10 days of receiving the advice, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area or a medication cart, that is used exclusively for drugs and drug-related supplies.

Inspector #545 observed the 0800 medication pass on a specified unit on February 9, 2015, with RPN #117.

From 0726 to 0811, the RPN went around the unit, administering eye drops, insulin, medications and delivering and applying hearing aids to residents, for example she removed from the medication cart, resident #047, #051 and #052 hearing aids and delivered each to the resident in their room. The RPN indicated that it was the home's

practice to store the hearing aids in the locked medication cart, and that staff signed in the medication administration record when removed from the residents in the evening and applied in the morning.

During an interview with the Director of Care, she indicated that it was the home's practice for over 30 years, to store the residents' hearing aids in the Medication Cart for safeguard. [s. 129. (1) (a)]

2. The licensee has failed to ensure that 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.

Inspector #545 observed the 0800 medication pass on a specified unit on February 9, 2016 with RPN #117.

At 0744, the Inspector observed the RPN removing resident #042's medication from the medication cart. One of the packages contained one tablet of Hydromorphone 1mg. The inspector did not observe the RPN open the double-locked storage area located in the bottom drawer of the Medication Cart. Later, the RPN indicated to the Inspector that when she completed the narcotic/controlled substance count at the change of shift with the night nurse, she removed all 0800 narcotic/controlled substances for all residents on the unit, from the double-locked narcotic/controlled substance storage area located in the bottom drawer of the locked medication cart, including the Hydromorphone 1mg for resident #042. She indicated that she then placed each narcotic/controlled substance in the medication bin for each resident. The RPN confirmed that the narcotic stored in the resident's medication bin was no longer stored in a separate, double-locked area.

During an interview with the Director of Care, she indicated that narcotics and controlled substances should always be stored in the separate double-locked storage area located within the locked medication cart. She further indicated that registered staff were expected to remove the narcotic, such as the Hydromorphone 1mg for resident #042 only at time of administration, and the RPN should not have removed it during the narcotic/controlled substance count at the change of shift. [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 to ensure that drugs are stored in an area that is used exclusively for drugs and drug related supplies and that controlled substances are stored in a separate double-locked stationary cupboard in the locked area within the locked medication cart, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (2) The drug destruction and disposal policy must also provide for the following:
2. That any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs. O. Reg. 79/10, s. 136 (2).

Findings/Faits saillants :

1. The licensee has failed that the home's drug destruction and disposal policy includes that any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs.

The Narcotics and Controlled Drugs Disposal, Pharmacy Policy Number 14-a-29, dated: November 6, 2013 with revision notes was provided by the Director of Care, to the Inspector upon request of the home's current drug destruction and disposal policy. The DOC indicated that the policy had been revised, and that the nursing staff had received communication about the changes. The policy was reviewed by the Inspector; and it indicated on page 2, that the nurse shall:

- item 1.4. Wrap the Narcotic Count Record around the discontinued medication strip package and store in the narcotic drawer until it is picked up and destroyed by pharmacy.

-item 1.5. Include the discontinued Narcotics or Controlled drugs in the Narcotics count each shift until picked up by pharmacy.

There was no provision in this revised policy to indicate that home's drug destruction and disposal policy shall include any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs, as per legislation.

On February 9, 2016, Inspector #545 observed in the double-locked storage area, the following drugs ready for destruction and disposal:

- A benzodiazepam medication belonging to resident #053: 4 tablets, each in their own original labelled packages dated February 4 and 5, 2016 (0800 and 2000 doses), in a clear plastic bag
- used narcotic for resident #054 (one dated: Feb 5, 2016 removed at 1530, another dated Feb 8, 2016 removed at 16:18), applied to a "Used narcotic Patch medication Disposal Sheet", in a clear plastic bag
- used narcotic for resident #011 (one dated: Feb 5, 2016 at 1900, another dated: Feb 8, 2016 at 19:28) applied to a "Used narcotic Patch medication Disposal Sheet", in a clear plastic bag

RPN #117 indicated that the discontinued medications were stored in the narcotic/controlled substance double-locked storage area within the Medication Cart, until they were picked up by the pharmacy service provider once per week, usually on Thursday.

On February 10, 2016, in an interview with RPN# 120, she indicated to the Inspector that the home did not provide staff with a separate double-locked storage area to store controlled substance that is to be destroyed and disposed of, until the destruction and disposal occurs. She indicated that she was directed to store the discontinued narcotics/controlled substances in the double-locked storage area located within the locked Medication Cart with the PRN controlled substance that is available for administration to residents. The RPN opened the PRN double-locked storage area and the following discontinued controlled substance were observed: Hydromorph 1mg (1 tablet), Clonazepam 0.5mg (1 tablet), Hydromorph 6mg (7 tablets).

During an interview with the Director of Care, she confirmed with inspector #545, that the

home's revised Drug Destruction and Disposal policy did not include that any controlled substance that was to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that was available for administration to a resident, until the destruction and disposal occurred, as per legislation. [s. 136. (2) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage separate from any controlled substance that is available for administration, until the destruction and disposal occurs, to be implemented voluntarily.

WN #8: 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 equipment for residents #011, #019 and #024 are kept clean and sanitary.

On February 2, 3, 5 and 8, 2016, Inspector #545 observed the following:

-Resident #011: sticky dried debris lodged between two sections of the seat of the resident's 4-wheeled walker

-Resident #019: white dried debris on the seatbelt of the resident's wheelchair
-Resident #024: white debris and moderate amount of dust on the seatbelt of the resident's wheelchair, as well as hardened beige debris lodged in the buckle of the seatbelt. Food debris, dust and crumbs were also observed on the padded footrest of the wheelchair on Feb 3 and 5, 2016

Upon review of the home's mobility aide cleaning schedule, it was documented that resident #019 and #024's wheelchairs and resident #011's walker were cleaned weekly in January and February 2016.

During an interview with PSW #106 indicated that it was the responsibility of the night PSW to clean the wheelchairs and walkers according to a schedule. She indicated that 4 to 5 mobility aids are assigned each night and that each equipment was cleaned weekly. She further indicated that sprayed Vioxx on the wheelchair or walker and used a brush for the hard to clean areas, and that very soiled equipment were brought in the walk-in showers for thorough cleaning.

PSW #107 indicated that the night staff cleaned the mobility aids, and that he used a rag that he soaked in Vioxx to clean the frames, the wheels and belts. He further indicated that he didn't use a brush, that he preferred to let soiled area soak for a long period of time when required.

The PSW supervisor indicated that it was the responsibility of the PSW on night shift to clean all wheelchairs and walkers, according to the schedule. After observing the wheelchair of residents #019 and #024 and the walker of resident #011, she indicated that these mobility aid equipments were unclean and unsanitary, and would direct staff to clean them. [s. 15. (2) (a)]

2. The licensee failed to ensure that resident #024's equipment such as the reclined wheelchair is maintained in a safe condition and in a good state of repair.

On February 2, 2016, Inspector #545 observed resident #024 in a reclined wheelchair. A laminated label attached to the back of the wheelchair indicated that the wheelchair was loaned to the resident and to return it to storage area when no longer required. A padded plate was screwed to the footrest plate on the right side, but not on the left, making the padded plate slide backward and exposing the metal plate on the left side of the footrest. The padded plate was partly covering the ripped corner of the right side and a piece of soiled foam was exposed in one area. Part of the duct tape was removed and hanging off

the padded plate. The resident was wearing a pair of disposable light blue shoe covers without socks or shoes, increasing risk of injury to the feet, with the metal footrest plate exposed.

During an interview with PSW #112 on February 8, 2016, he indicated that the damaged foot rest had been in disrepair since the resident admission. He further indicated that the padded plate was not screwed on the left side to allow staff to remove the footrest during transfers. The PSW indicated that staff were responsible to notifying the nurse when observed equipment in disrepair and/or completing a work order on the computer and that an Occupational Therapist and/or maintenance staff would repair it. He indicated that he had not completed a work order this issue, then indicated one would be done.

Later that same day, the Environmental Services Supervisor indicated to the inspector that resident #024's wheelchair had been repaired in the past; on a specified date in September 2015 for a loose brake line that was preventing the chair from reclining. He added that he had just received a work order from the occupational therapist indicating that the left foot plate required an adjustment, to bring forward one hole and once the adjustment was completed to bolt the foot board on the left foot plate.

The progress note documented by Occupational Therapist #125 indicated that upon her assessment, the foot rests were found uneven, the left plate farther back than the right one, contributing to board sliding off. She directed maintenance to bolt the foot board to both foot plates in order to increase safety.

During an interview with the DOC, she indicated that the resident was admitted to the home with the current wheelchair, it had been a loaner from the previous home where he/she resided and she believed that the home had given it to him/her. She further indicated that the home was responsible in keeping it in a good state of repair for this resident. [s. 15. (2) (c)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that at a minimum the policy to promote zero tolerance of abuse and neglect of residents, shall clearly set out what constitutes abuse and neglect and contain an explanation of the duty under s.24 to make mandatory reports.

The home's policy 4-a-1, titled Zero Tolerance of Abuse and/or Neglect of Resident and Patients, was reviewed.

The explanation of s.24 of the Act includes that employees and affiliated personnel with information pertaining to items of s.24 are to be immediately reported to the Manger/designate and that the ED/DOC/designate will facilitate notification to the Ministry (Director) and that an employee may choose to notify the Ministry directly. The explanation does not include that "a person" shall immediately report information pertaining to items described in s.24 to the Director.

It addition, it was determined that the policy does not set out what constitutes neglect. [s. 20. (2)]

WN #10: 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:
1. The circumstances precipitating the application of the physical device. O. Reg. 79/10, s. 110 (7).
2. What alternatives were considered and why those alternatives were inappropriate. O. Reg. 79/10, s. 110 (7).
3. The person who made the order, what device was ordered, and any instructions relating to the order. O. Reg. 79/10, s. 110 (7).
4. Consent. O. Reg. 79/10, s. 110 (7).
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and the licensee shall ensure that the following are documented:
(6) all assessment, reassessment and monitoring, including the resident's response.

On February 2, 5, 8 to 11, 2016 Inspector #545 observed resident #019 in a wheelchair with a 4-point alligator sealtbelt.

Upon review of the resident's health record it was indicated that the resident required a 4-point alligator seatbelt while in wheelchair for his/her safety and positioning.

During an interview with RPN #120, she indicated that resident #019 was prescribed a seatbelt for safety and positioning, that staff checked and repositioned the resident hourly, and added that she was responsible to monitor the restraint at least once per shift and documented her assessment on the Restraint Observation Record.

In an interview, RPN#114 indicated to the Inspector that she did not initial the Restraint Observation Record as she understood that her signature indicated that she had observed the PSW applying the restraint and she felt that she could not observe each application of each restraint on the unit during an 8-hr shift due to other responsibilities, like the Medication Passes.

The home's restraint policy titled: Least Restraint Policy 11-a-178, revised Dec 2, 2015 was reviewed by the inspector.
On page 2, item 4.4 it was documented that the RN/RPN shall:

Include on the Resident Observation Record (Appendix G) the following information:
4) eight(8)hour reassessment is to be completed by the RN/RPN if the restraint is to be reapplied

A review of the Restraint Observation Record from January 27, 2016 to February 9, 2016, indicated that the resident was in the wheelchair from 0700 to 2000 daily. There are 28 regular staff shifts (days and evenings) for the time period of January 27, 2016 to February 9, 2016. Twenty-one of the twenty eight shifts for this time period, do not have a registered staff's signature indicating that the resident's condition was reassessed. [s. 110. (7)]

Issued on this 19th day of February, 2016

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

Original report signed by the inspector.