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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 5, 2017	2017_593573_0009	005940-17	Resident Quality Inspection

Licensee/Titulaire de permis

ROYAL OTTAWA HEALTH CARE GROUP
1141 Carling Avenue OTTAWA ON K1Z 7K4

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

ROYAL OTTAWA PLACE
1145 CARLING AVENUE OTTAWA ON K1Z 7K4

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

ANANDRAJ NATARAJAN (573), JOANNE HENRIE (550), MEGAN MACPHAIL (551)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 03, 04, 05, 06, 07, 10, 11, 12 and 13, 2017.

During the Resident Quality Inspection Critical Incident Inspection Log #033840-16 related to an alleged incident of staff to resident abuse and Log #027339-16 related to resident injury with transfer to hospital and a change in health status was completed.

During the course of the inspection, the inspector(s) spoke with Residents, Family members, the President of the Residents' Council/ Family Council, Personal Care Aides (PCA), Housekeeping Aides, Dietary Aide, Recreation therapists, Registered Practical Nurses (RPN), Registered Nurses (RN), RAI Coordinator, Office Coordinator, the Infection Control and Program (IPAC) Coordinator, the Manager of Resident and Family Services and the Acting Administrator/ Director of Care (DOC).

During the course of the inspection, the inspector(s) toured residential and non-residential areas of the home, observed medication administration passes, observed recreation activities, observed exercise therapy classes, observed meal and snack services, reviewed residents health care records, reviewed the home's relevant policies and procedures, reviewed minutes for Residents' Council and Family Council, reviewed cleaning schedules, and reviewed maintenance schedules.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **8 WN(s)**
- **3 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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents, at a minimum, shall contain an explanation of the duty under section 24 to make mandatory reports.

The home's policy to promote zero tolerance of abuse and neglect of residents is titled Zero Tolerance of Resident Abuse and Neglect, #110, last reviewed September 14, 2016. A review of the policy indicated, that the policy does not includes paragraph 1, 3, 4 or 5 under s.24 of the Act, as it relates to mandatory reporting of improper or incompetent care, unlawful contact and misuse or misappropriation of resident's money or funding provided to the licensee.

On April 10, 2017, Inspector #573 reviewed the home's abuse policy in the presence of home's Acting Administrator/ DOC, who agreed with the inspector that home's abuse policy does not include explanation of s.24 paragraph 1, 3, 4 and 5. Further she indicated to the inspector that she will update the home's policy to promote zero tolerance of abuse and neglect with accordance to the legislation requirement. [s. 20. (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 the home's zero tolerance of abuse and neglect policy contain an explanation of the duty under section 24 of the Act to make mandatory reports, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area or a medication cart,
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 (e.g. expiration dates, refrigeration, lighting).

On April 04, 2017, Inspector #551 observed two identified prescribed creams on resident #035's dresser. On April 07, 2017, Inspector #550 observed the same two identified prescribed creams on the resident's dresser.

During an interview on April 07, 2017, RPN #107 indicated to the inspector that resident #035 does not self-administer any medication and that she/he is not to keep any drugs in her/his room. The prescribed creams are applied by the PCAs and after the application, the PCAs are to return the creams to the nurse so they can be locked with other drugs.

As evidenced above, the licensee did not ensure that the creams for resident #035 were not stored in an area that is secure and locked. [s. 129. (1) (a)]

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

On April 07, 2017, during the observation of the medication storage room, Inspector #550 observed a specific controlled substances drug that was stored in a small medication refrigerator for resident #044 and one specific controlled substances drug for the emergency stock. Both the drugs were in a small clear plastic container that is kept locked and can be unlocked with a key. The medication refrigerator is not locked. RPN #107 indicated to the inspector that she was not aware that the controlled substances required to be double locked in a locked area.

On April 10, 2017, during an interview, the Acting Administrator/ DOC indicated to the inspector that she was not aware that the medication refrigerator did not have a lock on it as this was one of their requirement when they changed pharmacy provider, that they supplied the home with a refrigerator equipped with a lock. [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 a) the topical creams for resident #035 are stored in an area that is secure and locked, 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, to be implemented voluntarily.

WN #3: 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. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

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 is:
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and
(b) reported to the resident, the resident's SDM, 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.

Inspector #550 reviewed the home's medication incident reports from January 01, 2017 to April 06, 2017. It was noted that four medication incidents occurred during that period of time and were documented as follows:
Resident #007: On an identified date in 2017, medication error related to incorrect dosage of a specific drug.
Resident #009: On an identified date in 2017, medication error related to incorrect administration of two identified drugs on a specific day and time.
Resident #045: On two identified dates in 2017, medication error related to incorrect dosage of a specific drug.

During a review of those medication incident reports and health care records, the inspector noted the following:
Resident #007: the medication incident that occurred on a specified date in 2017 was not reported to the Medical Director/ the attending physician or the registered nurse in the extended class attending the resident/ prescriber of the drug.
Resident #009: the medication incident that occurred on a specified date in 2017 was not reported to the Medical Director/ the attending physician or the registered nurse in the extended class attending the resident/ prescriber of the drug.
Resident #045: there was no documentation of the immediate actions taken to assess and maintain the resident's health status; the Medical Director and the attending physician or the registered nurse in the extended class attending the resident/ prescriber for the drug were not informed of the incident on the identified date in 2017. The resident who is capable of making her/his own decisions was also not informed about the incident.

During an interview, the Manager of Resident and Family Services who was the home's previous Administrator indicated to the inspector that registered staff document in the progress notes and/or on the incident report the immediate actions taken to assess and maintain the resident's health status and the person(s) they notified of the incident. After reviewing the above incident reports and the documentation in the resident's health care records, the Manager of Resident and Family Services indicated to the inspector that she was unable to find documentation of the missing information as described above. She further indicated that if it was not documented, it was because it was not done. [s. 135. (1)]

2. The licensee has failed to ensure that:
a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed
(b) corrective action is taken as necessary, and
(c) a written record is kept of everything required under clauses (a) and (b).

During a review of the medication incidents reports on specific dates in 2017 for residents #007, and #045 and the resident's health care records, the inspector noted that there was no documentation of the review, the analysis of the medication incidents and the corrective actions taken by the home's management team at the Professional Advisory Committee (PAC) meeting.

During an interview on April 12, 2017, the Manager of Resident and Family Services who was the home's previous Administrator indicated to the inspector that the documentation of the review, the analysis of the medication incidents and the corrective actions taken were not documented for the above incidents as they were not reviewed at the PAC meeting. [s. 135. (2)]

3. The licensee has failed 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,
(b) any changes and improvements identified in the review are implemented, and
(c) a written record is kept of everything provided for in clause (a) and (b).

During an interview with the Manager of Resident and Family Service and the Acting Administrator/ DOC on April 11 and 12, 2017, they indicated to Inspector #550 that the quarterly reviews of the medication incident reports were done through the PAC meetings. The inspector reviewed the PAC meeting minutes for the past three meetings dated December 20, 2016, September 27, 2016 and June 28, 2017. There was no information noted related to the review of medication incidents. The Acting Administrator/ DOC confirmed that the medication incident reports are not reviewed quarterly. [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 to ensure that all medication incident involving a resident and every adverse drug reaction is documented, reported and a quarterly review is undertaken as per O. Reg 135. (1), (2) and (3), 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. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of the abuse investigation were reported to the Director.

The home's Acting Administrator/ DOC became aware of an allegation of staff to resident abuse involving resident #042 and PCA #115 on a specified date in 2016, and the Ministry of Health and Long Term Care (MOHLTC) after hours pager was contacted on the same day. The Critical Incident Report (CIR) was submitted to the MOHLTC. According to the home's investigation notes, resident #042 and two staff members were interviewed on a specified date in 2017.

The CIR was amended on a specified date in 2017, however the results of the home's investigation were not reported to the Director. On April 13, 2017, the Manager of Resident and Family Services indicated that the allegation of abuse was unfounded. (Log #033840-16) [s. 23. (2)]

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 abuse of a resident by anyone has occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director.

The Ministry of Health and Long Term Care after Hours pager was contacted on two specified date in 2016, Critical Incident Report detailing an allegation of staff to resident abuse was submitted to the Director, under O. Reg 79/10, s. 104. The incident was alleged to have occurred on the evening shift of a specified date in 2016.

According to the home's investigation, on an identified date, which was five days after the alleged incident of abuse, a PCA brought the bruising on resident #042's specific body part to the attention of the Administrator/ DOC who began an investigation. The home's investigation revealed that two registered staff members had prior knowledge of the bruising which the resident said was caused by a staff member, specifically:
On the night shift of a specified date in 2016, RPN #116 was asked by a PCA to look at a bruise on resident #042's specific body part. During the RPN's assessment, the resident reportedly indicated that the bruise was caused by PCA #115 whom the resident described as rough with the care.

On a specified date, RPN #116 wrote on the resident's kardex "bruise noted" and during a meeting with the home's management on an identified date, he described that the bruise was three to four inches in length, discoloured and swollen at the time of observation. RPN #116 did not report the allegation of abuse to the charge nurse or have the PCA removed from the work schedule.

On April 12, 2017, in an interview with RPN #111, she indicated that on the specified date in 2016, a PCA asked her to look at resident #042's bruising. The RPN described an old looking, purplish, blue coloured bruise on the resident's specific body part. The resident reported to the RPN that she/he had been manhandled. According to the RPN she did not chart on or report the bruising or the resident's allegation of having been manhandled until she was questioned by the Administrator/ DOC on a specified date in 2016. The RPN indicated that at the request of the Administrator/ DOC, she wrote a late entry progress detailing her observations from the specified date and completed an incident report.

On a specified date in 2016, resident #042 presented with a bruise on a specific body part and reported to RPN #116 that it was caused by a staff member who had been rough. Two days later, the resident's bruising was assessed by RPN #111, and the resident reported that it was caused as the result of being manhandled. Neither registered staff member reported the allegation of abuse or began an investigation. This allegation was reported to MOHLTCH after five days, when the PCA reported the resident's bruising to the Administrator/ DOC who began an investigation.

According to the home's policy titled Zero Tolerance of Resident Abuse and Neglect, the ROHCGROP- LTC requires a person who has reasonable grounds to suspect that a resident has suffered abuse to immediately report the suspicion and the information upon which it is based to the Director of Care/Delegate/After Hours Manager and the MOHLTC. (Log #033840-16) [s. 24. (1)]

WN #6: 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 :

1. The licensee has failed to ensure that a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Resident #030 was admitted to the home on a specified date in 2016. Resident #030 use wheel chair for the primary mode of locomotion. Since admission, the resident has fallen on several occasions. Most recently, the resident had a fall from the wheel chair on a specified month in 2017 while attempting to self-transfer, sustaining pain to specific body part, and three days prior to that incident, resident had an fall while trying to open the bathroom door sustaining pain to specific body part.

According to RPN #110, the home's clinically appropriate instrument that is specifically designed for falls is a Slip/Trip/Fall Incident Report completed in the Incident Management System portal. The RPN #110 indicated that this is completed each time a resident slips, trips or falls. The home's policy titled Resident Falls directs registered staff to complete an incident report and submit it to the DOC when a resident has fallen.

The home's Acting Administrator/ DOC checked the Incident Management System portal and was not able to locate a completed post-fall assessment using the Slip/Trip/Fall Incident Report for resident #030's fall incidents on two specified dates in 2017. [s. 49. (2)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (2) Subject to subsection (3), the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director. O. Reg. 79/10, s. 104 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director was made within 10 days of becoming aware of the alleged incident of abuse.

The home's Acting Administrator/ DOC became aware of an allegation of staff to resident abuse involving resident #042 and PCA #115 on a specified date in 2016, and the Ministry of Health and Long Term Care after hours pager was contacted on the same day.

A completed CIR report was submitted to the Director on a specified date in 2016, which is not within 10 days. (Log #033840-16) [s. 104. (2)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that all areas where drugs are stored are restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator.

On April 07, 2017, Inspector #550 observed two baskets with prescribed medicated creams stored on a shelf in the clean utility room located across from the south dining room on the third floor. RPN #107 indicated to the inspector that the door to the clean utility room was kept locked but can be accessed by PCAs, the recreation therapist and the delivery person from ROH. She further indicated being aware that the creams are not supposed to be stored in this room and that they are supposed to be stored in the medication cart or the medication room.

On April 11, 2017, during an interview, the Acting Administrator/ DOC indicated to Inspector #550 not being aware that the medicated creams were stored in the clean utility room on the third floor. [s. 130. 2.]

Issued on this 5th day of May, 2017

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

Original report signed by the inspector.