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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 14, 2018	2018_761733_0001	011767-18, 018557-18	Critical Incident System

Licensee/Titulaire de permis

Dundas Manor Limited
533 Clarence Street P.O. Box 970 WINCHESTER ON K0C 2K0

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

Dundas Manor Nursing Home
533 Clarence Street P.O. Box 970 WINCHESTER ON K0C 2K0

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

MARK MCGILL (733)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): December 4, 5, 10, 11, 12

Log #018557-18, CIS#2674-000015-18 and Log #011767-18, CIS#2674-000010-18 were related to falls. Log #028453-18, CIS#2674-000023-18 was related to a medication incident/adverse drug reaction.

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Associate Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and residents.

The following Inspection Protocols were used during this inspection:
Falls Prevention

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

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

Resident #007 was assessed as a high falls risk after experiencing a fall. The resident was initiated on the Falling Leaf Program as part of the homes falls prevention strategy and remains on this program at present.

Upon review of resident's #007 Falls Risk Assessment Level 3 Screening Tool for High Risk Residents v3 July 31, 2018, question 1 : Initiate a bedside safety plan for this high risk resident- check all Falling Leaf & Falls Interventions that are implemented, the following interventions were selected : A) Falling Leaf logo above bed and B) Falling Leaf logo on ambulatory aides.

On December 11, 2018, Inspector #733 observed resident #007's room and noted that there was no falling leaf logo present above the bed. On December 12, 2018, Inspector #733 again observed resident #007's room and noted that there was no falling leaf logo above the bed. Inspector #733 then observed the resident's assistive device and noted that there was no falling leaf logo present.

On December 12, 2018, during an interview with Inspector #733, DOC #102 confirmed that resident #007 was active on the falling leaf program as per their current care plan.

In an interview with Inspector #733 on December 12, 2018, RPN #121 verified that resident #007 was missing a falling leaf logo both above their bed and on their assistive device.

On December 12, 2018, Inspector #733 reviewed the homes policy NURS 04-040 entitled Falls Prevention Strategy and Goals which states under components of a falls preventions program that residents deemed high risk will be identified at the bedside with a fall symbol – which is the falling leaf logo. The policy goes on to state that it is Nursing (RN & RPN) who will apply the falling leaf logo above the bed, in specific bathrooms, and to any assistive device on assessment of high risk for falls as a visual cue to all staff. These logos are located in the filing cabinet at nursing stations.

The licensee did not follow their policy on falls prevention as related to the falling leaf program by failing to post the required visual reminders. [s. 8. (1) (a),s. 8. (1) (b)]

2. Log #028453-18 was inspected by Inspector #732 (inspection number 2018_785732_0001)

Medication A and medication B were ordered together for resident #006. Pharmacy noted that resident #006 had an allergy to one of these medications. The order was not filled until clarification from the physician. The physician discontinued medication A and ordered medication C. The registered practical nurse (RPN) signed the order as being processed; however, the order was not entered into the electronic medication administration record (eMAR) by pharmacy, and the medication was not received. Resident #006 started on medication C and received doses of it without medication B before having a medical issue resulting in transfer to hospital.

Inspector #732 met with the Associate Director of Care (ADOC) #109 on December 10, 2018, to discuss the medication incident involving resident #006. ADOC #109 told Inspector #732 that Administrator #101 met with the home's Board of Directors to go over the incident with them. ADOC #109 gave Inspector #732 a document of the points Administrator #101 went over with the Board of Directors. This document is entitled "Resident Story – November 22, 2018 Board Meeting". Inspector #732 and ADOC #109 reviewed this document together. In the document it states that during root cause analysis, it was found that the Registered Practical Nurse had signed off the order as being processed, however, the order was not entered and the medication was not received. It should not have been signed off.

ADOC #109 confirmed this is correct.

On December 12, 2018, Inspector #732 met with Administrator #101 to review the

document presented to the Board of Directors entitled “Resident Story – November 22, 2018 Board Meeting”.

Administrator #101 confirmed that the order for medication A and medication B should not have been signed off by the RPN.

On December 12, 2018, Inspector reviewed resident #006's chart. Inspector #732 located the "Prescriber's Orders" sheet where the order for medication A and medication B were written. There was a stamp with the word 'faxed' and an initial below. Below that, there was a second initial. ADOC #109 confirmed with Inspector #732 on December 12, 2018, that the second initial was that of RPN #122. Inspector #732 reviewed resident #006 eMAR and confirmed that medication B was not on resident #006's eMAR.

In an interview with ADOC #109, Inspector #732 asked ADOC #109 what the responsibility of a registered staff member is when new orders for medications are written. ADOC #109 stated that registered staff are to fax orders to pharmacy and then sign the order noting that it was faxed. Once the order is processed, they check to make sure it is in e-MAR and they sign again once they have confirmed this is done. ADOC #109 stated that once an order is faxed to the pharmacy and signed, a red flag on the resident’s chart goes up to indicate a need for a second check and signature. Once the medications are received from pharmacy, and the orders are completed in eMAR, the second signature is added and the red flag is lowered.

ADOC #109 confirmed that this process was not followed by the RPN that shift.

During the interview with ADOC #109 on December 10, 2018, Inspector #732 was given a policy entitled “Processing New and Changed Orders, Policy#: PHRM 125”. This document was not dated. Inspector #732 reviewed this policy. At the bottom of the document there was a section entitled "Checks For All Orders" documenting how to perform a second check.

ADOC #109 confirmed with Inspector #732 that this was the current policy

Inspector #732 interviewed RPN #122 on December 11, 2018, at 1500. Inspector #732 asked RPN #122 what the process is when a new order is received from the physician. RPN #122 informed Inspector #732 that an order is written on a physican order sheet. The nurse will check the order and fax to pharmacy, call the family to make sure they are in agreement to it, and document this. RPN #122 stated they will initial that they faxed to

pharmacy and usually write 'noted', and then put the red flag up and the yellow flag down on the chart. The red flag is for a co-sign from a registered staff member. Inspector #732 asked RPN #122 what they would do if they saw a red flag up. RPN #122 informed inspector #732 that they would know something needed to be signed. They would check the paper order with eMar, make sure family is aware, and make sure it was faxed to pharmacy and entered in eMar correctly, as per physician order sheet. Then the red flag goes down. When Inspector #732 asked RPN #122 what went wrong, RPN #122 stated they did not fully check eMAR to make sure it was correct before signing their name and putting the red flag down. RPN #122 confirmed she did not follow the home's policy on processing new orders.

The licensee failed to ensure that the home's policy entitled "Processing New and Changed Orders", developed for the medication management system, was complied with. [s. 8. (1) (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 the policy "Processing New and Changed Orders" is followed, to be implemented voluntarily.

Issued on this 17th day of December, 2018

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

Original report signed by the inspector.