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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 18, 2019	2019_543561_0008	027747-17, 028905-17, 028911-17, 002163-18, 010506-18, 012756-18, 017314-18, 025414-18, 030776-18, 031288-18, 003397-19, 006193-19	Critical Incident System

Licensee/Titulaire de permis

The Regional Municipality of Halton
1151 Bronte Road OAKVILLE ON L6M 3L1

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

Allendale
185 Ontario Street South MILTON ON L9T 2M4

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

DARIA TRZOS (561), DIANNE BARSEVICH (581)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 5, 8, 9, 10, 11, 12, 15, 16, 17, 18, 23, 24, 25, 26 and 29, 2019.

The following Critical Incident System (CIS) Inspections were completed:
027747-17, M536-000039-17 - related to improper transfer resulting in injury,
028905-17, M536-000041-17 - related to a fall with injury,
028911-17, M536-000042-17 - related to a fall with injury,
002163-18, M536-000003-18 - related to a fall with injury,
010506-18, M536-000013-18 - related to a fall with injury,
012756-18, M536-000015-18 - related to a fall with injury,
017314-18, M536-000017-18 - related to staff to resident alleged abuse,
025414-18, M536-000024-18 - related to a fall with injury,
030776-18, M536-000030-18 - related to a missing narcotic,
003397-19, M536-000007-19 - related to a fall with injury,
006193-19, M536-000012-19 - related to a fall with injury.

A Follow Up (FU) Inspection log #031288-18 related to O. Reg 79/10 s. 8(1)(b) was completed during this inspection.

The following complaint inspections were completed concurrently with this CIS inspection:
025759-18 - related to alleged resident to resident abuse,
025729-18 - related to alleged resident to resident abuse,
001780-18 - related to alleged resident to resident abuse,
030655-18 - related to management of care needs and medication error.

Please note: Non-compliance was identified during the complaint inspection with the log #030655-18, and is issued in this report as a Written Notification (WN) related to O. Reg 79/10 s. 8(1)(b).

During the course of the inspection, the inspector(s) spoke with the Administrator, Senior Nursing Manager (SNM), Manager of Resident Care (MoRC), Registered Dietitian, Resident Assessment Instrument (RAI) Coordinator, Physiotherapist, Clinical Nurse Specialist, Social Worker, Resident Care Clerk, Administrative Assistant, Registered staff including Registered Nurses (RNs) and Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), family members and residents.

During the course of the inspection, the inspectors toured the home, observed provision of care, reviewed clinical records, reviewed policies and procedures,

reviewed investigation notes, training materials and records, and any other relevant documentation pertaining to the inspection.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 8. (1)	CO #001	2018_543561_0014	561

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

A Critical Incident System (CIS) report was submitted to the Director on an identified date in 2017, and identified that resident #004 was transferred with a device and sustained an injury.

A review of the manufacturers' instructions for the device identified under using attachments that, an assessment must be made for each individual resident who utilized the device by a medically qualified person as to whether the resident requires the attachments when using the device.

Review of the clinical records identified that resident #004 was being transferred with the identified device by PSW #141 and PSW #142 on an identified date in 2017. During the transfer the resident sustained an injury.

On an identified date in 2019, PSW #141 who was one of the staff members that transferred the resident on the day of the incident, was interviewed and stated that the attachments were not applied during the transfer.

During an interview with the Physiotherapist (PT), they said they completed the transfer assessment on all new residents admitted to the home and quarterly on any residents that were on physiotherapy treatment; however, the assessment did not include whether the resident required the attachments applied when being transferred with the identified device.

In an interview with Manager of Resident Care (MoRC) #002, they stated that the attachments were not applied on all residents but were to be applied based on the assessed needs of individual residents. They said that an assessment of the application of attachments was not being completed by the PT or the registered staff at this time for all residents in the home that required the use of the identified device.

MoRC #002 confirmed staff did not use the identified device in the home in accordance with manufacturers' instructions.

B) Review of clinical records identified that resident #014 was transferred with an identified level of assistance with a device.

On an identified date in 2019, resident #014 was observed being transferred with a device by PSW #112 and PSW #113 with attachments applied. Both PSWs stated during an interview, that they applied the attachments on all the residents they

transferred for safety reasons; however, stated that they did not know if that was documented or if the resident was assessed by PT or the registered staff for the application of the attachments when being transferred.

In an interview with RPN #114, they stated that the attachments were not applied to all residents that were assessed to use the identified device. Residents that had a level of ability and did not want the attachments, did not have them applied. They said that the PT completed all the transfer assessments in the home and only if they were not available the registered staff would complete the assessment; however, registered staff would send a referral to PT to complete another assessment when available.

Review of the PT quarterly assessment completed on an identified date 2019, with RPN #114, indicated that resident #014 was transferred with an identified device but did not identify if the resident was assessed for the application of the attachments during the transfer.

In an interview with PT, they confirmed that when they assessed the residents in the home for the identified device, the assessment did not include whether the residents required the attachments applied when being transferred.

RPN #114 confirmed staff did not use the identified device in the home in accordance with manufacturers' instructions.

C) Review of the plan of care for resident #022, identified they were using an identified device for transfers.

In an interview with PSW #132, they stated that the resident was transferred with an identified device and that the attachments were not applied as the resident did not want them applied during the transfer.

Resident #022 was interviewed and confirmed that they were only transferred with the device to get out of bed and they did not want the attachments applied.

In an interview with MoRC #002, they stated that the attachments were not applied on all residents but were to be applied based on the assessed needs of individual residents. They said that an assessment of the application of the attachments was not being completed by the PT or the registered staff at this time for all residents in the home that required the identified device.

MoRC #002 confirmed staff did not use the identified device in the home in accordance with manufacturers' instructions. [s. 23.]

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 all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions, to be implemented voluntarily.

WN #2: 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:
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care was based on, at a minimum, interdisciplinary assessment of the physical functioning, and the type and level of assistance that was required relating to activities of daily living, including hygiene and grooming.

The licensee's policy related to transfers, identified that the licensee was to ensure that transfer techniques used were based on a mobility assessment completed by the Physiotherapist or Registered Staff.

The licensee's procedure, related to attachments to the devices used in the home, included but was not limited to the following:
1. Residents requiring the use of an attachment would be assessed for the most appropriate one based on their individual criteria including physical, cognitive and

medical requirements.
2. Based on the resident's assessment, a logo will be placed in the resident's room and/or care cupboard to identify which attachment to use during transfers".

A) A CIS report was submitted to the Director on an identified date in 2017, identified that resident #004 was transferred with an identified device and sustained an injury.

Review of the plan of care for resident #004, identified there was no mobility assessment completed when the resident's transfer was changed from one device to another on an identified date in 2017, and when the transfer was changed back at a later date in 2017. There was no assessment or documentation to identify the most appropriate attachment to be applied for the resident's transfer using the device.

MoRC #002 was interviewed and stated that all lift and transfer assessments were to be completed by the PT and if they were not available by the registered staff and the assessment was to be documented in Point Click Care (PCC) under the Mobility Assessment. This assessment would include what attachments they required if the resident was transferred with any device.

MoRC #002 reviewed resident #004's plan of care on PCC and they acknowledged there was no interdisciplinary assessment by PT or registered staff to document the resident's change in transfer status or the use of the type of attachment as directed in the licensee's policies and procedures.

During an interview with the PT they said they completed the transfer assessment on all new residents admitted to the home and quarterly on any residents that were on physiotherapy treatment; however, the assessment did not include assessing the resident for the appropriate attachment when being transferred with a device.

MoRC confirmed there was no assessment completed on transfers for resident #004 when their toileting transfer was changed twice. There was also no assessment for what type of attachment the resident should be using for the transfer.

B) Review of resident #014's plan of care identified there was no assessment of the type of attachment required when the resident's transfer changed on an identified date in 2019. There was no assessment of the most appropriate attachment to be applied for the transfer for the identified device nor a referral to the Physiotherapist to reassess the resident's transfers.

Resident #014 was observed being transferred by PSW #112 and #113 using a device. They applied the identified attachments for the transfer.

During an interview with PSW #112 and #113, they stated that they were instructed to use the identified attachments based on the resident's status; however, confirmed that this information was not documented on the resident's logo posted in the room or in the Kardex.

RPN #114 was interviewed and stated that transfer assessments were to be completed by the PT, and if not available, registered staff would do an assessment but registered staff would send a referral to PT to reassess as well. RPN #114 reviewed the most recent Physiotherapist Quarterly Assessment, they confirmed there was no assessment related to what type of attachments the resident should be using and there was no mobility assessment completed.

PT was interviewed and stated when they completed a transfer assessment for the identified device, their assessments did not include assessing the resident for the appropriate attachments required for the transfer. They confirmed they did not complete a transfer assessment when there was a change for resident #014 as they did not receive a referral.

During an interview with the MoRC stated residents using the devices should have been assessed by PT or registered staff for the type of attachments they required and confirmed at this time this was not completed.

C) Review of the clinical record identified, resident #022 was transferred with an identified device at all times.

During an interview with the resident #022, they stated since they were admitted to the home they have only been transferred out of bed during a specific time of day using a device. This was also confirmed by PSW #132.

During an interview with RN #108, they acknowledged after reviewing the written plan of care they documented under transfers, the resident would be using a device at all times. They confirmed that they did not assess the resident for the use of the device and they were not assessed by the PT to require a device.

PT was interviewed and stated when they assessed any resident in the home for the use of devices, their assessments did not include assessing the resident for the appropriate attachments required for the transfer.

During an interview with the MoRC they stated residents using a device should have been assessed by PT or registered staff for the appropriate attachments they required and confirmed at this time this was not completed or documented in the plan of care.

The licensee failed to ensure that the plan of care was based on, at a minimum, interdisciplinary assessment of the physical functioning, and the type and level of assistance that was required for residents #004, #014 and #022. [s. 26. (3) 7.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care is based on, at a minimum, interdisciplinary assessment of the physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts. 2007, c. 8, s. 195 (12); 2017, c. 25, Sched. 5, s. 23.

Findings/Faits saillants :

1. The licensee failed to comply with the following requirement of the LTCHA: It is a condition of every license that the licensee shall comply with every order made under this Act.

On November 15, 2018, the following compliance order (CO #001) from inspection number 2018_543561_0014 made under O. Reg 79/10 s. 8(1) of the LTCHA was issued:

The licensee must:
1. Ensure that the written polices and protocols related to Narcotics/Controlled/Monitored Drugs are complied with.
2. Ensure that two registered staff at shift change count the narcotics together and sign the Narcotic and Controlled Substance Administration Record together.
3. Ensure that when narcotics are delivered to the home, two registered staff count all individual narcotics together and sign the Narcotic and Controlled Substance Administration Record together to account for the received narcotics.
4. Ensure that registered staff comply with the re-admission policy related to reconciliation of medications.

The compliance date was March 4, 2019.

The licensee completed items 1, 3 and 4 in CO #001. The licensee failed to complete item 2.

(2) Ensure that two registered staff at shift change count the narcotics together and sign the Narcotic and Controlled Substance Administration Record together.

A) On an identified date in 2019, LTCH Inspector #561, arrived at the home to observe the process for counting of narcotics at shift change. At an identified time, RPN #107 was observed by the medication cart preparing medications. LTCH Inspector #561 requested to see the Narcotic and Controlled Substance Administration Record. All narcotics and controlled substances were counted and signed by the nurse on the outgoing shift. The signatures from the incoming shift were missing. RPN #107 stated that the outgoing nurse was going to return to count narcotics again with them. RN #105, the outgoing nurse, arrived on the unit approximately fifteen minutes later. RN #105 and RPN #107 stated they were going to count the narcotics. RN #105 indicated that the process in the home was to count and sign the narcotics together with the incoming nurse.

B) On an identified date 2019, LTCH Inspector #561 interviewed RPN #108 about the process for counting narcotics at shift change. RPN #108 stated that two nurses count the narcotics together and sign for the count at shift change. When interviewed by LTCH Inspector #561, RPN #108 stated that the outgoing nurse that day, RN #105, had

counted and signed the Narcotic and Controlled Drug Administration Record prior to their arrival on the unit. Then, RN #105 returned and they both counted and signed the Narcotic and Controlled Substance Administration Record.

C) LTCH Inspector #561 reviewed the binders with the Narcotic and Controlled Drug Administration Records on three units and identified that there were two records, in total, not signed at shift change on two home areas.

The Narcotic and Controlled Drug Administration Record for resident #019, had a missing registered staff signature on the outgoing shift on an identified date in 2019. The Narcotic and Controlled Drug Administration Record for resident #020, had a missing registered staff signature on the outgoing shift on an identified date in 2019.

D) On an identified date in 2019, RPN #136 who was the outgoing nurse, was observed documenting on point click care (PCC). LTCH Inspector #561 reviewed the binder with Narcotic and Controlled Drug Administration Records and identified that the narcotics and controlled substances were already counted and signed by RPN #136. The RPN stated that they will count the narcotics again once the incoming nurse arrives.

The home's policy titled "Narcotics/Controlled/Monitored Drugs, policy number 06-03-20, revised August 2018, stated that two registered staff (one oncoming and one outgoing) will jointly count monitored medications at every shift change, and both will verify by signature the quantity of each monitored medication on hand with the Narcotic and Controlled Substance Administration Record.

In an interview with the Senior Nursing Manager they confirmed that the process in the home was to count and sign the Narcotic and Controlled Drug Administration Records together. The nurses should not be counting first on their own and then recounting with another nurse.

The licensee failed to comply with all the conditions specified in the order under the LTCHA. [s. 101. (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 they comply with this Act, the Local Health System Integration Act, 2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every directive issued, order made or agreement entered intounder this Act and those Acts, to be implemented voluntarily.

WN #4: 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 failed to ensure policies included in the required Falls Prevention and Management program were complied with.

In accordance with O. Reg. 79/10, s. 48(1) 1 the licensee was required to have an interdisciplinary Fall Prevention and Management program and in accordance with O. Reg. 79/10, s. 49(1), the licensee was required to ensure that the falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids.

The licensee's policy, "Head Injury Routine" (HIR), identified as procedure number 19-01-01 last revised in June 2017 and included as part of the licensee's Falls Prevention and

Management Program, directed that the HIR was initiated with every un-witnessed fall, with every witnessed fall when the resident sustained a head injury and with every resident who fell and was on an anticoagulant. The HIR would be completed post fall every hour for four hours and then every two hours times two, every four hours times four and then every eight hours for the next 24 hours. This would ensure that a resident was monitored 48 hours for head injury.

A CIS report was submitted to the Director on an identified date in 2019, and identified that resident #001 fell, sustained an injury and was transferred to hospital for further assessment and received treatment.

A) A review of the clinical record for resident #001, identified they had an unwitnessed fall on an identified date in 2019, sustained an injury, was sent to hospital, and was treated. They also had an unwitnessed fall on another date in 2019 and had no injuries.

Review of the Head Injury Routine (HIR) records post falls on identified date is 2019, identified the registered staff initiated the HIR; however, they did not fully complete it as directed by the licensee's policy.

In an interview with RPN #102, they stated the registered staff initiated the HIR after identified falls as identified above; however, did not fully complete the HIR as directed by the licensee's policy.

The licensee's HIR policy for the unwitnessed falls for resident #001 was not complied with.

B) A CIS report was submitted to the Director on an identified date in 2019, identified that resident #002 fell, and sustained an injury, was transferred to hospital to receive treatment.

A review of the clinical record for resident #002, identified they had two un-witnessed falls in 2018, with no injuries identified.

Review of the HIR records post identified two un-witnessed falls in 2019, identified that registered staff initiated the HIR but did not fully complete it as directed by the licensee's policy.

In an interview with RPN #102, they stated the registered staff initiated the HIR after the

falls identified above; however, did not fully complete the HIR as directed by the licensee's policy.

The licensee's HIR policy for the unwitnessed falls for resident #002 was not complied with. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee failed to ensure that any plan, policy, instituted or otherwise put in place was complied with.

In accordance with O. Reg 79/10 s. 114 (2), the license was required to ensure that written policies and protocols were 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.

A) The home's policy titled "Narcotics/Controlled/Monitored Drugs", Number 06- 03-20, indicated that all monitored drugs must be counted at every shift change by two registered staff, one coming on shift and one going off shift, both will verify by signature the quantity of each monitored medication on hand with the Narcotic and Controlled Substance Administration Record (NSCAR). The two registered staff will jointly count monitored medications at every shift change and both will verify by signature the quantity of each medication on hand with the NSCAR.

A CIS report was submitted to the Director related to a missing controlled substance on an identified date in 2018.
The CIS indicated that on the identified date in 2018, at shift change, registered staff noted one broken ampule of a medication inside the medication box. There was no residue, or liquid on the broken ampule nor on the packaging noted. The incident was reported to the Manager on call.

Investigation notes were reviewed and indicated that on the identified date in 2018, RN #118 noticed that one ampule of a medication was broken and there was no residue inside. This was reported to the Manager on call. During interviews with registered staff by the home it was identified that the last dose of the medication was administered to resident #010 several days prior. During that time the registered staff had not identified that there were any issues with the vials. When RN #105 was interviewed by the management, they stated that when they were counting the vials, they did not remove them from the packaging, they looked through the window in the package to conduct the count.

RPN #143 was interviewed by the home and stated during shift change when they were counting narcotics with another nurse they did not remove the vials from the box, they looked through the window on the package and did not notice any issues, with the vials as they could see in the packaging.

RN #118 was interviewed by Inspector #561, and stated that on the day when the incident was identified, prior to the shift change count, they removed all the narcotics from the medication cart to prepare for the count with another nurse, and noticed that one of the vials was broken. There was no residue and the box was dry. They reported the incident to the Manager immediately.

The Manger of Resident Care #001 was interviewed and stated that the investigation concluded that registered staff did not follow the home's process for counting narcotics. They did not open each box to remove the vials during count. They peeked through the window on the package to count the medication. The home was not able to verify when the vial cracked.

The licensee failed to ensure that the "Narcotics/Controlled/Monitored Drugs" policy was complied with.

B) The home's policy titled "Narcotics/Controlled/Monitored Drugs", policy number 06-03-20, revised August 2018, indicated that the nurse who processes an order to discontinue a monitored medication was responsible for removing the medication(s) along with the count sheet from the medication cart and narcotic bin. The medication was to be deposited in the Surplus Narcotic Bin.

A complaint was submitted to the Director on an identified date in 2018, related to a medication error involving resident #011.

The investigation notes were reviewed and indicated that on an identified date in 2018, RN #144 administered a medication to resident #011. The investigation notes revealed that the identified medication was already discontinued and during the last quarterly review completed by the physician. The narcotic was not removed from the medication cart until the medication error occurred.

Clinical records were reviewed and a progress note stated that resident #011's SDM was notified by RN #108 that the identified medication was discontinued.
When interviewed RN #108, they stated that they did notify the family of the discontinued

medication; however, they did not remove the medication from the medication cart.

RN #144 who made the error was interviewed and stated that prior to administering the medication they did not check the order on Electronic Medication Administration Record (EMAR), they removed the medication from the medication cart and administered it to resident #011. After they administered the medication, they wanted to sign for the administration on EMAR and noticed then, that it was discontinued.

In an interview with the Senior Nursing Manager, they confirmed that the process for the drug destruction was not followed when registered staff failed to remove the discontinued medication from the medication cart.

PLEASE NOTE: This non-compliance (B) was identified during a complaint inspection # 2019_560632_008, and is being issued in this report. [s. 8. (1) (b)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that, a care conference of the interdisciplinary team providing a resident's care was held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision maker.

On an identified date in 2019, during an interview with resident #022, they informed LTCH Inspector #581, that they had never had a six week care conference or an annual care conference since they were admitted. The resident stated they cancelled the admission care conference but wanted it to be rescheduled and that did not happen.

Review of the clinical health record did not identify any documentation that a care conference was held six weeks after the resident was admitted, or in 2019 for the annual conference.

Resident Care Clerk (RCC) was interviewed and stated that they scheduled the six week and annual conference for every resident in the home; however, if the conference was cancelled or changed after the initial conference date was selected, the registered staff would reschedule with the resident or substitute decision maker (SDM).

The RCC provided documentation that the six week care conference was initially scheduled on an identified date in 2018. The annual care conference was scheduled on an identified date in 2019. After reviewing the progress notes with the RCC, they confirmed there was no documentation that either care conference had taken place on the schedule dates or why they were cancelled or changed.

In an interview with RPN #122, they stated the resident cancelled the six week conference as they did not want a care conference and confirmed there was no documentation in the plan of care that the conference was held. RPN #122 stated that the annual conference was scheduled, but it was cancelled.

RPN #122 confirmed that the six week care conference, following the resident #022's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident, did not occur. [s. 27. (1)]

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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Issued on this 26th day of June, 2019

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

Original report signed by the inspector.