Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 28, 2018	2018_741178_0017	018302-18	Resident Quality Inspection

Licensee/Titulaire de permis

0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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

Forest Hill
6501 Campeau Drive KANATA ON K2K 3E9

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

SUSAN LUI (178), HEATH HEFFERNAN (622)

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): July 27, 31, August 1, 2, 3, 7, 8, 9, 10, 14, 15, 16, 17, 20, 21, 22, 24, 2018.

The following Critical Incident inspections were conducted concurrently with this RQI:
Log #028100-17 (CIR #2834-000018-17), Log #006282-18 (CIR #2834-000006-18), Log #007868-18 (CIR #2834-000008-18), all involving resident falls with injuries.
Log #029512-17 (CIR #2834-000022-17), involving an allegation of staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with residents, family members of residents, President of Residents' Council, Housekeeping Staff, Environmental Services/Maintenance Manager, Nutritional Care Manager, the Life Enrichment Coordinator, Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), the Resident Assessment Instrument (RAI) Coordinator, the Assistant Director of Care (ADOC), the Director of Care (DOC), the Administrator.

During the course of the inspection, the inspectors completed a tour of resident areas, observed medication storage areas, observed medication administration, reviewed medication incident documentation, reviewed Residents' Council meeting minutes, reviewed resident health records, reviewed staff training records, reviewed relevant home policies, protocol and procedures, reviewed critical incident reports and documents related to the licensee's investigation into the identified alleged incident of abuse.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

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

- **3 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A review Medical Pharmacies Policy and Procedure used by the home titled; The Medication Pass - Policy 3-6 which was revised January 2018 indicated:

- Locate medications for the resident and check each medication label against the Medication Administration Record (MAR) or electronic Medication Administration Record (eMAR) to ensure accuracy.
- Document on the MAR in the proper space provided for each medication administered or document by code if the medication is not given.

A review of the Medication Incident Report titled; "Original Report", on an identified date, indicated resident #022 had been ordered two identified medications daily, which had been added to the eMar by the pharmacy for 0800 hours. The Medication Incident Report stated that the home had not received resident #002's two identified medications, as the pharmacy required consent for payment from the Substitute Decision Maker (SDM). Furthermore, on an identified date, RPN #100 had documented on the eMar that they had administered the two identified medications to resident #022 when the medications were not in the strip.

A review of the progress notes on Mede-Care on an identified date, indicated that resident #022's two identified medications had been ordered on an identified date, and were absent from the medication strips as the pharmacy required consent from the SDM.

A review of the eMAR for the identified month, indicated the two identified medications had been documented as administered to resident #022 on 11 separate days, by RPNs #100, #103, #104 and #105.

During an interview with inspector #622 on August 8, 2018 at 1305 hours, DOC #101 and ADOC #102 stated resident #022 had been ordered two identified medications on an identified date. The medications were not available as the pharmacy required the SDMs approval for payment. Approximately two weeks after the two medications were ordered, RPN #100 noted that the two identified medications were absent from the medication strip and contacted the pharmacy. The issue was rectified at that time. Furthermore,

RPN #100 had not observed that there had been errors in documentation of the medication for 11 days until after reviewing the medication incident with the pharmacist. RPN #100 reported the medication errors and the medication incident report was filed on that date.

During a separate interview with inspector #622 on August 8, 2018 at 1010 hours, DOC #101 stated that RPNs #100, #103, #104 and #105 had documented that they had administered the two identified medications to resident #022 eleven times during the identified month in error, which indicated that the staff were not checking the strip against the eMar as policy would state. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy or procedure, the policy or procedure is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas were kept closed and locked when they are not being supervised by staff.

Observations on August 20, 2018 indicated that on floors three, four and five, the washroom beside the elevator was not locked, not supervised by staff, and was accessible to residents on the units. Observations on the first floor on August 20, 2018 indicated that the washroom beside the elevator was not locked, not supervised by staff, and could be accessed by any resident on the main level of the home. None of these washrooms contained call bells.

On August 20, 2018, the Administrator indicated to Inspector #178 that the washrooms on each floor beside the elevator are public washrooms and residents never use them. The Administrator further indicated that these washrooms are not equipped with call bells because they are public washrooms, and not meant for resident use. The Administrator indicated that the doors to the washrooms beside the elevator are not kept locked, so they could potentially be accessed by a resident, but the Administrator has never seen a resident use one of these washrooms. The ADOC also indicated to Inspector #178 on August 20, 2018 that the washrooms beside the elevator are not used by residents, and the ADOC has never seen a resident use one of these washrooms. [s. 9. (1) 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 all doors leading to non-residential areas are kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The Licensee has failed to ensure that resident #012's mobility aid was kept clean and sanitary.

On July 31, 2018 at 1455 hours, inspector #178 observed resident #012's mobility aid was soiled with food and crumbs.

During an observation on August 15, 2018 at 1300 hours, inspector #622 observed dried food debris in the right side of resident #012's mobility aid.

A review of the Night Duties Log Sheet for wheelchair cleaning indicated resident #012's mobility aid was scheduled to be cleaned weekly on a specified day. There had been no documentation of cleaning for resident #012's mobility aide for the month of August 2018.

During an interview with inspector #622 on August 15, 2018 at 1352 hours, RPN #100 observed the dried food debris in the right side of resident #012's mobility aid. RPN #100 stated that the soiling appeared as though it had been on the mobility aid for a while. RPN #100 further stated that the mobility aid should have been cleaned when the spill happened or when the mobility aid was washed during the night and staff should have documented the cleaning.

During an interview with inspector #622 on August 15, 2018 at approximately 1400 hours, Director of Care (DOC) #101 and Assistant Director of Care #102 observed the dried food debris on the right side of resident #012's mobility aid.
DOC #101 stated that the soiled area on resident #012's mobility aid appeared as though it had not been cleaned. DOC #101 said the expectation would be that staff would have cleaned resident #012's mobility aid. [s. 15. (2) (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 equipment is kept clean and sanitary, to be implemented voluntarily.

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Issued on this 24th day of October, 2018

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

Original report signed by the inspector.