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 6, 2017	2017_508137_0026	002811-17	Resident Quality Inspection

Licensee/Titulaire de permis

THE CORPORATION OF THE CITY OF LONDON
c/o Dearness Home for Senior Citizens 710 Southdale Road East LONDON ON N6E 1R8

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

DEARNESS HOME FOR SENIOR CITIZENS
710 SOUTHDALE ROAD EAST LONDON ON N6E 1R8

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

MARIAN MACDONALD (137), AMIE GIBBS-WARD (630), DEBRA CHURCHER (670)

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 27 - December 1, 2017

The following intakes were completed within the Resident Quality Inspection (RQI):
Log # 006243-17 - Complaint # IL-49958-LO related to staffing;
Log # 010330-17 - Complaint # IL-51019-LO and Log # 010326-17 - Complaint # IL-51017-LO related to alleged staff to resident abuse;
Log # 025879-17 - Complaint # IL-54848-LO related to care provision;
Log # 032271-16 - Critical Incident System (CIS) # M514-000058-16; Log # 035065-16 - CIS # M514-000060-16; Log # 006808-17 - CIS # M514-000011-17; Log # 015908-17 - CIS # M514-000020-17 related to falls prevention.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Assistant Director of Care, Manager of Community Life, Manager of Dietary Services, Manager of Environmental Services, Manager of Accounting and Reporting, Social Worker, Resident Assessment Instrument (RAI) Coordinator, two Dietary Supervisors, one Registered Nurse, 14 Registered Practical Nurses, 16 Personal Support Workers, one Housekeeper, residents, family members and representatives from Family and Residents' Councils.

The Inspector(s) also conducted a tour of the home, observed care provision, resident to staff interactions, medication administration, medication storage areas, general maintenance and cleanliness of the home, infection prevention and control practices, the posting of Ministry information and inspection reports.
The Inspectors reviewed residents' clinical records, relevant meeting minutes, internal investigative notes, medication incident reports, relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Residents' Council
Skin and Wound Care

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

- **3 WN(s)**
- **2 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 has failed to ensure that an identified resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff.

A clinical record review and an interview with a Registered Staff Member, showed an identified resident had altered skin integrity and was to have a weekly skin assessment completed.

A review of the weekly skin assessments in Point Click Care (PCC), for an eight week period, showed that skin assessments were not completed during four of the eight (50 per cent) weeks for the identified resident.
A review of the electronic Treatment Administration Records (e-TAR) showed that the weekly skin assessments had been signed by Registered Staff, as having been completed.

During an interview, the Director of Care (DOC), Assistant Director of Care (ADOC) and a Registered Staff Member said weekly skin assessments were to be completed in PCC.
A review of the weekly skin assessments in PCC and the e-TAR for the identified resident, with Inspector # 137, the DOC, ADOC and a Registered Staff Member said the weekly skin assessments had been signed for but had not been completed as ordered and as per the home's policy.

The licensee has failed to ensure that an identified resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff.

The scope of this area of non-compliance was determined to be a level one, isolated, the severity was a level two, potential for actual harm/risk and the compliance history was a level two, no history of previous related noncompliance. [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 that residents 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, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

The licensee has failed to ensure that each resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident required, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

Staff interviews and a clinical record review showed that an identified resident had a

change in continence status but there was no documented evidence that a continence assessment had been completed.

The home’s policy "Continence Management Program RESI-10-04-01" with version date November 2013, included the following statement: "Staff will complete a continence assessment using a clinically appropriate assessment tool that is specifically designed for assessing continence. This assessment will include a thorough process for review of clinical health records, an interview of the resident and feedback from care staff. An assessment is completed: upon a resident's admission, with any deterioration in continence level, at required jurisdictional frequently if different from above; with any change in condition that may affect bladder and bowel continence."

The Assistant Director of Care (ADOC) said that it was the expectation that a continence assessment was completed using the clinically appropriate assessment instrument in PCC when a resident has had a change in continence status and that there was no continence assessment completed for the identified resident.

2. The licensee has failed to ensure that each resident who was incontinent had an individualized plan, as part of their plan of care, to promote and manage bowel and bladder continence based on the assessment.

Staff interviews and a clinical record review showed that there was no care plan focus related to toileting or incontinence for an identified resident.

The home’s policy "Continence Management Program RESI-10-04-01" with version date November 2013, included the following statement: " "Individualized plan of care: must reflect a resident's current needs and the interdisciplinary approaches that are aligned to meet those needs and maximize independence and comfort. Must be reviewed and revised at least every three months and as a resident's status changes. The care plan will identify: a resident's elimination patterns; level and type of incontinence; amount and type of assistance required; individualized toileting routine if applicable; participation in toileting program if applicable, the resident's method of communicating the need to eliminate, equipment or continence products required including sizing; appropriate interventions to have potential to restore, maintain prevent decline of elimination function and that maximize toileting independence, comfort and dignity."

The Assistant Director of Care (ADOC) said that it was the expectation that each resident would have an individualized plan of care related to toileting as well as bowel and

bladder incontinence and there was no care plan focus related to toileting or incontinence for an identified resident.

The scope of this area of non-compliance was determined to be a level one, isolated, the severity was a level two, potential for actual harm/risk and the compliance history was a level two, no history of previous related noncompliance. [s. 51. (2) (b)]

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 each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence and to ensure that each resident who is incontinent has an individualized plan, as part of their plan of care, to promote and manage bowel and bladder continence based on the assessment, to be implemented voluntarily.

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 has failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident, the resident's substitute-decision maker (SDM), 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.

A review of the medication incidents was completed for August, September and October 2017.
Review of a medication incident in the home, where a medication was signed for but not given, did not contain any documentation related to physician notification or pharmacy notification for an identified resident.

The Inspector was unable to locate any documented evidence in the identified resident's electronic chart or paper chart related to the notification of the physician or pharmacist. Review of the Pharmacy's Incident Log did not include reference to the incident.

The home's policy 8.11, titled "Medication Incidents", last revised February 2016, stated "If the medication in error is administered to the resident, nursing shall promptly notify the Director of Care (or delegate), attending physician, the pharmacy service provider and the resident/power of attorney".

The Assistant Director of Care (ADOC) stated that the pharmacy had not been notified of the incident and acknowledged that there was no documentation of the physician being notified. ADOC stated that if there was no documentation the physician was probably not notified and shared that the pharmacy and physician should have been notified.

The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident's attending physician and the pharmacy service provider.

The scope of this area of non-compliance was determined to be a level one, isolated, the severity was a level one, minimal risk and the compliance history was a level two, no history of previous related noncompliance. [s. 135. (1)]

Issued on this 7th day of December, 2017

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

Original report signed by the inspector.