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
Dec 12, 2017	2017_615638_0025	026447-17	Resident Quality Inspection

Licensee/Titulaire de permis

BAY HAVEN NURSING HOME INCORPORATED
499 HUME STREET COLLINGWOOD ON L9Y 4H8

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

BAY HAVEN NURSING HOME
499 HUME STREET COLLINGWOOD ON L9Y 4H8

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

RYAN GOODMURPHY (638), STEPHANIE DONI (681)

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): December 4 - 7, 2017.

The following intake was inspected during this Resident Quality Inspection:
-One log was related to a critical incident the home submitted to the Director regarding an alleged incident of staff to resident physical abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, acting Director of Nursing (DON), Registered Dietitian (RD), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), residents and their families.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, reviewed relevant staff personnel files, internal investigation notes, licensee policies, procedures, programs and relevant resident health care records.

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
Prevention of Abuse, Neglect and Retaliation
Residents' Council

During the course of this inspection, Non-Compliances were issued.
- **4 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 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 all drugs were stored in an area or a medication cart, that was secure and locked.

During an observation of the medication pass on December 7, 2017, Inspector #638 observed a medication cart left unlocked and unattended in the dining room on three separate occasions during a specific period of time. The medication cart was left unattended with multiple residents and staff members in the area while the registered staff member administered medication and treatments to multiple residents while out of sight of the medication cart.

In an interview with Inspector #638, RN #102 indicated that they typically left the medication cart unlocked in the dining room while administering medications to residents at the tables nearest to the medication cart. Upon reviewing the observations made by the Inspector (treatments being provided out of sight of the cart), the RN indicated that they should have locked the cart when they were not in the immediate vicinity of the medication cart.

The Inspector observed a second medication cart left unlocked and unattended in another area of the home at a specified time on December 7, 2017, while the registered staff member was in a resident's room administering medications. In an interview with Inspector #638, RPN #108 indicated that medication carts should be locked when left unattended.

The home’s MediSystem “Medication System - Medication Storage” policy, last reviewed January 2017, indicated that the medication cart is to be kept locked at all times when not in use.

During an interview with Inspector #638, the acting DON indicated that medication carts should be kept locked when registered staff are not using the cart. The acting DON indicated that this was an ongoing concern and they were working with registered staff to ensure that medication carts were being locked appropriately. [s. 129. (1) (a) (ii)]

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 drugs are stored in an area or a medication cart, that is secure and locked, to be implemented voluntarily.

WN #2: 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was reassessed and the plan of care was reviewed and revised when the resident's care needs changed or the care set out in the plan was no longer necessary.

Resident #005 was identified as having a potential restraint during a resident observation on December 5, 2017, by Inspector #638.

The Inspector reviewed resident #005's care plan and identified that the resident was to have a specific intervention implemented when the resident was in bed to aid with specific activities of daily living.

During an observation on December 6, 2017, at 0853 hours. The Inspector identified that resident #005's specific intervention had been secured in a manner, which would not allow the intervention to be implemented.

Inspector #638 reviewed resident #005's health care records and identified a progress

note, which indicated that the resident had the specific intervention in place and that the resident did not consistently utilize this intervention. The progress note identified that this intervention had been discontinued and would be secured in a manner, which would not allow the intervention to be implemented.

In an interview with Inspector #638, PSW #101 indicated that resident #005 required the specific intervention implemented while the resident was in bed. Upon reviewing the notation made in the progress notes, with the PSW, they indicated that the care plan should have been updated to avoid confusion.

Inspector #638 interviewed RN #102 indicated that resident #005 did not utilize this specific intervention. The Inspector reviewed the resident's care plan and progress note, with the RN who indicated that the resident's care plan should have been updated after the intervention was discontinued.

The home's policy titled "Resident Assessment Protocols (RAPS) and Care Planning - Nursing Section 7" last revised July 2015, indicated that the effectiveness of the care plan must be evaluated from its initiation and modified as necessary.

In an interview with Inspector #638, the acting DON stated that residents' care plans were updated after the Minimum Data Set (MDS) reviews and at any other time when a resident's care needs changed. The Inspector reviewed resident #005's current care plan with the acting DON, who indicated that the care plan should have been updated to indicate that the resident no longer required the aforementioned intervention on their bed. [s. 6. (10) (b)]

WN #3: 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 the home's policy titled “Dietary Procedures - Weight Changes” was complied with.

As identified in Ontario Regulation (O. Reg.) 79/10 s. 68 (2) (e) (ii), the licensee shall ensure that the nutrition care and hydration program include a weight monitoring system to measure and record with respect to each resident, body mass index and height upon admission and annually thereafter.

Inspectors #638 and #681 reviewed health care records for 20 residents. Through this record review, it was identified that residents; #001, #003, #005, #007, #010, #011, #012, #013, #014, #015, #016, #017, #018, and #019 did not have their heights measured in the past year.

The home’s policy titled “Dietary Procedures - Weight Changes”, last reviewed July 2017, indicated that residents’ heights will be updated annually by the nursing staff.

During an interview with Inspector #681, PSW #107 stated that residents' heights were only measured when the resident was admitted to the home. The PSW indicated that they had not measured any residents' heights, aside from at the time of their admission.

During an interview with Inspector #681, RD #104 stated that residents' heights should be measured annually. The RD indicated that they did not review the "weight/vitals" tab of their electronic health care records on Point Click Care (PCC) (where residents' heights were documented) to ensure that residents' heights had been measured annually after admission.

During an interview with Inspector #681, the acting DON stated that the home did not have a process in place to ensure that residents' heights were measured annually after their admission. The acting DON stated that RD #104 made them aware that several residents had not had their heights measured since 2015, or 2016, (after their interview with Inspector #681) and the acting DON verified that residents' heights should have be measured annually. [s. 8. (1) (b)]

WN #4: 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. (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 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.

Inspector #638 requested the written record of the quarterly review of the medication incidents and adverse drug reactions that had occurred in the home since the last review.

In an interview with Inspector #638, the acting DON indicated that medication incidents were reviewed quarterly during the Professional Advisory Committee (PAC) meetings. The DON stated that the last PAC meeting was held November 28, 2017, however, they did not forward the medication incidents for the committee to review.

Inspector #638 interviewed the Administrator who indicated that the quarterly medication review did not occur during the November 28, 2017, PAC meeting due to a potential miscommunication. [s. 135. (3)]

Issued on this 13th day of December, 2017

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

Original report signed by the inspector.