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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 6, 7, 2018; Feb 12, 2019	2018_621547_0036	029079-18	Resident Quality Inspection

Licensee/Titulaire de permis

Bruyère Continuing Care Inc.
43 Bruyère Street OTTAWA ON K1N 5C8

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

Élisabeth-Bruyère Residence
75 Bruyère Street OTTAWA ON K1N 5C8

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

LISA KLUKE (547), GILLIAN CHAMBERLIN (593), LINDA HARKINS (126), LYNE DUCHESNE (117)

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): November 5,6,7,8,9,13, 14, 15, 16,19, 20, 21, 22, 23, 2018

The following critical incidents and complaint inspections were conducted concurrently during this inspection:

Log #018869-18, CIS #2759-000021-18, Log #019790-18, CIS #2759-000023-18, relating to falls with injuries,
Log #018554-18, CIS #2759-000026-18, relating to an unexpected death,
Log #025365-18, 023439-18 and 017987-18, relating to complaints regarding provision of resident care, food quality and alleged abuse of resident.

During the course of the inspection, the inspector(s) spoke with residents, family members, Volunteers, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Housekeeping and Maintenance attendants, the ward clerk, the Office Manager, the Director of Emergency Management Environmental Services and Telecommunications (DEMEST), a Maintenance Engineer, a Maintenance Operating Engineer, The Facility Maintenance Supervisor (FMS), Fire Prevention Officers, a Recreation Therapist, Food Attendants, Food Services Managers, the Registered Dietitian, a Physiotherapy Assistant (PTA), the Director of Care (DOC), the Administrator and the Executive Director.

In addition the inspector (s) reviewed resident health care records, food production documents including planned menus, Residents' Council minutes, Family Council minutes, documents related to the home's investigations into critical incidents submitted by the Licensee and policies and procedures related to Emergency response plan for code red, Resident Abuse, Critical Incident reporting, Skin and Wound, Falls, Nutrition and Hydration Program and Medication Incidents. The inspectors observed the delivery of resident care and services and staff to resident as well as resident to resident interactions. The Inspectors reviewed medication administrations and storage areas and observed several meal services. The inspector also reviewed internal investigation documents, employee training information, employee schedules, work assignments and employee records relevant to this inspection.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Food Quality
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Skin and Wound Care

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

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 130.	CO #902	2018_621547_0036	547
O.Reg 79/10 s. 230. (5)	CO #901	2018_621547_0036	547

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Légende
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 230. Emergency plans

Specifically failed to comply with the following:

s. 230. (5) The licensee shall ensure that the emergency plans address the following components:
1. Plan activation. O. Reg. 79/10, s. 230 (5).
2. Lines of authority. O. Reg. 79/10, s. 230 (5).
3. Communications plan. O. Reg. 79/10, s. 230 (5).
4. Specific staff roles and responsibilities. O. Reg. 79/10, s. 230 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that their emergency plans addressed the following components:

1. Plan activation,
2. Lines of Authority,
3. Communication plans,
4. Specific staff roles and responsibilities.

On November 6, 2018, on a unit servery, during the lunch time meal service, Personal Support Worker (PSW) #101 put a food item in the servery microwave for it to be reheated. The PSW left the servery to attend residents in the unit's main dining room.

Dietary Aide (DA) #103 noted that there was a fire and smoke in the microwave. The Dietary Aide stopped the microwave oven and removed the food item. There was the presence of grey smoke in the servery, billowing out into the dining room and unit hallway. There were several residents and staff in the dining room. Residents remained seated with staff in attendance.

Dietary Aide #103 called "222", the home's emergency call centre to advise them of the smoke. Three staff members came up to assess the situation. Grey smoke was observed by Ward Clerk #111, inspector #126 and PSW #101 in the dining room adjoining the servery and no alarm was activated. No residents were noted to be in distress.

Resident #007 was observed to be talking to maintenance attendant #109 and expressing their concerns related to the smoke and nothing being done.

Resident #021 was in the dining room and informed inspector #126 that they had an irritated throat due to the smoke and was upset that no one had done anything to address the smoke.

Resident #006 was in the smaller dining room across from the servery. The resident told Inspector #547 that there was lots of smoke. Resident #006 was coughing, hiding their mouth and nose with a clothing protector and was upset.

This incident was discussed at 1305 hours with the Administrator, the Director of Emergency Management, Environmental Services and Telecommunications (DEMEST), the Manager of Facilities Management and a Maintenance Engineer. The Maintenance Engineer said that they received a call from "222" that there was smoke from burnt toast on the 5th floor and made the decision to bypass the fire alarm system and send some staff to the 5th floor unit.

The Manager of Facilities Management said that the bypass was done because the source of the smoke was burnt toast. They said that it was the right decision in this situation to bypass the fire alarm as the alarm is for the whole building.

The Administrator and the DEMEST said that all staff know the fire process of SCATEE (save, contain, alarm, telephone, evacuate and extinguish) and are expected to implement this process as soon as smoke is discovered. The DEMEST said that it is the licensee's expectation for all staff to react and remove residents from the affected area. [s. 230. (5)]

Additional Required Actions:

CO # - 901 was 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. 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 of a long-term care home has failed to ensure that steps were taken to ensure that security of the drug supply, including the following:

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

On November 6, 2018 Inspector #547 observed RPN #114 working on one of the resident care units and was responsible for the medication cart.

At approximately 1115 hours, Inspector #547 observed this unit's medication cart unlocked and accessible to residents on this unit. This cart was observed to be unsupervised by any registered nursing staff. The resident care unit was identified during this inspection to have several residents with dementia and wandering behaviours.

At approximately 1158 hours, Inspector #547 observed the same medication cart located outside the dining room on the unit to be unlocked. This cart was observed to be unsupervised by any registered nursing staff. Inspector #547 observed resident #024 wandering outside this dining room next to this medication cart. Resident #024 is cognitively impaired with wandering behaviours identified in the resident's plan of care.

Inspector #547 interviewed RPN #114 on both these occasions who indicated that

medication carts are required to be kept locked at all times when unsupervised for safety.

The next day, Inspector #547 observed RPN #113 working on the same resident care unit and to be responsible for the medication cart. At approximately 1200 hours, Inspector #547 observed the unit's medication cart located outside the dining room on the unit to be unlocked. Several residents were observed walking in this hallway outside this dining room next to this medication cart to go to lunch. This unlocked medication cart was unsupervised by any registered nursing staff. RPN #113 indicated to be running late and was not aware that the medication cart was required to be locked at all times.

That same day, at 1245 hours on the same unit, it was observed by inspector #117 that the medication cart was unlocked and unsupervised. The unit RPN #113 was in the unit main dining room giving medication to a resident. The RPN could not be seen from the medication cart. The RPN returned to the cart. RPN #113 said to inspector #117, when asked about the security of the medication cart, to not be aware of having left the medication cart unlocked when the RPN left to administer a medication to a resident.

At approximately 1325 hours, inspector #547 observed the same unit's medication room, located in a common area that had a set of keys inserted in the door locking mechanism. Inspector #547 was able to open the door to the medication room that was not supervised by any registered nursing staff. Inspector #547 observed three residents wandering around this area with their walkers as well as other residents in wheelchairs outside this medication room.

At approximately 1330 hours, inspector #547 brought the medication room keys to the Administrator, who indicated that these keys are supposed to be kept with the registered nursing staff at all times, and should not be left unattended or inside the locking mechanism of the medication room for resident safety. The Administrator further indicated that medication carts are expected to be kept locked at all times when unsupervised by registered nursing staff. [s. 130. 1.]

Additional Required Actions:

CO # - 902 was served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(e) is approved by a registered dietitian who is a member of the staff of the home;
O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's menu cycle was approved by the Registered Dietitian (RD), who is a member of the staff of the home.

During an interview with Inspector #593, November 19, 2018, Food Services Supervisor (FSS) #141 indicated that the current menu cycle was reviewed and approved by the RD in January, 2018. At the time of the interview, FSS #141 did not have the documentation to support this however advised that it would be provided the following day.

On November 20, 2018, a copy of the current menu cycle dated March 9, 2018 and current snack menu dated February, 2018 were provided to Inspector #593.

The following statement was documented on the menu cycle:

"Please take note that I (name- RD) have reviewed the EBR menu cycle and have indicated my concerns/questions/adjustments to follow up with food service as appropriate". Dated: November 7, 2018

The following statement was documented on the snack menu:

"Please take note that I (name- RD) have reviewed the snack menu cycle and have indicated my questions/concerns to communicate to food service and follow up as appropriate". Dated: November 7, 2018

A review of the documented "Nutrition and Hydration Program", CLIN CARE 40 LTC, date revised August, 2017, found that the Dietitian will:

• Approve resident menus as developed by the Food Services department, ensuring that the menus meet the residents' nutritional and hydration intake requirements, and approve updated menus at least annually.

During an interview with Inspector #593 on November 19, 2018, the RD reported that they reviewed the current menu cycle last week, and prior to this, the last time they had completed a review of the menu cycle was approximately one year. The RD added that they had many comments and concerns and that once these had been addressed, the RD would approve the menu.

The review and approval of the menu cycle by the Registered Dietitian (RD) includes the regular menu, the snack menu, beverages, and the menu's for residents requiring a therapeutic diet who are also a higher nutritional risk, including those residents requiring a texture modified diet.

Non-compliance was also found related to the texture modified menu cycle and the comparability to the regular menu cycle (refer to WN #17). When the RD did review the menu cycle during the RQI, the RD documented concerns related to repetition of the texture modified menu and did not approve this menu at the time of review.

As indicated by the date stamps on the current menu cycle, the menu cycle was implemented in February and March, 2018. The licensee was unable to provide any evidence indicating that the current menu cycle was reviewed and approved by the RD and as indicated by the RD, the current menu cycle was not reviewed by the RD until early November, 2018 and has yet to be approved. [s. 71. (1) (e)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the written policies and protocols for the medication management to ensure the accurate storage and administration, of all drugs, are implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

As per O.Reg. s. 114, the licensee has the following policies regarding medication administration:

Medisystem Policy MEDI-CL-003, dated 01-Oct-2018: Medication Pass

6.4 – Medication administration is a continuous process and is always to be completed for the specific resident before moving on to another resident's medication or request.
6.8 – The nurse who prepares a medication or injection for administration, must administer it.
6.9 – Approach the resident when all medications to be given are prepared. Verify the resident's identify using two identifiers. Administer medications to the resident ensuring that ll oral medications have been swallowed Do not leave medications at bedside. Do not ask someone else to administer the medication; medication administration is a continuous process.
6.11 – Initial the MAR sheet for each medication.

Medisystem Policy MEDI-CL-ONT-042, dated 01-Oct-2018: Narcotic and Controlled Substances Administration Record

4. – When a new order of a narcotic or controlled drug arrives, it must be kept locked in the narcotic bin with its Narcotic and Controlled Substance Administration Record until

ready for use.

5. – All entries must be made at the time the drug is removed from the container
On November 15, 2018 at 1145 hours, inspector #117 was conducting a review of a resident care unit's controlled substances with RPN #102 when it was noted that multiple doses for three prescribed controlled substances for resident #004 were unaccounted for in the narcotic / controlled substances medication administration records.

Resident #004 was prescribed three controlled substances: one medication (#1) to be administered twice daily, one medication (#2) to be administered three times per day and another medication (#3) to be administered every 4-6 hours as needed. The controlled substances administration records indicated that one dose of medications #1 and #3 as well as two doses of medication #2 were missing from the doubled locked controlled substance section of the medication cart. The Narcotic and Controlled Substances Administration Record indicated that there was no documentation related to the missing controlled substances.

RPN #102 indicated that they had administered resident #004's morning dose of medication #1 and #2, however they had not documented the administration of these controlled substances in the Narcotic and Controlled Substance Administration Record at the time of administration. RPN #102 said that they often do not have time to document the administration of medication immediately after their administration, as required by the Licensee's policy.

RPN #102 also said that they had pre-poured a second tablet of medication #2 as well as one tablet of medication #3 for resident #004's next medication pass. These controlled substances were both observed by the inspector to be located in the unlocked medication cart, with resident #004's other medication. The RPN indicated that they regularly prepare resident #004's controlled substances medication in advance of the lunch time medication administration and do not document the removal and administration of the controlled substances until later in the day. When asked why the medication #3, an as needed medication, was pre-poured, the RPN said that it was because resident #004 usually asks for the as needed medication and they had prepared the medication in anticipation of the resident's potential need for the medication. The inspector asked RPN #102 in regards to the Licensee's policies related to the pre-pouring of medication and the documentation of controlled substance. RPN #102 said to the inspector that the Licensee's policies regarding medication administration and documentation are such that registered staff are to prepare medication for administration

at the time of administration and to document medication administration immediately post-administration.

On November 14 and 15 2018, RPN #114, #115 and #102 said to the inspector that they have some difficulties with the documentation of medication administration. All three registered staff members said that the eMAR system on the medication carts is very slow and they often are unable to document the administration of resident medication in the electronic eMAR at the time of administration. They reported that they often complete the eMAR medication documentation after their medication pass, at the nursing station. It is noted that on November 15 and 19, 2018, RPN #102 was observed by the inspector to be documenting the 0800 hours/0900 hours medication pass in one of the resident care units' documentation room at approximately 1050 hours.

RPNs #114, #115 and #102 are aware of the home's policy that all administered medication are to be documented in the eMAR at the time of administration. They reported that this has been an ongoing issue since the eMAR system was implemented approximately 2 years ago.

On November 15, 2018 with the DOC and Administrator said that they were not aware of any reported issues with eMAR documentation delays or issues. They both said that registered staff are to implement the Licensee's medication administration policies to ensure that medications/controlled substances are not to be prepared until their time of administration and that administered medications/ controlled substances are to be documented as administered at the time of administration.

As such, registered staff did not implement the Licensee's policies related to the administration and documentation of medication / controlled substances. [s. 114. (3) (a)]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in resident #031's plan of care was provided to the resident, as specified in the plan.

A review of resident #031's plan of care found a documented care plan (dated a specified day in 2018) focus: EATING supervision required related to: difficulty swallowing, risk of choking, with an intervention for honey-thick fluids.

A progress note documented by the Registered Dietitian (RD) on a specified date in 2017, indicated an assessment completed related to the residents swallowing function. The RD observed the resident at lunch time with nectar-thick juice, nectar-thick milk and honey-thick juice. Appeared to manage the honey-thick liquid better. Recommend the texture change of liquids to 'honey-thick'.

During a breakfast meal service observation, on November 15, 2018, in a resident care unit's main dining room, resident #031 was observed to be fed two nectar thickened fluids- a pre-thickened apple juice and a pre-thickened water, by PSW #115. PSW #115 told Inspector #593 that resident #031 was required to have thickened fluids but did not specify the specific level of thickened fluids.

During the same breakfast meal service observation, Inspector #593 observed the dietary Kardex posted on the wall in the kitchen, resident #031 was listed as requiring honey thickened fluids.

During an interview with Inspector #593, November 15, 2018, Dietary Aide #114 indicated that nectar thickened fluids were available and provided to residents requiring thickened fluids. When questioned as to whether honey thick fluids could be provided to resident #031, Dietary Aide #114 responded that they could probably use the powdered thickener to thicken fluids to honey consistency, then proceeded to call one of the Food Service Supervisors to confirm this process.

During an interview with Inspector #593, November 19, 2018, the RD confirmed that

resident #031 required honey thickened fluids and it was the expectation that the nursing staff would use the powdered thickener to thicken fluids to honey consistency in the dining room or servery during the meal service.

During an interview with Inspector #593, November 15, 2018, the DOC indicated that it was the expectation that the PSW staff follow the Kardex in relation to the resident's dietary requirements. [s. 6. (7)]

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 care set out in the resident's plan of care was provided to the resident as specified in the plan, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that furnishings and equipment are kept clean and sanitary.

On November 6, 8, 13, 14 and 15, 2018 inspector #547 observed the following:

Resident #008's green sitting chair in the resident's room to have a yellow stain to the seat cushion covered with a beige blanket inside the resident's room. The resident's blue mattress was observed on these days under the sheets to have ring stains and odours present.

Room #613Y the lounge/salon in the home has six easy chairs for resident use, and two fabric chairs were observed to be soiled with odours present. This lounge also had a brown leatherette style rocking chair, exposing the sub material to the leatherette to the arm rests and head rests with odours present.

The public bathroom on the 6th floor was observed on November 8, 13, and 15, 2018 to have a raised toilet seat soiled with brown/yellow fluid matter to the base on the raised toilet seat with damaged foam handle bars with odours present.

Urine collector containers used to empty urine from resident's catheter bags were observed inside resident bathrooms #505 on November 8, 14, and 15, 2018 to have fluid in the bottom with odour of urine present. PSW #135 indicated the process in the home with urine collector containers is to drain catheter bags and then to rinse these containers with water and store them in their bathrooms. These containers are changed on the resident's first bath of the week.

Over the course of this inspection, the walls and baseboards in resident care hallways on 5th and 6th floors were observed by the inspection team to be scuffed with black marks, soiled areas, dust and debris. On November 15, 2018 Environmental Services Supervisor indicated that housekeeping and nursing staff can call 4444 when they need something done outside their usual routine. Baseboards are part of a special project for cleaning when flagged by the 4444 work order. Housekeeper #134 indicated to inspector #547 that walls and baseboards are not washed in the home as part of the regular housekeeping routines and that a special project would be required for this. Housekeeper #134 indicated having worked in the home regularly for the last three years, and has not had to call 4444 as housekeeping has been well managed.

As such, the licensee has not ensured that the home, furnishings and equipment are kept clean and sanitary as required by this section.[s. 15. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that furnishings and equipment are kept clean and sanitary, to be implemented voluntarily.

WN #7: 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 has 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 are documented.

On November 6, 2018, Resident #012 was observed to have three dressings. A review of resident #012's current plan of care identified the resident as having fragile skin and being at risk of altered skin integrity.

A review of the resident's health care record was conducted. It notes that since a specified month in 2018, the resident as having recurring skin integrity issues requiring the application of dressings. On a specified day in 2018, the resident was sent to hospital post fall and injury. The resident returned with dressings to four (4) injury sites. There are no weekly skin or wound assessments regarding the status of the four injury sites noted in the resident's electronic record Point Click Care (PCC) or the hard copy chart between the day of the injury and the next 32 days post injury. There is no documentation indicating if the status of these four injuries.

Further review of the resident's health care record indicated in the progress notes that

the resident sustained skin injuries requiring the application of various dressings on the following days:

On a specified day in 2018, the resident had a large laceration to an identified limb. Notes indicated that this dressing was to be in place for 21 days or as needed. No further documentation regarding the status of the wound was found in the resident's health care record.

The next day, the resident was noted to have sustained a skin injury with partial tissue loss to an identified limb. A dressing was noted to have been applied. No further documentation regarding the status of the wound was found in the resident's health care record.

Five days later, the resident was noted to have a skin injury to another identified limb. A dressing was noted to have been applied. No further documentation regarding the status of the wound was found in the resident's health care record.

Four days later (10 days after the first reported injury), the resident was noted to have a skin injury to another identified limb. A dressing was noted to have been applied. No further documentation regarding the status of the wound was found in the resident's health care record.

Three days later, the resident was noted to have three skin injuries, to three different skin areas. These were cleansed and dressings applied. There is no documentation to identify if these were previous or new skin injuries.

Two days later, the resident was noted to have a skin injury to another limb. A dressing was noted to have been applied. No further documentation regarding the status of the wound was found in the resident's health care record.

Three days later (19 days after the first reported injury) the resident was noted to have skin injuries to the back of the identified limbs. These were cleansed and dressings applied. There is no documentation to identify if these were previous or new skin injuries.

Two days later, the resident was noted to have a wound to the back of another limb. These were cleansed and dressings applied. There is no documentation to identify if these were previous or new skin injuries.

Two days later, the resident was noted to have a wound to identified limbs. These were cleansed and dressings applied. There is no documentation to identify if these were previous or new skin injuries.

Nine days later (32 days after the initial injury) the resident was noted to have a new injury to an identified limb. A dressing was noted to have been applied. Documentation regarding the status of the wound was found seven (7) days, ten (10) days and 24 days after this injury occurred in the resident's health care record.

Fifteen (15) days later, the resident was noted to have a change of dressing to an identified limb. These were cleansed and dressings applied. There is no documentation to identify if these were previous or new skin injuries.

On another specified date in 2018, 62 days after the first reported injury, the resident was noted to have a new injury to an identified limb.

RN #100 said to Inspector #117 that when a resident has a wound or skin integrity issue with a dressing, it is the responsibility of the registered nursing staff to ensure that the wounds/ skin integrity issue are assessed on a weekly basis, using the home's Point Click Care (PCC) skin assessment tool and that this be documented in the electronic chart. RN #100 also said that resident #012's wounds / injuries with their associated treatments and dressings are also identified in the resident's eMAR which helps to remember when to do weekly wound assessment. Nursing staff can also document the status of the resident's wound in the progress notes. RN #100 and RPN #102 could not explain as to why there was inconsistent documentation related to the status of the multiple wounds and treatments for resident #012. The DOC said to the inspector that it is the responsibility of both the unit RN and RPN to ensure that residents presenting with wounds have their wound care treatments and interventions documented in the resident's chart. [s. 30. (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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #8: 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,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

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 has failed to ensure that when the resident exhibiting altered skin integrity received a skin assessment by a member of the registered nursing staff upon any return from hospital.

On a specified date in 2018, resident #005 fell to the floor and sustained several injuries. The resident was sent to the hospital and came back to the home two days later.

Resident #005's health care record was reviewed and no documentation was found related to a skin assessment upon return from hospital. As such, resident #005 did not received a skin assessment upon return from the hospital on a specified date in 2018. [s. 50. (2) (a) (ii)]

2. This inspection is related to Critical Incident #2759-000021-18 reported by the Licensee on a specified date in 2018 regarding a resident fall with injury and significant change in condition of the resident that had occurred two days prior. Resident #011 was documented to have returned from the hospital on a specified day in 2018, eight (8) days after the fall.

Inspector #547 reviewed resident #011's health care records that did not have any skin assessment completed upon return from hospital until two days post return when resident #001 was observed to have identified bruising. The resident returned from hospital on a specified date in 2018 with a wound site from hospital procedure that was also not assessed until eight (8) days after the resident returned from hospital. [s. 50. (2) (a) (ii)]

3. This inspection is related to Critical Incident #2759-000023-18 reported by the Licensee on a specified date in 2018, related to hospitalization and change in condition related to resident #025 that had a fall.

Inspector #547 reviewed resident #025's health care records related to this hospitalization. Resident #025 had a fall on a specified date in 2018 and was sent to the hospital for the further assessment of two identified injuries. Resident #025 returned from the hospital the next day with a medical device in place, however no post hospital skin assessment was documented in the resident's health care records as required.

On November 20, 2018 RN #100 indicated that the skin assessments post hospitalization

were to be completed by the Registered Nurse on the evening shift of the resident's date of return from hospital. Upon review of the resident's health care records, RN #100 did not find any skin assessment completed for residents #005, #011 and #025 as required for this section. [s. 50. (2) (a) (ii)]

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

Resident #001 was observed by inspector #547 on November 7, 2018 to have a wound to an identified limb with bruises noted to other identified areas.

Inspector #547 reviewed resident #001's assessments however no skin and wound assessment was identified for the skin wound to the resident's identified limb. Resident #001's progress notes were reviewed, however the last note related to the resident's sound was on a specified date, two months prior, after the resident had a fall with skin injuries. The resident's skin was cleansed and a dressing was applied. No skin assessment was completed, or reassessments to indicate if the current open skin wound was dated from this fall. On a specified date in 2018, almost five weeks later, an old dressing was documented as removed, cleansed and covered with a dressing.

On November 20, 2018 RN #100 indicated to inspector #547 that all skin wound, tears, ulcers required an assessment in the electronic documentation system, that is to be completed once the altered skin is identified and then completed weekly.

As such, resident #001 with altered skin integrity of skin tear or wound to an identified limb did not receive any skin assessment using a clinically appropriate assessment instrument as required by this section. [s. 50. (2) (b) (i)]

5. The Licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

Inspector #547 reviewed resident #001's health care records revealing the following altered skin issues:

On a specified date in 2018, wound to an identified area as identified in the resident's progress notes that required to be cleansed and dressing applied.

On a specified day in 2018, 27 days after the above wound was identified, an initial skin and wound assessment for the resident's wound identified as stage 1 wound, was documented as deteriorated that required to be cleansed and dressing applied.

Twenty-six (26) days later, the resident was identified to have had bruises to an identified limb.

Twelve (12) days after this, the resident had a red open skin area noticed on another area of their body and identified as stage 2 wound that required to be cleansed and dressing applied.

Nine (9) days later, on a specified day in 2018, the resident had a fall with wounds to two identified areas that required to be cleansed and dressings applied.

One day after the above fall, scab and bruise to an identified limb was documented.

On a specified day in 2018, 29 days after the above entry, the resident had an old dressing remove, skin wound was cleansed and dressing was applied.

On a specified day in 2018, 72 days later, the resident was observed to have a small skin injury noted to an identified area that required to be cleansed and a dressing was applied.

Inspector #547 reviewed the resident's Electronic Medication Administration Record (EMAR) identified by the Director of Care to be where skin treatment and interventions are to be identified for residents. The EMAR for resident #001 for a six (6) month period in 2018 did not have any documented treatment or interventions required for any of the altered skin integrity issues identified above. [s. 50. (2) (b) (ii)]

6. The Licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

The DOC indicated to inspector #547 that a weekly reassessment for each skin tear, wound or ulcer is required to be completed by the registered nursing staff in the

electronic documentation system, called Point Click Care (PCC).

Inspector #547 reviewed resident #001's health care records that identified altered skin integrity issues to the three identified areas. The only weekly skin assessment on the resident health care records was that of a specified date in 2018, related to the first of three identified resident wound areas. No weekly skin assessments were identified for each of these three altered skin issues over a six month period as required by this section. [s. 50. (2) (b) (iv)]

7. Inspector #547 reviewed resident #014's health care records that indicated in the resident's Minimum Data Set (MDS) assessment dated a specific date in 2018, to have a stage two ulcer to an identified area related to mobility issues. The resident's skin assessments in the Point Click Care (PCC) documentation system was last completed four months prior to the specified date.

As such, resident #014 exhibited altered skin integrity of pressure ulcer on a specified date in 2018 did not have weekly skin assessments that continued as documented in the MDS assessment done four months later, as required by this section. [s. 50. (2) (b) (iv)]

8. On November 6, 2018, Resident #012 was observed to have three dressings. A review of resident #012's current plan of care identified the resident as having fragile skin and being at risk of altered skin integrity.
A review of the resident's health care record was conducted. It notes that since a specified month in 2018, the resident as having recurring skin integrity issues requiring the application of dressings. On a specified day in 2018, the resident was sent to hospital post fall and injury. The resident returned with dressings to four (4) injury sites. There are no weekly skin or wound assessments regarding the status of the four injury sites noted in the resident's electronic record Point Click Care (PCC) or the hard copy chart between the day of the injury and the next 32 days post injury. There is no documentation indicating if the status of these four injuries.

On a specified date in 2018, the weekly skin and wound assessment noted that the resident had a large wound to an identified limb presenting with discharge from the wound site. It did note that a dressing had been applied eight (8) days prior and it was intact. Notes indicate that this dressing was to be in place for 21 days or as needed. No further documentation regarding the status of the wound was found in the resident's health care record.

The next day, the resident was noted to have sustained a skin injury with partial tissue loss to an identified limb. A dressing was noted to have been applied. No further documentation regarding the status of the wound was found in the resident's health care record.

On a specified day in 2018, 32 days later, resident #012 sustained another injury to two identified areas. Medical orders dated the next day, gave directions for registered staff to cleanse the wounds with sterile water and to cover them with a specified dressing and to monitor the wound and dressing twice weekly. A review of two identified monthly Electronic Medication Administration Record (eMAR), where wound care dressings and treatments are documented indicated that the resident's wound was assessed three times over a four week period, on three specified dates. There was no weekly skin assessment done by registered staff regarding this wound in from the day of the injury to when the treatment order was discontinued, 28 days later.

RN #100 said to inspector #117 that when a resident has a wound with a dressing, it is the responsibility of the registered nursing staff to ensure that the wounds are assessed on a weekly basis, using the Point Click Care (PCC) skin assessment tool and that this be documented in the electronic chart. The RN #100, also said that resident #012's wounds with their associated treatments and dressings are also identified in the resident's eMAR which helps to remember when to do weekly wound assessment. RN #100 and RPN #102 could not explain as to why the PCC weekly wound assessments for resident #012 had not been completed when the resident was presenting with multiple skin injuries requiring dressings, since a specified date in 2018. The DOC said to the inspector that it is the responsibility of both the unit RN and RPN to ensure that residents presenting with wounds have weekly skin assessments and that these be documented in the resident's PCC electronic chart. [s. 50. (2) (b) (iv)]

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 when a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff upon any return of the resident from hospital [s. 50(2) (a) (ii)] and shall ensure that shall ensure that, [s.50 (2)] (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, and (iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the nutrition and hydration program required under clause 11 (1) (a) of the Act included, (e) a weight monitoring system to measure and record with respect to each resident, (i) weight on admission and monthly thereafter.

On November 19, 2018, Inspector #593 reviewed the monthly weights documented in Point Click Care (PCC) for the following residents:

Resident #007, on a specified day in 2018, the resident was weighed, the weight documented was 19.2 kg heavier than the previous month's weight. There was no recheck completed.

Resident #026 monthly weights were not documented for three consecutive months in 2018.

Resident #034 monthly weights were not documented for 6 identified months of the past 10 months in 2018.

Resident #035 monthly weights were not documented for 6 identified months of the past 10 months in 2018.

Resident #036 monthly weights were not documented for 3 identified months in 2018. On a specified date in 2018, the resident was weighed, the weight documented was 36.6 kg heavier than the previous month's weight. There was no recheck completed.

Resident #037 monthly weights were not documented for 9 identified months of the past 11 months in 2017 and 2018.

Resident #038 monthly weights were not documented for 4 identified months of the past 9 months in 2018.

Resident #029 on a specified date in 2018, the resident was weighed, the weight documented was 2.0 kg. There was no recheck completed.

Resident #002 on a specified date in 2018, the resident was weighed, the weight documented was 24.4 kg heavier than the previous month's weight. There was no recheck completed.

Resident #019 monthly weights were not documented for 8 identified months of the past 9 months in 2018.

Inspector #593 reviewed the home's policy, "Nutrition and Hydration Program, Long-Term Care, CLIN CARE 40 LTC", date revised August, 2017. Under "roles and responsibilities", for Registered Nurses (RN) and Registered Practical Nurses (RPN), it was documented to "Record resident's weight and height on admission, also measuring height yearly and weight at least monthly".

During an interview with Inspector #593 on November 19, 2018, the Registered Dietitian (RD) indicated that when they were reviewing the monthly weights, there were often missing weights as well as inaccurate weights and they were often requesting re-weighs, however only for residents that they were following that were a higher risk.

During an interview with Inspector #593, November 20, 2018, the Administrator indicated that monthly weights were supposed to be taken and documented in Point Click Care (PCC) during the first five or six days of the month. If there was a discrepancy of two or

more kilograms, then a reweigh should be done and then flagged to the Registered Nursing staff. The Administrator said that PCC does not flag any weight discrepancies. [s. 68. (2) (e) (i)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the nutrition and hydration program required under clause 11 (1) (a) of the Act included, (e) a weight monitoring system to measure and record with respect to each resident, (i) weight on admission and monthly thereafter, to be implemented voluntarily.

WN #10: 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 has failed to ensure that procedures are developed and implemented for addressing incidents of lingering offensive odours.

The following resident care areas were noted to have lingering offensive odours present on November 6, 8, 13 and15, 2018:

-the 6th floor television lounge,
-Resident #008's bedroom near the bed and easy chair covered with blankets,
-Resident #004 and #021's shared bathrooms

On November 13, 2018 housekeeper #110 indicated that there were several resident care areas that had lingering offensive odours that were not resolved with the Oxypur

neutralizer product used for these type of odours. Housekeeper #110 sprays these products in drains in these areas, such as sinks and floor drains to manage these odours, however this does not seem to work.

On November 14, 2018 PSW #112 indicated to inspector #547 that certain resident bathrooms had lingering offensive odours present, and that they have a process to change personal equipment weekly during the first bath of the week to try to limit these odours. These personal equipment items such as urinary catheter bags, urine collection containers and bedpans are supposed to be rinsed after each use, that may not be completed as required.

On November 15, 2018 PSW #133 was making resident #008's bed with fresh linen as it was bath day for this resident, and thought that there were no odours present. PSW #133 indicated the resident's mattress was not washed, as this equipment was not part of the home's process. PSW #133 thought possibly the housekeeping were responsible for washing of the mattresses.

Housekeeper #134 indicated to inspector #547 that resident's mattresses are only washed at admission and then once the resident leaves the home unless the nursing staff ask them to wash a resident mattress. Housekeeper #134 indicated that nursing staff had not informed them of the need to clean resident #008 mattress.

On November 15, 2018 the Environmental Supervisor for the home indicated that the home utilized specialized product called Oxypur that housekeeping staff have on their cleaning trolley carts. This product is to be used directly on areas that have lingering odours present, the housekeeper is then to wait five minutes, and return to clean the area. Once the area is dry, this process can be repeated if odours persist. If the housekeeper is unable to remove the lingering odour, the staff are to call the Facitity Maintenance Supervisor (FMS).

Upon observation of the resident care areas, the Environmental Supervisor indicated that the Licensee's developed procedures had not been implemented for addressing incidents of lingering offensive odours as required. [s. 87. (2) (d)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that procedures are developed and implemented for addressing incidents of lingering offensive odours, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area or a medication cart, specifically that is secure and locked.

On November 7, 2018, around 1325 hours, Personal Support Worker (PSW) #112 was observed with a trolley with personal care supplies and with two jars of prescribed medication cream belonging to residents #022 and #023.

PSW #112 indicated to Inspector #126 that the Administrator requested that all residents' rooms be checked to ensure that personal supplies are identified and to remove what does not belong in the resident's room. PSW #112 indicated that the two jars of

prescribed medication cream were found in the resident rooms.

As such, the two jars of prescribed medication cream were not stored in an area that was secure and locked. [s. 129. (1) (a)]

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

On November 21, 2018 inspector #547 observed housekeeping staff #134 enter the locked nursing station on a resident care unit. The nursing station was observed to contain unlocked prescribed creams and ointments for residents residing on the sixth floor of the home.

The nursing station is a common meeting area for staff for documentation, meetings and taking staff breaks.

The Administrator indicated the nursing station is not an area that is used exclusively for drugs and drug related supplies and should not have the prescribed creams and ointments stored here and they would have to relocate them to another location as required. [s. 129. (1) (a)]

3. The licensee has failed to ensure that controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

On November 15, 2018 at 1145 hours, inspector #117 was conducting a review of a resident care unit's controlled substances with RPN #102 when it was noted that two doses for two prescribed controlled substances for resident #004 were unaccounted for in the narcotic/controlled substances medication administration records.

Resident #004 is prescribed two controlled substances: medication #1 three times per day and medication #2 every 4-6 hours as needed. The controlled substances administration records indicated that one dose for each of these medication was missing from the doubled locked controlled substance section of the medication cart.

RPN #102 indicated that they had pre-poured medication #1's lunch time dose as well as a dose of medication #2 . These were both observed by the inspector to be located in the unlocked medication cart, with resident #004's other medication. The RPN indicated that

they always prepare resident #004's controlled substances medication in advance of the lunch time medication administration. These are then placed with the resident's other regular medication in a clear plastic medication cup. The resident's other medication are not stored in a separate locked area within the locked medication cart. When asked why medication #2 which is an as needed medication was pre-poured, the RPN said that it was because resident #004 usually asks for the as needed medication and they had prepared the medication in anticipation of the resident's potential need for the medication.

As such, medication #1 and #2, which are both controlled substances, were not stored in a separate locked area within the locked resident care area medication cart. [s. 129. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are stored in an area or a medication cart, specifically that is secure and locked, to be implemented voluntarily.

WN #12: 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).

Findings/Faits saillants :

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

Resident #027 has a medication order for specified medication that is to be administered three times a day. The medication is to be administered at 0600 hours, 1300 hours and 1700 hours.

On a specified day in 2018, RN #138 went to administer the resident's prescribed medication at 0600 hours. The RN brought the prepared medication to the resident's bedside. However, RN #138 was called away to attend to another resident's needs. The prepared medication was discovered at the resident's bedside by staff from the next shift. The resident was assessed, and noted to have no adverse effects. The resident's physician and power of attorney were notified that resident #027 had not received their prescribed medication as ordered. [s. 131. (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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rights of the resident are fully respected and promoted:

11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. Participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

On November 20, 2018, Inspector #126 was going up the public hospital stairwell outside the home and observed ripped pieces of paper on the side of the window between the 4th and the 5th floors. The pieces of paper were ripped in large pieces and the name of several residents that live on the 5th floor were observed.

Resident #007's name was documented and included the blood glucose and the blood pressure. The blood sugars were documented for resident # 004 and #026. There was a column with the name of a specified medication and four names of residents beside it. There was also the name of a resident with the vital signs documented which included temperature, blood pressure, oxygen saturation, respiration and pulse.

As such, the licensee failed to have the personal health information kept confidential for the above residents. [s. 3. (1) 11.]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

On November 14, 2018, resident #027 observed by inspector #117, during the morning medication pass with RPN #114, to be inside the bedroom at 0920 hours. At the time, the resident was noted to be elevated in a mechanical lift with PSW #125 at the resident's side. At 0935 am, the resident room door opened, PSW #125 wheeled the resident out of the room into the unit's main dining room. No other staff were noted to come out of the room. It was observed by inspector #117 that the resident was seated on top of a transfer sling, in their wheelchair.

Inspector #117 asked PSW #125 about the resident's transfer needs and how this was done this morning. PSW #125 said that PSW #126 were helping each other in providing part of resident #027's morning care, which included the resident's transfer needs. PSW #125 confirmed that the resident is a mechanical lift transfer and said that PSW #126 had provided some assistance with the resident's mechanical lift transfer this morning. Inspector #117 spoke with PSW #126 who was in the third unit dining room, providing feeding assistance to another resident. When asked, PSW #126 said that they are assigned to provide resident #027's care. However, this morning they provided assistance with a mechanical lift transfer from the bed to the commode for resident #027, with PSW #125. They then left the resident room to assist with other residents' care needs. They were not approached or asked by PSW #125 to assist with resident #027's transfer from the commode to the wheelchair.

Inspector #117 spoke with resident #027 regarding who had provided their care this morning. The resident indicated that PSW #125 was the only staff member who provided care to them this morning.

A review of the resident's current plan of care identified that the resident is a two-person mechanical lift transfer. At the resident's bedside, there is a transfer log identifying that the resident is a two-person mechanical lift transfer. The Administrator and DOC both said to the inspector that the home's transfer policy if very clear that two staff are to be present and assist with any mechanical lift transfers.

On November 15, 2018, the Administrator confirmed that they had spoken with both PSW #125 and #126 regarding the transferring techniques use during resident #027's November 14, 2018 morning care routine. The Administrator said that PSW #125 completed by themselves the resident's transfer from the commode to the resident's wheelchair. The Administrator said that the home's policy and the resident's plan of care required that there be 2 staff members to ensure safe mechanical lift transfers.

As such, PSW #125 did not use safe transferring techniques when assisting resident #027 with their transfers from a commode to a wheelchair. [s. 36.]

WN #15: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee responds in writing within 10 days of receiving Family Council advice related to concerns or recommendations.

Inspector #547 reviewed the Licensee's Family Council Minutes 2018 to date and the following concerns were identified:

The January 30, 2018 minutes section 5.3 hot water on level 6 washing machine was identified. The Family Council identified concern that the 6th floor washing machine does not function with hot water. The Assistant to the Family Council had put in a request to have this washing machine checked and repaired as required as a response to the Family Council.

The March 27, 2018 minutes section 4.1 regarding business arising from previous minutes that the hot water function is still not working in the 6th floor washing machine.

The Administrator indicated as response to verify this concern with facilities management to ensure that the machine repair is addressed. The Administrator indicated there was no initial record of this repair request from the January 2018 meeting. A service repair request was made by the Administrator on March 28, 2018 to facilities management. The Administrator provided inspector #547 a copy of an email from the President of Family Council dated April 23, 2018 that restated the Family Council concern that the 6th floor washing machine required repair. The Administrator responded to the President of Family Council in an Email the same day to indicate that the washing machine required a new part, and that the floor will need to be replaced. This written response to the Family Council was 27 days after the Licensee was made aware of this concern, and 83 days from the initial concern raised at the January 2018 meeting.

The May 29, 2018 minutes section 5.5 regarding concern for the main lobby chairs that were covered in fabric and used by numerous residents on the 6th floor that posed numerous hygienic issues. Action identified in the minutes indicated the Administrator would follow-up with the president of Family Council. These concerns were identified to the Licensee on June 14, 2018. The meeting minutes were shared with the Family Council by Email July 11, 2018, 27 days after this concern was identified to the Licensee. No other records could identify any response to the Family Council within 10 days as required by this section.

The September 25, 2018 minutes section 5.1 regarding concerns of serving residents at the tables before nursing staff are available to assist the residents. The minutes documented a response from the Administrator to indicate that this issue would be addressed with staff. The September 25, 2018 minutes were shared with Family Council on October 10, 2018, twelve days after this concern was brought to the Licensee's attention. [s. 60. (2)]

WN #16: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 67. A licensee has a duty to consult regularly with the Residents' Council, and with the Family Council, if any, and in any case shall consult with them at least every three months. 2007, c. 8, s. 67.

Findings/Faits saillants :

1. The licensee has failed to ensure that they consult regularly with the Residents' Council at least every three months.

Inspector #126 interviewed the President of the Resident Council who indicated that the last Residents' Council was held in May 2018, therefore there was no Residents' Council meetings or consultations between May 2018 and November 2018.

Recreation Therapist #136 and the Administrator indicated to Inspector #126 that the last Residents' Council meeting was conducted in May 2018.

As such, the licensee did not consult with the Residents' Council at least every three months as required. [s. 67.]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(e) menu substitutions that are comparable to the planned menu; O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that at a minimum, the food production system must provide for (e) menu substitutions that are comparable to the planned menu.

Inspector #593 observed that the posted menu in both the fifth and sixth floor dining rooms was dated March 9, 2018. This was the menu currently in rotation at the home.

Inspector #593 reviewed the menu cycle dated March 9, 2018. The cycle was 21 days in length.

Inspector #593 found the following:

• Documented for 30/42 lunches and dinners, the minced/pureed menu was different to the regular menu for one or both of the choices.

• Of the choices that were comparable, multiple choices offered the same protein however the meal itself was not comparable:

Day 3 lunch- one of the choices on the regular menu was meat lasagna, the minced/pureed option was minced/pureed beef.
Day 7 lunch- one of the choices on the regular menu was chicken pot pie, the minced/pureed option was minced/pureed chicken.
Day 9 lunch- one of the choices on the regular menu was butter chicken, the minced/pureed option was minced/pureed chicken.
Day 11 lunch- one of the choices on the regular menu was meat lasagne, the minced/pureed option was minced/pureed beef.
Day 12 lunch- one of the choices on the regular menu was teriyaki meatballs, the minced/pureed option was minced/pureed beef.
Day 14 lunch- one of the choices on the regular menu was chicken al la king, the minced/pureed option was minced/pureed chicken.
Day 15 lunch- one of the choices on the regular menu was sweet and sour meatballs, the minced/pureed option was minced/pureed beef.
Day 17 lunch- one of the choices on the regular menu was sweet curry chicken, the minced/pureed option was minced/pureed chicken.
Day 20 lunch- one of the choices on the regular menu was chilli con carne, the minced/pureed option was minced/pureed beef.
Day 20 dinner- one of the choices on the regular menu was chicken pot pie, the minced option was minced chicken pasta and this option was not available in pureed.

During an interview with Inspector #593, November 19, 2018, the Registered Dietitian (RD) indicated that they had not reviewed and approved the current menu before it was implemented in March, 2018. The RD was not sure why the minced/pureed menu was so different to the regular menu, however indicated that it could be a supply issue.

During an interview with Inspector #593, November 19, 2018, Food Service Supervisor (FSS) #141 indicated that they were more limited with the minced and pureed menu, as they do not have the staff or the resources to mince and puree on-site. FSS #141 added that the menu depended upon the availability of that item as all the meals were pre-prepared and then delivered to the home. If the same menu item was not available in minced and pureed, they may be offered something different to the regular menu. [s. 72. (2) (e)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home has a dining and snack service that included the following elements: 6. Food and fluids being served at a temperature that was both safe and palatable to the residents.

During stage 1 of the RQI, several residents indicated that the meals being served were not hot enough for their enjoyment.

During an interview with Inspector #593, November 16, 2018, resident #007 indicated that the food was often not hot enough when it was served. Resident #007 described the food being served as "luke warm" and added that they will add a sugar packet to the food, to make it more palatable.

During an interview with Inspector #593, November 16, 2018, resident #006 indicated that the food was never hot enough. Resident #006 described the food as being "always cold".

During an interview with Inspector #593, November 16, 2018, resident #004 indicated that the food was never hot enough. Resident #004 said that "the food was rarely hot enough" and would like the food to be served hotter. When asked if the staff heated it up for the resident, resident #004 replied "no, they are too busy".

During an interview with Inspector #547, November 23, 2018, resident #033 indicated that the food was often cold, however when they asked the staff to reheat the food, the resident was ignored and the staff would walk away.

Observations of the fifth floor dining room during the breakfast meal period on November 14th, 2018, found that the service started late as the Dietary Aide (DA) who was scheduled was sick and this shift was not replaced. The breakfast meal service for the fifth floor was scheduled to start at 0800 hours, which is when the hot food was delivered to the servery. At 0900 hours, it was observed that out of 20 residents seated in the dining room, two had been served toast, one served cereal. No resident had yet to be served the hot portion of the meal.

During an interview with Inspector #593, November 14, 2018, Dietary Aide (DA) #146 indicated that the food usually arrived in the servery at 0800 hours. DA #146 said that the temperature checks were supposed to be completed when the food arrived however it was not completed this morning as there were no staff in the servery when the food was delivered. When asked about checking the temperature at the end of the meal service, DA #146 replied "no, we don't do that".

Inspector #593 reviewed the menu sheets/temperature records for the following (it was noted that there were two columns for recording temperatures):

November 14, 2018- Breakfast fifth floor: No temperature checks were completed for this meal service.
November 14, 2018- Lunch fifth floor: Temperature checks were not completed for the end of the meal service.
November 15, 2018- Breakfast fifth floor: Temperature checks were not completed for the end of the meal service.
November 15, 2018- Breakfast sixth floor: Temperature checks were not completed for the end of the meal service.

During an interview with Inspector #593, November 19, 2018, DA #144 indicated that they were the regular DA for the sixth floor dining room. DA #144 added that there were several residents who regularly complained that the food was not hot enough and that certain pans of food delivered from the kitchen were consistently not hot enough and had to be reheated in the servery. There have also been times where the pan of food has arrived frozen in the middle.

During an interview with Inspector #593, November 20, 2018, Food Service Supervisor (FSS) #141 indicated that the temperature of the food was to be taken and documented as soon as the cart arrived to both serveries located on the fifth and sixth floors. FSS #141 explained that the temperature was also to be taken at the end of the meal service

to ensure that the food being served had retained heat during the service and maintained a minimum temperature. FSS #141 added that this was something they were constantly working on as the second temperature checks were usually not completed. When asked about historical data of the temperature checks completed at the end of the meal service, FSS #141 said that they do not have this information as it has been a long period since the temperature checks at the end of the meal service have been completed. [s. 73. (1) 6.]

Issued on this 14th day of February, 2019

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

Original report signed by the inspector.

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

Ministère 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) :	LISA KLUKE (547), GILLIAN CHAMBERLIN (593), LINDA HARKINS (126), LYNE DUCHESNE (117)
Inspection No. / No de l'inspection :	2018_621547_0036
Log No. / No de registre :	029079-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 6, 7, 2018; Feb 12, 2019
Licensee / Titulaire de permis :	Bruyère Continuing Care Inc. 43 Bruyère Street, OTTAWA, ON, K1N-5C8
LTC Home / Foyer de SLD :	Élisabeth-Bruyère Residence 75 Bruyère Street, OTTAWA, ON, K1N-5C8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Chantale Cameron

To Bruyère Continuing Care Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 901

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 230. (5) The licensee shall ensure that the emergency plans address the following components:

1. Plan activation.
2. Lines of authority.
3. Communications plan.
4. Specific staff roles and responsibilities. O. Reg. 79/10, s. 230 (5).

Order / Ordre :

The licensee must be compliant with O.Reg 230(5).

Specifically the Licensee shall ensure:

1. Staff working in the home during the next 24 hours post serving of this order, review the Licensee's emergency plan "SCATEE process" for fire and smoke and that the review be documented;

2. During the next 24 hours the Licensee is to assess the health and emotional status of residents #006, #007, #021, and any other residents exhibiting symptoms related to this incident that occurred on November 6, 2018 in the fifth floor servery, over the next 24 hour period, and that these assessments be documented in the resident's health care record.

Grounds / Motifs :

1. The licensee has failed to ensure that their emergency plans addressed the following components:
1. Plan activation,
2. Lines of Authority,
3. Communication plans,
4. Specific staff roles and responsibilities.

On November 6, 2018, on a unit servery, during the lunch time meal service, Personal Support Worker (PSW) #101 put a food item in the servery microwave

for it to be reheated. The PSW left the servery to attend residents in the unit's main dining room.

Dietary Aide (DA) #103 noted that there was a fire and smoke in the microwave. The Dietary Aide stopped the microwave oven and removed the food item. There was the presence of grey smoke in the servery, billowing out into the dining room and unit hallway. There were several residents and staff in the dining room. Residents remained seated with staff in attendance.

Dietary Aide #103 called "222", the home's emergency call centre to advise them of the smoke. Three staff members came up to assess the situation. Grey smoke was observed by Ward Clerk #111, inspector #126 and PSW #101 in the dining room adjoining the servery and no alarm was activated. No residents were noted to be in distress.

Resident #007 was observed to be talking to maintenance attendant #109 and expressing their concerns related to the smoke and nothing being done.

Resident #021 was in the dining room and informed inspector #126 that they had an irritated throat due to the smoke and was upset that no one had done anything to address the smoke.

Resident #006 was in the smaller dining room across from the servery. The resident told Inspector #547 that there was lots of smoke. Resident #006 was coughing, hiding their mouth and nose with a clothing protector and was upset.

This incident was discussed at 1305 hours with the Administrator, the Director of Emergency Management, Environmental Services and Telecommunications (DEMEST), the Manager of Facilities Management and a Maintenance Engineer. The Maintenance Engineer said that they received a call from "222" that there was smoke from burnt toast on the 5th floor and made the decision to bypass the fire alarm system and send some staff to the 5th floor unit.

The Manager of Facilities Management said that the bypass was done because the source of the smoke was burnt toast. They said that it was the right decision in this situation to bypass the fire alarm as the alarm is for the whole building.

The Administrator and the DEMEST said that all staff know the fire process of SCATEE (save, contain, alarm, telephone, evacuate and extinguish) and are expected to implement this process as soon as smoke is discovered. The DEMEST said that it is the licensee's expectation for all staff to react and remove residents from the affected area. [s. 230. (5)]

(547)

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

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

Ministère 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 : 902

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 130. 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.

Order / Ordre :

The licensee shall comply with O.Reg. 79/10 s. 130 (1)
The licensee shall ensure that:
a. Medication carts are locked at all times when not in use and,
b. The medication room keys are kept at all time in the possession of registered nursing staff and not left unattended.

This is to be demonstrated immediately.

Grounds / Motifs :

1. Every licensee of a long-term care home shall ensure that steps are taken to ensure that security of the drug supply, including the following: All areas where drugs are stored shall be kept locked at all times, when not in use.

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

On November 6, 2018 Inspector #547 observed RPN #114 working on one of the resident care units and was responsible for the medication cart.

At approximately 1115 hours, Inspector #547 observed this unit's medication cart unlocked and accessible to residents on this unit. This cart was observed to be unsupervised by any registered nursing staff. The resident care unit was identified during this inspection to have several residents with dementia and wandering behaviours.

At approximately 1158 hours, Inspector #547 observed the same medication cart located outside the dining room on the unit to be unlocked. This cart was observed to be unsupervised by any registered nursing staff. Inspector #547 observed resident #024 wandering outside this dining room next to this medication cart. Resident #024 is cognitively impaired with wandering behaviours identified in the resident's plan of care.

Inspector #547 interviewed RPN #114 on both these occasions who indicated that medication carts are required to be kept locked at all times when unsupervised for safety.

The next day, Inspector #547 observed RPN #113 working on the same resident care unit and to be responsible for the medication cart. At approximately 1200 hours, Inspector #547 observed the unit's medication cart located outside the dining room on the unit to be unlocked. Several residents were observed walking in this hallway outside this dining room next to this medication cart to go to lunch. This unlocked medication cart was unsupervised by any registered nursing staff. RPN #113 indicated to be running late and was not aware that the medication cart was required to be locked at all times.

That same day, at 1245 hours on the same unit, it was observed by inspector #117 that the medication cart was unlocked and unsupervised. The unit RPN #113 was in the unit main dining room giving medication to a resident. The RPN could not be seen from the medication cart. The RPN returned to the cart. RPN #113 said to inspector #117, when asked about the security of the medication cart, to not be aware of having left the medication cart unlocked when the RPN left to administer a medication to a resident.

At approximately 1325 hours, inspector #547 observed the same unit's medication room, located in a common area that had a set of keys inserted in the door locking mechanism. Inspector #547 was able to open the door to the

medication room that was not supervised by any registered nursing staff. Inspector #547 observed three residents wandering around this area with their walkers as well as other residents in wheelchairs outside this medication room.

At approximately 1330 hours, inspector #547 brought the medication room keys to the Administrator, who indicated that these keys are supposed to be kept with the registered nursing staff at all times, and should not be left unattended or inside the locking mechanism of the medication room for resident safety. The Administrator further indicated that medication carts are expected to be kept locked at all times when unsupervised by registered nursing staff. [s. 130. 1.] (547)

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

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. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(a) is a minimum of 21 days in duration;
(b) includes menus for regular, therapeutic and texture modified diets for both meals and snacks;
(c) includes alternative choices of entrees, vegetables and desserts at lunch and dinner;
(d) includes alternative beverage choices at meals and snacks;
(e) is approved by a registered dietitian who is a member of the staff of the home;
(f) is reviewed by the Residents' Council for the home; and
(g) is reviewed and updated at least annually. O. Reg. 79/10, s. 71 (1).

Order / Ordre :

The Licensee must be compliant with O. Reg. 79/10, s. 71.(e).

Specifically, the licensee shall ensure that:

1. The home's menu cycle is reviewed and approved by a Registered Dietitian who is a member of the staff of the home,

2. The Food Service Supervisor documents menu revisions/changes and receives approval from the Registered Dietitian prior to sending the menu for production, and

3. The texture modified menu cycle is comparable to the regular menu cycle.

Grounds / Motifs :

1. The licensee has failed to ensure that the home's menu cycle was approved by the Registered Dietitian (RD), who is a member of the staff of the home.

During an interview with Inspector #593, November 19, 2018, Food Services

Supervisor (FSS) #141 indicated that the current menu cycle was reviewed and approved by the RD in January, 2018. At the time of the interview, FSS #141 did not have the documentation to support this however advised that it would be provided the following day.

On November 20, 2018, a copy of the current menu cycle dated March 9, 2018 and current snack menu dated February, 2018 were provided to Inspector #593.

The following statement was documented on the menu cycle:

"Please take note that I (name- RD) have reviewed the EBR menu cycle and have indicated my concerns/questions/adjustments to follow up with food service as appropriate". Dated: November 7, 2018

The following statement was documented on the snack menu:

"Please take note that I (name- RD) have reviewed the snack menu cycle and have indicated my questions/concerns to communicate to food service and follow up as appropriate". Dated: November 7, 2018

A review of the documented "Nutrition and Hydration Program", CLIN CARE 40 LTC, date revised August, 2017, found that the Dietitian will:

• Approve resident menus as developed by the Food Services department, ensuring that the menus meet the residents' nutritional and hydration intake requirements, and approve updated menus at least annually.

During an interview with Inspector #593 on November 19, 2018, the RD reported that they reviewed the current menu cycle last week, and prior to this, the last time they had completed a review of the menu cycle was approximately one year. The RD added that they had many comments and concerns and that once these had been addressed, the RD would approve the menu.

The review and approval of the menu cycle by the Registered Dietitian (RD) includes the regular menu, the snack menu, beverages, and the menu's for residents requiring a therapeutic diet who are also a higher nutritional risk, including those residents requiring a texture modified diet.

Non-compliance was also found related to the texture modified menu cycle and the comparability to the regular menu cycle (refer to WN #17). When the RD did review the menu cycle during the RQI, the RD documented concerns related to repetition of the texture modified menu and did not approve this menu at the time of review.

As indicated by the date stamps on the current menu cycle, the menu cycle was implemented in February and March, 2018. The licensee was unable to provide any evidence indicating that the current menu cycle was reviewed and approved by the RD and as indicated by the RD, the current menu cycle was not reviewed by the RD until early November, 2018 and has yet to be approved. [s. 71. (1) (e)]

The scope of the non-compliance is identified as being a pattern and the severity is identified as being that of minimal harm or the potential for actual harm. The compliance history is identified as being a level 4) in that despite MOH action (VPC, order), non-compliance continues with the original area of non-compliance.
• O.Reg 71 (3) b – was issued as a compliance order under inspection # 2016_330573_0014 on June 20, 2016. This was re-issued as an order on October 6, 2016.
• O.Reg. s. 71 (3) b and c – were re-issued as a compliance order under inspection # 2016_450138_0032 on October 6, 2016. This was found to be in compliance on December 22, 2016.
(593)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2019

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

Ministère 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 : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The Licensee must be compliant with O. Reg. 79/10, s.114(3)a.

Specifically, in order to ensure compliance with the medication management system, the licensee shall:

1. Provide training to RPN #102, #114, #115 and any other registered nursing staff regarding the Licensee's policy on medication administration practices,

2. At a minimum, ensure adherence to the home's policies and procedures related to the dispensing of regular and as needed (PRN) medication; administration of the medication and documentation of medication administration, by conducting weekly audits on all three shifts for a period of 4 consecutive weeks, and

3. Take immediate corrective action if deviations from the home's policies and procedures are identified.

A written record must kept of everything required from 1-3.

Grounds / Motifs :

1. The licensee failed to ensure that the written policies and protocols for the medication management to ensure the accurate storage and administration, of

all drugs, are implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

As per O.Reg. s. 114, the licensee has the following policies regarding medication administration:

Medisystem Policy MEDI-CL-003, dated 01-Oct-2018: Medication Pass

6.4 – Medication administration is a continuous process and is always to be completed for the specific resident before moving on to another resident's medication or request.
6.8 – The nurse who prepares a medication or injection for administration, must administer it.
6.9 – Approach the resident when all medications to be given are prepared. Verify the resident's identify using two identifiers. Administer medications to the resident ensuring that ll oral medications have been swallowed Do not leave medications at bedside. Do not ask someone else to administer the medication; medication administration is a continuous process.
6.11 – Initial the MAR sheet for each medication.

Medisystem Policy MEDI-CL-ONT-042, dated 01-Oct-2018: Narcotic and Controlled Substances Administration Record

4. – When a new order of a narcotic or controlled drug arrives, it must be kept locked in the narcotic bin with its Narcotic and Controlled Substance Administration Record until ready for use.

5. – All entries must be made at the time the drug is removed from the container

On November 15, 2018 at 1145 hours, inspector #117 was conducting a review of a resident care unit's controlled substances with RPN #102 when it was noted that multiple doses for three prescribed controlled substances for resident #004 were unaccounted for in the narcotic / controlled substances medication administration records.

Resident #004 was prescribed three controlled substances: one medication (#1) to be administered twice daily, one medication (#2) to be administered three

times per day and another medication (#3) to be administered every 4-6 hours as needed. The controlled substances administration records indicated that one dose of medications #1 and #3 as well as two doses of medication #2 were missing from the doubled locked controlled substance section of the medication cart. The Narcotic and Controlled Substances Administration Record indicated that there was no documentation related to the missing controlled substances.

RPN #102 indicated that they had administered resident #004's morning dose of medication #1 and #2, however they had not documented the administration of these controlled substances in the Narcotic and Controlled Substance Administration Record at the time of administration. RPN #102 said that they often do not have time to document the administration of medication immediately after their administration, as required by the Licensee's policy.

RPN #102 also said that they had pre-poured a second tablet of medication #2 as well as one tablet of medication #3 for resident #004's next medication pass. These controlled substances were both observed by the inspector to be located in the unlocked medication cart, with resident #004's other medication. The RPN indicated that they regularly prepare resident #004's controlled substances medication in advance of the lunch time medication administration and do not document the removal and administration of the controlled substances until later in the day. When asked why the medication #3, an as needed medication, was pre-poured, the RPN said that it was because resident #004 usually asks for the as needed medication and they had prepared the medication in anticipation of the resident's potential need for the medication. The inspector asked RPN #102 in regards to the Licensee's policies related to the pre-pouring of medication and the documentation of controlled substance. RPN #102 said to the inspector that the Licensee's policies regarding medication administration and documentation are such that registered staff are to prepare medication for administration at the time of administration and to document medication administration immediately post-administration.

On November 14 and 15 2018, RPN #114, #115 and #102 said to the inspector that they have some difficulties with the documentation of medication administration. All three registered staff members said that the eMAR system on the medication carts is very slow and they often are unable to document the administration of resident medication in the electronic eMAR at the time of

administration. They reported that they often complete the eMAR medication documentation after their medication pass, at the nursing station. It is noted that on November 15 and 19, 2018, RPN #102 was observed by the inspector to be documenting the 0800 hours/0900 hours medication pass in one of the resident care units' documentation room at approximately 1050 hours.

RPNs #114, #115 and #102 are aware of the home's policy that all administered medication are to be documented in the eMAR at the time of administration. They reported that this has been an ongoing issue since the eMAR system was implemented approximately 2 years ago.

On November 15, 2018 with the DOC and Administrator said that they were not aware of any reported issues with eMAR documentation delays or issues. They both said that registered staff are to implement the Licensee's medication administration policies to ensure that medications/controlled substances are not to be prepared until their time of administration and that administered medications/ controlled substances are to be documented as administered at the time of administration.

As such, registered staff did not implement the Licensee's policies related to the administration and documentation of medication / controlled substances. [s. 114. (3) (a)]

The scope of the non-compliance is identified as being widespread and the severity is identified as being that of minimal harm or the potential for actual harm.
The compliance history is identified as being a level 3) in that there are one (1) or more related non-compliances regarding in the last 3 years.
• O.Reg. s.130 Security of Drug Supply – was issued as an immediate compliance order CO #902 under this inspection # 2018_621547_0036 on November 7, 2018. This order was found to be in compliance on November 13, 2018.
• O.Reg s.131 (3 and 5) Administration of Drugs – were issued as a VPC under inspection # 2018_549592_0002 on February 23, 2018.
• O.Reg s.129 (1) Safe Storage of Drugs – was issued as a VPC under inspection # 2018_619550_0006 on June 12, 2018.

• O.Reg s.129 (1) Safe Storage of Drugs – was issued as a VPC under inspection # 2018_549592_0002 on February 23, 2018.
• O.Reg s.129 (1) Safe Storage of Drugs – was issued as a VPC under inspection # 2017_683126_0016 on November 7, 2017.
• O.Reg s.129 (1) Safe Storage of Drugs – was issued as a VPC under inspection # 2016_330573_0014 on June 20, 2016
(117)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2019

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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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 6th day of November, 2018

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lisa Kluke

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