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
Jun 26, 2017	2017_532590_0008	007522-17	Resident Quality Inspection

Licensee/Titulaire de permis

THE CORPORATION OF THE COUNTY OF MIDDLESEX
c/o Strathmere Lodge 599 Albert Street, P.O. Box 5000 STRATHROY ON N7G 3J3

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

STRATHMERE LODGE
599 Albert Street Box 5000 STRATHROY ON N7G 3J3

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

ALICIA MARLATT (590), AMIE GIBBS-WARD (630), MELANIE NORTHEY (563), NEIL KIKUTA (658)

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 19 - 21, 24 - 28, 2017.

The following Critical Incident (CI) System Reports were inspected concurrently:

LSAO Log #018035-16/CIS #M627-000012-16 was related to abuse and neglect prevention.
LSAO Log #032737-16/CIS #M627-000023-16 was related to falls prevention.
LSAO Log #031568-16/CIS #M627-000020-16 was related to falls prevention.
LSAO Log #032816-16/CIS #M627-000024-16 was related to medication management.
LSAO Log #017265-16/CIS #M627-000011-16 was related to falls prevention.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Resident Care (DRC), the Environmental Services Manager (ESM), a Physiotherapist, a Registered Dietitian (RD), a Nursing Coordinator, a Clinical Support Nurse, a Staff Educator, a Resident Assessment Instrument Coordinator (RAI Coordinator), a Housekeeper, six Registered Nurses (RN), ten Registered Practical Nurses (RPN), 13 Personal Support Workers (PSW), the representative of the Residents Council, the representative of the Family Council, three family members and 40+ Residents.

During the course of the inspection, the inspector(s) toured all resident home areas, observed dining services, medication rooms, medication administration, the provision of resident care, recreational activities, resident/staff interactions, infection prevention and control practices and reviewed resident clinical records, posting of required information, meeting minutes to the inspection and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services -
Housekeeping Continence Care and
Bowel Management 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
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **13 WN(s)**
- **10 VPC(s)**
- **3 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that 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.

A) Critical Incident (CI) Report #M627-000024-16 was submitted to the Ministry of Health and Long Term Care (MOHLTC) for an incident of a missing controlled substance. The CI documented that a Registered Nurse (RN) may have left the one remaining controlled substance and the box containing the controlled substance on top of the medication cart while attending to a resident. The medication cart was left in the hallway outside the resident's room. Investigation notes detailed that the RN suggested that the box containing the controlled substance and the individual controlled substance was left on top of the medication cart when it went missing, but that the RN was unable to recall if this was what happened. The remaining controlled substance was not stored in a separate locked area within the locked medication cart as the medication was missing at the time of the shift change narcotic count at 2300 hours.

Review of the Medication Storage, Policy number NMM003, last revised in August 2014, states:
"Registered staff will lock the medication/treatments carts at all times when unattended" and "Narcotics will be kept in the separate locked compartment inside the medication cart. Therefore providing a double locked system."

The Director of Resident Care (DRC) shared that the RN reported leaving the controlled substance on top of the medication cart in the hallway outside a resident's room and acknowledged that the controlled substance should have been stored in a separate locked area within the locked medication cart.

B) On April 25, 2017, an observation of the narcotic count was conducted with two Registered Practical Nurse's (RPN) on a specified Resident Home Area (RHA) in the medication room at shift change between days and evenings. One of the RPN's started the narcotic count by removing the cards of narcotics without using a key to open the narcotic storage area within the medication cart. The RPN acknowledged that narcotics were to be stored in a separate double-locked area. The RPN further shared that the bin did not always close properly, and stated, "really push it down hard for it to lock" and acknowledged that the narcotics were not double locked.

On April 28, 2017, a RN on a different specified RHA opened the bottom drawer of the medication cart and was able to lift open the lid to the narcotic bin without using a key. The bin was unlocked and the RN acknowledged that the narcotic bin should be locked at all times when not in use.

The licensee failed to ensure that controlled substances were stored in a separate locked area within the locked medication cart.

The severity was determined to be a level two as there was minimal harm or potential for actual harm to the residents. The scope of this non-compliance was widespread throughout the inspection. The home has a history of unrelated non-compliance. [s. 129. (1) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that 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 #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A) Upon review of the daily count sheets, monthly audit of the daily count sheets and recent medication incidents, it was discovered that an identified resident had an incorrect amount of a specific medication available for administration.

Record review of the physician's orders in Point Click Care (PCC) for this resident showed specific directions for dosages and administration times for the specific medication.

Record review of the "Medication Incident - Original Report" for this resident showed when the RPN was taking the medication out of the box it was discovered that the medication was not the same dosage identified on the box. Another box of medication identifying another dosage was checked and it did contain the dosage as indicated on the box however, it was discovered that a specific dosage of medication was missing.

The incorrect dosage of medication was given to an identified resident.

The DRC acknowledged that the medication incident involving this resident where the resident was administered the incorrect dosage of medication was not administered in accordance with the directions for use specified by the prescriber.

The licensee failed to ensure that the medication dosage for a specified resident was administered in accordance with the directions for use specified by the prescriber.

B) A medication administration observation was completed on a specific day, for a specified resident.

Record review of the electronic Medication Administration Record (e-MAR) documented the following for this resident:
- Specified treatment once daily on two specified days in the week, at alternate times
- A specified medication, twice daily at specific times
- A specified medication, one tablet by mouth twice daily at specific times.
Medication documented as "HAZARDOUS, DO NOT CRUSH"

On a specific date and time, Inspector #563 observed a RPN administer medications to this resident. The DRC was present at the time of the observation. The resident was administered all their medications at that time crushed with a fluid. The clear plastic strip pack containing the tablet medication was placed into the pill crushing device by the RPN. The crushed tablet was added to the fluid with other crushed medications for administration to this resident. Observation of the strip package for the tablet medication demonstrated the medication was crushed and residue was present. The package clearly stated "HAZARDOUS, DO NOT CRUSH".

On a specific date and time, Inspector #563 observed the RPN administer a medication to the resident. The DRC was present at the time of the observation. The resident was administered a specific medication. This medication was due to be given five hours earlier.

The RPN stated the medication was held because the resident did not have a meal. The RPN acknowledged that there was no physician's order to postpone the administration of the medication. The RPN also acknowledged that the order for medication was not given at the time prescribed by the physician. The RPN shared that a specified treatment was scheduled at a certain time and that the resident was treated one and a half hours later

and acknowledged that the physician's order was for the treatment to be provided at a specific time and that this was not done.

Record review of the "Medication/Treatment Administration Record" for this resident for a specific month in 2017, documented the following:
- A specified medication due at a specific time was administered to the resident between four and a half and five and a half hours later on seven of 25 days and on 11 of 25 days the medication was documented as "not delivered"
- A specified medication due at a specific time was administered to the resident between one and a half and five hours later on five of 25 days and on seven of 25 days the medication was documented as "not delivered"
- A specified date, the resident's medication was documented as "not delivered" twice, with an identified treatment result. No progress note documentation related to the non- delivery of medication was found
- A specified date, the resident's medication was documented as "not delivered" at both administration times with no documented treatment results. Progress notes dated the same day stated that the medications were held.
- A specified date, the resident's treatment was provided one and a half hours later by the RPN and not at the prescribed time

On a specific date, the DRC acknowledged that the RPN administered a specified medication to this resident that was not in accordance with the directions for use specified by the prescriber and that the treatment should have been provided at the prescribed time. The DRC also acknowledged that the specified medication tablet was crushed by the RPN and was not administered in accordance with the directions for use specified by the prescriber where the directions stated "do not crush."

The licensee failed to ensure that two medications and treatments were administered to this resident in accordance with the directions for use specified by the prescriber.

The severity was determined to be a level two as there was minimal harm or potential for harm. The scope of this issue was recognized as a pattern throughout this inspection. The home has a history of unrelated non-compliance. [s. 131. (2)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #3: 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 required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee was required to ensure that the policy was in compliance with and was implemented in accordance with all applicable requirements under the Act.

Ontario Regulation 79/10 s. 50 (2)(b)(iii) states that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care related to nutrition and hydration are implemented.

Skin care and wound management procedure for wound and ulcer assessment policy SW009, last reviewed on June 1, 2016, stated in part that the Clinical Support Nurse "will complete referral to Dietician for supplement consideration for wound healing purposes

and Nutritional screening for ulcers Stage 3 or greater."

The policy only addressed ulcers stage III or greater, but did not include other types of altered skin integrity including stage I or II pressure ulcers, skin breakdown, skin tears or wounds.

On April 26, 2017, the DRC acknowledged that policy SW009 was not in compliance with the Regulation.

The licensee has failed to ensure that the homes skin and wound policy was in compliance with and was implemented in accordance with all applicable requirements under the Act. [s. 8. (1) (a),s. 8. (1) (b)]

2. Ontario Regulation 79/10 s. 136 (2)2. states that the drug destruction and disposal policy must also provide for the following: 2. That any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs.

Upon inspection of CI Report #M627-000024-16, it was noted that a registered staff member who was involved in the CI was also the same staff member involved in another medication incident.

On a specific date, the DRC shared that the registered staff member was suspected of removing a specific medication for destruction from the narcotic destruction box during the evening on a specified date. The DRC stated the home could not account for the specified medication that was found in the identified RHA. The DRC shared that the resident's medication were replaced the evening before the incident, and that the medications for destruction were not in the destruction box in the specified RHA, rather found in the medication room.

Review of the "Report Form for Facility Operators and Employers" to the College of Nurses of Ontario dated after the incident, documented an incident involving narcotic destruction.

Review of the home's policy titled Drug Destruction and Disposal, policy number 5-4 dated 2/17 stated that "Medications for destruction/disposal are removed from all medication storage areas and retained in a locked area in the medication room, separate

from medications for administration to a resident. These medications should not be available to reuse." The policy further stated "Retain the medications in the double-locked wooden box, in the locked medication room, separate from those medications available for administration to a resident. Only the Director of Care will hold keys to the wooden box, however the box is only accessed with the DOC (or designate) and the pharmacist or physician."

On a specified date, a RN stated that sometimes the narcotic destruction box gets full enough that you can reach down and retrieve medications that had been placed in the box by other registered staff. The RN stated that if the medications are not pushed all the way down the ledge you can still retrieve them and that the RN has been able to put their arm into the opening of the box and push other medications down.

On a specified date, a RPN stated there have been times where the destruction box has been so full that you can see and grab medications.

The licensee failed to ensure that controlled substances waiting to be destroyed were stored in a separate, double-locked stationary cupboard in the locked area as per the homes policy.

The severity was determined to be a level one as there was minimum risk for harm. The scope of this issue was identified as widespread throughout the inspection. The home has a history of this legislation being issued in the home on November 2, 2015, as a Voluntary Plan of Correction (VPC) in a Resident Quality Inspection (RQI) #2015_326569_0023. [s. 8. (1) (b)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee is required to ensure that the policy was in compliance with and was implemented in accordance with all applicable requirements under the Act, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

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

Fall Prevention – Post-Fall Procedure, Policy number NMF014, last reviewed on October 2, 2014, stated in part that registered nursing staff would decide what type of lift to utilize when moving a resident who had fallen.

Record review of a specified resident's progress notes showed documentation by a RN that the resident had fallen and was assisted to bed using a specific transfer technique by staff. It was discovered three days later that the resident had sustained an injury, however, the cause and time of the injury remains unknown due to the resident's multiple falls.

On a specific date, a RN explained that if a resident had fallen, no one was allowed to pick them up off the floor themselves, and staff would utilize a specific device to transfer. The RN stated that they had not used the specific device to transfer this resident because the resident was already sitting on the floor and was able to pull themselves up off the floor with assistance.

On a specified date, the DRC clarified that if a resident had fallen, staff were to assist the resident off the floor with a specific device. The DRC reviewed the progress note and stated that the action taken was inappropriate and was not according to policy.

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

The severity was determined to be a level two as there was minimal harm or potential for harm. The scope of this issue was isolated. The home has a history of unrelated non-compliance. [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #5: 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 when a resident has fallen, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Post-Fall Assessment Checklist, Policy number NMF013, dated June 19, 2012, stated in part that after a resident has fallen, a post-fall checklist and incident report in the Med-E-Care documentation system would be completed and forwarded to the DRC.

CI Report #M627-000011-16 outlined that a specified resident had multiple falls in a specific month in 2016. On a specified day the resident had a fall and sustained an injury.

On a specific date, the RN acknowledged that a post fall assessment was not completed for the fall on the specified day, as they had documented in a non-incident note instead of a falls incident note.

On a specific date, the DRC stated that a post fall assessment should have been completed for the fall on the specified day, and that they were not flagged of the incident because there was no falls incident report.

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

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was identified as an isolated incident. The home has a history of unrelated non-compliance. [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 required, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds has been assessed by a RD who is a member of the staff of the home, and had any changes made to the plan of care related to nutrition and hydration been implemented.

Two specified resident's both had altered skin integrity.

Review of both resident's clinical records showed that neither resident was followed by the homes RD for their skin issues during the time the areas of altered skin integrity were present.

On a specific date, a RPN explained that registered staff had not been sending referrals to the RD for wounds including pressure ulcers.

On a specific date, the CSN stated that they would only contact the RD for stage III or IV pressure ulcers, and that registered staff on the floor were not responsible for referring residents with altered skin integrity to the RD.

The RD shared in an interview, that they were not aware of either resident's altered skin integrity and had not seen the residents for their skin integrity.

In an interview with the DRC they shared that the home refers only stage III and IV wounds to the RD for intervention as per the homes policy. [s. 50. (2) (b) (iii)]

2. On a specified day, a resident returned to the home following a hospitalization. A registered staff documented in a skin care and wound management manual that the resident had altered skin integrityr, and a treatment care plan was initiated.

On a specified day, a RPN explained that registered staff had not been sending referrals to the RD for wounds including pressure ulcers.

On a specified day, the CSN stated that they would only contact the RD for stage III or IV pressure ulcers, and that registered staff on the floor were not responsible for referring residents with altered skin integrity to the RD.

On a specified day, the RD acknowledged that they were notified by the CSN of this resident's altered skin integrity only when the skin condition worsened. The RD was not notified of the area of altered skin integrity that was indicated in the skin care and wound management manual. The RD stated that registered staff should be notifying them immediately of all pressure ulcers.

The licensee has failed to ensure that the resident exhibiting altered skin integrity, was assessed by a registered dietitian who is a member of the staff of the home, and had any changes made to the plan of care related to nutrition and hydration been implemented.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was identified as widespread throughout the inspection. There is a compliance history of this legislation being issued in the home on May 16, 2016, as a VPC in a RQI #2016_276537_0022. [s. 50. (2) (b) (iii)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is assessed by a registered dietitian who is a member of the staff of the home, and have any changes made to the plan of care related to nutrition and hydration been implemented, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's condition has been reassessed and the effectiveness of the restraining evaluated by a physician or a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time based on the resident's condition or circumstances.

A Resident was observed during stage one of this RQI to be wearing a safety device. The resident was cognitively impaired and unable to release the device themselves. The resident's care plan identified that the device was a restraint.

In an interview with a RN, they shared that the specified resident used the device for safety reasons. They shared that the registered staff do not document the monitoring of this device for the resident every eight hours, and that restraint monitoring by the registered staff was documented on the eMAR. They further shared that the PSW's document safety checks when they turn and reposition the resident every two hours and documents this in Point Of Care (POC). The RN stated that the registered staff document on restraints every eight hours, but not Personal Assistive Services Device's (PASD's).

In an interview with a PSW, they shared that residents who use restraints are to be monitored by the PSW's and documented on a restraint form every shift. The form helps staff to identify when the restraint was last released, applied and by whom. They further shared that they felt restraint documentation was not being completed as it was still being documented on a paper form. When we looked at the restraint forms for the unit, there was no restraint monitoring form for this specific resident.

Review of the homes policy titled Alternative Methods to Restraints and PASD's with Restraining Effects, Policy number NMM016, and last reviewed in August 2014, stated in part that:

"Monitor the resident as required while he/she is in the restraint or PASD with Restraining Effect. Any resident in such devices must be monitored every hour by a registered staff member or a staff member assigned by a registered staff member. Release, repositioning and reapplication must occur every two hours and be documented. An RN or RPN must complete a reassessment for continued effective use, safety and comfort of the device every eight hours. At Strathmere Lodge, this means signing that the need for the restraint still exists (even if the resident is not actively restrained during that shift,) and if the resident is actively restrained, ensuring that he/she is comfortable and safe every eight hours."

Review of the eMAR for this resident showed that registered staff were not documenting restraint device safety checks every eight hours as required.

In an interview with the DRC, they shared that their expectations were that registered staff document every eight hours that the restraint device is applied correctly and still

needs to be used. They further stated that this resident's restraint device should be classified as a PASD with restraining effects.

The licensee has failed to ensure that the resident's condition had been reassessed and the effectiveness of the restraining evaluated by a physician or a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time based on the resident's condition or circumstances.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was identified as isolated throughout the inspection. The home has a history of unrelated non-compliance. [s. 110. (2) 6.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the written policies and protocols were developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Record review of the Controlled Substances – Counting – Narcotics, Policy number NMC014 stated, "All narcotics shall be counted at the end of every shift, preferably when the new shift has arrived. The leaving and on-coming nurse on a given unit will normally do the counting in tandem, but if this is not possible for any reason, any two registered staff members working on adjacent units may count the narcotics according to policy."

A) CI Report #M627-000024-16 was submitted to the MOHLTC for an incident of a missing controlled substance.

Record review of the "Monitored Medication Record for 7 -Day Card" for a specific controlled substance, documented medication count discrepancies over a nine day time period for a specified resident.

Record review of the "Shift Change Monitored Medication Count" documented the specific medication for the identified resident on a specified date, showed there was a count of "2" at two specific times, and a count of "0" seven hours later.

Record review of the home investigation notes documented that the RN and RPN failed to complete the shift change narcotic count at a certain time on a specified date, as per policy. Subsequently, between a 16 hour time period on a specified date, a controlled medication for the identified resident went missing resulting in a narcotic count error. Narcotic count at a specific time was conducted with a second staff and they were unable to locate the missing medication. The RPN acknowledged during an investigation interview that they were aware of the missing medication at a certain time on a specified date, and had still not completed the shift narcotic count for the previous shift change.

B) Record review of the "Medication Incident - Original Report" for an identified resident on a specified date, showed when the RPN was taking the medication out of the box it was discovered that the medication was not the same dosage identified on the box. Another box of medication identifying another dosage was checked and it did contain the dosage as indicated on the box however, it was discovered that a specific dosage of medication was missing. The incorrect dosage of medication was given to an identified

resident.

During a telephone interview with a RPN, they recalled the medication incident involving the identified resident on the specified date, and that the error was not discovered until several days after the incident occurred.

Record review of the "Individual Monitored Medication Record" for a specific medication dosage for the identified resident documented several medication count discrepancies over a specific seven day time period.

Record review of the "Individual Monitored Medication Record" for a specific medication dosage for the identified resident documented several medication count discrepancies over a specific seven day time period.

Record review of the "Shift Change Monitored Medication Count" on the identified resident's Home Area for a specific time period, documented the incorrect number of medication dosages for two medications for the identified resident. There appeared to be six different registered staff initials over 12 shift changes which were documented in the identified time frame, on the "Shift Change Monitored Medication Count" sheet for the routine narcotic count for this resident.

The DRC acknowledged that the registered staff did not implement the home's policy where all narcotics shall be counted at the end of every shift by any two registered staff members.

The licensee failed to ensure that the written policies related to counting controlled substances was implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was identified as a pattern throughout the inspection. The home has a history of unrelated non-compliance. [s. 114. (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 the written policies and protocols related to medication management are developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee failed to ensure that a monthly audit was undertaken of the daily count sheets of controlled substances to determine if there were any discrepancies and that immediate action was taken if any discrepancies were discovered.

Record review of the "Shift Change Monitored Medication Count" on a specified RHA, for a specific time period documented the incorrect number of specific doses of medication. There appeared to be six different registered staff initials documented between the identified time period, on the "Shift Change Monitored Medication Count" sheet for the routine narcotic count.

Record review of the Controlled Substances – Counting – Narcotics, Policy number NMC014 stated, "controlled substances will be counted on every shift and audits are to be completed monthly on the count sheets."

Record review of the "Medication Incident – Original Report", documented a medication administration error where the incorrect dose was given to a resident.

The DRC shared that the home's policy stated that monthly audits are to be conducted of the shift count sheets monthly, but there was no documented evidence that this had occurred. The DRC shared that it is the home's expectation to audit the "Shift Change Monitored Medication Count" sheets monthly to determine any discrepancies. The discrepancy related to the medication error was not determined during the audit of the resident's count sheets for the identified month.

The licensee failed to ensure that a monthly audit was undertaken of the daily count sheets of controlled substances to determine if there were any discrepancies with an identified resident's medication for the identified month.

The severity was determined to be a level one as there was minimum risk. The scope of this issue was identified as widespread. The home has a history of unrelated non-compliance. [s. 130. 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 a monthly audit is 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, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

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

every adverse drug reaction was reported to the resident, the resident's Substitute Decision Maker (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.

Review of the "Strathmere Lodge Medication Incidents" over a three month time period, documented a total of 12 incidents for this quarter with errors related to drug administration and dispensing/delivery.

Record review was completed of the "Infection Control and Professional Advisory Committee (IPAC) Minutes" dated March 22, 2017. The Medical Director was listed as attending this meeting, however the medication incidents were documented as being discussed with the DRC.

Record review of the "Clinical Consultant Pharmacist Quarterly Report" dated March 22, 2017, for a time period of December 2016, to February 2017, documented, "Medication incidents- Reviewed and discussed with Director of Care (DOC)." DRC #115 clarified this was themself the report is referring to.

The DRC shared that the registered staff who discovered the medication error was also the one who would contact the resident/family and the physician and a progress note would be completed to indicate that the resident/family was notified and physician was telephoned. The DRC stated that the Medical Director was informed of all medication incidents at the IPAC meetings.

A medication incident occurred on a specified date involving an identified resident. Review of this resident's progress notes showed that the medication incident was not reported to the physician, as there was no note present to review.

A medication incident occurred on a specific date involving an identified resident. Review of this resident's progress notes showed that the medication incident was not reported to the resident, the resident's Substitute Decision Maker (SDM), if any, or the resident's attending physician, as there was no note present to review.

A medication incident occurred on a specific date involving an identified resident. Review of this resident's progress notes showed that the medication incident was not reported to the resident, the resident's SDM, if any, or the resident's attending physician, as there was no note present to review.

A RPN recalled the medication incident involving an identified resident on a specified date, and stated that the medication incident was not reported to the attending physician or the physician on-call.

During a telephone interview, a RPN recalled the medication incident involving an identified resident on a specified date, and that the error was not discovered until several days after the incident occurred. The RPN stated that the medication incident was not reported to the resident/family or the physician, only reported to the DRC. The DRC stated that they did not report the incident to the resident/family or the physician. The RPN also recalled the medication incident involving an identified resident on a specified date, and stated that the medication incident was reported to the resident, but not the physician.

The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident, the resident's SDM, if any, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident. [s. 135. (1) (b)]

2. The licensee 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, any changes and improvements identified in the review were implemented, and a written record was kept of everything.

Record review of the "Clinical Consultant Pharmacist Quarterly Report" dated March 22, 2017, for a time period of December 2016, to February 2017, documented, "Medication incidents- Reviewed and discussed with DOC." There was no written record of the quarterly review of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review and there was no written record of the changes and improvements identified in the review.

The DRC shared that although the medication incidents and adverse drug reactions were discussed as part of the "Infection Control and Professional Advisory Committee Minutes", there was no written record of the quarterly review of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review. The DRC also stated there was no written record of the changes and improvements identified in the review and the improvements were not documented as

part of this quarterly review and there was no written record of implementation.

The licensee failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions and a written record was kept of everything.

The severity was determined to be a level one as there was minimal risk. The scope of this issue was identified as widespread throughout the inspection. The home has a history of unrelated non-compliance. [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 every medication incident involving a resident and every adverse drug reaction is 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, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (2) The drug destruction and disposal policy must also provide for the following:
2. That any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs. O. Reg. 79/10, s. 136 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the drug destruction and disposal policy provided for the following: that any controlled substance that was to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that was available for administration to a resident, until the destruction and disposal occurs.

CI Report #M627-000024-16 was submitted to the MOHLTC for an incident of a missing controlled substance.

Record review of the Medical Pharmacies Patch Disposal for Monitored Medication, Policy number 6-8 stated, "to standardize and allow safe and secure disposal of monitored (Narcotic & Controlled) medication dispensed in a specific form." The procedure provided specific directions for staff.

A RN and RPN on a specific RHA stated that at times the "Specific Disposal Record Sheet" would be placed in the locked narcotic bin in the medication cart until there was an opportunity for disposal with a second registered staff member. Specific Disposal Record Sheets were seen in the narcotic drawer by the inspector when observing the narcotic count.

The DRC acknowledged that the homes policy instructs registered staff to follow the specified directions.

The licensee failed to ensure that the drug destruction and disposal policy related to the disposal and destruction of narcotic and controlled medication was stored in a double-locked storage area within the home, separate from any controlled substance that was available for administration to a resident, until the destruction and disposal occurs.

The severity was determined to be a level one as there was minimum risk. The scope of this issue was identified as widespread throughout the home. The home has a history of unrelated non-compliance. [s. 136. (2) 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 drug destruction and disposal policy provided for the following: that any controlled substance that was to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that was available for administration to a resident, until the destruction and disposal occurs, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on an interdisciplinary assessment with respect to the resident's sleep pattern and preferences.

On a specific date, a resident told Inspector #630 that often staff woke them up at a specific time and they would prefer to get up an hour and 20 minutes later. The resident said they had told staff their preference for getting up later.

On a specific date, the resident told Inspector #630 that they would like to sleep longer each morning and that they frequently told staff that they thought it was too early to get up. The resident said that for the last few days the staff had woken them up later and that was much better but last week they had gotten up earlier. The resident said it depended on what staff member was working what time they had to get up in the morning.

On a specific date, a PSW said that they would look on the admission profile sheet and in the plan of care to find out what care a resident required regarding sleep preferences. The PSW said that this resident usually would get up within an hour time period. The PSW said that sometimes they would get this resident up and dressed and then the

resident would go back to bed until breakfast meal service.

The "Initial Plan of Care" showed trouble sleeping sometimes but did not include assessment or indication of this resident's customary routine for waking up in the morning. The admission progress note assessment stated "sleep: resident says they are sometimes awake at night but no concerns" and did not include further assessment of sleep preferences. The clinical record included no other documentation regarding the assessment of sleep preferences included in the progress notes between admission and the current date.

The electronic and hard copy plan of care regarding "sleep" for this resident stated that they had troubles sleeping and included the intervention "maintain past bedtime and waking time" but did not specify the resident's preference for time to get up in the morning.

The Nurse Coordinator (NC) told Inspector #630 that part of their role was to do the admission assessment and initial profile. The NC said at admission the practice was to ask the resident about the time they preferred to go to bed but there was not a specific question about preferred time to get up unless the resident volunteered that information. The NC said that the admission progress notes captured the admission assessment regarding sleep preferences. The NC said that some residents were able to express when they wanted to get up or their family could express and then they would accommodate that request. The NC said that this resident was capable of expressing sleep preferences and it would be expected that any requests would be captured in the progress notes or plan of care. The NC said it was the expectation in the home that a resident's sleep preferences would be reflected in the plan of care.

The licensee has failed to ensure that the plan of care was based on an interdisciplinary assessment with respect to the resident's sleep pattern and preferences.

The severity was determined to be a level one as there is minimum risk. The scope was identified as an isolated issue. There is a compliance history of this legislation being issued in the home on August 20, 2014, as a VPC in a Critical Incident Inspection #2014_183135_0067. [s. 26. (3) 21.]

WN #13: 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:
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the restraint plan of care include alternatives to restraining that were considered, and tried, but have not been effective in addressing the risk.

An identified resident was observed in stage one of this RQI to be wearing a safety device. The resident was cognitively impaired and unable to release the device themselves. The resident's care plan identified that the device was a restraint.

Review of the homes policy titled Alternative Methods to Restraints and PASD's with Restraining Effects, Policy number NMM016, and last reviewed in August 2015, stated:

"Prior to considering the use of restraints or PASD's with restraining effects, implement all possible alternatives as outlined in chart. Use the 'Alternative Treatments to Restraints' document at the end of this policy if useful to this end."

Review of this resident's clinical record, showed that an 'Alternative Treatments to Restraints' assessment had not been completed prior to the use of the device.

In an interview with a RN they stated that the Occupational Therapist (OT) completes the alternative to restraint assessments and they are directed by them as to what to use.

In an interview with the DRC they shared that they expect staff to complete the Alternative to Restraints form prior to initiating the use of restraints or PASD's.

The licensee has failed to ensure that the restraint plan of care included alternatives to restraining that were considered, and tried, but have not been effective in addressing the risk.

The severity was determined to be a level one as there is minimum risk. The scope was identified as isolated throughout the inspection. There was a compliance history of this legislation being issued in the home on November 2, 2015, as a Written Notice (WN) in a RQI #2015_326569_0023. [s. 31. (2) 2.]

Issued on this 6th day of July, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ALICIA MARLATT (590), AMIE GIBBS-WARD (630), MELANIE NORTHEY (563), NEIL KIKUTA (658)
Inspection No. / No de l'inspection :	2017_532590_0008
Log No. / Registre no:	007522-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 26, 2017
Licensee / Titulaire de permis :	THE CORPORATION OF THE COUNTY OF MIDDLESEX c/o Strathmere Lodge, 599 Albert Street, P.O. Box5000, STRATHROY, ON, N7G-3J3
LTC Home / Foyer de SLD :	STRATHMERE LODGE 599 Albert Street, Box 5000, STRATHROY, ON, N7G-3J3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Brent Kerwin

To THE CORPORATION OF THE COUNTY OF MIDDLESEX, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that all controlled substances are stored in a separate double locked area.

Grounds / Motifs :

1. The licensee 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.

A) Critical Incident (CI) Report #M627-000024-16 was submitted to the Ministry of Health and Long Term Care (MOHLTC) for an incident of a missing controlled substance. The CI documented that a Registered Nurse (RN) may have left the one remaining controlled substance and the box containing the controlled substance on top of the medication cart while attending to a resident. The medication cart was left in the hallway outside the resident's room. Investigation notes detailed that the RN suggested that the box containing the controlled substance and the individual controlled substance was left on top of the medication cart when it went missing, but that the RN was unable to recall if this

was what happened. The remaining controlled substance was not stored in a separate locked area within the locked medication cart as the medication was missing at the time of the shift change narcotic count at 2300 hours.

Review of the Medication Storage, Policy number NMM003, last revised in August 2014, states:
"Registered staff will lock the medication/treatments carts at all times when unattended" and "Narcotics will be kept in the separate locked compartment inside the medication cart. Therefore providing a double locked system."

The Director of Resident Care (DRC) shared that the RN reported leaving the controlled substance on top of the medication cart in the hallway outside a resident's room and acknowledged that the controlled substance should have been stored in a separate locked area within the locked medication cart.

B) On April 25, 2017, an observation of the narcotic count was conducted with two Registered Practical Nurse's (RPN) on a specified Resident Home Area (RHA) in the medication room at shift change between days and evenings. One of the RPN's started the narcotic count by removing the cards of narcotics without using a key to open the narcotic storage area within the medication cart. The RPN acknowledged that narcotics were to be stored in a separate double-locked area. The RPN further shared that the bin did not always close properly, and stated, "really push it down hard for it to lock" and acknowledged that the narcotics were not double locked.

On April 28, 2017, a RN on a different specified RHA opened the bottom drawer of the medication cart and was able to lift open the lid to the narcotic bin without using a key. The bin was unlocked and the RN acknowledged that the narcotic bin should be locked at all times when not in use.

The licensee failed to ensure that controlled substances were stored in a separate locked area within the locked medication cart.

The severity was determined to be a level two as there was minimal harm or potential for actual harm to the residents. The scope of this non-compliance was widespread throughout the inspection. The home has a history of unrelated non-compliance.

(563)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2017

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that medications for all residents, specifically two identified resident's, are administered in accordance with the directions specified by the prescriber.

Grounds / Motifs :

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

A) Upon review of the daily count sheets, monthly audit of the daily count sheets and recent medication incidents, it was discovered that an identified resident had an incorrect amount of a specific medication available for administration.

Record review of the physician's orders in Point Click Care (PCC) for this resident showed specific directions for dosages and administration times for the specific medication.

Record review of the "Medication Incident - Original Report" for this resident showed when the RPN was taking the medication out of the box it was discovered that the medication was not the same dosage identified on the box. Another box of medication identifying another dosage was checked and it did contain the dosage as indicated on the box however, it was discovered that a specific dosage of medication was missing. The incorrect dosage of medication was given to an identified resident.

The DRC acknowledged that the medication incident involving this resident where the resident was administered the incorrect dosage of medication was not administered in accordance with the directions for use specified by the

prescriber.

The licensee failed to ensure that the medication dosage for a specified resident was administered in accordance with the directions for use specified by the prescriber.

B) A medication administration observation was completed on a specific day, for a specified resident.

Record review of the electronic Medication Administration Record (e-MAR) documented the following for this resident:
- Specified treatment once daily on two specified days in the week, at alternate times
- A specified medication, twice daily at specific times
- A specified medication, one tablet by mouth twice daily at specific times. Medication documented as “HAZARDOUS, DO NOT CRUSH”

On a specific date and time, Inspector #563 observed a RPN administer medications to this resident. The DRC was present at the time of the observation. The resident was administered all their medications at that time crushed with a fluid. The clear plastic strip pack containing the tablet medication was placed into the pill crushing device by the RPN. The crushed tablet was added to the fluid with other crushed medications for administration to this resident. Observation of the strip package for the tablet medication demonstrated the medication was crushed and residue was present. The package clearly stated “HAZARDOUS, DO NOT CRUSH”.

On a specific date and time, Inspector #563 observed the RPN administer a medication to the resident. The DRC was present at the time of the observation. The resident was administered a specific medication. This medication was due to be given five hours earlier.

The RPN stated the medication was held because the resident did not have a meal. The RPN acknowledged that there was no physician's order to postpone the administration of the medication. The RPN also acknowledged that the order for medication was not given at the time prescribed by the physician. The RPN shared that a specified treatment was scheduled at a certain time and that the resident was treated one and a half hours later and acknowledged that the physician’s order was for the treatment to be provided at a specific time and that

this was not done.

Record review of the "Medication/Treatment Administration Record" for this resident for a specific month in 2017, documented the following:
- A specified medication due at a specific time was administered to the resident between four and a half and five and a half hours later on seven of 25 days and on 11 of 25 days the medication was documented as "not delivered"
- A specified medication due at a specific time was administered to the resident between one and a half and five hours later on five of 25 days and on seven of 25 days the medication was documented as "not delivered"
- A specified date, the resident's medication was documented as "not delivered" twice, with an identified treatment result. No progress note documentation related to the non-delivery of medication was found
- A specified date, the resident's medication was documented as "not delivered" at both administration times with no documented treatment results. Progress notes dated the same day stated that the medications were held.
- A specified date, the resident's treatment was provided one and a half hours later by the RPN and not at the prescribed time

On a specific date, the DRC acknowledged that the RPN administered a specified medication to this resident that was not in accordance with the directions for use specified by the prescriber and that the treatment should have been provided at the prescribed time. The DRC also acknowledged that the specified medication tablet was crushed by the RPN and was not administered in accordance with the directions for use specified by the prescriber where the directions stated "do not crush."

The licensee failed to ensure that two medications and treatments were administered to this resident in accordance with the directions for use specified by the prescriber.

The severity was determined to be a level two as there was minimal harm or potential for harm. The scope of this issue was recognized as a pattern throughout this inspection. The home has a history of unrelated non-compliance. (563)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2017

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

1. The licensee shall ensure that their wound and ulcer assessment policy is in compliance with and is implemented in accordance with applicable requirements under the Act and is complied with.
2. The licensee shall ensure that all drugs are securely stored according to their policy and this legislation.

Grounds / Motifs :

1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee was required to ensure that the policy was in compliance with and was implemented in accordance with all applicable requirements under the Act.

Ontario Regulation 79/10 s. 50 (2)(b)(iii) states that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care related to nutrition and hydration are implemented.

Skin care and wound management procedure for wound and ulcer assessment policy SW009, last reviewed on June 1, 2016, stated in part that the Clinical Support Nurse "will complete referral to Dietician for supplement consideration for wound healing purposes and Nutritional screening for ulcers Stage 3 or

greater."

The policy only addressed ulcers stage III or greater, but did not include other types of altered skin integrity including stage I or II pressure ulcers, skin breakdown, skin tears or wounds.

On April 26, 2017, the DRC acknowledged that policy SW009 was not in compliance with the Regulation.

The licensee has failed to ensure that the homes skin and wound policy was in compliance with and was implemented in accordance with all applicable requirements under the Act.
(658)

2. Ontario Regulation 79/10 s. 136 (2)2. states that the drug destruction and disposal policy must also provide for the following: 2. That any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs.

Upon inspection of CI Report #M627-000024-16, it was noted that a registered staff member who was involved in the CI was also the same staff member involved in another medication incident.

On a specific date, the DRC shared that the registered staff member was suspected of removing a specific medication for destruction from the narcotic destruction box during the evening on a specified date. The DRC stated the home could not account for the specified medication that was found in the identified RHA. The DRC shared that the resident's medication were replaced the evening before the incident, and that the medications for destruction were not in the destruction box in the specified RHA, rather found in the medication room.

Review of the "Report Form for Facility Operators and Employers" to the College of Nurses of Ontario dated after the incident, documented an incident involving narcotic destruction.

Review of the home's policy titled Drug Destruction and Disposal, policy number

5-4 dated 2/17 stated that "Medications for destruction/disposal are removed from all medication storage areas and retained in a locked area in the medication room, separate from medications for administration to a resident. These medications should not be available to reuse." The policy further stated "Retain the medications in the double-locked wooden box, in the locked medication room, separate from those medications available for administration to a resident. Only the Director of Care will hold keys to the wooden box, however the box is only accessed with the DOC (or designate) and the pharmacist or physician."

On a specified date, a RN stated that sometimes the narcotic destruction box gets full enough that you can reach down and retrieve medications that had been placed in the box by other registered staff. The RN stated that if the medications are not pushed all the way down the ledge you can still retrieve them and that the RN has been able to put their arm into the opening of the box and push other medications down.

On a specified date, a RPN stated there have been times where the destruction box has been so full that you can see and grab medications.

The licensee failed to ensure that controlled substances waiting to be destroyed were stored in a separate, double-locked stationary cupboard in the locked area as per the homes policy.

The severity was determined to be a level one as there was minimum risk for harm. The scope of this issue was identified as widespread throughout the inspection. The home has a history of this legislation being issued in the home on November 2, 2015, as a Voluntary Plan of Correction (VPC) in a Resident Quality Inspection (RQI) #2015_326569_0023. (590)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 26th day of June, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Alicia Marlatt

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