Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 10, 2018	2017_563670_0026	013186-17	Resident Quality Inspection

Licensee/Titulaire de permis

CORPORATION OF THE CITY OF WINDSOR
1881 Cabana Road West WINDSOR ON N9G 1C7

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

HURON LODGE LONG TERM CARE HOME
1881 CABANA ROAD WEST WINDSOR ON N9G 1C7

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

DEBRA CHURCHER (670), ALI NASSER (523), TRACY RICHARDSON (680)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 23, 24, 25, 26, 27 and 30, 2017.

The following complaints were inspected during this RQI:
Log #002078-17 Infoline #49010-LO related to alleged improper care
Log #032458-16 Infoline #47921-LO related to alleged improper care
Log #006647-17 Infoline #50063-LO related to alleged improper care
Log #009385-17 Infoline #50734-LO related to alleged improper care

The following inspections were completed concurrently while in the home:
Complaint Inspection #2017_607523_0029, Log# 003929-17 related to alleged improper care.
Complaint Inspection #2017_678680_0020, Log# 012124-16 related to alleged improper care.

PLEASE NOTE: A Written Notification and Voluntary Plan of Correction related to O. Reg. 79/10, s 48. (2), identified in concurrent inspection #2017_678680_0020 (Log# 012124-16) will be issued in this report.

During the course of the inspection, the inspector(s) spoke with more than twenty residents, Residents' Council representative, the Administrator, the Director of Care, the Assistant Director of Care, the Registered Nurse Educator, the Pharmacist, six Registered Nurses, six Registered Practical Nurses, fifteen Personal Support Workers, more than six family members, and one Dietary Aide.

During the course of the inspection, the inspectors toured all resident home areas, observed the general maintenance and cleanliness of the home, dining services, medication rooms, medication administration and medication count, the provision of resident care, recreational activities, staff to resident interactions, infection prevention and control practices and reviewed resident clinical records, posting of required information and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

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

- **7 WN(s)**
- **6 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 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 of 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 was required to ensure that the plan, policy protocol, procedure, strategy or system was complied with.

Ontario Regulation 79/10, s. 114 (2) states, "The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home".

Review of the Clinical Consultant Pharmacist quarterly review, dated August 14, 2017, was completed when the medication incidents were reviewed during the Resident Quality Inspection (RQI). The section of the Clinical Consultant Pharmacist quarterly review titled, "Miscellaneous" stated "we should recommend destroying/denaturing the drugs, by adding liquid just before stericycle picks them up (i.e. when the pail is full) in order to reduce off gasing. Also strip pouches should be open before being put into Stericycle bin for proper destruction of pills, consider cutting the roll in the middle to save time."

The home's policy titled "Drug destruction and disposal," dated February 2017, stated "All medications which are surplus, excluding monitored medications (narcotic and controlled drugs), are destroyed by the team of nursing staff and one other staff member appointed by the Director of Nursing." "Medications are considered destroyed when they are altered to such an extent that their consumption is rendered impossible or improbable."

During an observation of the medication room on October 26, 2017, Inspector #680 noted there was a white pail and inside the pail were packages of unopened labelled medications that were still intact. Registered Practical Nurse (RPN) #116 stated that if the pail was full the nurse would not slur the medications, seal the pail, and the pail would go to the stock room for removal by Stericycle. RPN #116 stated that if the pail was not full that pharmacy would slur them at the time when narcotic destruction was completed.

Observations by Inspector #680 with Pharmacist #134 showed that on the second floor in the drug destruction medication pail there were two pill bottles with medications still inside and the medications were not denatured. Pharmacist #134 acknowledged that there were strip packages with pills in the pail on the third floor that were still intact.

Pharmacist #134 stated that best practice was to remove the pills from the strip packages, and that the packages did not dissolve when wet. Pharmacist #134 stated that the nurses should be placing a bit of water at the bottom of pail, and then they should be adding more water each time and at the end the nurses should cover the medications with water to denature the pills. Pharmacist #134 showed inspector #680 the denatured bag of narcotics in the pail on the third floor. Pharmacist #134 acknowledged that there was no water in the pail on the third floor.

In an interview on October 27, 2017, RPN #106 stated that they threw the whole strip package into the pail. RPN #106 stated that they did not pour any liquid on the medications and that they were aware of the policy to add water. RPN #106 also stated that they threw their empty medication packages into the pail for destruction as well.

In an interview on October 30, 2017, DOC #101 stated that when the non-narcotic destruction pails were sealed in the medication rooms and they were not opened again to denature anywhere else. DOC #101 stated that Stericycle removed the full pails every four weeks.

The licensee has failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system was complied with.

The severity of this non-compliance is minimum risk and the scope is a pattern. The home has a compliance history of one or more unrelated non-compliance in the last three years. [s. 8. (1) (b)] (680) [s. 8. (1) (b)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and of acquiring, in the case of new items.

Observations of the spa areas were done on October 23, 2017, during the Resident Quality Inspection (RQI). The spa room on Hickory home area had a razor that was not labelled and had a thick white sediment noted on the blade sitting on the ledge of the shower area. In the tub room by the tub, a cart was present for supplies. In the top drawer of the cart there were numerous nail clippers that had not been labelled laying in the drawer. In the Magnolia spa room, there was a hairbrush in the tub area that had not been labelled and had a lot of hair in the brush.

RN #106 stated that the razor should have been labelled and should have been put away

when care was completed. They acknowledged that it had a thick white sediment on it and appeared to be used.

Personal Support Worker (PSW) #108 stated that the nail clippers should be labelled and stated that the nail clippers would be removed, cleaned and then labelled.

On October 23, 2017, in the Sycamore spa Inspector #680 observed a container with three bars of used soap laying on top of each other by the tub. There was no label on the container to identify which resident the soap belonged to. Also in this area was five containers of body butter which had appeared used and they were not labelled.

Registered Nurse (RN) #111 stated that the bars of soap should not be in tub room and they should have been labelled. RN #111 acknowledged that the body butter creams were not labelled and that the home did not supply this and they should not have been left in the spa area.

On October 24, 2017, Inspector #670 observed two used unlabelled deodorants and one used unlabelled hairbrush in the Hickory spa area.

On October 25, 2017, in the Sycamore spa area Inspector #680 observed labelled nail clippers were in a container together sitting by the side of the tub.

Director of Care (DOC) #101 stated that all personal items should be labelled and that the nail clippers should be labelled and in separate containers.

The licensee has failed to ensure each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and of acquiring, in the case of new items.

The severity of this non-compliance is minimum risk and the scope is a pattern. The home has a compliance history of this legislation being issued in the home on December 16, 2014, as a Voluntary Plan of Correction (VPC) in a Resident Quality Inspection #2014_216144_0067. [s. 37. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and or acquiring, in the case of new items, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (2) Each program must, in addition to meeting the requirements set out in section 30,
(a) provide for screening protocols; and O. Reg. 79/10, s. 48 (2).
(b) provide for assessment and reassessment instruments. O. Reg. 79/10, s. 48 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that each program, in addition to meeting the requirements set out in section 30, provided for assessment and reassessment instruments.

Ontario Regulation 79/10 s. 48 (1) 2 states, "Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions."

Review of the home's Skin and Wound Management policies and procedures demonstrated no reference, procedure or instruction related to the completion of assessments or reassessments of residents with impaired skin integrity.

Director of Care (DOC) #101 stated that in 2016, they had updated the home's policy titled "Skin Care and Wound Management" and that the reference to the procedure and scheduling of skin and wound assessments and reassessments had been inadvertently removed and should not have been removed. DOC #101 acknowledged that the skin and wound care program did not provide for assessment and reassessment instruments.

The licensee has failed to ensure that the skin and wound program provided for assessment and reassessment instruments.

The severity of this non-compliance is minimal harm or potential for actual harm and the scope is widespread. The home has a history of one or more unrelated non-compliance in the last three years. [s. 48. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each program will, in addition to meeting the requirements set out in section 30, provide for assessment and reassessment instruments, to be implemented voluntarily.

WN #4: 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 a specific condition was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

This inspection was completed within this RQI in relation to a Complaint Infoline received by the Ministry of Health and Long-Term Care, on a specific date.

A specific resident was admitted to the home on a specific date with specific altered skin integrity to a specific area.

Review of resident's clinical record showed the home had completed assessments on two specific dates. The Inspector and the Director of Care (DOC) were unable to locate any additional specific assessments for the resident.

The DOC acknowledged that specific assessments should have been completed weekly using a clinically appropriate tool, weekly. The DOC stated that if there were no documented assessments that the assessments were not completed. The DOC acknowledged that there should have been assessments on eight specific dates for a total of eight assessments that were not completed.

The licensee has failed to ensure that the resident exhibiting a specific condition had been reassessed at least weekly by a member of the registered nursing staff.

The severity of this non-compliance is minimal harm or potential for actual harm and the scope is a pattern. The home has a history of one or more unrelated non-compliance in the last three years. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that, a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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, and is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #5: 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 were stored in an area or a medication cart that was secure and locked and 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.

Review of the home's policy titled "The Medication Pass, " dated February 2017, stated "Wheel cart to the area where the medication administration begins. Ensure that the cart

is locked if out of the line of site of the nurse."
The policy also stated "When medication pass is completed: secure all locks, on all sections of the cart, return medication cart back to nursing station or medication room."

A) During the Resident Quality Inspection (RQI), on October 25, 2017 at 0820 hours, Inspector #680 observed a Registered Practical Nurse (RPN) in the dining room with their back away from the medication cart. The medication cart was unlocked. On top of the cart was a bottle of medication. There were more than fifteen residents in the dining room near the cart at the time. The RPN returned to the medication cart and then left the area with a Registered Nurse (RN) and entered the medication room, the medication cart was unlocked and was not visible to them.

On October 25, 2017 at 0824 hours, the RPN stated that leaving the medication on top of the medication cart was their normal practice.

B) On October 25, 2017 at 0829 hours, the RPN left the medication cart unlocked with a bottle of medication and a package of medications labelled for a specific resident on the top of the medication cart and entered the dining room. A resident walked by the medication cart with a personal support worker (PSW) to enter the dining room in front of the medication cart. The dining room was full with residents eating breakfast. RPN #117 was not facing the cart.

C) Outside of the dining room, on October 25, 2017 at 0900 hours, inspector #670 observed the medication cart to be locked, a package with pills inside it on the top of the medication cart and a medication cup with liquid in it on top of the medication cart. The RPN responsible for the medication cart was not within site.

On October 25, 2017 at approximately 0915 hours, the Director of Care (DOC) and the Administrator were notified to come to the area by Inspector #670. The DOC and the Administrator acknowledged that the medication cart had medications that were on top of the cart. The medications were placed in the cart by the DOC. The Administrator stated this was not normal practice for staff to leave medications unattended on the medication cart.

An RN stated that leaving medications on top of the medication was not normal practice.

D) On October 25, 2017 at 1302 hours, on a specific home area, Inspectors #670 and #680 observed a medication cart to be sitting in the lounge area near the nursing desk.

There were two residents sitting in this area and the nurse was in the dining room and at times not facing the cart. On top of the medication cart there was a labelled bottle of eye drops and a labelled medicated cream.

An RPN stated that it is not the policy of the home to leave medications on the cart and acknowledged they had left medications on top of the cart.

The DOC acknowledged that the medication cart had medications on top and that the nurse was not able to visualize the cart. The DOC spoke with the RPN and then the RPN locked the medication in their cart.

The licensee has failed to ensure that drugs were stored in an area or a medication cart that was secure and locked.

The severity of this non-compliance is minimal harm or potential for actual harm and the scope is isolated. The home has a history of one or more unrelated non-compliance in the last three years. [s. 129. (1) (a)]

Additional Required Actions:

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

WN #6: 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 was reported to the Medical Director.

During the Resident Quality Inspection (RQI) a review of medication incidents was completed. There were seventeen medication incidents during a specific time period. There was no documentation to show that the Medical Director was aware of the

incidents.

The home's policy titled "Medication Administration and Drug Management," stated "tracking and trending of medication incidents will occur through the quality improvement process and be reviewed quarterly at the Professional Advisory Committee."

The home's policy titled "Medication Incident Reporting," dated February 2017, stated "All medication incidents are reviewed by the home interdisciplinary team including the Administrator, the Director of Care, the Medical Director or prescriber and the Clinical Consultant Pharmacist. Changes and improvements identified in the review are to be implemented and a written record kept on file in the home."

Review of the Clinical Consultant Pharmacist Quarterly Report, dated August 14, 2017, stated "meeting to be scheduled to review last two quarters (January-June) medication incidents with DOC/ADOC and review type of incidents, severity of incidents, and follow up regarding each incident."

On October 26, 2017 at 1400 hours, Director of Care (DOC) stated that the Medical Director had not been informed of each incident as medications incidents had not been discussed at the Professional Advisory Committee (PAC) this year thus far.

The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the Medical Director. [s. 135. (1)]

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

During the Resident Quality Inspection (RQI) a review of medication incidents was completed. There were seventeen medication incidents for a specific time period. There was no documentation to show that the medication incidents were reviewed and analyzed and that corrective had taken place.

The home's policy titled "Medication Incident Reporting," dated February 2017, stated "for an incident originating from nursing or the prescriber, the service centre will send an email of the report to the Director of Nursing/Nurse Manager to initiate corrective action."

A) A medication incident report dated for a specific date, regarding a specific resident, stated that the resident was given a specific dose of a specific medication instead of the scheduled dose of the specific medicaiton. The error was immediately noticed by the nurse. A review of the medication incident report showed that the investigation section was blank. In an interview on October 26, 2017, Director of Care (DOC) stated that there was no trend with this nurse, and that the nurse had reported it themselves. When the Inspector requested any investigative notes related to the medication incidents the DOC stated that she looks them over and if the medication incidents look completed she saves them to a file and no further investigation is completed.

Medication incident dated for a specific date, regarding a specific resident, stated that the resident's specific medications had been discontinued as well as specific health monitoring and there was no doctor's order to support this. Review of the medication incident report showed that the investigation section was blank. In an interview on October 26, 2017, Director of Care (DOC) stated that a specific process in the home was not working, and pharmacy was unaware of the order being discontinued. The DOC explained that the physician had written the orders but that the specific process in the home was not working. The DOC stated there was no harm to the resident.

B) A medication incident report dated for a specific date, stated that a specific medication for a specific resident was removed and was not found on a specific documentation tool. Review of the medication incident report showed the investigation notes section of this form was blank. In an interview on October 26, 2017, Director of Care (DOC) stated that they had a new registered staff member and they disposed of the specific medication incorrectly as they were not trained on the process of drug destruction.

In an interview on October 26, 2017, Director of Care (DOC) stated that they reviewed the medication incidents as they were received and that there was not always a formal written plan to prevent further incidents. The DOC stated that they used an excel sheet to track the medication incidents by home area and the nurse involved in the medication incident for trending however, there was no documentation kept on the corrective action done for each incident. The DOC stated that before they went to the online excel sheet they would write their actions on the bottom of the medication incident report but since going to the excel sheet that was no longer done. The DOC was unable to provide documentation of the review, analysis and corrective action on the above medication incidents.

The licensee has failed to ensure that,
(a) All medication incidents and adverse drug reactions were documented, reviewed and analyzed;
(b) Corrective action was taken as necessary;
(c) A written record was kept of everything required under clauses (a) and (b). [s. 135. (2)]

3. The licensee has failed to ensure that,
(a) a quarterly review was undertaken of all medication incidents and adverse drug reactions that had 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 were implemented;
(c) a written record was kept of everything provided for in clause (a) and (b).

Review of the home's policy titled “Medication Administration and Drug Management,” stated "tracking and trending of medication incidents will occur through the quality improvement process and be reviewed quarterly at the Professional Advisory Committee (PAC).”

The home's policy titled “Medication Incident Reporting,” dated February 2017, stated “All medication incidents are reviewed by the home interdisciplinary team including the Administrator, the Director of Care, the Medical Director or prescriber and the Clinical Consultant Pharmacist. Changes and improvements identified in the review are to be implemented and a written record kept on file in the home.”

Review of the Clinical Consultant Pharmacist Quarterly Report, dated August 14, 2017, stated “meeting to be scheduled to review last two quarters (January-June) medication incidents with DOC/ADOC and review type of incidents, severity of incidents, and follow up regarding each incident.”

In an interview Director of Care (DOC) stated that the quarterly review had not been completed at the last PAC meeting on August 14, 2017, as the pharmacist was not present for this meeting. The medication incident review was to be scheduled for a later date when the pharmacist could attend.

The licensee has failed to ensure that,
(a) a quarterly review was undertaken of all medication incidents and adverse drug reactions that had 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 were implemented;
(c) a written record was kept of everything provided for in clause (a) and (b).

The severity of this non-compliance is minimum harm and the scope is widespread. The home has a history of one or more unrelated non-compliance in the last three years. [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,
1) 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 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.
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; (b) corrective action is taken as necessary; and (c) a written record is kept of everything required under clauses (a) and (b).
3) 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; (b) any changes and improvements identified in the review are implemented; and (c) a written record is kept of everything provided for in clauses (a) and (b), to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a specific device that was used to assist a resident with a routine activity of living was included in the residents' plan of care.

Observations of a specific resident on a specific date at two specific times showed the resident in a specific position.

The home's policy titled Personal Assistance Service Device Procedure (PASD), stated the following:
"As the purpose of the device determines it as a personal assistance service device, a description of the approved devices for PASD use is detailed below:
Tilted/reclined wheelchair- when the chair is tilted/reclined for therapeutic or a comfort reason. The tilt/recline feature is released during meal times, nourishment, transferring, toileting and repositioning. The degree of the tilt/recline is to be determined by the PSW based on resident assessment."
Under procedure it stated:
"PASD's may be ordered by an Occupational Therapist or by a physician. Upon assessment by the registered nurse that the resident may benefit from the use of the device to assist with positioning, comfort or with ADL's, the following is to occur:
-RN is to complete a referral to the physician or to the occupational therapist for assessment of PASD use.
-Consent is to be obtained from the resident/substitute decision maker
-the resident's plan of care is to be updated to include PASD use."

Review of a specific resident's care plan showed that the resident was had a specific limitation and specific risks. There was no mention of the use of a specific piece of equipment.

On a specific date, a Personal Support Worker (PSW) stated that they provide specific care to the resident for a specific purpose.

On a specific date, a PSW stated that if residents were experiencing a specific condition they would provide a specific intervention. The PSW stated that if they provided the specific intervention for the resident that the resident did not require monitoring.

On a specific date, in an interview with Inspector #670, a PSW stated that they were told which residents could not be provided a specific intervention, otherwise they would provide this intervention to the residents.

On a specific date, a Registered Nurse (RN) stated that a specific resident has a specific condition, and that they would not ask for a specific intervention. The RN acknowledged that the residents' plan of care did not include the specific intervention. The RN stated it would not be in the care plan as there was no doctors' order for specific intervention. The RN stated that staff provided this specific intervention to every resident that utilized a specific piece of equipment and it should be in the residents' care plans.

The Director of Care (DOC) stated that staff did provide a specific intervention to residents for a specific reason for 15 minutes then the specific intervention would be removed, and that was an accepted practice. The DOC stated that if staff provided a specific intervention to a specific resident, then they did need a consent and it should be in the plan of care.

The licensee has failed to ensure that a specific device that was used to assist a resident with a routine activity of living was included in the residents' plan of care.

The severity of this non-compliance is minimum risk and the scope is isolated. The home has a history of one or more unrelated non-compliance within the last three years. [s. 33. (3)]

Issued on this 11th day of January, 2018

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

Original report signed by the inspector.