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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 19, 2019	2019_591623_0010	000811-18, 001047-18, 010572-18, 020099-18, 020840-18, 022925-18, 026131-18, 028078-18, 028283-18, 005645-19, 005655-19	Critical Incident System

Licensee/Titulaire de permis

Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

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

Chartwell Wynfield Long Term Care Residence
451 Woodmount Drive OSHAWA ON L1G 8E3

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

SARAH GILLIS (623), CHANTAL LAFRENIERE (194), KELLY BURNS (554)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): July 8 - 12, and 15 - 19, 2019

The following intakes were inspected concurrently:
Log #000811-18 related to a fall resulting in injury (bundled)
Log #001047-18 related to alleged staff to resident abuse
Log #010572-18 related to a fall resulting in injury
Log #020099-18 related to missing controlled substances
Log #020840-18 related to a fall resulting in injury (bundled)
Log #022925-18 related to alleged resident to resident abuse
Log #026131-18 related to a fall resulting in injury
Log #028078-18 related to a fall resulting in injury (bundled)
Log #028283-18 related to a fall resulting in injury (bundled)
Log #005645-19 related to missing controlled substances
Log #005655-19 related to a fall resulting in injury

Report #2019_603194_0016 - related to resident #003 - similar non-compliance was identified related to s.24. (1) - immediate reporting. This non-compliance will be reflected in this report as the inspections were completed concurrently and the non-compliance will not be applied twice.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), the Corporate Consultant for Resident Care & Services -Nursing, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Care Providers (PCP), Director of Social Services (DSS), Occupational Therapist (OT), Registered Physiotherapist (RPT), Environmental Services Manager (ESM), Housekeepers, residents and families.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Critical Incident Response
Dining Observation
Falls Prevention
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
10 WN(s)
8 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	Légende 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 resident #002 as specified in the plan regarding leaves of absence (LOA).

Related to Log #005645-19:

A Critical Incident Report was submitted to the Director on a specified date for an incident involving a missing or unaccounted for controlled substance. The incident involved resident #002

The CIR indicated the following:
Resident #002 left the long-term care home (LTCH), for a leave of absence (LOA) on a specified date. Registered Practical Nurse (RPN) #114 gave resident #002 a supply of regularly prescribed medications. Medications given to the resident were signed for by both RPN #114 and the resident. Resident returned to the LTCH a number of days later.

The health record for resident #002 was reviewed by Inspector #554 with the following identified:
- resident has a history which includes specific identified health concerns.
- Power of Attorney for Care (POA-Care) had been appointment prior to resident’s admission to long-term care (LTC). The licensee and or designate had been previously communicating with the POA for all care decisions.
- consult by Internal Medicine Specialist indicated the following:
The SDM is concerned that if resident #002 leaves the LTCH unaccompanied to go out on a leave that the resident could be at risk for harm.

A review of the physicians orders by Inspector #554 indicated the following:
- Leave of Absence up to eight (8) hours without medications and or forty-eight (48) hours with medications and with responsible person.

A review of the progress notes by Inspector #554 indicated the following:
- On a specified date, Nursing Unit Clerk called a taxi for resident #002 after being told by RPN #114 that resident #002 could leave the LTCH unaccompanied.

RPN #114 was not available for an interview during this inspection.

During an interview Registered Nurse (RN) #101 indicated to Inspector #554 that staff are to provide care to each individual resident according to the plan of care, which includes physician’s orders related to LOA’s.

During an interview Registered Practical Nurse (RPN) #120 and the ADOC indicated that on specific identified dates, resident #002's plan of care at the time of the LOA, outlined that resident was to have a LOA up to eight hours without medications and or forty-eight hours with medications. The resident must also be accompanied by a responsible person. The ADOC indicated that a responsible party for resident #002 would have been the 'resident's SDM or family'.

In an interview the ADOC and the Director of Social Services (DSS) indicated to Inspector #554 that resident had left the LTCH unaccompanied on a specific identified date.

Documentation by registered nursing staff, DSS and the Administrator indicated that during resident's LOA, resident #002 misplaced prescribed controlled substances, inappropriately took prescribed medications, consumed over the counter medications, consumed alcohol for pain relief and ate inadequately.

The licensee has failed to ensure that the care set out in the plan of care was provided to resident #002 with regards to LOA's.

The scope was expanded and the health records were reviewed for residents #001 and #007 with no areas of non-compliance identified specific to LTCHA, 2007, s. 6 (7). [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 by ensuring that the care set out in the plan of care is provided as specified in the plan, 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 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, protocol, procedure, strategy or system the plan, policy, protocol, procedure, strategy or system was complied with.

Related to Log #020099-18:

A CIR was submitted to the Director on a specified date regarding a missing or unaccounted for controlled substance. The incident involved a drug prescribed for resident #001.

In accordance with O. Reg. 79/10, s. 114 and in reference to O. Reg. 79/10, s. 114 (2) the licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration and destruction and disposal of all drugs used in the home.

Specifically, staff did not comply with the licensee's policy - Narcotics, which is part of the licensee's Medication Management System.

The licensee's policy, Narcotics directs the following:
- Registered Staff going off shift and the registered staff coming on shift will count and sign for all resident narcotics (controlled substance) at each shift change. It is imperative that on coming shift and off going shift registered staff complete at the same time the end/beginning of shift narcotic (controlled substance) count.
- Any discrepancies in narcotic/controlled drug count must be reported to the DOC or designate immediately.

The licensee’s investigation of the incident was reviewed. The licensee’s investigation identified the following:
- On a specified date and time, RPN #100 and RPN #140 were identified as completing a narcotic/controlled substance count.
- On a specified date and time, RPN #100 is identified as re-counting the narcotic/controlled substance count. RPN #100 identified that three tablets of a specific identified controlled substance belonging to resident #001 are missing. RPN #100 is indicated as saying in the investigation that narcotics or controlled substances had been given.
- RN #101 is identified in the licensee’s investigation as the Charge Nurse (CN) responding to the missing or unaccounted for controlled substance incident.
- The former DOC indicated in the investigation that RPN #100 was re-educated on shift to shift narcotic and controlled substances counts, specifically on both registered nursing staff seeing and counting each individual resident narcotic and or controlled substance card.

RPN #100 was not available for an interview during this inspection.

During an interview RN #101 indicated to Inspector #554 being notified by RPN #100 at a specified date and time, of the missing or unaccounted for controlled substance belonging to resident #001. RN #101 indicated RPN #100 had noticed the controlled substance to be missing at a specified time but had not notified the Charge Nurse (CN). RN #101 indicated that RPN #100 did not notify the CN on shift as staff had been an agency staff. RN indicated that RPN #101 should have immediately reported the missing narcotic or controlled substance to the night CN. RN #101 indicated that registered nursing staff off going and on coming shifts are to both simultaneously visualize the actual narcotic or controlled substance packaged card and the Narcotic and Controlled Drug Administration and Shift Count Record for accuracy. RN #101 indicated that RPN #100 could not recall visualizing the packaged card for the identified controlled substance on the specific identified date and time.

During an interview RPN #140 indicated to Inspector #554 that they were aware of the missing or unaccounted for controlled substance belonging to resident #001. RPN #140 indicated no recall of how the controlled substance shift count had been conducted on the identified date. RPN #140 indicated that in the past, around the time of the incident, off going registered nursing staff pre-counted controlled substances and the oncoming registered nursing staff took their word that the counts were correct. RPN #140 indicated

this might have happened on the specific identified date but RPN could not recall.

During an interview with Inspector #554 the ADOC, DOC and the Administrator indicated that all registered staff are expected to follow the licensee policy and procedures. The ADOC, DOC and the Administrator indicated that during the investigation the review of the documents related to the incident confirmed that RPN #101 did not properly complete the narcotic/controlled substance count on the identified date.

The licensee has failed to ensure that the Narcotics policy was complied with, specifically in relation to controlled substance shift counts.

2. Related to Log #020099-18:

In accordance with O. Reg. 79/10, s. 114 and in reference to O. Reg. 79/10, s. 135 (2) the licensee shall ensure that all medication incidents and adverse reactions are documented reviewed and analyzed, corrective action taken and a written record is kept.

Specifically, staff did not comply with the licensee's policy, Medication Incidents and Adverse Drug Reactions and Reporting of Medication Incidents which are part of the licensee's Medication Management System.

The licensee's policy, Medication Incidents and Adverse Drug Reactions directs the following:
- All medication incidents are to be reported and documented
- The contracted pharmacy medication incident will be completed for all medication incidents and faxed to the pharmacy
- Medication Tracking Workbook will be used to track and trend all medication incidents and adverse reactions.

The licensee's policy, Reporting Medication Incidents directs the following:
- All incidents regardless of the origin are to be communicated to the contracted pharmacy by providing a completed medication incident form called Medication Incident Report form.

A CIR was submitted to the Director on a specified date for an incident involving a missing/unaccounted for controlled substance. The CIR involved medications prescribed for resident #001 and involved RPN #114.

RPN #114 and the former DOC was not available for an interview during this inspection.

During an interview RN #101 indicated to Inspector #554 that all medication incidents are to be documented using the Medication Incident Report form. RN indicated that RPN #114 had reported a medication incident on a specified date but indicated being unaware if RPN #114 completed a medication incident report.

In an interview with Inspector #554 the ADOC indicated that all medication incidents are to be documented by registered nursing staff using the Medication Incident Report form and are documented by management in the Medication Tracking Workbook. The ADOC and the DOC indicated to Inspector #554 that there was no documented medication incident report on file for the specific identified incident as well as no documentation to support that the pharmacy service provider was notified.

The licensee has failed to ensure that the Medication Incidents and Adverse Drug Reactions and Reporting Medication Incidents policies were complied with, specifically the documentation of a medication incident using the Medication Incident Report form and notification of the pharmacy service provider.

3. Related to Log #005645-19:

A CIR was submitted to the Director on a specified date regarding a missing or unaccounted for controlled substance. The incident is related to an LOA involving resident #002.

In accordance with O. Reg. 79/10, s. 114 and in reference to O. Reg. 79/10, s. 128 the licensee is required to have a policy developed to govern the sending of a drug that has been prescribed for a resident with them when the resident leaves the home on a temporary basis.

Specifically, staff did not comply with the licensee's policy, Leave of Absence with Medication, which is part of the licensee's Medication Management System.

The licensee's policy, Leave of Absence with Medications directs the following:
- All medications sent with the resident should be handed to the responsible party for the safety of the resident.
- All medications provided are to be documented with the administration directions on the Leave of Absence Responsibility Acceptance form. All spaces on the form are to be

completed including the name of the person to whom the medication is given.
- Give the resident/responsible party written directions for administration including a copy of the Leave of Absence with Medication form. Have the person sign on the Leave of Absence with Medications form for all medications received.

The health record for resident #002 was reviewed with the following documented:

Progress Notes;
- On a specified date, resident #002 approached RPN #114 and requested medications for LOA. RPN #114 packaged medications and gave them to the former DOC. Documentation indicated that the former DOC went over the medications, with resident #002, indicating the date and time medications were to be taken. RPN #114 indicated that resident repeated some things and seemed to understand the process. RPN #114 directed the Nursing Unit Clerk to call a taxi for resident. Resident #002 left the LTCH unattended.

Physician’s Orders;
- leave of absence up to 8 hours without medications and or up to 48 hours with medications and with a responsible party.

The is no physician’s order for resident #002 to self-administer drugs.

The Leave of Absence form completed by RPN #114 on the specific identified date, was reviewed by Inspector #554. The Leave of Absence form identified that RPN #114 gave resident #002 medications over a number of days for an LOA. The form identifies that all routine medications and a specific number of identified controlled substances were given to the resident. The Leave of Absence form identified that RPN #114 failed to give medications prescribed for resident #002 to a responsible party, failed to identify which medications, including the name of drug(s) and the quantity of each drug sent and failed to provide written directions for the administration of the drugs sent.

RPN #114 and the former DOC were unavailable for an interview during this inspection.

RPN #120 indicated to Inspector #554 that registered nursing staff are to identify on the Leave of Absence form, all medications sent with the responsible party including the name of the drug, dosage, the quantity of each drug sent and written directions for the administration of each drug. RPN #120 indicated that a responsible party was intended to mean ‘POA or family’. RPN indicated that at the time of the incident, the identified

responsible party would have been resident #002's POA. RPN #120 indicated, that according to the progress note, on the specific identified date and the Leave of Absence form, resident #002 left the LTCH unattended.

The ADOC indicated to Inspector #554 that RPN #114 should have completed the Leave of Absence form as directed by the licensee's policy including identifying all medications sent, the quantity sent and written directions for taking the drugs. The ADOC confirmed that the physician's orders for resident #002 indicated leave of absence up to eight hours without medications or up to 48 hours with medications and with a responsible party. The ADOC confirmed that resident #002 left the LTCH unattended on the specific identified date.

The Administrator indicated to Inspector #554 that the licensee's policy, Leave of Absence with Medications should have been complied with, specifically RPN #114 should have completed the Leave of Absence form as indicated in the policy and indicated that medications should not have been given to resident #002.

The licensee has failed to ensure that the Leave of Absence with Medications policy was complied with. [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 by ensuring that 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, protocol, procedure, strategy or system the plan, policy, protocol, procedure, strategy or system was complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written policy that promotes zero tolerance of abuse and neglect of residents and that it is complied with.

Related to Log #001047-18:

A CIR was submitted to the Director on a specified date for an allegation of staff to resident abuse, that occurred on a specified date and was reported on a specified date.

Review of the licensee's internal investigation indicated that Personal Care Provider (PCP) #129 provided a letter to the former DOC #115, that was stamped as received on an identified date. The letter indicated the following:

- On a specified date PCP #131 provided care to resident #015 with PCP #129. While providing care to the resident, PCP #131 was stating the resident's name. PCP #129 indicated that they looked up to see PCP #131 involved in a staff to resident abuse towards resident #015. The resident did not appear to be in any pain.
- On the morning of January 6, 2018 PCP #129 and #131 were both providing care to resident #015 and PCP #129, observed PCP #131 exhibit abuse towards resident #015. PCP #131 then stated, "I like to tease resident #015". PCP #129 reported the alleged staff to resident abuse to RN #130 and the former DOC on a specific identified date.

Review of the licensee’s policy Abuse Allegations and Follow-up indicated the following:
Policy: Abuse reporting is immediate and mandatory. All employees are required to, as a component of Chartwell’s internal reporting structure to ensure safety for all, report immediately to their respective supervisor/person in charge of the building when:
- An abuse is witnessed and/or
- An abuse is suspected and/or
- At any time, information of knowledge of an allegation of an abuse is received or learned from any person.

PCP #129 was unavailable for interview during this inspection.

During an interview with Inspector #623, the Administrator indicated that the expectation of the licensee is that all abuse, suspected, alleged or witnessed, is reported immediately. The Administrator indicated that the PCP would be expected to report to the RPN or RN nurse manager immediately upon becoming aware of abuse, or any witnessed or suspected abuse. The Administrator indicated that they expectation of the licensee is that the abuse policy is followed.

The licensee failed to ensure that the written policy Abuse Allegations and Follow-up was followed when PCP #129 witnessed PCP #131 abuse resident #015 and did not immediately report the incident. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring that there is a written policy that promotes zero tolerance of abuse and neglect of residents and that it is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated:

(i) Abuse of a resident by anyone

Related to Log #001047-18:

A critical incident report was submitted to the Director on a specified date for two separate incidents of alleged staff to resident abuse that occurred on two identified dates and were reported on a specific identified date.

The CIR indicated that an initial verbal report to RN #130 and the former DOC #115 on a specific identified date by PCP #129 and provided details of the alleged incident. A letter was also received by the former DOC on a specified date from PC #129 which provided further details of the alleged incident.

Review of the licensee's internal investigation indicated that the former DOC #115 did not initiate the investigation until three days after becoming aware of the allegation of staff to resident abuse.

The former DOC #115 was not available for interview during this inspection.

RN #130 was not available for interview during this inspection.

During an interview with Inspector #623, the Administrator indicated that RN #130 should have initiated the investigation when they became aware of the alleged incident on a specific identified date. The former DOC #115 should have immediately began an investigation when PCP #129 notified the former DOC by phone, regarding the alleged incident involving resident #015. The Administrator indicated that the licensee's investigation package identifies that an investigation did not begin until three days later when the former DOC received a written statement from PCP #129 that provided details of the conversation that took place on a specific identified date between PCP #129 and the former DOC.

The licensee failed to ensure that the allegation of staff to resident abuse involving resident #015 was immediately investigated. [s. 23. (1) (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 by ensuring that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of, or that is reported is immediately investigated, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Non-compliance identified from report #2019_603194_0016 related to resident #003 is reflected in this report as the inspections were completed concurrently:

Related to Log # 009423-18:

A CIR was submitted to the Director on a specified date for allegations of staff to resident abuse involving resident #003, that occurred on a specific identified date.

Review of the Licensee's abuse investigation was completed by Inspector #194 on a specified date which indicated the following had occurred:

The family provided a video to the home of the incident involving resident #003 on a specified date. RN #120 who viewed the video tape on an identified date indicated that PSW #108 and #110 assisted resident #003 with a mechanical transfer from bed to chair during which time the PSW 's dialogue with resident was noted to be inappropriate by the family. RN #120 indicated in their statement that Director of Social Services (DSS) #121 (Manager on Call) was informed of the incident and an e-mail was sent to the former Director of Care on a specified date.

During interview with Inspector #194 the DSS #121 indicated that as manager on call, the registered staff would have been directed to contact the DOC and follow the decision tree related to abuse of a resident, with any concerns reported related to abuse of a resident.

During interview with Inspector #194 the Administrator indicated that the video evidence of the incident involving resident #003 was provided to the home on an identified date, where it was determined that there was an allegation of staff to resident abuse identified and the incident was reported to the Director. The home completed their investigation and the allegations of staff to resident abuse were not founded.

The Director was notified of the allegations of staff to resident abuse involving resident #003 on a specified date, six days after RN #120 had informed the former DOC [s. 24. (1)]

2. Related to Log #001047-18:

A critical incident report was submitted to the Director for an incident that occurred on a specified date and was not reported until a specified date.

The CIR indicated that an initial verbal report to RN #130 and the former DOC #115 on a specified date by PCP #129 indicating that PCP #131 was providing care to resident

#015 and PCP #131 inappropriately touched the resident.

Review of the licensee's internal investigation package indicated that PCP #129 provided a letter to the former DOC #115, that was stamped as received on a specified date. The letter provided a details of the two separate alleged incidents and was indicated to be a follow up letter to a phone call that had occurred several days prior.

An email to the former DOC #115 that was received on a specified date and was written by RN #130, indicated that the RN became aware of the alleged staff to resident abuse, on a specified date when PCP #129 reported the incidents. RN #130 indicated that PCP #129 informed them that they would be calling the former DOC to report the incident. The RN indicated that the PCP “down played” the details of the alleged incident and the PCP indicated that they did not feel it was abuse, therefore the RN did not immediately report the incident to the Director.

The former DOC #115, PCP #129 and RN #130 were not available for interview during this inspection.

During an interview with inspector #623, RN #133 indicated that when any staff member suspects or witnesses abuse, the expectation of the home is that they would immediately report this to the RN or RPN who is in change of the unit. All abuse is to be reported immediately. The RN or RPN would then begin the process to initiate the reporting and investigation. The RN would call the Action line and report to the Director as well as notify the manager on call. Witness statements are collected in writing from anyone who has information to add to the allegation.

During an interview with Inspector #623, the Administrator indicated that the expectation of the licensee is that all abuse, suspected, alleged or witnessed, is reported immediately. The Administrator also indicated that once an allegation of abuse is reported, the RN nurse manger would notify the Director, the manager on call, the police and the SDM.

The licensee failed to ensure that the person who had reasonable grounds to suspect that staff to resident abuse has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director. RN #130 became aware of the allegation of staff to resident abuse towards resident #015 on an identified date and did not immediately report the allegation to the Director. The former DOC also became aware of the allegation of staff to resident abuse on an identified date and did not initiate

the report to the Director until several days later. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring that the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director; Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #002 had been approved by the prescriber to self-administer drugs.

Related to Intake #005645-19:

A Critical Incident Report (CIR) for an incident involving a missing or unaccounted for controlled substance. The incident involved resident #002. The CIR indicated resident #002 left the long-term care home (LTCH) on a specified date on an LOA. RPN #114 gave resident #002 a supply of regularly prescribed medications. Medications being taken on LOA were signed for by both RPN #114 and the resident. Resident returned to the LTCH on a specified date without any medications.

The health record for resident #002 was reviewed by Inspector #554 with the following identified:

- On a specified date RPN #114 indicated in a progress note that resident #002's prescribed medications were packaged and that the former DOC reviewed the packaged medications with resident #002. Package medications included a specific quantity of identified controlled substance. Resident #002 left on LOA unattended.

Review of the physician's orders indicated that resident #002 could have a Leave of Absence up to eight hours without medications and or 48 hours with medications and with responsible person.

There is no physician's order for resident #002 to self-administer medications.

During resident #002's LOA, on specific identified dates documentation by registered nursing staff, DSS and the Administrator, indicated that resident #002 reported missing or unaccounted for controlled substances. Documentation on a specified date by RPN #120 indicated that resident #002 was not administering medications as indicated by the physician's orders, specifically indicated that resident had taken prescribed medications twice daily versus the prescribed three times daily dosages and had taken medications prescribed for a specific identified date, on an unknown date.

RPN #114 was not available for an interview during this inspection.

During an interview RPN #120 and the ADOC indicated to Inspector #554 that there was no physician's order for resident #002 to self-administer prescribed medications during the specific identified dates.

The licensee failed to ensure that resident #002 had been approved by the prescriber to self-administer drugs during the dates of the LOA.

The scope was expanded and the health records were reviewed for residents #001 and #007 with no non-compliance identified specific to O.Reg. 79/10, s. 131 (5). [s. 131. (5)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring that the resident who is permitted to self-administer drugs has been approved by the prescriber to self-administer drugs, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee failed to ensure that appropriate actions were taken in response to any medication incident involving resident #002 and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs.

Related to Log #005645-19:

A CIR was submitted to the Director on a specified date for an incident involving a missing or unaccounted for controlled substance. The CIR involved resident #002.

Inspector #554 reviewed the progress notes for an identified period of time. The progress notes indicated that on a specified date documentation by registered nursing staff

indicated that resident returned form LOA at a specified time. No medications were returned to registered nursing staff following resident’s LOA. At a specified time, RPN #120 entered resident’s room, observes resident #002 lying on bed and observes three attached but empty medication pouches on the bedside table. RPN indicated, in the progress notes, that the empty medication pouches are dated for a future specified date and time. Resident indicated when questioned by RPN #120 that no medications had been taken today and having taken medications twice daily. RPN indicated to resident medications should have been taken three times daily as prescribed by the physician. RPN indicated in the progress notes that there were no medications in the LTCH to be given to resident #002 for the specific identified date and time and including the next day’s supply. RPN indicated calling pharmacy to have resident #002’s medications replaced. Pharmacy replied to RPN indicated medications would be sent that day. RPN #120 indicated notifying ADOC that resident did not return from LOA with any prescribed medications including medications for specific identified dates and controlled substance.

There is no indication that the physician for resident #002 was notified of the medication incident on a specified date.

Inspector #554 reviewed the Electronic Medication Administration Record (eMAR) from a specified period of time which indicated specific medications administered and signed for by RPN #120 on an identified date and time.

During an interview RPN #120 indicated to Inspector #554 being aware of the licensee’s policy regarding medication incidents and that all medication incidents involving a resident are to be reported immediately to the physician for direction. The error must also be communicated to the SDM.

During an interview RPN #120 indicated resident #002 returned to the LTCH from LOA on a specified date and time. RPN #120 indicated working that date and being aware that resident returned from LOA without any medications. RPN #120 indicated finding empty medication pouches dated for the next day on resident’s bedside table. RPN indicated notifying the ADOC of the medication incidents, including the empty medication pouches for the future date and not having any medications to administer for that day and time. RPN #120 indicated calling the pharmacy for ‘replacement medications’ and administering prescribed medications to resident #002 when the medications arrived that shift, as no other direction had been given by the ADOC. RPN #120 indicated that the physician and the SDM were not notified of the medication incidents that shift. RPN indicated that looking back the physician should have been notified of the medication

incident and direction sought prior to administering residents medications.

The ADOC indicated to Inspector #554 during an interview, that medication incidents involving a resident are to be communicated to the physician at the time of the incident for direction. The ADOC further indicated, that medication incidents are to be communicated the same day as the incident occurs to the SDM and to the DOC or designate. The ADOC indicated being aware of the medication incident related to resident #002 and as reported by RPN #120. ADOC indicated reporting the incident to the former DOC and taking no further actions as it was left with the former DOC.

The Administrator indicated to Inspector #554 during an interview, that the medication incident involving resident #002 should have been immediately communicated to the physician for further direction before administering any further medications.

The licensee has failed to ensure that appropriate actions were taken in response to a medication incident involving resident #002.

The scope was expanded and the health records were reviewed for residents #001 and #007 with no non-compliance identified specific to O.Reg. 79/10, s.134 (b). [s. 134. (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 by ensuring that appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that a medication incident involving resident #002 was documented, together with a record of the immediate actions taken to assess and maintain the resident’s health, and that the incident was reported to the pharmacy service provider.

Related to Log #005645-19:

A CIR was submitted to the Director on a specified date for an incident involving a missing or unaccounted for controlled substance. The incident according to the CIR occurred on a specified date and involved resident #002.

Review of the progress notes for resident #002 was completed by Inspector #554 and identified the following:
- On a specified date documentation by RPN #120 indicated that resident returned form

LOA at a specified time. No medications were returned to registered nursing staff following resident's LOA. At a specified time, RPN #120 entered resident's room, observed resident #002 lying on the bed and observed three attached but empty medication pouches on the bedside table. RPN indicated, in the progress notes, that the empty medication pouches were dated for the next day. Resident indicated when questioned by RPN #120 that no medications have been taken today and having taken medications twice daily during the LOA. RPN indicated to resident #002 that the medications should have been taken three times daily as prescribed by the physician. RPN #120 indicated notifying ADOC that resident did not return from LOA with any prescribed medications including medications for two specific identified dates.

RPN #120 indicated to Inspector #554 that all medication incidents, along with the action taken and the notification of SDM and the physician are to be documented in the progress notes, in Risk Management and on a Medication Incident Report form. RPN indicated that the medication incident is to be provided to the DOC. RPN indicated not documenting the medication incident using the Medication Incident Report form and or Risk Management. RPN indicated not contacting the SDM, the physician and or the pharmacy service provider regarding the medication incident. RPN indicated notifying the ADOC of the medication incident.

During an interview the ADOC and DOC indicated to Inspector #554, that medication incidents are to be documented in the progress notes, in Risk Management and on the Medication Incident Report form. The ADOC and the DOC also indicated that the Medication Incident Report form and related information including action taken, notification of SDM, physician and pharmacy service provider were to be documented together. The ADOC indicated that all medication incidents and related documentation are stored in a binder in the DOC office.

The ADOC provided Inspector #554 with a copy of a Medication Incident Report for resident #002, dated on a specified date.

The Medication Incident Report fails to indicate action taken by RPN #120 or the licensee and fails to indicate that the pharmacy service provider was notified of the incident.

During an interview with Inspector #554 the ADOC and DOC indicated that there is no other documentation on file related to the medication incident involving resident #002, specifically action taken and notification of the pharmacy service provider.

The licensee had failed to ensure that a medication incident involving resident #002 was documented, together with a record of the immediate actions taken to assess and maintain the resident’s health, and that the incident was reported to the pharmacy service provider.

The scope was expanded and the health records were reviewed for residents #001 and #007 with no non-compliance identified specific to O.Reg. 79/10, s. 135 (1) [s. 135. (1)]

2. The licensee has failed to ensure that, a quarterly review was undertaken of all medication incidents that had occurred in the home since the time of the last review in order to reduce and prevent medication incidents, any changes and improvements identified in the review are implemented, and a written record is kept of everything.

Related to Log #020099-18:

A CIR was submitted to the Director on a specified date for an incident involving a missing or unaccounted for controlled substance. The CIR involved medications prescribed for resident #001.

The CIR indicated that the registered nursing staff counted the controlled substances at the change of shift. Registered nursing staff indicated that during the second count, at a specified time, one dose of resident #001’s prescribed medication was missing or unaccounted for. The one dose was identified in CIR as a specific controlled substance – three tablets.

During an interview the ADOC indicated to Inspector #554 that all medication incidents are reviewed quarterly by the Pharmacy and Therapeutics Committee during the Physician Advisory Committee (PAC). The ADOC indicated that all quarterly medication incident reviews are documented in the Medication Tracking Workbook including the tracking of trends and improvements. The ADOC and the DOC indicated to Inspector #554 that there was no written record of the medication incident related to the specific identified incident.

The ADOC provided Inspector #554 with the Medication Tracking Workbook, quarterly summary for and identified period of time, medication incidents. The ADOC and the DOC indicated they were not employed by the LTCH at the time of the incident. The Medication Tracking Workbook, quarterly summary for a specified period of time, was reviewed by Inspector #554, it does not identify the medication incident related to the

missing or unaccounted for controlled substance for a specified date, nor changes and improvements made as a result.

The Administrator indicated to Inspector #554 that all medications incidents are to be reviewed quarterly during the PAC meetings and that the review is to be documented.

The licensee has failed to ensure that, a quarterly review was undertaken of all medication incidents, specifically did not include a review of a medication incident on a specified date relating to medications prescribed for resident #001, during the quarterly review.

The scope was expanded and the health records were reviewed for residents #002 and #007 with no non-compliance identified specific to O.Reg. 79/10, s. 135 (3) [s. 135. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring that every medication incident involving a resident and every adverse drug reaction is documented, together with a record of the immediate actions taken to assess and maintain the resident's health and reported to the pharmacy service provider, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any neglect, suspected of witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

Related to Log #001047-18:

A critical incident report was submitted to the Director on a specified date for an allegation of staff to resident abuse, that occurred on a specified date and was reported on a specific identified date.

Review of the licensee’s internal investigation by Inspector #623 failed to reveal evidence that the police were notified of the alleged of abuse.

During an interview with Inspector #623, the Administrator indicated that they were unable to find evidence to support that the police were notified of the alleged abuse by PCP #131 towards resident #015. The Administrator indicated that the licensee’s expectation is that all alleged, suspected or witnessed abuse is reported to the police.

The licensee failed to ensure that the appropriate police force was immediately notified of the allegation of staff to resident abuse by PCP #131 towards resident #015. [s. 98.]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that Director was informed no later than one business day after the occurrence of an incident, specifically a missing or unaccounted for controlled substance.

Related to Intake #005645-19:

A CIR was submitted to the Director on a specific identified date for an incident involving a missing or unaccounted for controlled substance. The CIR states the incident occurred on an identified date and involved resident #002.

A review of resident #002's progress notes indicated the following:
- On a specific date and time, RPN #114 indicated giving resident #002 packaged medications for LOA including an identified quantity of a specific controlled substance. Resident #002 left the LTCH in a taxi unaccompanied.
- On a specific date and time, the Director of Social Services (DSS) indicated calling

resident #002 by phone for a 'well-being check'. DSS indicated that during this call, resident #002 indicated being 'unable to find specific pills that were in the blister package'. Resident indicated having complaints of pain during this call. At a specified time, DSS documents, for the second time, that resident #002 is unable to locate pain medications. At a specified time, DSS indicated updating the RN regarding resident #002's LOA and well-being check.
- On a specific date and time, DSS indicated calling resident #002 for a well-being check. During the call, resident again indicated being unable to locate pain pills and had been using an alternative method to relieve pain.

During an interview with Inspector #554, the DSS indicated being advised by resident #002, on two identified dates, of the missing or unaccounted for controlled substance. The DSS indicated the missing or unaccounted for controlled substance was reported to the nursing department. The DSS indicated being unable to recall specifically who it was reported to.

On a specified date the ADOC indicated to Inspector #554 during an interview, of being aware of the missing or unaccounted for controlled substance prescribed for resident #002. The ADOC indicated being notified of the missing or unaccounted for controlled substance on a specified date, by the resident. ADOC indicated checking the resident's room for the medications without success, communicating the missing or unaccounted controlled substance to RPN #114 and then to the former DOC.

The former DOC was not available for an interview during this inspection.

During an interview the Administrator indicated to Inspector #554, of being aware of time lines for the reporting of Critical Incidents, specifically missing or unaccounted for controlled substance. The Administrator indicated that the Director should have been notified 'sooner' of the missing or unaccounted for controlled substance. The Administrator indicated that it meant according to the legislation.

The Director was not notified of the missing or unaccounted for controlled substance for six days following the initial notification by resident #002 to the DSS.

The licensee failed to ensure that the Director was informed no later than one business day after the occurrence of an incident, related to missing or unaccounted for controlled substances for resident #002.

The scope was expanded and the health records were reviewed for residents #001 and #007 with no non-compliance identified specific to O.Reg. 79/10, s. 107 (3) 3. [s. 107. (3)]

Issued on this 27th day of August, 2019

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

Original report signed by the inspector.