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
Feb 12, 2018	2018_546585_0002	000970-18	Resident Quality Inspection

Licensee/Titulaire de permis

Schlegel Villages Inc.
325 Max Becker Drive Suite. 201 KITCHENER ON N2E 4H5

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

Erin Mills Lodge Nursing Home
2132 Dundas Street West MISSISSAUGA ON L5K 2K7

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

LEAH CURLE (585), KATHLEEN MILLAR (527)

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): January 22, 23, 24 and 25, 2018.

During the course of the inspection, the inspector(s) spoke with residents, families, Personal Care Attendants (PCAs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), environmental staff, dietary staff, the Scheduling Coordinator, Director of Food Services (DFS), Registered Dietitian (RD), Director of Recreation, Assistant Director of Care (ADOC), Director of Care (DOC) and the General Manager.

During the course of the inspection, the inspector(s) toured the home, observed the provision of resident care and services, reviewed resident clinical records, meeting minutes, program evaluations, training records as well as relevant policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.
- **4 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 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for the resident that set out clear directions to staff and others who provided direct care to the resident.

On an identified date in June 2017, the Registered Dietitian (RD) added an intervention to resident #008's written care plan. The intervention directed staff to provide a specified diet texture with modifications. The individual care service plan used by Personal Care Attendants (PCAs) was reviewed and also included the specified diet texture and modifications.

Dietary staff #113 and PCA #112 were interviewed and reported the resident received a specified diet texture with modifications. Dietary staff #113 stated they referred to the dietary cardex located in the servery for the resident's diet texture needs as well as any additional serving notes. The diet cardex was reviewed and noted resident #008's diet texture; however, did not include any specified modifications.

The Director of Food Services (DFS) was interviewed and reported the resident was to be offered the specified diet texture and modifications; however, confirmed the dietary cardex did not provide clear direction to dietary staff and others who provided direct care to the resident. [s. 6. (1) (c)]

2. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A) Resident #003's clinical health record was reviewed and noted they were at risk for

impaired skin integrity. On an identified date in November 2017, nursing staff noted an area of altered skin integrity on their body. The RD added an intervention to the plan of care to provide a specified nutritional supplement to help address the noted area of altered skin integrity.

During an identified period in November and December 2017, registered nursing staff documented approximately 10 times that the specified nutritional supplement was not available.

Long Term Care Homes (LTCH) Inspector #585 reviewed nursing documentation with Registered Practical Nurse (RPN) #111. RPN #111 reported registered staff were expected to contact other home areas if the specified nutritional supplement was not available on the home area; however, stated there were times when the supplement was not available in the home. RPN #111 confirmed there were times when residents did not receive the specified supplement.

The DFS was interviewed and reported there was sufficient stock of the specified nutritional supplement in the home at all times and if there was not enough on one home area, staff were expected to contact another home area or inform a manager on duty.

The DOC was interviewed and confirmed resident #003 had an area of altered skin integrity. The DOC confirmed that the care set out in the plan of care was not provided to the resident as specified in the plan approximately 10 times when the home failed to provide the specified nutritional supplement.

B) Resident #002's clinical health record was reviewed and noted they were at risk for impaired skin integrity. On an identified date in August 2017, an area of altered skin integrity was noted on their body. The RD added an intervention to the plan of care to provide a specified nutritional supplement to help address the noted area of altered skin integrity.

During an identified period in November and December 2017, registered nursing staff documented approximately 10 times that the specified nutritional supplement was not available.

The DOC was interviewed and confirmed resident #002 had an area of altered skin integrity. The DOC confirmed that the care set out in the plan of care was not provided to the resident as specified in the plan approximately 10 times when the home failed to

provide the specified nutritional supplement.

C) Resident #010's clinical health record was reviewed and noted they were at risk for impaired skin integrity. On an identified date in September 2017, the RD received a referral regarding a new area of altered skin integrity. The RD added an intervention to the resident's plan of care to provide a specified nutritional supplement to help address the noted area of altered skin integrity.

During an identified period in November and December 2017, registered nursing staff documented approximately 10 times that the specified nutritional supplement was not available.

The DOC was interviewed and confirmed resident #010 had an area of altered skin integrity. The DOC confirmed that the care set out in the plan of care was not provided to the resident as specified in the plan approximately 10 times when the home failed to provide the specified nutritional supplement. [s. 6. (7)]

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 and ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident and that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the use of a personal assistance services device (PASD) under subsection (3) to assist a resident with a routine activity of living was included in a resident's plan of care only if 1. Alternatives to the use of a PASD had been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living.

On identified dates in January 2018, resident #005 was observed using a specified device. Review of their written plan of care identified they used the device as a PASD for specified reasons. The clinical record was reviewed and did not include whether alternatives to the use of a PASD had been considered, and tried where appropriate.

RPN #111 was interviewed and reported the device was used as a PASD for specified reasons. RPN #111 reported that whenever a PASD was being considered or used as an intervention to assist a resident, staff were expected to complete an Alternatives To PASD/Restraint Assessment. RPN #111 confirmed no Alternatives To PASD/Restraint Assessment was completed for resident #005 regarding the use of their device.

RPN #128 was interviewed and located a form, "Consent Form for the use of Restraint/PASD", dated from July 2017, that identified how the device would be effective to assist the resident with their activities of daily living. The form also included approval of the use of the PASD by the physician as well as consent obtained by the substitute decision maker (SDM); however, RPN #128 confirmed that there was no documentation to support that alternatives to the use of a PASD had been considered for resident #005 in relation to their specified PASD. [s. 33. (4) 1.]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 113. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes or improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared. O. Reg. 79/10, s. 113.

Findings/Faits saillants :

1. The licensee failed to ensure that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented was promptly prepared.

The home's annual restraint program evaluation for 2017 was reviewed and indicated that there were no dates for all the changes that were being implemented as a result of the evaluation.

The home's policy, "Restraint & PASD Procedures in LTC - number 04-52", revised June 1, 2017, directed the staff that a written record of the analysis must be kept and should include the date of the evaluation, the names of the persons who participated in the evaluation, and the date the changes were implemented.

The General Manager was interviewed and confirmed that the specific dates the changes were implemented were not documented on their written record of their annual restraint program evaluation. [s. 113. (e)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were stored in an area or a medication cart that complied with the manufacturer's instructions for the storage of the drugs.

The home's policy, "Administration of Medications - number 05-03", revised October 23, 2017, directed staff that medications that were not labeled and/or expired were to be discarded.

On January 25, 2018, the government stock was observed and there were a number of medications that were expired. The following medications were expired:
- Seven (7) Alugel 320 milligram (mg) per 5 mililitres (ml), 425 ml bottles, expired in December 2017, and
- Anusol Hemorrhoidal ointment 30 gram per tube had two (2) tubes expired in December 2016, three (3) tubes expired in April 2017, and one (1) tube expired in June 2017.

The DOC was interviewed and indicated they checked the government stock every month, ordered what medications they needed for resident use, checked the expiry dates on the medications and discarded them as necessary. The DOC confirmed they were expected to discard the expired medications according to their policy and procedures. The home failed to ensure that they complied with the manufacturer's instructions related to discarding expired medications. [s. 129. (1) (a)]

Issued on this 12th day of February, 2018

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

Original report signed by the inspector.