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
Nov 30, 2017	2017_638609_0021	022415-17	Resident Quality Inspection

Licensee/Titulaire de permis

Algonquin Nursing Home of Mattawa
231 TENTH STREET P.O. BOX 270 MATTAWA ON P0H 1V0

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

Algonquin Nursing Home
231 TENTH STREET P.O. BOX 270 MATTAWA ON P0H 1V0

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

CHAD CAMPS (609), LOVIRIZA CALUZA (687)

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 30-31 and November 1-3, 2017.

Additional logs inspected during this RQI included:

One complaint submitted to the Director related to multiple falls by a resident;

Two critical incidents submitted to the Director by the home related to resident falls; and

One critical incident submitted to the Director by the home related to a missing controlled substance.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Vice-President, Resident and Family Services Coordinator, Office Manager, Nutrition Manager, Dietitian, Resident Assessment Instrument (RAI) Coordinator, Scheduler, Behavioural Supports Ontario (BSO) Lead, Physiotherapists, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Dietary Aides, maintenance staff, residents and family members.

The inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident and resident to resident interactions, reviewed relevant health care records, internal investigations and reviewed numerous licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Residents' Council
Skin and Wound Care

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

3 WN(s)
1 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

During a staff interview resident #006 was identified as having altered skin integrity.

During an interview with RPN #105 they verified to Inspector #609 that resident #006 had an area of altered skin integrity.

A review of resident #006's health care records found that between a specified time frame, the resident's area of altered skin integrity had deteriorated.

A review of the home's policy titled "Skin and Wound Care Program" last revised February 2016 indicated that the registered staff were to submit referrals to the

Registered Dietitian (RD) via email related to skin integrity.

During an interview with the DOC they explained that any resident with deteriorating skin integrity was to have a referral generated to the RD for further assessment.

During an interview with the RD a review of resident #006's health care records were conducted. The RD verified that no referral email was generated to them, that they were unaware of the resident's deteriorating skin integrity and should have been. [s. 6. (4) (a)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A complaint was submitted to the Director related to multiple falls sustained by resident #002.

Inspector #687 conducted a record review regarding resident #002's fall incidents and found that between a specified time frame resident #002 fell multiple times.

A review of resident #002's plan of care plan indicated that staff were to ensure that a specified intervention was in place during specified times.

A review of resident #002's post fall assessment indicated that the resident was found without the specified intervention in place at the time of fall.

Review of the home's policy titled "Falls Prevention and Management– #NM-E-05" directed PSWs to follow the interventions as outlined in the resident's plan of care.

During an interview with the Behavioural Supports Ontario (BSO) lead they informed the Inspector that they found resident #002 on the particular day, that the resident did not have the specified intervention in place at the time of fall and that staff should have followed the interventions outlined for fall prevention in resident #002's plan of care.

During an interview with the DOC they stated that all staff including PSWs were to follow the interventions outlined in the plan of care and that this did not occur when resident #002 fell on a particular day. [s. 6. (7)]

3. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

a) A CI report was submitted by the home to the Director which outlined how resident #005 had fallen, was transferred to hospital and diagnosed with an injury.

Inspector #609 reviewed resident #005's plan of care at the time of the fall which directed PSWs to perform a specified intervention to ensure the resident's safety.

A review of documentation for resident #005's personal support provision of care found no documentation to support that the specified intervention was being performed.

A review of the home's policy titled "Point of Care (POC)- #NM-C-09" last revised September 2016 indicated that the online clinical record was compiled of tasks created and driven from the resident's care plan and was to be completed as administered care progressed over all shifts.

During an interview with PSW #119 they verified that they were present and working on a particular day when resident #006 fell. The PSW indicated that the specified intervention for safety was performed for the resident but that there was no task within POC to document that the specified intervention was completed.

During an interview with the Resident Assessment Instrument (RAI) Coordinator they verified that the specified intervention was to be documented in POC and that currently there was no task in POC for PSWs to document that the intervention was completed.

During an interview with the DOC they verified that the specified intervention would be a part of the provision of care to a resident and should have been documented.

b) A CI report was submitted by the home to the Director which outlined how on a particular day, resident #004 had fallen, was transferred to the hospital and diagnosed with an injury.

Inspector #609 reviewed resident #004's plan of care at the time of the fall which directed PSWs to perform a specified intervention to ensure their safety.

A review of documentation for resident #004's personal support provision of care found no documentation to support that the specified intervention was performed.

During an interview with PSW #111 they verified that until recently POC did not have any

functionality to document the specified intervention. [s. 6. (9) 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 that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident.

Inspector #687 reviewed the home's last quarter of medication incidents.

On a particular day, a medication incident occurred whereby RN #118 did not check resident #008's Electronic Medication Administration Record (EMAR) prior to administering an identified medication to the resident that was taken from another resident's drug supply. This resulted in the resident receiving twice the prescribed amount of medication.

On a different day, another medication incident involved RN #118 who was to have administered an identified medication to resident #007, to which the resident's stock of medication had been exhausted. RN #118 then proceeded to administer a different medication to the resident from another resident's stock. This resulted in the incorrect medication and dose being administered to resident #007.

During an interview with RN #116 they indicated that if a resident required a medication and their medication supply was depleted, registered staff could borrow from another resident's medication supply as long as the dose and the drug were the same.

During an interview with the DOC they indicated that they were aware that registered staff were borrowing medications between residents who had the same medication and dosage. The DOC also indicated that they would look into staff's borrowing of medications to prevent future medication incidents. [s. 131. (1)]

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. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that corrective actions were taken as necessary to medication incidents and adverse drug reactions.

A CI report was submitted by the home to the Director outlining how on a particular day, an identified medication was missing. The CI report further outlined how the home was going to conduct an education session for all registered staff on accountable substances and how to follow proper procedures.

During an interview with the DOC they verified that the corrective action identified in CI report was to include an educational in-service by the DOC, regarding controlled substance management.

During another interview with the DOC they acknowledged that the corrective action of an educational in-service on controlled substance management did not occur and should have. [s. 135. (2)]

Issued on this 1st day of December, 2017

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

Original report signed by the inspector.