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 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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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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
Nov 16, 2018	2018_768693_0014	028222-18	Resident Quality Inspection

Licensee/Titulaire de permis

Riverside Health Care Facilities Inc.
110 Victoria Avenue FORT FRANCES ON P9A 2B7

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

EMO Health Centre
170 Front Street P.O. Box 390 EMO ON P0W 1E0

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

MELISSA HAMILTON (693), DEBBIE WARPULA (577)

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 5-9, 2018.

The following additional intakes were inspected during this Resident Quality Inspection:
- Two Complaint logs (#009263-17; and #012099-17) related to staff to resident abuse and neglect.

During the course of the inspection, the inspector(s) spoke with the Manager of Care (MOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Office Manager, Registered Dietician (RD), Hair Dresser, residents and residents' family members.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
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	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. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and of acquiring, in the case of new items.

During a tour of the home, Inspector #577 observed a rolling hair cart in the tub room with multiple used, unclean, unlabeled personal hair care items as follows:

-three drawers contained multiple hair rollers covered in grey hair and hair clips/pins, unlabeled;
-the top of the cart contained one pink and one white hair comb with hair debris, unlabeled;
-the first drawer contained one green pic comb with hair debris, one beige comb with hair debris, one black brush with grey hair, and one red comb with hair debris, unlabeled;
-the second drawer contained one black/red brush covered with grey hair, unlabeled;
-the third drawer contained one black brush with grey hair, unlabeled and three used electric shavers with debris, unlabeled;
-the fourth drawer contained one black hair brush covered with grey hair, unlabeled.

During an interview with RPN #100, they reported to Inspector #577 that the rolling hair cart belonged to the hair dresser and nursing staff have not used the cart.

During an interview with RPN #102, they reported that sometimes staff would have used the rollers and pins from the hair cart. They further reported that the personal hair care items should have been labeled and should not have been shared between residents.

In an interview with the hair dresser, they reported that they had been offering their hair care services to the residents for a specified amount of time, where they would shampoo, set and curl the residents hair. They further reported that the rolling hair cart does not belong to them, but they had used some items from the cart.

The MOC and Inspector #577 observed the personal items in the rolling hair cart. They confirmed that the personal items appeared to be shared items between the residents, and should have been labeled and separated; further, they would remove the cart and items from being used. [s. 37. (1) (a)]

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 of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and of acquiring, in the case of new items, to be implemented voluntarily.

WN #2: 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 has failed to ensure that when a resident was taking any drug or combination of drugs, including psychotropic drugs, there was monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

During an interview with resident #002, they had reported to Inspector #577 that they experienced pain to a specific area of their body.

A review of the physician orders indicated that the resident was prescribed a pain medication as needed (prn).

Inspector #577 reviewed the Medication Administration Record (MAR) from a one month time period, and found that the resident received prn medication for pain on a number of occasions. A review of the 'response notes' on the MAR and the progress notes identified that the response of the effectiveness to the medication was documented on a small percent of the time.

A review of the home's policy entitled "Pain Management Program - #ORG-II-RES-05.1" last revised April 11, 2018, identified that when PRN medications were administered, residents were assessed to determine medication effectiveness and that the effects of the medication were documented on the 'Pain Monitoring Flow Sheet', or on the back of the MARS, and could also be documented in the electronic medical record.

In an interview with RPN #102, they reported to the Inspector that staff were required to document the response to pain medication on the backside of the MAR.

During an interview with RN #103, they reported to the Inspector that a response to a prn medication should be documented on the backside of the MAR.

During an interview with the MOC, Inspector #577 reviewed the back of the MAR for resident #002, for the specified one month time period. They confirmed that the follow up documentation was inconsistent and staff were required to document the effectiveness of prn pain medication on the back of the MAR to determine the effectiveness. [s. 134. (a)]

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 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, 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).

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, (a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and (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.

The Long-Term Care Homes Act, 2007, C.8 describes a medication incident as "a preventable event associated with the prescribing, ordering, dispensing, storing, labelling, administering or distributing of a drug, or the transcribing of a prescription, and includes,
(a) an act of omission or commission, whether or not it results in harm, injury or death to a resident, or
(b) a near miss event where an incident does not reach a resident but had it done so, harm, injury or death could have resulted".

Inspector #577 conducted a review of the home's most recent medication incident report which occurred on an identified day. The incident report indicated that RPN #104 had not administered a specified medication to resident #007 until an extended amount of time after the scheduled time.

A review of the incident report and the progress notes indicated that the resident, the SDM, the Medical Director, pharmacy and the prescriber were not notified of the medication incident.

Inspector #577 identified that immediate actions taken to assess and maintain the residents' health were not documented on the incident report or progress notes.

A review of the home's policy titled "Goldcare Incident Reporting Documentation Procedure" indicated that all adverse events such as medication errors, must be disclosed to the resident if capable or to the Power of Attorney (POA)/SDM if the resident had been deemed incapable.

During an interview with the MOC, they confirmed with Inspector #577 that the resident, the resident's SDM, the Medical Director, the prescriber of the drug, the resident's attending physician and the pharmacy service provider had not been notified, and immediate actions were not documented. [s. 135. (1)]

2. The licensee has failed to ensure that a written record was kept of the quarterly review 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.

Inspector #577 conducted a record review of the home's Pharmacy and Therapeutics Committee meeting minutes from three specified dates, which identified medication incidents as an agenda item of discussion. The minutes indicated the following:

-on the first specified date- the meeting was cancelled;
-on the second specified date- medication errors, no report; and
-on the third specified date- there was not a review of medication errors.

A review of a medication error report generated from a 6 month time period, indicated a medication error that had occurred in an identified month, where a resident had not received their medication scheduled at a specific time; the drug was not noted and there was no harm.

During an interview with the MOC, they reported to Inspector #577 that that there was not a written record of a quarterly review undertaken of medication incidents and adverse drug reactions; all medication incidents were forwarded to the Patient Safety Officer who would input the information into the database; the information was compiled for the Pharmacy and Therapeutics Committee for statistical purposes which would indicate the number of incidents and the areas where the incidents occurred. The committee had not had not kept a written record of quarterly reviews undertaken. [s. 135. (3) (c)]

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Issued on this 16th day of November, 2018

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

Original report signed by the inspector.