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**

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486


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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 |
|---|---|---|---|
| Nov 27, 2017 | 2017_673554_0027 | 023189-17 | Resident Quality Inspection |

## Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
5015 Spectrum Way Suite 600 MISSISSAUGA ON 000 000

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

EAGLE TERRACE
329 EAGLE STREET NEWMARKET ON L3Y 1K3

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

KELLY BURNS (554), SAMI JAROUR (570)

## 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): November 20-23, 2017**

**Resident Quality Inspection (RQI) Intake #023189-17. Intakes #024254-16, #025549-16, and #024492-17 inspected concurrently with Resident Quality Inspection.**

**Summary of Intakes:**
**1) #024254-16 - Complaint - resident care, specifically physiotherapy plan;**
**2) #025549-16 – Complaint – resident care, specifically continence care, and handling of complaints;**
**3) #024492-17 – Complaint – resident care concerns.**

**During the course of the inspection, the inspector(s) spoke with Interim Executive Director, Interim Director of Care, Registered Nurse(s), Registered Practical Nurse (s), Personal Support Worker(s), Housekeeping Aid (HSK), Dietary Aid (DA), Program Manager, Registered Dietitian (RD), Staff Educator, Physician, Physiotherapist, Resident Council President, Family, and residents.**

**During the course of the inspection, the inspector(s) toured the long-term care home, observed meal and snack service, observed staff to resident interactions, resident to resident interactions, and observed medication administration; reviewed clinical health records (identified residents), medication incidents, reviewed Resident Council Meeting Minutes, Complaints/Concerns/Compliments Log, and reviewed licensee policies, specifically, Medication Administration Program Overview, End of Life Care, Medication Incidents, Adverse Events, and Complaints Management.**

**The following Inspection Protocols were used during this inspection:**
**Continence Care and Bowel Management**
**Hospitalization and Change in Condition**
**Infection Prevention and Control**
**Medication**
**Nutrition and Hydration**
**Personal Support Services**
**Reporting and Complaints**
**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<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 101. Dealing with complaints**

**Specifically failed to comply with the following:**

**s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:**
**2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances. O. Reg. 79/10, s. 101 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that a follow-up response was provided to a complainant, whose complaint could not be investigated and resolved within ten (10) business days.

Related to Intake #024492-17:

The Interim Executive Director (ED) indicated, to Inspector #554, that he/she received a verbal complaint from resident #021's Substitute Decision Maker (SDM) on an identified date. The complaint was related to care of resident #021. The ED indicated that it was mutually agreed between he/she and the SDM that a response would be provided on an agreed upon date.

Executive Director indicated, to Inspector #554, that resident #021 was no longer residing at the long-term care home. The Executive Director indicated that he/she attempted to reach the SDM ten days following the initial complaint without success. Executive Director indicated no further attempts were made to contact the SDM.

Executive Director indicated that as of this time, there has been no follow-up response forwarded to SDM, specific to care concerns/complaint, issued to the licensee on the identified date. [s. 101. (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 there is a process in place and monitored to ensure that a follow-up response is provided to a complainant, whose complaint cannot be investigated and resolved within ten (10) business days, to be implemented voluntarily.***

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**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 are administered to residents in accordance with directions for use specified by the prescriber.

Related to Intake #024492-17:

Resident #021 has identified medical diagnosis. Resident #021 was discharged from hospital on an identified date, with orders to refer to an identified program.

Registered Nurse (RN) #105 indicated, to Inspector #554, that the Substitute Decision Maker (SDM) had voiced concerns regarding resident #021 receiving an identified medication. RN #105 indicated the SDM did not believe resident #021 needed the identified medication to be administered.

The Attending Physician, for resident #021, prescribed the identified medication; the medication prescribed was to be administered based on specific directions for use.

The Interim Director of Care, and the Attending Physician, both indicated, to Inspector

#554, that the identified medication was considered a drug.

The clinical health record, for resident #021, was reviewed for the period of approximately two months. Documentation contained within the progress notes, and/or the electronic medication record (eMAR) indicates that resident #021 was administered the identified medication approximately fourteen times during this period, when he/she was assessed, by identified Registered Practical Nurses, and Registered Nurses, to have a level greater than the physician identified.

Registered Nurse #105, who is a Charge Nurse, is identified in progress notes as administering the identified medication, when resident's levels were greater than the physician identified. RN #105 indicated, to Inspector #554, that he/she administered the identified medication to resident #021 for comfort. RN #105 indicated being aware of the directions specified by the physician, specific to the use of the medication for resident #021, but indicated, he/she did not follow the physician's order, as resident #021's condition had declined, and he/she (RN) administered the medication for comfort. RN #105 indicated he/she had not contacted the physician with regards to the order regarding the identified medication.

Registered Nurse #105, as well as other registered nursing staff failed to ensure that drugs, specifically the identified medication, was administered to resident #021 in accordance with directions for use specified by the prescriber.

2. Resident #025 was prescribed an identified medication, by mouth, twice daily. On an identified date, the physician changed the medication order and prescribed resident #025 to receive a higher dosage.

Registered Nurse (RN) #105 administered the wrong dosage of medication to resident #025 on an identified date.

Registered Nurse #105 indicated, to Inspector #554, that he/she was aware of the change in direction, for resident #025, specific to the identified medication, but further indicated the correct dosage was not available for administration that evening.

The Director of Care indicated, to Inspector #554, that resident #025 did not sustain any adverse effects, on the identified date.

Registered Nurse #105 failed to ensure that drugs, specifically an identified medication,

was administered to resident #025 in accordance with directions for use specified by the prescriber.

3. Resident #026 was prescribed an identified medication and dosage, by mouth, and was to receive the prescribed medication at specific hours.

Registered Practical Nurse (RPN) #106 administered the wrong dosage of the identified medication on an identified date, and time. The dosage error was noted by registered nursing staff approximately six hours later.

The Director of Care indicated, to Inspector #554, that resident #026 did not sustain any adverse effects, on the identified date.

Registered Practical Nurse #106 failed to ensure that drugs, specifically the identified medication, was administered to resident #026 in accordance with directions for use specified by the prescriber. [s. 131. (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 there is a process in place, and monitored ensuring drugs are administered to residents in accordance with directions for use specified by the prescriber, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee failed to ensure that every medication incident involving a resident is documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and is reported to the resident, the resident's SDM (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 nurse practitioner and the pharmacy provider.

Inspector #554 reviewed medication incidents occurring within the long-term care home, during a three month period. There were two medication incidents during this identified time period, both of which involved residents receiving the wrong dose of medication.

Medication Incidents were as follows:

- Medication Incident Report (MIR) #06424 – Resident #026 was prescribed an identified medication. On an identified date, Registered Practical Nurse #106 administered a lower dosage of the medication, to resident #026. The dosage error was noted by registered nursing staff approximately six hours later.

The clinical health record, for resident #026, as well as the MIR fails to provide documentation that actions were taken to assess and maintain resident #026's health, specifically to monitoring of resident #026's comfort. The MIR indicates that the Physician and SDM (Substitute Decision Maker) were not notified of the medication incident, until the next day.

Registered Practical Nurse #106 was not available for an interview during this inspection.

The Interim Director of Care indicated, to Inspector #554, that based on the licensee's policy, 'Medication Incidents', RPN #106 should have documented actions taken in assessing and monitoring resident's health, and should have immediately notified the physician and SDM of the medication incident.

- Medication Incident Report (MIR) #06426 – Resident #025 was prescribed an identified medication twice daily. On an identified date, the physician changed the medication order and prescribed resident #025 to receive a higher dosage.

On an identified date, Registered Nurse (RN) #105 administered the wrong dosage of the medication to resident #025.

The clinical health record, for resident #025, as well as the MIR fails to provide documentation that actions were taken to assess and maintain resident #025's health. Nor is there documentation to support that the physician and SDM were notified of the medication incident.

Registered Nurse #105 indicated, to Inspector #554, that he/she did not assess and/or monitor resident #025, nor did he/she notify the Physician or SDM, of the medication incident, as he/she does not believe that administering the wrong dose of the identified medication was a medication incident, indicating he/she administered what medication he/she had on-site, in the long-term care home, at the time. Registered Nurse #105 indicated he/she did not contact the contracted pharmacy service provider, nor did he/she contact the after-hours pharmacy to obtain the correct dosage. RN #105 indicated, to the Inspector, that he/she did leave a written message for the Director of Care to follow up with pharmacy the next day.

The licensee failed to ensure that immediate action was taken in response to assessing and maintaining the health of residents #025 and #026, nor were the Physician and SDM for the identified residents notified. [s. 135. (1)]

***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 there is a process in place, and monitored ensuring that every medication incident involving a resident is documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and is reported to the resident, the resident's SDM (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 nurse practitioner and the pharmacy provider, to be implemented voluntarily.***

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**Issued on this 27th day of November, 2017**

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

**Original report signed by the inspector.**