Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 8, 2018	2018_569508_0016	010886-18	Resident Quality Inspection

Licensee/Titulaire de permis

Mennonite Brethren Senior Citizens Home
1 Tabor Drive St. Catharines ON L2N 1V9

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

Mennonite Brethren Senior Citizens Home
1 Tabor Drive St. Catharines ON L2N 1V9

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

ROSEANNE WESTERN (508), CATHY FEDIASH (214), DARIA TRZOS (561), YULIYA FEDOTOVA (632)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): May 30, 31, June 1, 5, 6, 7, 11, 12, 13, 14, 15, 18, 19, 2018.

Please note that the following Critical Incident System (CIS) Inspections were conducted concurrently during this Resident Quality Inspection (RQI):
- Log #002999-17, related to falls prevention and management;
- Log #007688-17, related to alleged abuse and neglect;
- Log #017744-17, related to alleged abuse;

- Log #020868-17, related to responsive behaviours;
- Log #015436-18, related to alleged abuse;

The following Complaint Inspections were conducted concurrently during this RQI:

- Log #008590-17, related to falls prevention and management, plan of care and responsive behaviours;
- Log #013215-17, related to falls prevention and management, plan of care and responsive behaviours;
- Log #026983-17, related to unsafe transferring and plan of care;

The following Inquiries were conducted concurrently during this RQI:
- Log #026619-17, related to plan of care;
- Log #003229-18, related to alleged abuse;
- Log #006410-18, related to infection prevention and control.

During the course of the inspection, the inspector(s) toured the home, observed dining service, observed staff to resident interaction and the provision of care, reviewed resident clinical records, relevant policies and procedures, the home's internal investigative notes, reviewed the complaint log, Residents' Council and Family Council minutes, staff training records and employee files.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), the Interim Director, the Director of Care (DOC), the Assistant Director of Care, the former Acting Assistant Director of Care, Clinical Quality Coordinator, Therapeutic Recreation Supervisor and Volunteer Coordinator, Hairdresser, Pharmacy Consultant, registered dietitian (RD), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Dietary Aides, residents and family members.

The following Inspection Protocols were used during this inspection:

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

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

a) A review of a Medication Incident Report indicated that on an identified date in 2017, resident # 017's prescribed medications had been omitted from the resident's weekly medication strips. A review of the resident's clinical records indicated that two tablets were missing from the resident's medication strips and were administered from the government supply.

An interview with registered staff #308 on an identified date, confirmed that the medications were not available in the medication strip and not administered, with

exception of the two tablets.

The Medication Incident Report contained an area for staff to document whom the incident was reported to and it was observed that no documentation was present in the area of resident/Power of Attorney (POA). A review of the resident's progress notes had not identified any documentation that the resident and or their POA had been informed that the medications above had not been available for administration on this identified date.

An interview with the DOC and ADOC on an identified date, confirmed that the medication incident had not been reported to the resident and or their POA.

b) A review of a Medication Incident Report indicated that on an identified date in 2017, registered staff # 337 received information that resident # 018 had an alteration to their skin integrity in an identified area and that a new treatment had been prescribed. The incident report indicated that the treatment in the PSW basket was not opened and that the registered staff spoke with PSW staff # 234, who was responsible for providing care to resident #018, on this identified date, who had indicated that they did not know about the treatment. The incident report indicated that the resident had been without the prescription treatment for two days.

A review of the resident's physician orders indicated that on an identified date in 2017, the resident was prescribed a specified treatment to their alteration in skin integrity twice daily (BID) for a specific time period.

The Medication Incident Report contained an area for staff to document whom the incident was reported to and it was observed that no documentation was present in the area of resident/POA or Pharmacy Service Provider. A review of the residents progress notes had not identified any documentation that the resident and or their POA or the pharmacy service provider, had been informed that the resident's prescribed treatment had not been administered.

An interview with the DOC and ADOC on an identified date, confirmed that the medication incident had not been reported to the resident and or their POA or to the pharmacy service provider.

c) A review of a Medication Incident Report indicated that on an identified date in 2017, resident # 025 had a missing package of medications that were scheduled to be

administered. The report indicated that the medications had been administered when the registered staff member used the last pouch in the weekly strip and then notified pharmacy to replace the pouch used.

The Medication Incident Report contained an area for staff to document whom the incident was reported to and it was observed that no documentation was present in the area of resident/POA. A review of the resident's progress notes had not identified any documentation that the resident and or their POA had been informed.

An interview with the DOC and ADOC on an identified date, confirmed that the medication incident had not been reported to the resident and or their POA. [s. 135. (1)]

2. The licensee failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that had occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions.

During an interview with the DOC on an identified date, it was indicated that the home last reviewed medication incidents and adverse drug reactions for the time period of October, November and December 2017.

A review of medication incidents and adverse drug reactions for this time period indicated that two medication incidents had occurred in October and November, 2017.
On an identified date in 2018, documentation was provided by the DOC of the home's quarterly review of all medication incidents for October, November and December 2017. Documentation indicated that the quarterly review had been conducted in March, 2018.

A review of the document titled, "Non-Pharmacy Origin Qualitative Medication Incident Analysis Tabor Manor 2017", indicated that this document contained only graph statistics of medication incidents of the frequency of incidents by route of administration; type of incident and time of incident and had not contained any information regarding the details of the incident (s), including any contributing factors or whether or not interventions put into place at the time of the incident (s), had been effective in reducing and preventing the medication incidents. A review of a corresponding document titled, "Qualitative Incident Analysis: Quality Improvement Plan" indicated that no information had been documented regarding the type of medication incidents that occurred in the quarterly review; any contributing factors or details of the incident(s); or whether or not interventions put into place at the time of the incident (s), had been effective in reducing

and preventing the medication incidents.

An interview with the DOC confirmed that the home did meet to conduct a quarterly review of all medication incidents in the home for the time period of October, November and December 2017; however, the review had not contained information specific to reducing and preventing the medication incidents and any adverse reactions. [s. 135. (3)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, 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 ensure that, where the Act or this Regulation required the licensee of a long-term care home to have, instituted or otherwise put in place any policy, the licensee was required to ensure that the policy was in compliance with and was implemented in accordance with all applicable requirements under the Act.

In accordance with O. Reg. 79/10, s.50(2)(b)(iii) the licensee was required to ensure that a registered dietitian (RD) assess a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds.

The licensee's policy and procedure for the Skin and Wound Care-Program with a revision date of March, 2016, stated that "the dietitian will be notified by the unit's registered staff and will complete the dietary referral/consult for all skin tears and stage 2 or higher pressure ulcers and full thickness wounds".

During interview with the DOC on June 14, 2018, it was confirmed that this was the licensee's current Skin and Wound Care policy and that it was not in compliance with and in accordance with all applicable requirements under the Act. [s. 8. (1) (a),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 where the Act or this Regulation requires the licensee of a long-term care home to have, instituted or otherwise put in place any policy, the licensee is required to ensure that the policy is in compliance with and is implemented in accordance with all applicable requirements under the Act, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
19. Safety risks. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care was based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: 19. Safety risks.

Resident #014's Substitute Decision Maker (SDM) expressed concerns to LTCH Inspector #561 regarding an incident in 2017, involving resident #014.
The plan of care for resident #014 at the time of this incident, indicated that resident required two staff assistance using a specific type of mechanical lift or another type of lift if fatigued; staff to provide privacy when on the toilet but check on resident.

The clinical record reviewed indicated that the latest lift and transfer assessment was to be completed on an identified date in 2017, after an incident.
The clinical record review and interview with staff indicated that the resident was not reassessed for lift and transfer after the incident.

Multiple direct care providers were interviewed during this inspection who had indicated that an identified mechanical lift was not safe to be used for the resident:

On an identified date, the Clinical Care Coordinator asked RN #282 to reassess resident #014 for lift and transfer, specifically for the identified lift. The assessment indicated that the resident was safe to use this identified lift. This assessment was completed by the RN and not in collaboration with any other discipline. The direct care providers stated to the LTCH Inspector that the resident was not safe using this lift and that they were not using it.

The interview with RN #288 and Clinical Care Coordinator indicated that the lift and transfer assessments were completed by RNs in the home. The assessments were not being completed in collaboration with the Physiotherapist or any other discipline, including direct care providers.

The plan of care was not based on the interdisciplinary assessment with respect to safety risks.

Please note: This area of non-compliance was identified during a complaint inspection conducted concurrently during this Resident Quality Inspection (RQI). [s. 26. (3) 19.]

2. The licensee failed to ensure that the plan of care was based on, at a minimum,

interdisciplinary assessment of the following with respect to the resident: 19. Safety risks.

On an identified date in June, 2018, resident #003 was observed by the LTCH Inspector seated in their wheelchair with a safety device applied.
During another observation by LTCH Inspector #508, the resident was observed in their room tilted back in their wheelchair with no safety device applied. The safety device was observed hanging on either side of the wheelchair.

During interview with registered staff #316 on an identified date in 2018, the staff indicated that the safety device was currently removed for a seven day trial to determine if it was still required for this resident.

Review of the resident's clinical record indicated that the resident was re-assessed prior to this trial and based on this assessment, it was determined that the safety device was still required. There was no re-assessment prior to implementing the trial of the discontinuation the resident's safety device two days later.

It was confirmed through documentation review and during interview with registered staff #316 that the plan of care was not based upon an interdisciplinary assessment with respect to safety risks. [s. 26. (3) 19.]

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 plan of care is based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: 19. Safety risks, to be implemented voluntarily.

WN #4: 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 the resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was assessed by a registered dietitian who was a member of the staff of the home, and that any changes made to the plan of care related to nutrition and hydration were implemented.

Resident #006 developed a new area of altered skin integrity which was identified and documented in the weekly wound assessment on an identified date in 2018, on an identified area. Further review of the resident's clinical record indicated that the registered dietitian (RD) had not assessed the resident and no nutritional interventions had been implemented as the RD had not received a referral related to this new area of altered skin integrity. The referral was sent to the RD and nutritional interventions were implemented after it had been identified by the LTCH Inspector during the course of this inspection.

It was confirmed through documentation review, interviews with the RD and the DOC, that the resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds had not been assessed by a registered dietitian who was a member of the staff of the home. [s. 50. (2) (b) (iii)]

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 resident who exhibits altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the plan of care related to nutrition and hydration are implemented, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (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. O. Reg. 79/10, s. 114 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that written policies and protocols were 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 and in accordance with Ontario Regulation 79/10, r. 114 (3)(a), the licensee was required to ensure that the written policies and protocols were developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

A review of a Medication Incident Report indicated that on an identified date in 2017, registered staff # 337 received information in a report that resident # 018 had an alteration to their skin integrity to an identified area and that a new treatment had been prescribed. The incident report indicated that the treatment in the PSW basket was not opened and that the registered staff spoke with PSW staff # 234 who had indicated that they did not know about the treatment.

A review of the licensee's policy titled, "Medication-Administration of Topical Medications by unregulated staff" (located in Nursing manual and dated with a reviewed date of September 2015), indicated the following under procedure:

a) All unregulated staff will receive training in administration of medicated topicals as arranged by the DOC/ADOC.
b) Unregulated staff (PSWs) will receive an annual update on training about administration of medicated topicals.

A review of documentation regarding the training of unregulated staff in the administration of medicated topicals, indicated that training was provided on an identified date in 2015.

During an interview with the DOC on an identified date, it was confirmed that an annual update on training of the administration of medicated topicals by unregulated staff, had not been completed annually. [s. 114. (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 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 and in accordance with Ontario Regulation 79/10, r. 114 (3) (a), the licensee is required to ensure that the written policies and protocols are developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

s. 131. (4) A member of the registered nursing staff may permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical, if,
(a) the staff member has been trained by a member of the registered nursing staff in the administration of topicals; O. Reg. 79/10, s. 131 (4).
(b) the member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and O. Reg. 79/10, s. 131 (4).
(c) the staff member who administers the topical does so under the supervision of the member of the registered nursing staff. O. Reg. 79/10, s. 131 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

a) A review of a Medication Incident Report indicated that on an identified date in 2017, resident # 017's prescribed medications had been omitted from the resident's weekly medication strips. A review of the resident's clinical records indicated that two tablets were missing from the resident's medication strips and were administered from the government supply.

An interview with registered staff #308 on an identified date, confirmed that the medications were not available in the medication strip and not administered, with the exception of the two tablets.

A review of the resident's Electronic Medication Administration Record (EMAR) on an identified date in 2017, indicated that a code of "10" was documented, indicating that the drug was not available; however, specific medications that were to be administered to the resident. An interview with registered staff #308 on an identified date, confirmed that the medications were not available in the medication strip and not administered to the resident on that identified date in 2017.

A review of a document titled, "Medication Incident: Response Report" completed by the pharmacy, indicated that it was determined that an error was made by the data entry technician when sending the medications for dispensing which resulted in their omission from the strip.

An interview with the DOC and ADOC on an identified date, confirmed that drugs had not been administered to resident #017 in accordance with the directions for use specified by the prescriber.

b) A review of a Medication Incident Report indicated that on an identified date in 2017, registered staff # 337 received information that resident # 018 had an alteration to their skin integrity in an identified area and that a new treatment had been prescribed. The incident report indicated that the treatment in the PSW basket was not opened and that the registered staff spoke with PSW staff # 234, who was responsible for providing care to resident #018, on this identified date. The PSW staff had indicated that they did not know about the treatment. The incident report indicated that the resident had been without the prescription treatment for two days.

A review of the resident's physician orders indicated that on an identified date in 2017, the resident was prescribed a specified treatment to their alteration in skin integrity twice

daily (BID) for a specific time period.

A review of the home's drug record book, indicated that the resident's prescription was received from pharmacy on an identified date in 2017 and an interview on an identified date, with registered staff # 294, confirmed that they had received the prescription with the evening delivery and that the prescribed topical was administered to the resident that evening.

During an interview with PSW staff #234 on an identified date, they indicated that PSW's do apply treatment creams and document the application in the Point of Care (POC) task section. The staff member indicated that documentation in the POC task is completed after care is provided. The staff member indicated that this was a new treatment that was to be applied at a specific time and they had not been made aware of the new treatment.

Interview with PSW staff #234 and review of the medication incident, indicated that resident # 018's prescribed treatment had not been administered.
An interview with the DOC confirmed that drugs had not been administered to resident #018 in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

2. The licensee failed to ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse. As identified in Ontario Regulation 79/10, s.131 (4) (b) (c), indicated the licensee failed to ensure that a member of the registered nursing staff permitted a staff member who was not otherwise permitted to administer a drug to a resident to administer a topical, if, the member of the registered nursing staff who permitted the administration was satisfied that the staff member safely administered the topical and the staff member who administered the topical did so under the supervision of the member of the registered nursing staff.

A review of a Medication Incident Report indicated that on an identified date in 2017, registered staff # 337 received information that resident # 018 had an alteration to their skin integrity in an identified area and that a new treatment had been prescribed. The incident report indicated that the treatment in the PSW basket was not opened and that the registered staff spoke with PSW staff # 234, who was responsible for providing care to resident #018, on this identified date. The PSW staff had indicated that they did not know about the treatment. The incident report indicated that the resident had been without the prescription treatment for two days.

A review of the resident's ETAR for October 2017, indicated that the resident's prescription treatment was documented as having been administered on two specific dates.

A review of the home's drug record book, indicated that the resident's prescription was received from pharmacy on an identified date in 2017 and an interview on an identified date, with registered staff # 294, confirmed that they had received the prescription with the evening delivery and that the prescribed topical was administered to the resident that evening.

During an interview with registered staff # 311 on an identified date, they indicated that they had discussed during huddle sessions at the home, a concern regarding treatments being applied at 0600 hours. The staff member indicated that PSW staff complete resident care between 0700 – 0900 hours and that the night registered staff leaves at 0700 hours and there is no way for the registered staff to follow up if the treatment was applied or not and suggested moving the time.

It was indicated that PSW staff obtained prescribed topical treatments from a treatment basket that was kept on the nursing desk and not directly from the registered staff. The staff member indicated that they were not sure if the resident had received their prescribed topical treatment on an identified date in October.

An interview with PSW staff #241 on an identified date, indicated that they had signed the Point of Care (POC) document indicating that the resident had received their prescribed topical treatment on an identified date and time. The staff indicated that the treatment cream was not given to them by registered staff, but was kept in a basket for PSWs to obtain. The staff member indicated that they thought they may have applied the treatment cream on this date and time.

An interview with PSW staff # 234 on an identified date, indicated that on an identified date in 2017, the staff member was not aware that resident #018 had been prescribed a new topical treatment that was to be applied at a specific time. The staff member indicated that PSW staff document the application of topical treatments in the resident's POC task; however, staff do the care first and document in POC, later in their shift. The staff member indicated that they had not been informed by registered staff at the start of their shift that the resident had a new prescription cream that was required to be applied. The staff member indicated that topical treatments were kept in a box in the storage

room across from the nursing station and that PSW staff had access and obtained the topical creams from the storage room.

A review of the home's policy titled, "Medication-Administration of Topical Medications by unregulated staff" (located in Nursing manual and dated with a reviewed date of September 2015), indicated the following:

A member of the registered staff may permit a PSW to administer a topical treatment to a resident under the following conditions:

1. The unregulated staff member has been trained by the Registered Staff in the administration of topicals.
2. The member of the Registered Staff who is permitting the administration is confident that the unregulated staff member can safely administer the topical; and
3. The staff member who administers the topical does so safely.
Under Procedure:
3. Registered staff are expected to supervise PSWs, as necessary, in administration of medicated topicals and identify staff who may need re-training. Registered staff must be satisfied that the unregulated staff can safely administer the topical.

An interview with the DOC and ADOC on an identified date, confirmed that the current practice in the home did not permit registered staff to be satisfied that the staff member could safely administer the topical and that the staff member who administered the topical, had done so under the supervision of the member of the registered nursing staff. [s. 131. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #7: 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

Resident #006 was observed by LTCH Inspector #508 sitting in their wheelchair with the wheelchair in a tilt position. The resident was again observed on two other identified dates during this inspection in their wheelchair sitting in the common area with their chair in the tilt position.

During interview with staff #217 on an identified date, staff indicated that they tilt the resident in their chair for pressure relief and comfort every two hours unless removed from the chair.

The resident's plan of care indicated that the resident was identified as a risk for developing alterations in skin integrity. The resident's plan also included that the resident was to be turned and repositioned every two hours while in their bed; however, there was no plan for the use of a tilt for repositioning the resident while in their wheelchair.

It was confirmed through documentation review and during interview with the Assistant Director of Care (ADOC) that the resident's written plan did not include the use of the tilt wheelchair. [s. 6. (1) (a)]

2. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

Resident #014's Substitute Decision Maker (SDM) expressed concerns to LTCH Inspector #561 regarding an incident in 2017, related to positioning and the use of a mechanical lift while unattended.
The plan of care for resident #014 at the time of this incident, indicated that resident required two staff assistance using a specific type of mechanical lift or another type of lift if fatigued; staff to provide privacy when on the toilet but check on resident.

LTCH Inspector was unable to confirm through interviews with staff or clinical record review what had occurred. There was no documentation found related to this incident. The staff including RPN #291 and the former Acting ADOC could not recall this situation. The former ADOC stated that they recall having a conversation with the SDM about resident being unattended; however, when they interviewed the PSWs this could not be confirmed.

The progress notes were reviewed for the month of November 2017, and a progress stated resident was found unresponsive. The progress note stated that the resident was not safe on a specific mechanical lift and that their lift and transfer was to be reassessed.

The clinical records were reviewed and the reassessment of the lift and transfer could not be found.

RN #288 was interviewed on an identified date and stated that the lift and transfer assessments were being completed by RNs and that they document the assessments in progress notes. RN #288 was not able to locate the assessment for this resident in November 2017 and confirmed that they had not completed one.

The Clinical Care Coordinator was interviewed on an identified date and indicated that lift and transfer assessments were being completed by RNs in the home. They used an algorithm called Arjohuntleigh Resident Assessment for Transfer and Repositioning and they document the assessment in progress notes. The Clinical Care Coordinator acknowledged that a reassessment for the lift and transfer for resident #014 was not completed in November 2017.

The licensee failed to ensure that the resident was reassessed an the plan of care reviewed and revised when resident's care needs changed.

Please note: This area of non-compliance was identified during a complaint inspection conducted concurrently during this Resident Quality Inspection (RQI). [s. 6. (10) (b)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

The home submitted a Critical Incident System (CIS) report to the Director on an identified date in 2018, of an alleged verbal abuse of resident #003 by PSW #207.

The Long Term Care Homes Act, 2007, Ontario Regulation 79/10 defines verbal abuse as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

The investigation notes were reviewed on an identified date and indicated that PSW #207, while providing care to resident #003, who demonstrated a responsive behaviour towards the PSW made a verbally abusive comment to the resident. This was reported to RN #280 by PSW #195, who witnessed the alleged verbal abuse. The RN sent an email to the immediate supervisors, including the Administrator, the ADOC and the DOC. The home initiated an investigation and they concluded that the PSWs remarks were abusive in nature and the PSW was suspended.

LTCH Inspector #561 attempted to interview resident #003; however, was unable to due

to resident #003's cognitive impairment.

The PSW #195, who witnessed the alleged verbal abuse, was not available for an interview; however, their written statement as documented, during the interview conducted by the Administrator, was reviewed by LTCH Inspector#561 and identified that PSW #207 did make the stated remark.

The alleged PSW #207, was interviewed on an identified date and stated that on the date of the incident, while providing care to resident #003 along with another PSW, the resident had responsive behaviours. The PSW stated that they were joking with the resident and did not mean to say that and that they would never hurt any resident.

The Administrator was interviewed on an identified date and indicated that through interviews with staff, including PSW #207 and the witness PSW it was confirmed that verbal abuse did occurr. The Administrator stated that PSW#207 was remorseful and indicated that they did not mean to say the comment.

The licensee failed to ensure that resident #003 was protected from verbal abuse by anyone.

Please note: This area of non-compliance was identified during a Critical Incident (CI) inspection conducted concurrently during this Resident Quality Inspection (RQI). [s. 19. (1)]

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 failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents did:
(a) provided that abuse and neglect were not to be tolerated,
(b) clearly set out what constituted abuse and neglect,
(c) provided for a program, that complied with the regulations, for preventing abuse and neglect,
(d) contained an explanation of the duty under section 24 of the Act to make mandatory reports,
(e) contained procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents,
(f) set out the consequences for those who abused or neglected residents,
(g) complied with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations, and,
(h) dealt with any additional matters as may be provided in the regulations.

The licensee's policy titled "Abuse", dated January 2005, and revised January 2017, was

reviewed by the LTCH Inspector and did not contain the explanation of the duty under section 24 of the Act to make mandatory reports. The policy did not state that any person who had reasonable grounds to suspect that any of the following had occurred or may occur shall immediately report the suspicion and the information upon which it was based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident’s money.
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006.

The licensee's "Abuse" policy indicated that the home shall investigate immediately every report of alleged, suspected, or witnessed incident of abuse relating to this home and the Regional office of the Ministry of Health and Long Term Care shall be contacted by the Administrator, by telephone, within 24 hours of such determination.
The licensee's "Abuse" policy also indicated that the investigations of any reported abuse shall be completed within one month of the initial report to the Director. It did not clearly identify the provisions under Ontario Regulation 79/10, r. 104 (3) which states that the licensee shall ensure that if unable to provide a report within 10 days, that a preliminary report is made to the Director within 10 days, followed by a final report within the time specified by the Director.

The Administrator was interviewed by LTCH Inspector #561 on an identified date and acknowledged that the licensee's policy did not state that any alleged abuse was to be immediately reported to the Director and that the completed investigation and report was required to be submitted within 10 days, followed by a final report within the time specified by the Director. [s. 20. (2)]

Please note: This area of non-compliance was identified during a Critical Incident (CI) inspection conducted concurrently during this Resident Quality Inspection (RQI). [s. 20. (2)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the person who had reasonable grounds to suspect that any of the following had occurred or may have occurred, immediately reported the suspicion and the information upon which it was based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

The licensee had submitted a Critical Incident System (CIS) report to the Director of an alleged verbal abuse towards resident #003 by a PSW #207 that occurred in 2018.

The investigation notes were reviewed on an identified date and indicated that PSW #207, while providing care to resident #003, who demonstrated a responsive behaviour towards the PSW made a verbally abusive comment to the resident. This was reported to RN #280 by PSW #195, who witnessed the alleged verbal abuse. The RN sent an email to the immediate supervisors, including the Administrator, the ADOC and the DOC. The home initiated an investigation and they concluded that the PSWs remarks were abusive in nature and the PSW was suspended.

The CIS report was not submitted to the Director until four days later. In an interview with the Administrator on an identified date, they acknowledged that this incident was not immediately reported to the Director.

The licensee failed to ensure that they reported the suspicion of abuse of a resident by anyone immediately to the Director.

Please note: This area of non-compliance was identified during a Critical Incident (CI) inspection conducted concurrently during this Resident Quality Inspection (RQI). [s. 24. (1)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

SDM of resident #014 had brought a concern forward with the LTCH Inspector that the staff in the home failed to notify them of the change in resident's condition. Specifically, alterations in their skin integrity and episodes of a specific disorder.

Registered staff #291 was interviewed and indicated that they would always notify the SDM of resident having these episodes. Registered staff #302 was interviewed and stated that it was an expectation that they documented any change in condition of the resident and if a treatment was prescribed and whether it was effective once ended or if the issue was resolved.

The clinical records were reviewed and indicated that on an identified date in 2017, resident #014 had an episode of fainting. Registered staff documented that resident needed to be reassessed for lift and transfer status because resident of this episode. On another identified date in November, 2017, the resident had a symptom of their identified disorder and was administered medication. The progress notes also indicated that the physician assessed the resident that day. There was no documentation of whether the SDM was notified of the incidents.

The progress notes indicated that on an identified date in November, 2017, the physician prescribed a specific treatment for resident's alteration in skin integrity to be administered for a specific period of time. Once the treatment ended there was no documentation indicating whether the treatment was effective or resident needed to be reassessed.

The ADOC was interviewed on an identified date and stated that staff were required to document that they notified the resident's SDM of any change in resident's condition. The

ADOC confirmed that this was not done.

The licensee failed to ensure that any actions in respect to the resident including interventions and responses to interventions were documented.

Please note: This area of non-compliance was identified during a complaint inspection conducted concurrently during this Resident Quality Inspection (RQI). [s. 30. (2)]

2. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Resident #003 was observed by LTCH Inspector #214 in May, 2018, sitting in a wheelchair with a safety device applied.

During another observation conducted in June, 2018, by Inspector #508, the resident was observed in their room tilted back in a tilt wheelchair with no safety device applied. It was observed hanging on either side of the wheelchair.

During interview with registered staff #316, the staff indicated that the safety device was currently unfastened for a seven day trial to determine if it was still required for this resident.

The staff indicated this trial was initiated on an identified date in June, 2018. During interview with the ADOC on an identified date, the ADOC indicated that staff would be expected to discuss with the resident or the Substitute Decision Maker (SDM) the trialling of removing devices and document this discussion including the responses in the progress notes in the resident's clinical record.

Review of the resident's clinical record specifically in the progress notes confirmed that the trial to remove the resident's device was initiated on an identified date in 2018.

On this date, it was documented by registered staff #301 that the SDM was to be notified of the trial; however, there was no documentation of any discussions to indicate that this occurred.

On an identified date in June, registered staff #301 stated that they spoke with one of the two joint SDM's who agreed to the trial but confirmed they did not document this

discussion.

It was confirmed during documentation review and by registered staff #301 that actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were not documented. [s. 30. (2)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 38. Notification re personal belongings, etc.
Every licensee of a long-term care home shall ensure that a resident or the resident's substitute decision-maker is notified when,
(a) the resident's personal aids or equipment are not in good working order or require repair; or
(b) the resident requires new personal belongings. O. Reg. 79/10, s. 38.

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's substitute decision-maker was notified when the resident's personal aids, or equipment were not in good working order or required repair; or the resident required new personal belongings.

SDM of resident #014 had brought a concern forward with the LTCH Inspector that a personal item belonging to the resident was damaged and they were not informed of when and how they became damaged.

Progress notes were reviewed and there was no documentation found related to resident's damaged personal belonging. LTCH Inspector observed resident during inspection and observed the item to be damaged. PSW #173 who provided direct care to the resident was interviewed and stated that they noticed that they were in fact damaged. They were not aware of how long they have been damaged.

The ADOC was interviewed on an identified date and stated that they were not aware of the damage. They also stated that staff were required to document that they notified the resident's SDM of any personal belongings being damaged. The ADOC confirmed that this was not done.

The licensee failed to ensure that the resident's substitute decision-maker was notified when resident's glasses were damaged.

Please note: This area of non-compliance was identified during a complaint inspection conducted concurrently during this Resident Quality Inspection (RQI). [s. 38. (a)]

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. In accordance with the LTCHA, 2007, the definition of staff, in relation to a long-term care home, means persons who work at the home,
(b) pursuant to a contract or agreement with the licensee.

The licensee failed to ensure that staff received training on the licensee's policy to promote zero tolerance of abuse and neglect of residents, prior to performing their responsibilities.

According to Critical Incident #C571-000004-18, contracted staff #339 witnessed the visitor of resident #028 using physical force towards resident #028 by striking the resident twice. Contracted staff #339 indicated during interview that the visitor used excessive force and the resident appeared to be agitated and upset. The resident could not verbally communicate with staff due to cognitive impairment and a language barrier.

Contracted staff #339 immediately went to a manager in the home to report what they had witnessed. The home's staff responded, intervened and contacted police to report the incident.

During interview with staff #339, they had indicated that they had worked regularly in the home providing direct care service to the residents in the home and had been for approximately five years. They also indicated that they had not received training on the home's abuse policy when asked by the LTCH Inspector.

It was confirmed during interview with contracted staff #339 and during review of the home's training records that the licensee failed to ensure that staff received training on the home policy to promote zero tolerance of abuse and neglect of residents, prior to performing their responsibilities.

Please note: This area of non-compliance was identified during a Critical Incident (CI) inspection conducted concurrently during this Resident Quality Inspection (RQI). [s. 76. (2) 3.]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation
Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee failed to ensure that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents.

The annual program evaluation of the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents was requested by LTCH Inspector from the home. The DOC stated that the home had not completed an annual evaluation of the abuse and neglect program in year 2016 or 2017.

The licensee failed to ensure that their policy to promote zero tolerance of abuse and neglect of residents was evaluated at least once in every calendar year. [s. 99. (b)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 115. Quarterly evaluation

Specifically failed to comply with the following:

s. 115. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 115 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that an interdisciplinary team, that included the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, met at least quarterly to evaluate the effectiveness of the medication management system in the home and to have recommended any changes necessary to improve the system.

During an interview with the DOC on an identified date, it was indicated that the home last met to evaluate the effectiveness of their medication management system on December 12, 2017 and that the evaluation was done through the home's Professional Advisory Committee (PAC). A review of the PAC meeting minutes for a specific time period in 2017, indicated that the Administrator was not listed as having attended the meeting. A review of the minutes under the heading, "Report from Director", indicated that they were unable to attend.

The DOC confirmed that the most recent quarterly evaluation of the effectiveness of the home's medication management system was conducted during a specific time period in 2017 and that the Administrator had not been in attendance. [s. 115. (1)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A review of a medication incident, indicated that it was identified that resident #018 had not had their prescription treatment applied on an identified date at a specific time. Review of the resident's physician order indicated that a new prescription was to be applied to a specific area twice daily (BID) for an identified period of time.

An interview on an identified date with PSW #234, and an interview on an identified date with PSW staff #186 and #187, indicated that prescribed treatment creams were stored in the storage room that also contained the incontinent product supply and that PSW staff had access to the storage room

On an identified date in June, 2018, during an observation of the second floor storage room, located across from the nursing station and medication room, three plastic tote boxes, not covered or secured and containing prescribed topical treatments, were observed to be stored on a shelving unit. Observation of the storage room identified that along with the prescribed topical treatments, incontinent products; wheelchairs and an oxygen tank were also stored in this room.

Observation of the prescribed topical treatments in the storage room, indicated that resident #029 had a prescribed treatment to be applied to affected areas topically as needed and was labelled with a Drug Identification Number. Resident #030 had a prescribed treatment to be applied to affected area topically one time a day on identified dates.

An interview with the DOC and ADOC on an identified date confirmed that drugs were not stored in an area or a medication cart that was used exclusively for drugs and drug-related supplies. [s. 129. (1) (a)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply

Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:

1. All areas where drugs are stored shall be kept locked at all times, when not in use.

2. Access to these areas shall be restricted to,

i. persons who may dispense, prescribe or administer drugs in the home, and

ii. the Administrator.

3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee failed to ensure that steps were taken to ensure the security of the drug supply, including access to these areas restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator.

During an inspection related to a medication incident involving resident #018, the Long Term Care Homes (LTCH) Inspector spoke with PSW#234 on an identified date and on an identified date in June, spoke with PSW staff #186 and #187. The staff indicated that prescribed treatment creams were stored in the second floor storage room that also contained the incontinent product supply and that PSW staff had access to the storage room.

During an observation of the storage room, the LTCH Inspector observed that an oxygen tank was stored in this room, which contained prescription creams. During a discussion with PSW staff #186, it was indicated that when an employee of the home's oxygen vendor comes to check and/or change the oxygen tank, the staff will open this storage door to let them in; however, they do not have time to stay with the vendor in the storage room where prescription creams are stored.

On an identified date, the LTC Inspector observed PSW #216 open the second floor storage room to allow access to a Vital Aire employee. The PSW then left the area and the Vital Aire employee was observed to be in the closed storage room for approximately 10 seconds.

An interview with the DOC and ADOC on an identified date, confirmed that the security of the drug supply had not been restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator. [s. 130. 2.]

Issued on this 15th day of October, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ROSEANNE WESTERN (508), CATHY FEDIASH (214), DARIA TRZOS (561), YULIYA FEDOTOVA (632)
Inspection No. / No de l'inspection :	2018_569508_0016
Log No. / No de registre :	010886-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Aug 8, 2018
Licensee / Titulaire de permis :	Mennonite Brethren Senior Citizens Home 1 Tabor Drive, St. Catharines, ON, L2N-1V9
LTC Home / Foyer de SLD :	Mennonite Brethren Senior Citizens Home 1 Tabor Drive, St. Catharines, ON, L2N-1V9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Tim Siemens

To Mennonite Brethren Senior Citizens Home, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Order / Ordre :

The licensee must be compliant with O.Reg 79/10, r. 135 (1).

Specifically, the licensee must:

Ensure that every medication incident and every adverse drug reaction involving residents #017, #018, #025 and all other residents, are reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

Grounds / Motifs :

1. The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

a) A review of a Medication Incident Report indicated that on an identified date in 2017, resident # 017's prescribed medications had been omitted from the resident's weekly medication strips. A review of the resident's clinical records indicated that two tablets were missing from the resident's medication strips and were administered from the government supply.

An interview with registered staff #308 on an identified date, confirmed that the medications were not available in the medication strip and not administered, with exception of the two tablets.

The Medication Incident Report contained an area for staff to document whom the incident was reported to and it was observed that no documentation was present in the area of resident/Power of Attorney (POA). A review of the resident's progress notes had not identified any documentation that the resident and or their POA had been informed that the medications above had not been available for administration on this identified date.

An interview with the DOC and ADOC on an identified date, confirmed that the medication incident had not been reported to the resident and or their POA.

b) A review of a Medication Incident Report indicated that on an identified date in 2017, registered staff # 337 received information that resident # 018 had an alteration to their skin integrity in an identified area and that a new treatment had been prescribed. The incident report indicated that the treatment in the PSW basket was not opened and that the registered staff spoke with PSW staff # 234, who was responsible for providing care to resident #018, on this identified date, who had indicated that they did not know about the treatment. The incident report indicated that the resident had been without the prescription treatment for two days.

A review of the resident's physician orders indicated that on an identified date in 2017, the resident was prescribed a specified treatment to their alteration in skin integrity twice daily (BID) for a specific time period.

The Medication Incident Report contained an area for staff to document whom the incident was reported to and it was observed that no documentation was present in the area of resident/POA or Pharmacy Service Provider. A review of the resident's progress notes had not identified any documentation that the resident and or their POA or the pharmacy service provider, had been informed

that the resident's prescribed treatment had not been administered.

An interview with the DOC and ADOC on an identified date, confirmed that the medication incident had not been reported to the resident and or their POA or to the pharmacy service provider.

c) A review of a Medication Incident Report indicated that on an identified date in 2017, resident # 025 had a missing package of medications that were scheduled to be administered. The report indicated that the medications had been administered when the registered staff member used the last pouch in the weekly strip and then notified pharmacy to replace the pouch used.

The Medication Incident Report contained an area for staff to document whom the incident was reported to and it was observed that no documentation was present in the area of resident/POA. A review of the resident's progress notes had not identified any documentation that the resident and or their POA had been informed.

An interview with the DOC and ADOC on an identified date, confirmed that the medication incident had not been reported to the resident and or their POA. [s. 135. (1)]

The severity of this issue was determined to be a level 1 as there was minimum risk to the residents. The scope of the issue was a level 3 as it related to three of three residents reviewed. The home had a level 3 history of 1 or more related NC in the last 36 months with this section of the O.Reg 79/10, that included:

-Voluntary Plan of Correction (VPC) issued December 6, 2017, (2017_575214_0022/ 025575-17).
(214)

(214)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 28, 2018

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

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, commercial courier or by fax upon:

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 8th day of August, 2018

Signature of Inspector /
Signature de l'inspecteur :

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

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Name of Inspector / Nom de l'inspecteur : Roseanne Western

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