Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 21, 2017	2017_509617_0022	024217-17	Resident Quality Inspection

Licensee/Titulaire de permis

SIOUX LOOKOUT MENO-YA-WIN HEALTH CENTRE
Fifth Avenue South PO Box 909 SIOUX LOOKOUT ON P8T 1B4

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

William A. 'Bill' George Extended Care Facility
75 FIFTH AVENUE SIOUX LOOKOUT ON P8T 1K9

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

SHEILA CLARK (617), DEBBIE WARPULA (577)

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 20-24, 2017, and November 27-December 1, 2017

During the course of the inspection, the inspector(s) conducted a tour of resident home areas, observed the delivery of care to residents, observed resident to resident and staff to resident interactions, reviewed resident health care records, and reviewed various home policies, procedures, and programs.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (AD/DOC), Resident Assessment Instrument (RAI) Coordinator, Environmental Services Supervisor, Accounts Receivable Clerk, Dietitian, Physiotherapist, Physiotherapist Aide, Pharmacist, Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Activity Aides (AAs), Aboriginal Interpreter, Mental Health Worker, residents and family members.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Skin and Wound Care
Trust Accounts

During the course of this inspection, Non-Compliances were issued.

8 WN(s)
7 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (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 the plan of care was provided to the resident as specified in the plan.

Inspector #617 interviewed resident #001's family member who had a concern that the resident was not provided with daily exercises resulting in a decline in their health status.

In an interview with the Physiotherapist (PT), they reported that they had assessed resident #001's mobility to be limited. The PT further explained that they had developed daily exercises to maintain a certain level of mobility that the nursing staff were to provide to the resident to be documented on the "physiotherapy exercise" forms.

A review of resident #001's physiotherapy documented assessment, current at the time of inspection, indicated that the resident's goal was to maintain their range of motion and strength. Their treatment plan to maintain this goal, was to be provided by the way of an individual seated exercise program and participation in the group exercise program.

On one occasion, Inspector #617 observed resident #001 in attendance at a group exercise program conducted by AA #100. The resident was observed to be participating in the group program.

In an interview with AA #100, they reported that they offered the group exercise program in which resident #001 had participated five days a week and showed the Inspector documentation of the resident's participation.

A review of resident #001's group exercise participation indicated that for the month of November 2017, they had participated in group exercise 100 per cent of the time when the program was offered.

A review of resident #001's care plan current to the time of inspection, indicated that the resident had a decline in their mobility and the staff were to provide an individual daily exercise program as recommended by the physiotherapist.

In an interview with PSW #115, they confirmed to the Inspector that to maintain resident #001's mobility, PSW staff were to provide the resident with daily individual exercises developed by the physiotherapist and that the AA department was to provide the resident a group exercise program. PSW #115 further explained that at times some staff did not provide the daily individual exercises to the resident. PSW #115 reported that staff provision of the resident's daily exercises were documented on the physiotherapy exercise form.

A review of resident #001's individual exercise program documentation indicated that they were to receive five specific range of motion exercises affecting different parts of their body on a daily basis.

The documentation indicated that for a four week period in November 2017, they were to receive the range of motion exercises on 25 occasions and signed documentation was missing for 18 of those 25 occasions, or 72 per cent of the time.

In an interview with the AD/DOC they clarified with the Inspector that resident #001 was to receive individual strengthening exercises provided by the PSW staff and participate in a group exercise program provided by the Activity Aide. The AD/DOC further expected that the PSW staff were to document the exercises provided. [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 plan of care is provided to resident #001 as specified in the plan regarding their exercise program, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's Medication Administration Program was complied with.

On November 27, 2017, Inspector #577 conducted a narcotic count with RPN #109. The Inspector observed three bottles of specific controlled substance medications labelled for resident #010. RPN #109 reported to the Inspector that they did not record and count those types of controlled drugs.

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

Inspector #577 reviewed the home's policy titled "Narcotic and Controlled Drugs – Control and Issue – PH.4.10" last revised July 18, 2014, which indicated that narcotics and controlled drugs were to be regulated in the hospital according to the Narcotic Control Act ensuring security and accountability of usage, wastage, and destruction.

Inspector #577 interviewed the AD/DOC to determine the home's practice for recording controlled medication. Together, the AD/DOC and the Inspector inspected the homes narcotic box, to find two bottles of specific controlled substances. The AD/DOC confirmed that staff had not been counting and recording the specific controlled substances on the narcotic count sheet. They further reported that the specific medication in question was considered to be a controlled substance, which required staff to be recording on the narcotic sheet. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's Medication Administration Program is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

The licensee has failed to ensure that when a resident had fallen, the resident was assessed and that where the condition or circumstances of the resident require, a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

1. Inspector #577 conducted a record review of resident #006's health care records and found that the resident had 11 documented falls in a period of two months.

Inspector #577 reviewed the home's policy titled "Fall prevention and Management Program - LTC.2.90" last revised July 7, 2017, which indicated that staff were to document the following post fall:

-24 hours (hrs) post fall, staff were document a 24hr post fall assessment on the Medication Administration Record (MARS);

-complete an incident report;

-progress notes were to include the date and time of incident and location of incident, whether the fall was witnessed or unwitnessed, the status of the resident (type and severity of injury), that the physician and the substitute decision maker (SDM) was notified, probable cause of fall, resident outcomes and interventions taken to prevent falls;

-a fall risk assessment using the Scott Falls Risk Tool would be conducted within 24 hrs of admission, a serious fall injury/multiple falls, with any significant change in condition and quarterly; and

-a Morse Fall Scale/assessment was re-done for residents who have had two falls in 72 hrs; more than three falls in three months; more than five falls in six months.

A review of the progress notes and fall incident reports for resident #006's falls determined that there wasn't a progress note that detailed the two falls which occurred in September 2017, and that the subsequent progress notes identifying the two falls did not contain documentation of interventions taken to prevent falls.

Inspector #577 conducted a review of the MARS for a specific month in 2017, which did not contain a 24 hr post fall assessment for seven of the documented falls during that month. A review of the MARS for a specific month in 2017, did not contain a 24 hr post fall assessment for two falls that occurred that month.

A further record review revealed a Scott Falls Risk Tool was completed on two occasions and the Morse Fall Risk Assessment Tool was completed on one occasion for the 11 falls that the resident experienced.

2. A Critical Incident System (CIS) report was received by the Director on a specific date in November 2017, related to resident #008's fall which resulted in injury.

Inspector #577 conducted a record review of resident #008's progress notes and fall incident report which confirmed that the resident had a fall on a specific date in November 2017, and the home determined an injury had occurred a few days post fall.

A review of the progress notes did not contain documentation of interventions taken to prevent falls. Additionally, a Scott Falls Risk Tool was not completed after the fall which resulted in injury.

Inspector #577 spoke with the RAI Coordinator who confirmed that the Scott Falls Risk Tool was not completed after the fall on a specific date in November 2017, when the resident had a significant change in condition.

3. Inspector #577 conducted a record review of resident #008's health care records and found that the resident had three documented falls over a three month period.

A review of the progress notes did not contain documentation of interventions taken to prevent falls. Additionally, a review of the MARS during that three month period, did not contain documentation of a 24 hr post fall assessment for two documented falls.

Inspector #577 spoke with RPN #108, who reported that a Scott Falls Risk Tool was done quarterly and when there was a change in the resident's condition. They further reported that they document a fall assessment in the progress notes.

Inspector #577 spoke with RPN #109 who reported that post fall, staff were to perform a head to toe assessment, they would then notify family, document an incident report and progress note; and 24 hrs after the fall they were to initial on the MAR that they have assessed the resident.

Inspector #577 spoke with RPN #103 who reported that post fall, staff were to document a progress note which would include the location of the fall, vital signs, any injuries, and pain. They further reported that an incident report would be completed, a 24 hr post fall assessment on the MARS would be documented and a Morse Fall assessment was to be done on admission, quarterly if the resident was was a high risk for falls and done annually if the resident a low risk for falls.

During an interview with the AD/DOC on November 29, 2017, they reported that post fall, staff were required to perform a head to toe assessment, assess vital signs, assess the resident 24 hr post fall, document a progress note and incident report, and notify the family and physician. They further reported that staff did a Scott Falls Risk screen when there has been a significant change in condition. The AD/DOC and the Inspector reviewed together the health care records for resident #006, 008 and #009, which included the missing documentation of their progress notes, incident reports, MARS, Scott Falls Risk tools and Morse Fall risk tools. They confirmed with the Inspector that staff were not following the home's fall policy. [s. 49. (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 when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee has failed to ensure that, for each resident demonstrating responsive behaviours, the behavioural triggers for the resident were identified, where possible.

1. Resident #005 was identified as requiring additional inspection regarding worsening responsive behaviours through the Resident Assessment Instrument Minimal Data Set (RAI MDS) over a 6 month period.

A review of resident #005's RAI MDS current to the date of inspection, indicated that they exhibited three specific types of responsive behaviours during that assessment period. A review of resident #005's care plan current to the date of inspection, identified one type of responsive behaviour and interventions to manage behaviours and safely provide care to

the resident. The care plan did not indicate the triggers that would result in the resident's responsive behaviour.

A review of the home's policy titled, "Responsive Behaviour Management Program in Long Term Care-#LTC2.10" last revised on August 29, 2016, indicated that understanding the sources/underlying causes of responsive behaviour was key to providing the optimal care for a resident. Responsive behaviours were a response to circumstances within the social or physical environment that may be frustrating, frightening or confusing to a person. The key aspect of resident care was to prevent or minimize the situations in which a resident exhibited responsive behaviours.

In an interview with RPN #103 and PSW #106 they both respectively described to the Inspector specifically what would would trigger resident #005 to demonstrate responsive behaviours. RPN #130 further explained that when resident #005 was not exposed to the trigger, they did not display responsive behaviours to staff or other residents and families. PSW #106 further explained that staff who were aware of the identified responsive behaviour trigger would be able to provide safe personal care to resident #005. Staff who were not familiar with the resident's responsive behaviour trigger would provide care that would initiate the responsive behaviour to occur in resident #005.

Both RPN #103 and PSW #106 reviewed resident #005's care plan and confirmed to the Inspector that the care plan did not indicate the triggers for responsive behaviours regarding care provision. [s. 53. (4) (a)]

2. Resident #006 was identified as requiring additional inspection regarding worsening responsive behaviours through the RAI MDS dated from a period over six months.

A review of resident #006's RAI MDS current to the date of inspection, indicated that they exhibited two different types of responsive behaviours. A review of resident #006's care plan current to the time of inspection, indicated that the resident exhibited behavioural symptoms and interventions to manage the behaviour. The care plan did not specifically identify the type of behavioural symptoms or their triggers.

During interviews with RPN #103 and PSW #106, they both described to the Inspector three specific situations that would trigger the resident to exhibit four specific responsive behaviours which resulted in upsetting themselves and other residents. PSW #106 further explained that if not approached correctly, resident #006 would react in a way that would prevent the staff from providing care.

Both RPN #103 and PSW #106 reviewed resident #006's care plan and confirmed to the Inspector that the care plan did not indicate the triggers for responsive behaviours regarding care provision.

In an interview with the AD/DOC they confirmed to the Inspector that responsive behaviour triggers were required to be identified in the resident's care plan to assist the staff in providing consistent care to the resident. [s. 53. (4) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that, for each resident demonstrating responsive behaviours, the behavioural triggers for the resident are identified, where possible, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the Residents' Council advised the licensee of concerns or recommendations, that the licensee, within 10 days of receiving the advice, responded to the Residents' Council in writing.

Inspector #617 reviewed copies of the minutes for the Residents' Council meetings held at the home on March 28, 2017, June 27, 2017, and September 26, 2017. The minutes posted for all three meetings identified that the meeting held in March documented the following resident concerns and recommendation:

-wait times for staff assistance with care was too long and sometimes took a half hour after they acknowledged the call bell and the help arrived,
-one resident had requested more assistance be given to them to and from the dining room, and
-food offered in the dining room during meals was disliked and required improvement.

A review of the attendance listed for the March 28, 2017, meeting indicated that 12 residents were in attendance including the president of the Residents' Council, resident #011. Also present at this meeting was AA #105 and the Interpreter for Ojibway and Cree languages.

On November 28, 2017, Inspector #617 interviewed resident #011, president of the Residents' Council. Resident #011 reported to the Inspector that they were not given a written response from the home regarding the three resident concerns raised at the March meeting.

On November 29, 2017, in an interview with AA #105 they confirmed to the Inspector that they had taken the minutes of the March 28, 2017, Residents' Council meeting. The home's process was to communicate the identified resident concerns to the AD/DOC, for the home to respond to the council within 10 days. AA #105 reviewed their past communications and reported to the Inspector that they did not communicate the three resident concerns from the council to the AD/DOC due to scheduling availability.

A review of the home's policy titled, "Residents' Council-#LTC.1.30", last revised on February 2017, indicated that Administration was required to respond in writing within 10 business days regarding any concerns or question the council members had.

On November 29, 2017, in an interview with the AD/DOC they reported to the Inspector that they were aware of the three resident concerns; however, they did not respond to the council, or to the president of the council, in writing within 10 business days of the home receiving the advice from the Residents' Council at the meeting on March 28, 2017. [s. 57. (2)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On November 27, 2017, Inspector #577 reviewed the medication orders for resident #008, which indicated a specific narcotic medication was to be administered by injection at a specific interval when needed.

The Inspector observed RPN #109 withdraw a partial amount of a narcotic medication from an ampoule with a syringe. The Inspector noted that the RPN placed the remaining amount of the narcotic ampoule into a medication cup on the counter in the medication room. Inspector #577 inquired whether the remainder of the narcotic would be wasted and RPN #109 reported they would administer the remaining medication later, and would not need to waste the narcotic. RPN #109 then proceeded to place the ampule and medication cup in a single locked cupboard, above the counter in the medication room.

Inspector #577 reviewed the home’s policy titled "Narcotic Administration/Disposal on Wards - PH.4.20" last revised July 18, 2014, which indicated the following:

-all narcotic ampoules were single dose use and any remaining narcotic in the ampoule were to be wasted at the time of preparation (or at the end of the shift if there was no other health professional to witness at the time); and

-if additional doses were anticipated within the shift, they may be drawn into syringes for later use.

Inspector #577 reviewed the home’s policy titled "Narcotic and Controlled Drugs – Control and Issue – PH.4.10” last revised July 18, 2014, which indicated that all stock narcotics would be stored in a locked narcotic cupboard in pharmacy and issued only to automated dispensing cabinets (ADC) and locked cabinets in the extended care facility.

Inspector #577 interviewed the AD/DOC who indicated that RPN #109 should have drawn up the remaining amount of the narcotic into a syringe for later use, or wasted the medication at the time of preparation, and confirmed that the policy was not being followed. They further confirmed that the medication cart narcotic box would be considered the locked cabinet. [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 controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident

and every adverse drug reaction was,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

The Long-Term Care Health Act described a medication incident as "a preventable event associated with the prescribing, ordering, dispensing, storing, labelling, administering or distributing of a drug, or the transcribing of a prescription, and includes,
(a) an act of omission or commission, whether or not it results in harm, injury or death to a resident, or
(b) a near miss event where an incident does not reach a resident but had it done so, harm, injury or death could have resulted."

Inspector #577 conducted a review of medication incident reports documented in the home over the past three months. A review of one high risk incident report involved a narcotic patch that was not removed until six hours after the ordered time of removal. In the incident report, notification was not provided to the resident, the resident's substitute decision-maker (SDM), the pharmacy service provider and the physician. Immediate actions were not documented on the incident report or in the nursing notes.

During an interview with RPN #103 they reported that when a medication error occurred, staff were required to document the error on an incident report, document a progress note and call the physician.

Inspector #577 spoke with the AD/DOC and together reviewed the medication incident. They confirmed that the resident, the physician, pharmacy and the resident's SDM were not notified, and immediate actions were not documented. The AD/DOC informed the Inspector that the home did not have a policy regarding the medication incident procedure. [s. 135. (1)]

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

Inspector #577 conducted a review of two medication incident reports documented in the home over the past three months.

Inspector #577 spoke with the AD/DOC and together reviewed the two medication incidents. They confirmed quarterly reviews had not been conducted to reduce and prevent medication incidents and adverse drug reactions. The AD/DOC informed the Inspector that the home did not have a policy regarding quarterly review of medication incidents. [s. 135. (3) (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 every medication incident involving a resident and every adverse drug reaction is reported to the resident, the resident's substitute decision maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider; and

-to ensure that a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

The licensee has failed to ensure that the restraining of a resident by a physical device may be included in a resident's plan of care only if the restraining of the resident had been consented to by a substitute decision-maker (SDM) of the resident with authority to give that consent.

Resident #005 was identified as requiring additional inspection regarding a potential restraint device being used for the resident.

On three occasions during the inspection, respectively, Inspectors #577 and #617 both observed that resident #005 had used a specific restraint device.

A review of resident #005's Resident Assessment Instrument Minimal Data Set (RAI MDS) current to the date of the inspection, indicated that they required supervision. A review of resident #005's care plan current to the date of inspection, indicated that they required the use of a physical restraint device and when the device was applied, staff were to check and document the use of the restraint device every hour for safety.

During interviews with both RPN #103 and PSW #106, they both confirmed to the Inspector that resident #005 required the use of a physical restraint device. Both staff members described to the Inspector three specific safety risks resident #005 exhibited that attributed to the use of the physical restraint device.

A review of resident #005's health care record identified a physician's order for the use of the physical restraint device on the quarterly medication review current for the month of November 2017. The record review indicated a current substitute decision maker (SDM) consent was missing.

A review of the home's policy titled, "Policy of Least Restraint-#AC.1.50" last revised on

March 14, 2017, indicated that a signed consent from a resident or SDM using the form called, "Consent to Restraint/Refusal to Restraint" was required to be completed when using a restraint. The policy defined a physical restraint that included any appliance attached to or worn by the resident which restricted free movement.

In an interview with RPN #103, they reviewed resident #005's chart and confirmed to the Inspector that use of the physical restraint device required a physician's order and SDM consent. RPN #103 reviewed resident #005's chart and confirmed to the Inspector that the SDM consent was missing.

In an interview with the AD/DOC they reported to the Inspector that a consent signed by resident #005's SDM for the use of the physical restraint device, as indicated in the home's policy. The AD/DOC confirmed to the Inspector that resident #005 currently did not have a consent signed by the SDM for the use of the resident's restraint. [s. 31. (2) 5.]

Issued on this 22nd day of December, 2017

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

Original report signed by the inspector.