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

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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
Jun 27, 2018	2018_734674_0001	009818-18	Resident Quality Inspection

Licensee/Titulaire de permis

Delhi Nursing Home Ltd.
750 Gibraltar Street DELHI ON N4B 3B3

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

Delhi Long Term Care Centre
750 Gibraltar Street DELHI ON N4B 3B3

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

JOSEE SNELGROVE (674), CATHIE ROBITAILLE (536), KELLY HAYES (583), LISA VINK (168)

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): May 23, 24, 28, 29, 30, 31, June 5, 6 and 15, 2018.

During this inspection the following inquiry listed below was conducted concurrently:

Critical Incident:

028950-17 - related to Prevention of Abuse and Neglect

During this inspection the following inspections listed below were conducted concurrently:

Critical Incidents:

007169-18 - related to Infection Prevention and Control Program
011058-18 - related to Falls Prevention and Management

Follow-up:

002661-18 - related to Plan of Care

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Resident Care (DRC), Assistant Director of Care (ADOC), Resident Assessment Instrument-Minimum Data Set (RAI-MDS) Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSWs), Dietary staff, Food Service Manager (FSM), Director of Program Services, Pharmacy Technicians, Maintenance staff, Corporate staff, residents and family members.

During the course of the inspection, the inspector(s) toured the home, observed the provision of care and services, reviewed clinical records, policies and procedures, the home's complaints process and investigative notes.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Reporting and Complaints
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **7 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #001	2017_689586_0014	674

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. 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 failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy or procedure, the policy or procedure was complied with.

In accordance with Ontario Regulation 79/10 section 114(2) the licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

A. Specifically, staff did not comply with the licensee's policy titled "IIIA08: Scheduled Medication Reviews - Annual or Quarterly" which was part of the medication management system.

The policy identified that "the facility registered staff will assess the review document for correctness and match with the current MAR (medication administration record)….annotate and sign the review when completed checking with their MAR".

Resident #015 had a Medication Review Report, also known as a Quarterly Medication Review, completed on a specified date in May 2018.
This report and all subsequent orders were compared against the May 2018, electronic MAR for correctness, by Inspectors #674 and #168.
The electronic MAR included an order that was not included on the Medication Review Report in May 2018 and all subsequent orders.
Interview with the ADOC identified that the Medication Review Report, once signed by the physician, discontinued all previous orders.
A review of the Medication Review Report, identified that the ADOC and RN #126 checked the document on a specified date in May 2018.
Following a review of the clinical record, the ADOC confirmed that direction for a specified order was included on the MAR; however, the Medication Review Report and the subsequent orders did not include this order. They identified the process for the first check of the report included comparing the report to the current orders, found under the orders tab of Point Click Care, and not matching the report with the current MAR.
RN #126 was not available for interview.
Interview with the DRC indicated that if an order was not included on the Quarterly Medication Review, it was the expectation for registered nursing staff to discontinue the order.

Staff did not comply with the policy as directed.

B. Specifically, staff did not comply with the licensee's policy titled "Medication Reconciliation on Admission, Readmission, Transfer and Discharge (aka Med Rec)" which was part of the medication management system.

The policy identified that on admission the pharmacy representative would complete a Best Possible Medication History (BPMH) and once the orders were received "the BPMH document will then be checked by two nurses".

A review was conducted of a medication incident report which identified a transcription error related to resident #018.
According to the incident report on a specified date in August 2017, the resident was ordered a medication at an identified dosage twice a day. This order was included on the resident's BPMH.
The order was initially processed by pharmacy and recorded on the MAR at a different dosage than the physician's order and BPMH.
In August 2017, on a specified date, the BPMH was checked by RN #121 and by RN #126.
Interview with RN #121 confirmed that they completed the first check of the BPMH; however, did not identify the error, which was in part the purpose of the check.
Interview with the DRC verified that the error was not identified during the checking of the BPMH by the two staff which was the expectation.

Staff did not comply with the policy as directed.

C. Specifically, staff did not comply with the licensee's policy titled "Administration Procedures for all Medications" which was part of the medication management system.

The policy identified that "Prior to removing the medication from the container, check the label against the MAR".

A review was conducted of a medication incident report which identified a transcription error related to resident #018.
In August 2017, on a specified date, the resident was ordered a medication at an identified dosage twice a day.
The order was initially recorded on the MAR at a different dosage than the physician's

order; however, the medication container (pouch) and medication was dispensed by the pharmacy, to the home, at the dosage prescribed.
Interviews with RN #107, RN #121 and the ADOC confirmed that they each administered the identified medication to the resident during the time of the error.
The registered staff verified that they had signed the MAR indicating one dosage of the medication and administered the medication from the pouch indicating a different dosage and that the error was not identified during the checks of the medication, the container (pouch) and against the MAR.
Interview with the DRC identified that the MAR and the medication pouch were inconsistent in dosage for the medication and that the error could have been identified during routine checks.

Staff did not comply with the policy as directed.

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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, 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. (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 were administered to residents in accordance with the directions for use specified by the prescriber.

A review of the home's medication incidents for a three month period of time was completed.
This review included an Incident Report on a specified date in February 2018, regarding an incident involving resident #019.
The Incident Report identified that, three days prior, the resident did not receive a scheduled dosage of medication as prescribed by their physician, as the medication was found in its dated and timed container in the locked medication cart on a subsequent shift.
A review of the clinical record identified that the resident was monitored after the error was identified and that there were no concerns identified.
Interview with the DRC identified that based on their internal investigation, the resident, at the identified date and time, did not receive their medication as prescribed, by RN #122.
The DRC reported that action was taken related to the incident.
Interview with RN #122 was unable to recall the identified medication incident.

Drugs were not administered to the resident in accordance with the directions for use specified by the prescriber.

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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that staff participated in the implementation of the infection prevention and control program.

The home had a procedure in place titled "Infection Control – Precautions" Reference No.: 005090.00. This procedure instructed staff that appropriate direction would be in place.

On a specified date in May 2018, observations of resident #016's area included specific supplies; however, there was no direction in place.
On four additional dates in May 2018, the supplies were identified in the areas of resident's #016 and #017; however, there was no direction in place.
A review of the plans of care for residents #016 and #017 included that the residents had a diagnosis.
Interview with the DRC verified that residents #016 and #017 both had a diagnosis and the expectation was that direction be in place.
A tour of the home, with the DRC confirmed that direction was not in place, as required.

Not all staff participated in the implementation of the infection prevention and control program.

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 staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #4: 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. (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 failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

Resident #006 had weekly skin assessments completed on an identified day in March 2018, and one week later, which indicated that the resident had an area of altered skin integrity.
A nutritional assessment completed during the time period between the two assessments, by the FSM, indicated that the resident's skin was intact.
Interview with FSM identified that information was collected to complete the nutritional assessment from a number of areas in the clinical record in addition to observations.
The "Skin Assessment" look back report in Point of Care (POC), on a specified date in March 2018, was utilized in the completion of the nutritional assessment which indicated that the resident's skin was "clear".
The POC "Skin Assessment" on a specified date in March 2018, was completed by PSW #115, as identified by the DRC.
The POC "Skin Assessment" identified that the resident required assistance with care and that their skin observation was "skin clear".
Interview with PSW #115, identified that an error was made in the documentation and

that the resident did not have clear skin on the date of the assessment.
The DRC recalled the status of the resident's skin and identified, following a review of the clinical record that the resident's skin was not intact or clear at the time of the documentation completed by the PSW or FSM.

Staff and others involved in the different aspects of care did not collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

2. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

According to the clinical record, resident #002 presented with a change in condition on a specified date in March 2018.
The resident was assessed for their change in condition, was ordered treatment and was monitored by the physician and nursing staff.
A review of the plan of care, in place at the time of the change, did not include a focus statement or interventions related to the change in status for the resident.
RN #121 identified during an interview, the expectation that when a resident had a change in condition, the plan of care was to be revised. Following a review of the resident's plan of care, the staff member, agreed that on a specified date in March 2018, when the resident had a change in condition the plan was not revised as required.
RAI-MDS Coordinator identified that when a resident had a change in condition, the plan of care should have been revised as this would be a change in care needs. The RAI-MDS Coordinator, following a review of the resident's March 2018 plan of care, was not able to locate a focus statement or interventions for the change in care needed during the identified period of time.

The plan of care for resident #002 was not revised when their care needs changed.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that planned menu items were offered at each meal.

Resident #004 was assessed to be at risk and had a change in status over a three month period of time. An intervention was added to the resident's plan of care as a result of this change by the Registered Dietician on a specified date in February 2018.
Resident #004 was observed on a specified date in May 2018, and they were not offered the intervention. The intervention was observed to be available at the identified time. In an interview with PSW #103 it was confirmed resident #004 was not offered the intervention.
The plan of care as well as the menu choice list located in the dining room that the dietary staff and nursing staff referred to, during meal service was reviewed. It was documented that resident #004 was to have the intervention.

Dietary staff #102 reviewed the menu choice list with Inspector #583 and confirmed that resident #004 was not offered their planned menu item at lunch.

WN #6: 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. (3) The licensee shall ensure that,
(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a written record was kept of each review and of the improvements that were made in response to the review and analysis.

An interview was completed with corporate staff #113 and DRC #112 on a specified date in June 2018. It was shared that the home reviewed and analyzed the summarized documented complaint records at least quarterly at their monthly leadership meetings and the results were taken into account when determining what improvements were required in the home. The documented meeting notes for the 2018 monthly leadership meetings were reviewed. There was no documentation of each review or of the improvements that were made. A template was provided titled "quarterly complaint analysis". Corporate staff #113 shared that a form was developed to keep a record of the review, analysis and improvements made in response to the complaints, and verified it was not implemented as of June 2018.

A written record was not kept of each review and of the improvements made in response to the review and analysis.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee failed to ensure that there was, at least quarterly, a documented reassessment of each resident's drug regime.

A review of the home's Medication Incident Report, on a specified date in March 2018, regarding resident #018, was completed.
During this review it was identified that a quarterly medication review was not completed for the resident between the months of August 2017 and March 2018, a period of greater than three months.
Interview with the ADOC, RN #121 and pharmacy technician #118 confirmed the expectation that medication reviews were to be completed quarterly.
The ADOC also confirmed, following a review of the clinical record, that the quarterly medication review was not completed for the resident between the months of August 2017 and March 2018, a period of approximately seven months.

There was not, at least a quarterly, a documented reassessment of each resident's drug regime.

Issued on this 27th day of June, 2018

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

Original report signed by the inspector.