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
Jan 4, 2018	2017_601532_0016	025537-17	Resident Quality Inspection

Licensee/Titulaire de permis

EDEN HOUSE CARE FACILITY INC
R.R. #2 GUELPH ON N1H 6H8

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

EDEN HOUSE NURSING HOME
5016 Wellington County Road 29 R. R. #2 GUELPH ON N1H 6H8

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

NUZHAT UDDIN (532), CAROLEE MILLINER (144), JANETM EVANS (659)

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 14, 15, 16, and 17, 2017.

A follow-up to compliance order #001 from Critical Incident System inspection # 2016_226192_0027 related to Medication Administration was completed.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Nursing Consultant, Pharmacist, Resident Assessment Instrument (RAI) Coordinator, Dietitian, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeeping staff, Family and Residents' Council Representatives, residents and family members.

Inspectors also toured the resident home areas and common areas, medication rooms, spa rooms, observed resident care provision, resident to staff interactions, dining services, medication administration, medication storage areas, reviewed relevant residents clinical records, posting of required information, relevant policies and procedures, as well as meeting minutes pertaining to the inspection, and observed general maintenance and cleanliness of the home.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **3 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. 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).

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 every medication incident involving a resident and every adverse drug reaction was documented, together with a record of the immediate actions taken to assess and maintain the resident`s health.

Review of medication incidents provided for an identified period of time showed that there were medication incidents.

The medication incident for an identified resident was documented. The incident was related to an identified resident being administered a medication when the order for the medication had not been renewed by the physician. Review of the clinical record showed the medication continued to be administered over a specified period of time, when the medication incident was discovered. At that time the physician was notified and an order for the medication was received. There was no documented evidence of immediate actions taken to assess and maintain the resident's health; and the medication incident

record documented no harm to the resident.

Review of the home's policy for resident medication error, last reviewed April 2017, procedure documented as:
"1. Upon discovery of the error, immediately examine the resident for adverse reactions. Take vital signs and continue to monitor according to physician's directions
2. Notify the physician immediately. Give full particulars of the error and any adverse reactions noted
3. Notify the Director of Resident Care
4. Notify the Consultant Pharmacist
5. Notify the resident/Substitute Decision Maker
6. Document all details of the error on the progress notes. Include: report to the physician and SDM; reaction; treatment and follow-up action.
6. Complete a risk management report within PCC."

In an interview Registered Nurse (RN) acknowledged when a medication incident was discovered registered staff were to assess the resident and document the assessment in a progress note. The RN stated that an assessment had not been completed for the identified resident and that they had notified the DOC of the incident.

In an interview, Director of Care (DOC) acknowledged that there was no documentation of immediate actions to assess and maintain the identified resident's health as the resident had been receiving the medication all along. DOC stated they had looked at this incident more as a process issue and not as a resident medication error.

The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was (a) documented, together with a record of the immediate actions taken to assess and maintain the resident`s health.

The severity of this area of non-compliance was minimal harm. The scope was determined to be a pattern. There was a history of previous related non-compliance being issued as a compliance order on August 25, 2016 from a Critical Incident System inspection #2016_226192_0027 and as a voluntary plan of correction on January 5, 2016, from a Resident Quality Inspection #2016_253614_0001. [s. 135. (1)]

2. 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.

Review of medication incidents provided for an identified period of time showed that there were medication incidents.

An identified Inspector was provided with the Clinical Consultant Pharmacist document titled Quarterly Summary Eden/EDRT. This report indicated there were three medication incidents year to date: two attributed to the pharmacy and one to nursing. No other information was documented related to the medication incidents.

The information on this Quarterly Summary related to any changes and improvements identified in the review that were implemented, but these did not correlate to the medication incidents reviewed.

In an interview, Director of Care (DOC) stated they fax the pharmacy a copy of all of the medication incidents. The DOC acknowledged that the Quarterly Summary did not correlate to the home's reported quarterly medication incidents. DOC stated that the Pharmacist Consultant was not always forwarded a copy of the medication incidents and only reported on those they had received.

In an interview, Pharmacy Consultant stated whenever there was a medication incident the home would complete a medication incident report and send it to pharmacy. The pharmacy manager would review the incident, the type of error, and complete an analysis, if appropriate. The manager determined which medication incidents were forwarded to the Pharmacy Consultant for review. Pharmacy Consultant acknowledged that the pharmacy's Quarterly Summary did not correlate to the home's quarterly timeline and medication incidents. In addition to this, the Pharmacy Consultant stated they did not receive all medication incidents that were faxed to the pharmacy and stated that their Consultant Pharmacist Quarterly Summary report was their personal notes and only included those medication incidents which they had received.

The home has failed to ensure that a quarterly review was 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. [s. 135. (3)] (659)

The severity of this area of non-compliance was minimal harm. The scope was determined to be a pattern. There was a history of previous related non-compliance

being issued as a compliance order on August 25, 2016 from a Critical Incident System inspection #2016_226192_0027 and as a voluntary plan of correction on January 5, 2016, from a Resident Quality Inspection #2016_253614_0001. [s. 135. (3)]

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 every medication incident involving a resident and every adverse drug reaction is documented, together with a record of the immediate actions taken to assess and maintain the resident`s health, 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 plan of care set out clear directions to staff and others who provided direct care to the resident.

Clinical record for an identified resident indicated a decline in continence since admission.

Clinical record for a specified date identified the resident as "frequently incontinent" and another assessment at a later date identified the resident as being "incontinent."

Continence Assessment stated “continent - complete control.”

The plan of care identified specific interventions related to toileting for both bladder and bowel.

An identified staff member in an interview said that the resident was toileted but not at the times that were documented in the kardex or the plan of care. The identified staff member said that the times in the plan of care were not reflective of the times that the resident was being toileted.

Registered Nurse was shown the clinical record and the kardex and they shared that the RAI Coordinator was the one who developed the plan of care and acknowledged that the POC, the plan of care and the kardex for the identified resident should all provide clear directions to staff who provided direct care to the resident.

The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

The severity of this area of non-compliance was minimal harm. The scope was determined to be as isolated. There was a history of related non-compliance issued as a written notification on September 12, 2016 from Resident Quality Inspection 2016_363659_0027 and August 25, 2016 as a written notification from a Critical Incident System inspection #2016_226192_0027. [s. 6. (1) (c)]

2. The licensee has 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.

Review of the clinical record for the identified resident stated that the resident had altered skin integrity.

The home’s policy called the Interdisciplinary Wound and Skin Care program, last

reviewed in April 2017, included under the section for roles and responsibilities of team members, that the "RN's and RPN's initiate the plan of care for residents to reduce identified risks."

Identified RN reviewed the clinical record for the specified resident and acknowledged that the care plan did not include altered skin integrity.

DOC told Inspector that the care plan should have included the altered skin integrity.

The licensee has failed to ensure that the plan of care for resident was revised to include the the areas of altered skin integrity.

The severity of this area of non-compliance was minimal harm. The scope was determined to be isolated. There was a history of related non-compliance issued as a written notification on September 12, 2016 from Resident Quality Inspection 2016_363659_0027 and August 25, 2016 as a written notification from a Critical Incident System inspection #2016_226192_0027. [s. 6. (10) (b)]

WN #3: 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 a 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, if clinically indicated.

Clinical record indicated a resident had altered skin integrity.

Review of the identified resident's weekly assessments indicated that the weekly assessment for the altered skin integrity had not been completed for an identified period of time. The area was being monitored under skin note, in the resident's progress notes, however, no weekly assessment was done using a clinically appropriate assessment instrument that was specifically designed for skin assessment. RN said that the expectation was that registered staff completed an assessment using a clinically appropriate assessment but there were no assessments except for skin notes.

In an interview, DOC acknowledged that weekly assessments were not done on the altered skin integrity as they had directed staff to complete a skin note rather than doing a weekly assessment. The DOC said that they thought since altered skin integrity was chronic and non-healing that a skin note would be sufficient and they did not consider that it was not a clinically appropriate skin assessment.

The licensee has failed to ensure that a resident altered skin integrity was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

The severity of this area of non-compliance was minimal harm. The scope was determined to be as isolated. There was a history of unrelated non-compliance in the last three years. [s. 50. (2) (b) (iv)]

Issued on this 8th day of January, 2018

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

Original report signed by the inspector.