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
Dec 4, 2015	2015_365194_0027	O-002665-15	Resident Quality Inspection

Licensee/Titulaire de permis

Glen Hill Terrace Christian Homes Inc.
200 Glen Hill Drive South WHITBY ON L1N 9W2

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

STRATHAVEN LIFECARE CENTRE
264 King Street East Bowmanville ON L1C 1P9

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

CHANTAL LAFRENIERE (194), CAROLINE TOMPKINS (166), KELLY BURNS (554), MARIA FRANCIS-ALLEN (552)

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): October 27, 28, 29, 30, November 02, 03, 04, 05 and 06, 2015

Also inspected concurrently with the RQI are the following Logs. Log #O-000792-14,
Log #O-000732-14, Log #O-001220-14,Log #O-001377-14,Log #O-001443-14,Log #O-001737-15
Log #O-002079-15, Log #O-002167-15 f/u lighting s. 18, Log #O-002207-15 f/u duty to protect s. 19 ,Log #O-002208-15 f/u care planning s. 6(7), Log #O-002236-15, Log #O-002275-15, Log # O-002321-15, Log #O-002437-15, Log #O-002572-15, Log #O-002592-15, Log #O-002696-15, Log # O-002859-15, Log #O-002945-15, Log #O-002946-15, Log #030127-15 Complaint and Log # 030454-15.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care(DOC),Assistant Director of Care(ADOC), Staff Educator, Environmental Service Manager(ESM), Food Service Manager(FSM),Business Manager, Maintenance, Housekeeping aides, Receptionist, Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), Families and Residents.

Also completed during the inspection was a tour of the building. Observation of the Medication Administration process, dining services, infection control practices, provision of staff:resident care. Reviewed relevant policies, clinical health records of identified residents, Internal investigation of abuse incidents, staff educational records and Resident Council Minutes.

The following Inspection Protocols were used during this inspection:

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

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **2 VPC(s)**
- **2 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
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2015_365194_0011	194

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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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

Findings/Faits saillants :

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

Related to Log #002208-15, for Resident #052:

Resident #052 is identified as being at high risk for falls in falls assessment over a six month period. The care plan directs staff to ensure bed/chair alarm is in place.
The resident was observed by Inspector #552 at approximately 0940 hours sitting in a wheelchair in the bedroom and the chair alarm was on the bedside table. The alarm was later attached to the resident at approximately 1000 hours.
During an interview PSW #136 explained that Resident #052 has a bed and chair alarm and that the chair alarm is to be used when the resident is seated in the recliner.

During an interview RPN #126 explained that Resident #052 is at risk for falls and reviewed the care plan which indicated the chair alarm should be in place but that it does not provide clear direction on when the alarm should be used - for the wheelchair, recliner or both. RPN #126 has made a request to the Nurse Practioner for clear directions. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the designate for Resident #059 Substitute Decision Maker (SDM)had been provided the opportunity to participate fully in the development and implementation of the plan of care

Related to Log #030127-15 for Resident #059:

On October 23, 2015 the SDM for Resident #059 observed a bruise to the residents left thigh area and reported this to the RN on duty.

An incident report was completed by RPN #126, indicating that the Primary PSW was aware of the bruised area two weeks prior.

During an interview with inspector #194, Primary RPN #126 indicated that the PSW staff had reported the bruise for Resident #059 but RPN#126 could not remember when this was reported.

SDM was not informed of the bruised area, when PSW reported the change in condition to the RPN #126.

Review of the physician's orders for a period of eleven months for Resident #059 was completed, as SDM expressed concerned that not all medication/treatment changes are being communicated.

On an identified date, a physician's order was received for a new treatment to be started for the resident.
On an other identified date, a 3 month Medication review completed by physician was completed and a medication was discontinued.

Review of the clinical health records was completed with numerous entries evident related to SDM being notified in change in condition and medication changes but there is no evidence that the SDM was notified of the medication/treatment changes noted above.[s. 6. (5)]

3. The licensee failed to comply with LTCHA, 2007, s. 6(7), by not ensuring the care set out in the plan of care is provided to the resident as specified in the plan of care, related to continence care.

Related to Log #030454-15, for Resident #054:

Resident #054 has impaired mobility and cognition impairment; resident is identified at risk for skin integrity issues related to incontinence. Resident #054 is dependent on staff for activities of daily living, including continence care.

The plan of care details the following care needs:
- Toileting, resident requires total assistance. Goals of care include, resident's dignity will be maintained. Interventions include, resident is unable to participate and is totally dependent for the entire process; staff to change continence product and assess for skin breakdown; one to two staff to provide extensive assistance.
- Urinary incontinence, inability to control urination; total incontinence.
Goals of care include resident to be clean, dry and odour free. Interventions include, staff to provide peri-care twice daily and or with each incontinent episode; staff check resident on rounds for incontinence and provide incontinent care when needed.

On an identified date, Resident #054 indicated to the inspector "I think I'm sitting in a glass of water", resident was tearful and indicated to the inspector "no one believes me". Resident #054 indicated to the inspector help was required. Inspector pulled the call bell for the resident, in an effort to get assistance for the resident.

Inspector #554 observed the following:
- Personal Support Worker (PSW) #118 and #119 entered Resident #054's room in response to call bell ringing; PSW #118 turned off resident's call bell and stated "hey, what do you want", Resident #054 verbalized the feeling of sitting in water to PSW #118; PSW #118 indicated "you are not wet" and walked out of resident's room.
- Resident #054 looked at inspector and commented "see, no one believes me".
- PSW #119 bent down beside Resident #054 in an effort to console the resident; PSW #119 placed hand inward toward resident and touched resident's wheelchair cushion and indicated aloud that the cushion of the chair was wet. Personal Support Workers #119 and #121, assisted resident into bed and provided continence care for Resident #054.

Personal Support Worker #119 indicated to the inspector that Resident #054's continence product was "wet enough, for resident to be uncomfortable".

The refusal of care incident was brought to the attention of the Administrator, by the inspector.

Administrator indicated to the inspector speaking with Personal Care Worker #118 and

that the PSW acknowledged Resident #054 did express being wet; PSW indicated to the Administrator that at the time, the PSW had thought the resident had dropped some water from a glass, which caused the resident to be wet.

Administrator indicated in the investigation notes that regardless of how the resident got wet, it is the responsibility of the staff to assess and change the resident when needed. (554)

Related to Log # 030127-15 for Resident #059:

Review of the plan of care for Resident #059 indicates that the resident requires total assistance related to: Cognitive deficit and physical limitations. The plan of care directs that a mechanical lift is to be used for all transfers.

During an interview with inspector #194 on November 04, 2015, PSW #130 indicated that Resident #059 had been transferred out of the wheelchair to bed using a side by side transfer. There is a logo above the bed indicating the Resident #059 is a mechanical lift. PSW's #120 and #130 indicated to inspector that they were aware that Resident #059 was to be transferred with mechanical lift. PSW #120 indicated that the resident's transfer sling was not in the room at the time of the transfer, which was why the mechanical lift was not used as directed in the plan of care.

Upon further assessment of the transferring requirements of Resident #059 it was decided by the Administrator that the resident be moved to the other side of the room where there was more space available and better access for staff to use the mechanical lift. (194)

Related to Log O-002696-15 for Resident #41:

Plan of care related to transfers for Resident #041 directs:
-Requires total assistance for transfer with mechanical lift
-Two staff to transfer with mechanical lift for all transfers.
- To receive the necessary physical assistance.
- Resident may remain on black sling when in wheelchair; sling to be positioned in safe manner to avoid fall risk.
- Ensure anti-tip bars are in the proper place facing the floor.

On an identified date, A Critical Incident was received reporting, Resident #041 was

being transferred from bed to wheelchair via a mechanical lift with assistance of two Personal Support Workers (PSW).

After the Resident was positioned in the wheelchair, one PSW left the room while S#124 completed the care. Resident#041 requested the sling be removed from the chair , S#124 advised the Resident that the sling was able to remain in position to ensure ease of transfer back to bed later. Resident #041 still requested the sling be removed. S#124 pulled the sling from underneath the Resident . Resident #041 leaned and fell forward from the wheelchair, resulting in an injury and was transferred to the hospital.

Interview with S#118 and S#119 indicated the procedure for transferring and positioning for Resident #041 requires two person assist at all times. Interview with the Administrator, and review of the licensee's investigation into the incident indicated that S#124 was aware that the plan of care directed that transfers and positioning for Resident #041 required two person assist at all times. (166) [s. 6. (7)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 134 (b), by not ensuring that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

Related to Log #O-001737-15, for Resident #046:

A Critical Incident Report was submitted to the Director, specific to a medication incident / adverse drug reaction, which resulted in altered health status of Resident #046.

Details of the CIR are as follows:
- Resident #046 was administered an analgesic medication, by Registered Practical Nurse #104. Resident #046's health declined as a result of the medication error, resulting in the need for resident to be transferred and admitted to hospital for treatment and observation.

A review of the progress notes, for a period of twenty days, detail the following:

Resident #046 had been experiencing in increase in pain; The resident's analgesic was no longer effective in controlling resident's discomfort. Resident #046 was assessed by the attending physician and prescribed a stronger analgesic medication. The first dose of analgesic medication was administered to Resident #046, with good effect; resident experienced no untoward side effects (as per the progress notes, written by registered nursing staff).

According to a progress note, written by Registered Practical Nurse (RPN) #104 , Resident #046 was administered a different analgesic medication, instead of the prescribed analgesic medication. The progress note, indicates RPN #104 recognized the error, took resident's vitals; and reported the medication error to RN Supervisor #105. RPN #104 indicated, in the progress note, that the medication error was placed in the physician's communication book for follow up by the oncoming day shift; RPN #104 also indicated in the progress note that the day shift was to contact Resident #046's family (substitute decision maker) of the medication error.

Registered Practical Nurse #107 came on duty, and was given report by RPN #104 and informed that a medication error was made involving Resident #046. Progress notes indicated RPN #107 went to assess Resident #046, the resident was found to have decreased level of consciousness and vitals had declined. RPN #107 indicated the resident was placed in high fowlers sitting position, oxygen initiated, 911 was called and

that RN #105 was notified.

Family of Resident #046 was notified of medication error, change in resident's health status and required transfer to hospital.

The resident was admitted to the hospital did not return to the long-term care home until fourteen days later.

The home's policy, Medication Incidents (#04-09-10), directs that all medication incidents that are identified are reported immediately to the nurse, designate and to the Director of Care; and that the immediate problem corrected. For incidents that involve residents, the severity level of the incident is to be assessed including the current status of the resident and any potential risk; immediate actions are to be taken to access and maintain the resident's health. The physician is to be informed of the medication incidents that involve residents.

The policy further indicates that in cases of inadvertent overdose, the nearest poison control centre must be consulted immediately regarding possible treatment.

Appropriate actions were not taken by Registered Practical Nurse #104, charge nurse and Registered Nurse-Supervisor #105 in response to a medication incident involving Resident #046, which lead to an adverse drug reaction, as evidenced by:
- Resident #046's health status was not monitored following a medication error;
- There is no documented evidence in progress notes, or risk management that Registered Nurse Supervisor #105 assessed Resident #046 following notification of RPN #104 administering the wrong medication or when notified by RPN #107 of resident's declining health status. RN #105 indicated to the inspector being unsure of when first assessing Resident #046, but believes assessing Resident #046 following the second notification by RPN #107. RN #105 indicated that the assessment should have been documented noting the severity of the medication error.
- A medication error- by RPN #104 was placed in the doctor's communication binder instead of contacting the physician or immediately contacting the nearest Poison Control (as per the home's policy, Medication Incidents).

Registered Nurses #106 and #108, who were the oncoming supervisors, as well as the current Director of Care indicated that noting the severity of the medication error, the physician should have been immediately notified and resident transferred to hospital for treatment. [s. 134. (b)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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 failed to comply with LTCHA, 2007, s. 15 (2) (c), by not ensuring that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The following observations were made during the dates of October 27-30, and November 02-03, 2015:
- Walls – were observed to be scuffed (blackish staining), chipped, gouged or having wall damage (corner beading exposed, and or holes) in resident rooms and or washrooms, located on resident home areas Pine #113, Spruce #100, Cedar #1016, 1018, 1019, Poplar #2006, Willow #2017; in tub room located on Pine and in the lounge shared with Pine and Spruce; (*room #1016 was identified in the maintenance request forms (binder) on September 16, 2015 as having wall damage beside resident's bed; as of this inspection there has been no identified action taken or recorded.);
- Doors, Door Frames and Washrooms Stalls – were observed to be scuffed (blackish staining) or having paint chipping in several areas along the door and door frames in resident rooms and or washrooms located on resident home areas Cedar #1018, 1017, Spruce #100 ; as well as in communal washrooms (male and female) on the first floor, especially on Pine, and in the tub room on Pine;

- Ceiling – was observed cracked and having visible damage, in resident room located on Cedar #1006;
- Wardrobe Door – was not able to be closed in resident room, located on Poplar #2001;
- Bathroom Vanity Door – was broken and not able to be closed in a resident washroom, located on Cedar #1017;
- Counter-top Vanity or Vanity Cupboard Surround – was observed to have chipped, peeling or lifting laminate (exposing porous surfaces) to areas on the sides or top of cupboard in resident washrooms, located on Spruce #100, Cedar #1002, 1004, 1006, 1018; and in the communal washroom located between Cedar and Pine;
- Bathroom Grab Bars – were observed to have rusted areas, in resident room on Cedar #1006; as well as in the male communal washroom located on Pine;
- Sink – was observed chipped in resident washroom, located on Cedar #1018
- Wall or Door Guard – was observed cracked, lifting or chipped (exposing jagged, sharp edges in resident rooms or washrooms, located on Cedar #1006, 1019; in the tub room on Pine, communal washrooms on Cedar/Pine and Spruce;
- Ceiling Fan – was observed to be loose and hanging from the ceiling in resident washroom, located in Spruce #100;
- Vents – ceiling vents were observed to have dark grey-black debris (dust) along the vent panels, in the tub room located on Pine and Cedar;
- Tub – the tub (acrylic tub surround) in the Cedar spa room was observed to be cracked;
- Window Closures – observed broken and or missing in resident rooms, located on Cedar #1014, 1018 and Spruce #100; windows in these areas were difficult to be opened or closed (by inspector); (* ESM indicated some windows are scheduled for replacement, but was unsure which windows)
- Baseboard Heaters (Rad) – were observed scraped or rusted in resident rooms, located on Cedar #1006;
- Bed – foot board laminate surround was observed to be loose and lifting in resident room, located on Spruce #100;
- Flooring –the laminate flooring, located in the female communal washroom on Pine, as well as in the tub room located on Pine, was observed to areas in which the laminate flooring seams were observed to be split or cracked, with the sub-flooring beneath exposed; both the tub room and the communal washroom flooring was wet during the initial observations (on October 28, 2015). The tiled floor outside of Pine #122 was observed chipped or cracked.

Housekeeping Aides, Personal Support Workers, Registered Nursing Staff and the Environmental Services Manager indicated (to the inspector) that any maintenance problems (e.g. repairs, broken equipment or furnishings, plumbing, electrical, etc.) are to

be reported to the maintenance department by completing the Maintenance Request Form, identifying the problem area.

A review of the Maintenance Request Forms (maintenance binders, located on resident home areas) for the period of November 02, through to August 14, 2015, failed to provide evidence (*unless otherwise indicated) that the above identified areas were identified by staff or communicated to the maintenance department as needing repairs.

Environmental Services Manager (ESM) identified that the home does have processes in place for day to day maintenance repairs, painting (as well as environmental services policies and schedules); ESM indicated the following:
- that there is a lot of "catch up of repairs to be done in the home", indicating he has only been employed as ESM for approximately five months and that he and the environmental staff are working hard to improve the overall aesthetics (appearance);
- wall repairs and painting are being completed when time permits, but the priority as of this time is resident hallways versus resident rooms; ESM indicated resident rooms will be repaired and painted as residents are discharged;
- knows of no plans in place for repair or replacement of identified flooring issues

Environmental Services Manager indicated (to the inspector) not being informed by staff or via the maintenance request forms of the above areas needing maintenance repair or replacement; nor had areas, identified above been captured in his monthly audits of the home.

Environmental Services Manager indicated that the expectation would be that the home, furnishings and equipment are to be kept in safe condition and in a good state of repair. [s. 15. (2) (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 by ensuring that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair., to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 131 (1), by not ensuring that drugs are used by or administered to a resident in the home unless the drug has been prescribed for the resident.

Related to Log #O-001737-15, for Resident #046:

A Critical Incident Report was submitted to the Director, specific to a medication incident/adverse drug reaction, which resulted in altered health status of Resident #046;

Details of the CIR are as follows:
- Resident #046 was administered an analgesic medication by Registered Practical Nurse #104. Resident #046's health declined as a result of the medication error, resulting in the need for resident to be transferred and admitted to hospital for treatment. The resident remained in hospital for approximately two weeks, before being re-admitted to the long-term care home.

Resident #046 had been prescribed an analgesic medication Attending Physician. Resident #046 had not been prescribed the analgesic medication which was administered in error, by RPN #104.(554)

Related to Log #O-002859-15, for Resident #044:

A Critical Incident Report was submitted to the Director, specific to a medication incident/adverse drug reaction, which resulted in altered health status of Resident #044.

Details of the CIR are as follows:
- Resident #044 was administered an analgesic medication, by Registered Practical

Nurse #109. Resident #044's health declined as a result of the medication error, resulting in the need for resident to be transferred to hospital, resident was treated and later returned back to the long-term care home for further monitoring.

Resident #044 had been prescribed an analgesic medication by the Attending Physician. Resident #044 had not been prescribed the analgesic medication which was administered in error, by RPN #109.

Director of Care indicated to the inspector that both medication errors were preventable, if the registered nursing staff involved in the medication incidents had been following the proper medication administration practices and procedures (e.g. "The Eight Rights of Medication Administration"). [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 by ensuring that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident., to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 16, by not ensuring that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres.

A window, in resident room #100, which is located on Spruce home area, was observed open on October 28, 2015, the window opening could be opened greater than fifteen centimetres and could not be closed by the inspector; a housekeeping staff was alerted to the window being open and rain blowing into the resident room.

Inspector #554 spoke with the Environmental Services Manager on October 28, 2015 alerting him of the window in room #100 needing repair as it was off the track of window ledge and that the window opened beyond fifteen centimetres; ESM indicated to the inspector that he would have the deficiency dealt with.

On November 06, 2015, the window in resident room #100 was found open and again could be opened greater than fifteen centimetres. The window, in room #100, could be opened approximately forty-four centimetres; this resident room is located on the ground level of the home and faces Hwy #2. [s. 16.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s. 87 (2) (d), by not ensuring that procedures are developed were implemented for addressing incidents of lingering offensive odours.

A pervasive malodour, which resembled the smell of urine, was smelt in resident washroom #1018 located on Cedar, home area, in the communal washroom located

between Pine and Spruce home areas and in the tub room located on Pine home area; the pervasive malodour was noted by the inspector on October 28-30 and on November 02-03, 2015.

Malodours, also resembling the smell of urine, were also noticed in one of the male communal washrooms on Pine, resident washroom #1017 located on Cedar, on November 02 and November 03, 2015.

The home's policy, Odour Neutralizer (#XII-I-20.00) directs that odour neutralizers will be used in specific areas to eliminate odours when cleaning; the policy speaks to odour neutralizers will not be generally used throughout the home to mask odours that should be remedied through better cleaning procedures, but will reduce odours that are the result of resident illness, soiled utility rooms with poor ventilation, urine odours inherent to carpet or floor tiles, garbage areas and in soiled linen room chutes.

Housekeeping Aides #122 and #123 indicated to the inspector that the home no longer has odour elimination sprays available for use in controlling odours in the home, as the sprays were removed due to allergies of some individuals. Both housekeeping aides indicated that if there is an odour in the home, they would open windows to air out the area. Housekeeping Aide #122 indicated that the home does have a spray (Detol) which is used in cases of "bad odours" but that the spray is locked up by the Environmental Services Manager and is rarely used by housekeeping staff.

Housekeeping Aide #122 and #123, who are both full-time workers on the first floor resident home areas Pine, Spruce and Cedar, indicated to the inspector not knowing of any resident rooms or washrooms with problematic odours.

Environmental Services Manager (ESM) indicated to the inspector 'Detol' disinfectant spray, which Housekeeping Aide #122 is referring to, is not used in resident rooms or for day to day odour problems. ESM indicated to the inspector that the home is currently looking at purchasing new products for use with lingering odours, as of this time, the home is not using any additional odour eliminators or neutralizers, other than the everyday cleaning products.

Environmental Services Manager indicated to the inspector that he wasn't aware of any problematic odours within the home; and the expectation is the home would be odour free. [s. 87. (2) (d)]

Issued on this 7th day of December, 2015

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

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

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CHANTAL LAFRENIERE (194), CAROLINE TOMPKINS (166), KELLY BURNS (554), MARIA FRANCIS-ALLEN (552)
Inspection No. / No de l'inspection :	2015_365194_0027
Log No. / Registre no:	O-002665-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Dec 4, 2015
Licensee / Titulaire de permis :	Glen Hill Terrace Christian Homes Inc. 200 Glen Hill Drive South, WHITBY, ON, L1N-9W2
LTC Home / Foyer de SLD :	STRATHAVEN LIFECARE CENTRE 264 King Street East, Bowmanville, ON, L1C-1P9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Michelle Stroud

To Glen Hill Terrace Christian Homes Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2015_365194_0012, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that the care set out in the plan of care is provided to the residents as specified in the plan.

-The plan of care for Resident #054 as it relates to continence care will be provided as specified in the plan.
-The plan of care for Resident #059 as it relates to safe transferring will be provided as specified in the plan.
-The plan of care for Resident #041 as it relates to safe transfer and positioning will be provided as specified in the plan
-Develop a monitoring system to ensure nursing staff are routinely providing Resident's #054, #059 and #041 the care set out in their respective plans of care.
-Develop a monitoring system where Registered Nursing staff/Unit Managers are monitoring to ensure that care is being provided to residents as specified in the plan of care

Grounds / Motifs :

1. Related to Log #030454-15, for Resident #054:

Resident #054 has impaired mobility and cognition impairment; resident is identified at risk for skin integrity issues related to incontinence. Resident #054 is dependent on staff for activities of daily living, including continence care.

The plan of care details the following care needs:
- Toileting, resident requires total assistance. Goals of care include, resident's

dignity will be maintained. Interventions include, resident is unable to participate and is totally dependent for the entire process; staff to change continence product and assess for skin breakdown; one to two staff to provide extensive assistance.
- Urinary incontinence, inability to control urination; total incontinence.
Goals of care include resident to be clean, dry and odour free. Interventions include, staff to provide peri-care twice daily and or with each incontinent episode; staff check resident on rounds for incontinence and provide incontinent care when needed.

On an identified date, Resident #054 indicated to the inspector "I think I'm sitting in a glass of water", resident was tearful and indicated to the inspector "no one believes me". Resident #054 indicated to the inspector help was required. Inspector pulled the call bell for the resident, in an effort to get assistance for the resident.

Inspector #554 observed the following:
- Personal Support Worker (PSW) #118 and #119 entered Resident #054's room in response to call bell ringing; PSW #118 turned off resident's call bell and stated "hey, what do you want", Resident #054 verbalized the feeling of sitting in water to PSW #118; PSW #118 indicated "you are not wet" and walked out of resident's room.
- Resident #054 looked at inspector and commented "see, no one believes me".
- PSW #119 bent down beside Resident #054 in an effort to console the resident; PSW #119 placed hand inward toward resident and touched resident's wheelchair cushion and indicated aloud that the cushion of the chair was wet.
Personal Support Workers #119 and #121, assisted resident into bed and provided continence care for Resident #054.

Personal Support Worker #119 indicated to the inspector that Resident #054's continence product was "wet enough, for resident to be uncomfortable".

The refusal of care incident was brought to the attention of the Administrator, by the inspector.

Administrator indicated to the inspector speaking with Personal Care Worker #118 and that the PSW acknowledged Resident #054 did express being wet; PSW indicated to the Administrator that at the time, the PSW had thought the resident had dropped some water from a glass, which caused the resident to be

wet.

Administrator indicated in the investigation notes that regardless of how the resident got wet, it is the responsibility of the staff to assess and change the resident when needed. (554)

Related to Log # 030127-15 for Resident #059:

Review of the plan of care for Resident #059 indicates that the resident requires total assistance related to: Cognitive deficit and physical limitations. The plan of care directs that a mechanical lift is to be used for all transfers.

During an interview with inspector #194 on November 04, 2015, PSW #130 indicated that Resident #059 had been transferred out of the wheelchair to bed using a side by side transfer. There is a logo above the bed indicating the Resident #059 is a mechanical lift. PSW's #120 and #130 indicated to inspector that they were aware that Resident #059 was to be transferred with mechanical lift. PSW #120 indicated that the resident's transfer sling was not in the room at the time of the transfer, which was why the mechanical lift was not used as directed in the plan of care.

Upon further assessment of the transferring requirements of Resident #059 it was decided by the Administrator that the resident be moved to the other side of the room where there was more space available and better access for staff to use the mechanical lift. (194)

Related to Log O-002696-15 for Resident #41:

Plan of care related to transfers for Resident #041 directs:
-Requires total assistance for transfer with mechanical lift
-Two staff to transfer with mechanical lift for all transfers.
- To receive the necessary physical assistance.
- Resident may remain on black sling when in wheelchair; sling to be positioned in safe manner to avoid fall risk.
- Ensure anti-tip bars are in the proper place facing the floor.

On an identified date, a Critical Incident was received reporting, Resident #041 was being transferred from bed to wheelchair via a mechanical lift with assistance of two Personal Support Workers (PSW).

After the Resident was positioned in the wheelchair, one PSW left the room while S#124 completed the care. Resident#041 requested the sling be removed from the chair , S#124 advised the Resident that the sling was able to remain in position to ensure ease of transfer back to bed later. Resident #041 still requested the sling be removed. S#124 pulled the sling from underneath the Resident . Resident #041 leaned and fell forward from the wheelchair, resulting in an injury and was transferred to the hospital.

Interview with S#118 and S#119 indicated the procedure for transferring and positioning for Resident #041 requires two person assist at all times. Interview with the Administrator, and review of the licensee's investigation into the incident indicated that S#124 was aware that the plan of care directed that transfers and positioning for Resident #041 required two person assist at all times. (166) [s. 6. (7)]

The following factors were used to determine the issue of an order for s. 6(7) at this time. Three incidents involving residents were identified during this inspection, where care set out in the plan of care was not provided as specified resulting in injury or potential for injury. The licensee compliance history directs that non compliance in this specific area was identified in May 11, 2015 with an order being issued. (194)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2015

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure;

-Re-instruction of all Registered Nursing staff related to the safe administration of medication, with particular attention to:
-Administration of narcotics
-The management of drug errors
-The adherence to the home's drug administration policy
-College of Nurse's Best Practice Guidelines
-Re-education of appropriate actions to be taken in response to any medication errors
-Development of a formal monitoring process to evaluate medication administration processes to promptly address medication administration issues and avoid adverse medication incidents.

Grounds / Motifs :

1. Related to Log #O-001737-15, for Resident #046:

A Critical Incident Report was submitted to the Director, specific to a medication incident / adverse drug reaction, which resulted in altered health status of

Resident #046.

Details of the CIR are as follows:
- Resident #046 was administered an analgesic medication, by Registered Practical Nurse #104. Resident #046's health declined as a result of the medication error, resulting in the need for resident to be transferred and admitted to hospital for treatment and observation.

A review of the progress notes, for a period of twenty days, detail the following:

Resident #046 had been experiencing in increase in pain; The resident's analgesic was no longer effective in controlling resident's discomfort. Resident #046 was assessed by the attending physician and prescribed a stronger analgesic medication. The first dose of analgesic medication was administered to Resident #046, with good effect; resident experienced no untoward side effects (as per the progress notes, written by registered nursing staff).

According to a progress note, written by Registered Practical Nurse (RPN) #104 , Resident #046 was administered a different analgesic medication, instead of the prescribed analgesic medication. The progress note, indicates RPN #104 recognized the error, took resident's vitals; and reported the medication error to RN Supervisor #105. RPN #104 indicated, in the progress note, that the medication error was placed in the physician's communication book for follow up by the oncoming day shift; RPN #104 also indicated in the progress note that the day shift was to contact Resident #046's family (substitute decision maker) of the medication error.

Registered Practical Nurse #107 came on duty, and was given report by RPN #104 and informed that a medication error was made involving Resident #046. Progress notes indicated RPN #107 went to assess Resident #046, the resident was found to have decreased level of consciousness and vitals had declined. RPN #107 indicated the resident was placed in high fowlers sitting position, oxygen initiated, 911 was called and that RN #105 was notified.

Family of Resident #046 was notified of medication error, change in resident's health status and required transfer to hospital.

The resident was admitted to the hospital did not return to the long-term care home until fourteen days later.

The home's policy, Medication Incidents (#04-09-10), directs that all medication incidents that are identified are reported immediately to the nurse, designate and to the Director of Care; and that the immediate problem corrected. For incidents that involve residents, the severity level of the incident is to be assessed including the current status of the resident and any potential risk; immediate actions are to be taken to access and maintain the resident's health. The physician is to be informed of the medication incidents that involve residents.

The policy further indicates that in cases of inadvertent overdose, the nearest poison control centre must be consulted immediately regarding possible treatment.

Appropriate actions were not taken by Registered Practical Nurse #104, charge nurse and Registered Nurse-Supervisor #105 in response to a medication incident involving Resident #046, which lead to an adverse drug reaction, as evidenced by:
- Resident #046's health status was not monitored following a medication error;
- There is no documented evidence in progress notes, or risk management that Registered Nurse Supervisor #105 assessed Resident #046 following notification of RPN #104 administering the wrong medication or when notified by RPN #107 of resident's declining health status. RN #105 indicated to the inspector being unsure of when first assessing Resident #046, but believes assessing Resident #046 following the second notification by RPN #107. RN #105 indicated that the assessment should have been documented noting the severity of the medication error.
- A medication error- by RPN #104 was placed in the doctor's communication binder instead of contacting the physician or immediately contacting the nearest Poison Control (as per the home's policy, Medication Incidents).

Registered Nurses #106 and #108, who were the oncoming supervisors, as well as the current Director of Care indicated that noting the severity of the medication error, the physician should have been immediately notified and resident transferred to hospital for treatment. [s. 134. (b)]

Two Critical Incident Reports (CIR) relating to medication errors within an eight month period were inspected concurrently with the RQI; Both medication incidents resulted in residents requiring hospital interventions. One CIR provided details of Resident #046 being administered an analgesic medication,

by a Registered Practical Nurse, which was not prescribed for the resident. Resident #046 sustained adverse effects related to the wrongly administered medication and was admitted to hospital and did not return to the long-term care home for approximately two weeks. The medication errors resulted due to a Registered staff not following safe medication practices and policies, specifically not following the 'eight rights of medication administration'.
(554)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 15, 2016

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
Performance Improvement and Compliance 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
Performance Improvement and Compliance 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
Direction de l'amélioration de la performance et de la conformité
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
Direction de l'amélioration de la performance et de la conformité
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 4th day of December, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Chantal Lafreniere

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