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
Oct 5, 2018	2018_533115_0020	025429-18	Resident Quality Inspection

Licensee/Titulaire de permis

The Corporation of the County of Elgin Municipal Homes
450 Sunset Drive ST. THOMAS ON N5R 5V1

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

Bobier Villa
1 Bobier Lane DUTTON ON N0L 1J0

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

TERRI DALY (115), CAROLEE MILLINER (144)

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): September 24, 25, 26, 27, and October 1, & 2, 2018.

The following Critical Incident intakes were completed within this inspection:
Related to falls prevention:
Critical Incident Log #028890-17/CI M603-000024-17
Critical Incident Log #000338-18/CI M603-000028-17.

Related to the prevention of abuse and neglect:
Critical Incident Log #023897-17/CI M603-000015-17
Critical Incident Log #023903-17/CI M603-000016-17
Critical Incident Log #027346-17/CI M603-000017-17
Critical Incident Log #029498-17/CI M603-000026-17.

During the course of the inspection, the inspector(s) spoke with more than twenty residents, a Residents' Council representative, a Family Council representative, the Director, the Manager of Resident Care, a Registered Nurse, five Registered Practical Nurses, the Manager of Program Therapy, one Activation Aide, seven Personal Support Workers, and family members.

During the course of the inspection, the inspectors toured all resident home areas, observed the general maintenance and cleanliness of the home, medication administration and narcotic
storage, the provision of resident care, recreational activities, staff to resident interactions, infection prevention and control practices and reviewed resident clinical records, the posting of required information and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

- **4 WN(s)**
- **4 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. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee of the long-term care home has failed to ensure that a resident exhibiting altered skin integrity is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

On a specific date the inspector observed resident #001 to have an area of altered skin integrity.

A review of the clinical record indicates that resident #001 received treatment on a certain date, at the hospital for the area of altered skin integrity. They received similar treatment for the same area on two other dates. Follow-up treatment was planned for approximately three months after the last treatment.

Further review of the clinical record for resident #001 noted that the last skin and wound assessment for this area was completed on a specific date.

Resident #001 was admitted to hospital, and readmitted to the home on a specific date. A wound and skin assessment was completed for resident #001 on return, but the skin and wound assessment did not include this area of altered skin integrity.

Manager of Resident Care (MRC) #109 and Registered Nurse (RN) #010 reviewed the clinical record for resident #001 and confirmed that a skin and wound assessment had not been recently completed.

MRC #109 further shared their awareness of the requirement to complete weekly skin and wound assessments for residents with impaired skin integrity and said that the weekly assessments should have been completed for resident #001’s area of altered skin integrity. [s. 50. (2) (b) (iv)]

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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month
2. A change of 7.5 per cent of body weight, or more, over three months
3. A change of 10 per cent of body weight, or more, over 6 months
4. Any other weight change that compromises their health status.

A clinical record review revealed that resident #002 had experienced a weight change.

On a specific date, the resident's weights were struck off the weight record in Point Click Care (PCC) by the Registered Dietitian (RD) with an accompanying note that stated the weights were incorrect.

A review of progress notes for resident #002 revealed that the RD requested that the resident be re-weighed.

Weight re-weighs for resident #002 could not be located in the resident's clinical record.

The home's Weight Change Management Policy last reviewed January 2015, included the following directives:
"Referral will be made to the Registered Dietitian (using the diet requisition form) for residents with significant weight loss or inappropriate weight gain. Nursing will re-weigh residents with a loss or gain of 2.5 kg (5 lbs) to confirm the weight."

Registered Practical Nurse (RPN) #105 and Personal Support Worker (PSW) #104 shared that the home's weight policy included that a resident would be re-weighed when there was a weight discrepancy from one month to the next of 5 per cent. They also indicated that the weight re-weighs should be done as soon as the discrepancy was noted and that the PSW would then report the discrepancy to the registered staff on duty at the time.

MRC #109 confirmed that the home's weight management policy directs nursing staff to re-weigh a resident when there is a weight discrepancy of 5 per cent and that the re-weigh should be done as soon as the discrepancy is observed.

MRC #109 said that PSW personnel should have re-weighed resident #002. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

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 residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated: 1. A change of 5 per cent of body weight, or more, over one month, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

On a specific date, the home submitted a Critical Incident System (CIS) Report to the Ministry of Health and Long Term Care (MOHLTC) which was identified as "abuse/neglect", "staff to resident". The report indicated that one staff member reported another staff member for rough care, and being verbally inappropriate with resident #017.

During an interview Director #101 stated that resident #017's was assessed post incident, at which time no concerns were noted. They also said that the resident was unable to recall the incident when asked.

A review of the CIS report and the home's investigative notes with Director #101 showed that both staff present during the incident were interviewed and the home determined that there were findings of verbal and emotional abuse related to the one staff member's actions. [s. 98.]

2. On a specific date, the home submitted a CIS Report to the Ministry of Health and Long Term Care (MOHLTC) which was identified as "abuse/neglect","staff to resident". The report indicated that during care with resident #016 a staff member witnessed another staff member speaking in a loud tone of voice, providing care in a rushed manner, and making unkind comments to the resident. Staff indicated that the resident became teary and apologized for being slow.

Resident #016 had a CPS of 0, after the incident the resident told the other staff member who was present during the incident, that was just how that staff member is, it's just their

personality and I have to get used to it.

A review of the CIS report and the home's investigative notes with Director #101 showed that both staff present during the incident were interviewed and the home determined that there were findings of verbal and emotional abuse related to the one staff member's actions.

A review of the home's policy: Resident Abuse Policy 2.11, last reviewed March 2017, part 2 (g) of the policy references notification of the police, "the medical director and the police will be notified as soon as possible when warranted through investigation (as guided by reference to the criminal code)".

An interview with Director #101 they stated that they did not call police. They indicated that they reviewed the home's process and the MOHLTC decision trees and that they had determined by definition in the criminal code that the incident did not constitute a cri

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 appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence, to be implemented voluntarily.

WN #4: 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 is used by or administered to a resident

in the home unless the drug has been prescribed for the resident.

A review of the home's Medication Incident Report from a specific date showed an administration error related to resident #013.

Review of the clinical record for resident #013 indicated that on a specific date, physician orders were received to provide specific care and services for the resident.

The home's new medical directives related to this care, located in the Point Click Care (PCC) software program were implemented on a certain date.

The previous medical directives included specific orders. The newly implemented medical directives for specific care did not include those same orders.

Review of the clinical record for resident #013 revealed that the resident did not have a physician's order for that specific order.

During the inspector's review of the home's quarterly medication errors for certain dates, it was noted that physician #115 discovered that resident #013 was administered a medication that was not prescribed.

Review of resident #013's medication record, confirmed that the resident was administered the specific medication.

MRC #109 shared that on a specific date, they had forwarded an email to all registered staff through their Bobier Villa email address announcing implementation of the new medical directives.

MRC #109 further said that registered personnel were responsible for reviewing their Bobier Villa email account when they are scheduled to work and that their work emails could also be accessed off site. MRC #109 advised that RPN #113 had opportunity to read their Bobier Villa emails during their worked shift on a certain date.

MRC #109 said that RPN #113 should have used the new medical directives that were implemented on a specific date, and instead used the medical directives that were in place prior to that. MRC #109 agreed that resident #013 did not have a physician's order for that specific medication to be administered and that alternative administration routes and medications included in the new medical directives should have been considered. [s.

131. (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 no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

Issued on this 5th day of October, 2018

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

Original report signed by the inspector.