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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 18, 2017	2017_531518_0031	019091-17	Resident Quality Inspection

Licensee/Titulaire de permis

HANOVER NURSING HOME LIMITED
700 19TH AVENUE HANOVER ON N4N 3S6

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

HANOVER CARE CENTRE
700-19TH AVENUE HANOVER ON N4N 3S6

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

ALISON FALKINGHAM (518), ALICIA MARLATT (590), NATALIE MORONEY (610)

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): August 21, 22, 23, 24, 25, 28, 29, 30 and 31, 2017.

**The following intakes were inspected within the Resident Quality Inspection:
Log 013569-15 CIS 2770-000006-15 related to alleged resident to resident abuse
Log 004713-17 follow up to compliance orders #001 related to the establishment of a Family Council within the home, #002 related to education on policies related to restraints, continence care and bowel management, ethics, documentation and medication, #003 related to skin assessments and referrals to the registered dietitian and #004 related to medication management and drug destruction issued during Inspection 2017_622521_0001.**

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care(DOC), four Registered Nurses(RN), four Registered Practical Nurses, the Food Service Manager, the Environmental Lead, the Activation Manager, the Pharmacy Manager, one Housekeeper, nine Personal Support Workers, the Residents' Council President, twenty residents and three family members.

The inspector(s) also conducted a tour of the home and made observations of residents, activities and care. Relevant policies and procedures, as well as clinical records of twenty residents, and plans of care for identified residents were reviewed. Inspectors observed a medication administration and drug storage areas, resident/staff interactions, infection prevention and control practices, the posting of Ministry information and inspection reports and general maintenance, cleanliness and condition of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

- **5 WN(s)**
- **5 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
O.Reg 79/10 s. 136. (3)	CO #004	2017_622521_0001	518
O.Reg 79/10 s. 50. (2)	CO #003	2017_622521_0001	518
LTCHA, 2007 S.O. 2007, c.8 s. 59. (3)	CO #001	2017_622521_0001	518
O.Reg 79/10 s. 8. (1)	CO #002	2017_622521_0001	518

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. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure the restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following were satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining.

A resident was observed with two medical devices in place.

The Resident Assessment Protocol (RAP) for the resident showed that the resident had medical conditions which required staff to anticipate the resident's care needs and that the second medical device was ordered by the physician with specific directions for the use of the device. There was no order for the first medical device with directions for it's use or application.

The licensee’s Least Restraint Policy #60-10 reviewed September 26, 2014, stated: "The Physician's order must include the type, the reason for application, and the duration of use".

A review of the resident clinical record showed that there was no current order for the first medical device and that it was not included in the resident's plan of care.

A registered staff member said that the resident should not be in the first medical device and that the only physician order was for the use of the second medical device.

A staff member observed the resident with the inspector and said that the resident was in the first medical device and said that the resident should have had an order for the use of the use of the first medical device.

The licensee has failed to ensure the restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following were satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining.

The scope of this issue was isolated. The severity was determined to be a level 2 minimal harm or potential for actual harm. There was no previous non compliance related to this subsection of legislation. [s. 31. (2) 4.]

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 the restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining, 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. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a Personal Assistance Services Device (PASD) described in subsection (1) used to assist a resident with a routine activity of living only if the use of the PASD was included in the resident's plan of care.

Observations of a resident showed that the resident was using a medical device. The resident was observed repositioning themselves in the medical device.

The Resident Assessment Protocol (RAP) for the resident showed that the resident had medical conditions, required assistance with daily routines and supervision and did not indicate the resident used a medical device.

The licensee’s Least Restraint Policy #60-10 reviewed August 28, 2017, stated:
"The use of the PASD had to be approved by a physician, Registered Nurse, Registered Practical Nurse, Occupational Therapist and Physiotherapist and would be reasonably light and would be effective to assist the residents with the routines of daily living, and alternatives would be used".

A review of the physician's orders and the plan of care for the resident showed that the medical device was not ordered or part of the resident's plan of care.

Two registered staff members stated that the resident was using the medical device for comfort. They also stated that the medical device had not been ordered, that the resident's Substitute Decision Maker (SDM) had not consented to the medical device and the medical device was not part of the resident's plan of care.

The licensee has failed to ensure that a Personal Assistance Services Device (PASD) described in subsection (1) used to assist a resident with a routine activity of living only if the use of the PASD was included in the resident's plan of care.

The scope of this issue was isolated. The severity was determined to be a level 2 minimal harm or potential for actual harm. There was no previous non compliance related to this subsection of legislation. [s. 33. (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 a Personal Assistance Services Device (PASD) described in subsection (1) used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Nutrition care and hydration program included:
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter.

During stage one of the Resident Quality Inspection while completing a census review and a staff interview it was noted that it had been two years since the resident's last recorded weight in the clinical record.

Review of a completed nutritional assessment for the resident showed that the home's Registered Dietitian did not document the resident's current weight.

Review of the resident's current care plan showed that there were stated interventions related to weights.

Review of the home's policy "Weighing a Resident", policy #100-85 last revised December 23, 1998, stated:
"Residents are weighed on admission and routinely every month or as ordered by the Physician or nursing staff."

Review of the resident's physician's orders showed that the resident should not be weighed for safety reasons.

Interviews with two staff members stated that the resident had not been weighed for two years. They said that the resident required a specific medical device for use when bathed however the device did not have the option for obtaining weights.

The licensee has failed to ensure that the Nutrition care and hydration program included:

(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter.

The scope of this issue was isolated. The severity was determined to be a level 2 minimal harm or potential for actual harm. This area of non compliance was previously issued as a voluntary plan of correction during a Resident Quality Inspection on January 16, 2017 Inspection 2017_622521_0001. [s. 68. (2) (e) (i)]

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 Nutrition care and hydration program included:
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 114 (3).
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policies and protocols related to the medication management system were developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

An observation was completed by the inspector during medication administration for a resident.
The resident received specified medications as prescribed by the physician.

Review of the current paper eMAR showed that the resident was to receive the specified medication at lunch as prescribed.
Further review of the medication orders in the resident's paper chart showed that the

physician’s medication quarterly review had three conflicting orders for a medication with differing dosages.

Review of the physician's quarterly medication review showed a line through the orders in the discontinued box for each medication prescribed as well as check marks in the continued box for each the medication prescribed. The physician had signed the medication quarterly review. One out of two pages of the quarterly review was processed and signed by two registered staff members. The second page was signed off as processed by only one registered staff member.

The Medisystem Pharmacy policy Physician Order Reviews, January 16, 2017, stated:
The prescriber can use the physician order sheet for the digital three or six month reviews and that:
" Each drug should be assessed and justified for continued use by the prescriber,
The prescriber may use the document as an order, medication can be continued, discontinued or put on hold using the appropriate box beside the medication order, changes should not be made to the existing order, if the medication is changed the physician is asked to clearly stroke out the old printed order and write “new” or changed in a new blank box on the page.
The completed physician order review will be processed by one nurse after the orders are processed and sign the review. The second nurse checks that the orders are processed".

The DOC stated that all staff were expected to follow the licensee’s medication management policy.

The Pharmacy Manager stated that the policies for the medication management program from Medisystem were based on regulatory legislation and best practices.

A registered staff member said that one physician had created an error on the medication quarterly review and had discontinued all the medication on that review. To rectify the error another physician was called and asked to review the medication quarterly review and the physician renewed all of the orders.

A registered staff member said due to the errors on the quarterly medication review for the resident a new medication quarterly review should have been requested and sent from the pharmacy for the resident.

The DOC stated that they confirmed the medication error for transcribing with the physician. The physician confirmed that the resident was receiving the correct dosage of medication as administered on the current eMAR and that the pharmacy had been notified of the transcription errors.

The DOC stated that all staff were expected to follow the licensee's medication management policy.

The Pharmacy Manager, registered staff in the home and the inspector observations showed that the policies and procedures related to the management of the medication program were not clearly understood by staff interviewed, and not implemented in a consistent manner by all staff.

The licensee has failed to ensure that the written policies and protocols related to the medication management system were implemented in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

The scope of this issue was isolated. The severity was determined to be a level 2 minimal harm or potential for actual harm. This area of non compliance was previously issued as a voluntary plan of correction during a Resident Quality Inspection on January 16, 2017 Inspection 2017_622521_0001. [s. 114. (3) (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 the written policies and protocols related to the medication management system were developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (3) The annual evaluation of the medication management system must,
(a) include a review of the quarterly evaluations in the previous year as referred to in section 115; O. Reg. 79/10, s. 116 (3).
(b) be undertaken using an assessment instrument designed specifically for this purpose; and O. Reg. 79/10, s. 116 (3).
(c) identify changes to improve the system in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 116 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the annual evaluation of the medication management system must:
(a) include a review of the quarterly evaluations in the previous year as referred to in section 115;
(b) be undertaken using an assessment instrument designed specifically for this purpose; and
(c) identified changes to improve the system in accordance with evidence- based practices and, if there are none, in accordance with prevailing practices.

O. Reg. 79/10, s.115 (1) states the licensee shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

During the Resident Quality Inspection observations were completed of the medication rooms, medication carts, medication administration, controlled and non-controlled drug substance destruction, documentation related to signage of ordering and receiving medication from pharmacy, documentation for medication administration on the eMAR, and signage of controlled substances by the registered staff. These observations identified areas of risk with findings of non-compliance issued related to O.Reg 79/10, s. 114.

Review of the licensee's annual evaluation on the medication management programs showed that the licensee had not completed an annual review for 2016.

The Administrator stated that they had not completed any quarterly medication management meetings in 2016 or 2017.

The pharmacy service provider General Section Policy CQI Program, revised on January 13, 2017, stated:
" The committee will be interdisciplinary and meet four times a year".

The Continuous Quality Improvement Program (CQI) last revised January 18, 2017, stated:
" Audits are derived from the Long Term Care Regulations, Nursing and Pharmacy standards of practice and that results will be reviewed at the PAC meeting".

The home's Audit Criteria Policy revised on January 18, 2017, showed that part of the auditing process completed by the pharmacy was to identify if the facility meets annually to evaluate the effectiveness of the medication management system and any changes identified would be implemented as well as written minutes of the PAC meetings.

The Administrator was not able to provide any written records of reviews to identify changes to improve the system in accordance with evidence-based practices or in accordance with prevailing practices and any evaluations of the effectiveness of the medication management system in the home or any assessment instrument designed specifically for evaluation of the medication management system.

The DOC stated they created a Policy “Quarterly Evaluations/Professional Advisory Meeting”, however they do not have an Annual Medication Management Evaluation Policy and that the home followed the licensee Policy and Procedures in the home.

The Administrator stated that they have not completed a quarterly evaluation or annual evaluation of the medication administration system for greater than ten years and had not completed any quarterly medication management meetings in 2016 or 2017.

The licensee has failed to ensure that the annual evaluation of the medication management system included:
(a) a review of the quarterly evaluations from the previous year as referred to in section 115;
(b) be undertaken using an assessment instrument designed specifically for this purpose;

(c) identified changes to improve the system in accordance with evidence- based practices and, if there were none, in accordance with prevailing practices.

The scope of this issue was isolated. The severity was determined to be a level 2 minimal harm or potential for actual harm. There was no previous non compliance related to this subsection of legislation. [s. 116. (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 the annual evaluation of the medication management system included:
(a) a review of the quarterly evaluations from the previous year as referred to in section 115;
(b) be undertaken using an assessment instrument designed specifically for this purpose;
(c) identify changes to improve the system in accordance with evidence- based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

Issued on this 24th day of October, 2017

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

Original report signed by the inspector.