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

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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
Dec 20, 2017	2017_636634_0015	023115-17	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON 000 000

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

HILLSIDE MANOR
R. R. #5 STRATFORD ON N5A 6S6

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

ADAM CANN (634), TRACY RICHARDSON (680)

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): October 10, 11, 12, 13, and 16, 2017.

The following intakes were conducted within this Resident Quality Inspection:

Critical Incident System (CIS) log # 017564-17, CIS # 1975-000011-17 related to alleged staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with twenty + residents, three family members, the Medical Director, the Interim Executive Director, the Interim Director of Care, the Assistant Director of Care, the Resident Assessment Coordinator, the Regional Manager of Clinical Services, four Registered Nurses, six Registered Practical Nurses, one Recreation Aide, two Health Care Aides, five Personal Support Workers, and the Residents' Council representative.

The inspector (s) conducted a tour of the home, reviewed clinical records, and plans of care or relevant residents, pertinent policies and procedures, Residents' Council minutes, and the staff schedule. Observations were also made of general maintenance, cleanliness, and condition of the home, infection prevention and control practices, provision of care, staff to resident interactions, medication administration, and Ministry of Health and Long Term Care postings.

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

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

8 WN(s)
4 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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 has failed to ensure that staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

During the Resident Quality Inspection (RQI), a resident was reviewed for continence care and bowel management related to their incontinence.

Review of the continence assessments completed for the resident showed on two separate occasions varying degrees of continence.

Review of Point of Care (POC) documentation showed during a certain time frame, the resident was incontinent a number of times. Review of the three day elimination tool for the resident during the same timeframe showed that the resident was continent for the same period.

In an interview with a Personal Support Worker (PSW) they stated that the resident was regularly toileted however still had incontinence and that the level of incontinence had not changed in several months.

In an interview with the Associate Director of Resident Care (ADRC), they stated that the

resident had deteriorated. ADRC stated that the resident's incontinence level had decreased since admission. ADRC stated that the POC documentation did not match the resident's voiding record, and that the continence assessment only reflected the documentation that was in the residents voiding diary.

In an interview Interim Director of Care (IDOC) stated that all assessments with continence should match and that POC documentation and the assessments should match.

The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other. [s. 6. (4) (a)]

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

A Resident was reviewed for falls prevention and management related to a fall that a resident had sustained.

Observations were conducted and showed a falls prevention and management device was beside the resident's bed on the floor.

Review of the resident's plan of care revealed that the resident was at a high risk for falls.

Review of the current plan of care for the resident at the time of the observation did not include use of the falls prevention and management device.

In an interview, a Health Care Aide (HCA) stated the falls device should be included on resident's Kardex but stated it was not.

In an interview with the Associate Director of Resident Care stated that the falls device should have been included in the resident's plan of care but was not.

In an interview with the Interim Director of Care (IDOC) stated if a resident had a falls device in place, the device should be included in the plan of care.

The licensee has failed to ensure that care set out in the plan of care was provided to the resident as specified in the plan. [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 to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other; and to ensure that 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 O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

Review of a resident's Material Data Set (MDS), showed the resident had a change in their continence.

In an interview with Personal Support Worker (PSW), they stated that the resident had a change in their continence status.

In an interview with Registered Practical Nurse (RPN), they stated that the resident should have had a continence assessment completed because of their change in continence.

In an interview with the Interim Director of Care (IDOC), they stated that a continence assessment should be completed on admission and change in continence status. IDOC stated the resident should have had a continence assessment completed in Point Click Care.

The licensee has failed to ensure that a resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence. [s. 51. (2) (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 residents who are incontinent receive an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the drugs were administered to residents in accordance with the direction for use specified by the prescriber.

A) A review of the current doctor's orders and medication quarterly review was completed for a resident.

Doctor's orders were written by a Doctor for the resident. The order stated a medication and testing was to be administered until a certain date and then reassessed however there were no further orders showing that the initial order was reassessed. Review of the electronic Medication Administration Record (eMAR) showed the resident had continued to receive the medication and testing as ordered after the reassessment date.

In an interview, Interim Director of Care (IDOC) was shown the orders and the eMAR by the inspector. IDOC stated they would follow up with the doctor regarding the order as it

was confusing and acknowledged a discrepancy. IDOC acknowledged that the order had stated to reassess on a date, and the IDOC was unable to locate where this order had been reassessed.

B) Review of the doctor's order for the same resident, showed the resident was to receive a medication on a particular sliding scale. Review of the electronic Medication Administration Record (eMAR) for a certain month showed the eMAR did not match the doctor's order.

In an interview with Associate Director of Resident Care (ADRC), they were shown the order and the eMAR record by the inspector. ADRC stated that the eMAR did not match the doctor's order and that it would need to be changed.

Observation of the medication administration for the resident showed the change had not been made to the eMAR. ADRC had brought the order to the nurse to review prior to the administration of the medication.

In an interview with the Interim Director of Care (IDOC) they stated that the registered staff were to have two registered staff check when entering medication orders into the eMAR system. IDOC reviewed doctor's orders with the inspector and acknowledged the eMAR was not as the doctor ordered. IDOC stated that the orders were very confusing and required more investigation into what happened.

The licensee has failed to ensure that the drugs were administered to residents in accordance with the direction for use specified by the prescriber. [s. 131. (2)]

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 drugs are administered to residents in accordance with the direction for use specified by the prescriber, to be implemented voluntarily.

WN #4: 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. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction were:
(b) Reported to the resident, the resident's substitute-decision maker (SDM), 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

Medication incident reports for a quarter in 2017, were reviewed during the course of the inspection. There were a certain number medication incidents during this time frame.

A) A medication incident occurred that involved a resident. The Medication Incident report (MIR) stated that a resident was to receive a medication twice per day. The MIR stated that the resident had only received four doses of the medication during a six day time

frame.

A review of the incident report, showed there was no documented evidence that the resident's SDM or attending physician were notified of the medication incident.

Review of the resident's progress notes, did not show any entries regarding a medication error or omission, and no information regarding notifications to the attending physician and SDM completed. Review of the doctor's progress notes showed no entries regarding a medication incident. Review of the doctor's book showed no documentation related to the medication incident.

In an interview, the Doctor stated that they were not aware of this incident, and that it was concerning.

Interim Director of Care (IDOC) stated that they did not believe the resident's SDM were notified as there was no documentation to support this. IDOC stated that the notifications of medication incidents to the attending physician and the resident's SDM were to be done.

B) A medication incident occurred involving a second resident. The Medication Incident report stated that the resident was not given a dose of medication that they should have received.

A review of the incident report, showed there was no documented evidence that the resident's SDM or attending physician were notified of the medication incident.

Review of the progress notes, did not show any entries regarding a medication error or omission, and no information regarding notifications completed to the attending physician or resident's SDM. Review of the doctor's progress notes showed no entries regarding a medication incident.

Review of the doctor's book was completed with IDOC and there was no entries regarding the medication incident.

In an interview, a Registered Practical Nurse (RPN) stated that they had left a message with the SDM for the resident regarding the medication incident, and that usually they would just write the information in the doctor's book for when the doctor was in the building next.

IDOC acknowledged that the doctor's book did not have any information regarding the medication incident for the resident. IDOC acknowledged that there were no notifications to the attending physician noted on the Medication Incident report. IDOC stated that they could not say that notifications to the attending physician happened if it was not documented.

The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was:
(b) reported to the resident, the resident's SDM, 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 [s. 135. (1)]

2. The licensee has failed to ensure that (a) all medication incidents and adverse drug reactions were documented, reviewed and analyzed (b) corrective action was taken as necessary, and (c) a written record was kept of everything required under clauses (a) and (b).

Review of three Medication Incident reports was completed during the Resident Quality Inspection (RQI).

There was no documentation of the medication incidents being reviewed, analyzed and that corrective action was taken as necessary regarding these medication incidents.

Review of a MIR, showed that a medication patch had had not been applied as ordered. There were no notifications of attending physician, resident's SDM indicated on the form, and no corrective action documented.

In an interview, a Registered Practical Nurse (RPN) shared that they had not been notified of the incident regarding the resident and that medication patch had not been administered by the RPN. The RPN stated that usually the person who found the error would also communicate it to the staff member involved, but that had not occurred either.

In an interview, the Doctor stated that they had never seen a report with all the incident reports for the home. The Doctor stated that he has not seen all the medication incident reports or a report regarding them.

Review of the Professional Advisory Committee (PAC) meeting minutes for April 18, 2017, showed that medications had not been reviewed. PAC meeting for June 2017, had not occurred and was to be done the following week after the inspection.

IDOC stated that they did not review the medication incidents at the last PAC meeting as the Executive Director was not there to chair the meeting and IDOC stated they held the meeting in their absence.

In an interview, Interim Director of Care (IDOC) stated that they had not followed up with the staff in regards to the medication incident reports. There was no written documentation regarding follow up with the medication incidents.

The licensee has failed to ensure that (a) all medication incidents and adverse drug reactions were documented, reviewed and analyzed (b) corrective action was taken as necessary, and (c) a written record was kept of everything required under clauses (a) and (b). [s. 135. (2)]

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 are reported to the resident, the resident's SDM, 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, to be implemented voluntarily; and to ensure that (a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed (b) corrective action is taken as necessary, and (c) a written record is kept of everything required under clauses (a) and (b), to be implemented voluntarily.

WN #5: 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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Review a resident's clinical records showed the resident had sustained a fall.

Review of the home's Post-Fall Management procedure stated "The most recent Fall Risk Assessment is immediately reviewed by a regulated health professional to determine any change in Resident-specific risk and action is taken accordingly".

Review of the assessment tab in Point Click Care revealed a post fall assessment was completed after the fall. The post fall assessment gave direction to complete a full fall risk assessment if the resident's previous risk score was low or medium prior to the fall.

In an interview with a Registered Practical Nurse (RPN), they stated that the resident was a medium risk for falls previous to the fall. The RPN stated that a falls risk assessment should have been completed for the resident after the fall.

In an interview with Associate Director of Resident Care, they stated that the resident should have received a falls risk assessment after their fall.

The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with [s. 8. (1) (a),s. 8. (1) (b)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident was dressed appropriately, suitable to the time of day and in keeping with his or her preferences.

A resident requested to speak with an inspector and shared that staff had awoken the resident early to get them dressed on that morning. Staff had then put the resident back to bed after they had partially dressed the resident.

In an interview with a Nurses Aide (NA), they had observed the resident that morning after they were dressed and put back to bed and subsequently reported the incident to a registered nurse.

In an interview with a Registered Nurse, they acknowledged that they had been told about the resident being dressed early and then being put back in bed. The RN stated that they did not investigate or report the concern.

In an interview Associate Director of Resident Care (ADRC) they stated that getting the resident dressed at such an early time and putting the resident back to bed was not acceptable.

Interim Director of Care shared that two staff members confirmed that the incident with the resident had occurred. IDOC stated that dressing the resident at such an early time and putting the resident back to bed was not dignified and was against resident's rights.

The licensee has failed to ensure that the resident was dressed appropriately, suitable to the time of day and in accordance with in keeping with his or her preferences.
[s. 40.]

WN #7: 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 has failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

During observation of a narcotic count, an inspector noted a controlled substance, was located in a small locked box that was removed from an unlocked fridge and counted during a narcotic count. The controlled substance was not in a double locked stationary cupboard at this time.

In an interview with a Registered Nurse, they acknowledged that the fridge where the small locked box that contained controlled substances was not locked.

Interim Executive Director (IED), acknowledged that a controlled substance was not in a double locked stationary cupboard.

The licensee has failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. [s. 129. (1) (b)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (6) For the purposes of this section a drug is considered to be destroyed when it is altered or denatured to such an extent that its consumption is rendered impossible or improbable. O. Reg. 79/10, s. 136 (6).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a drug was destroyed, the drug was altered or denatured to such an extent that its consumption was rendered impossible or improbable.

During an observation of the drug destruction box with the Interim Director of Care, it was observed that medication packages with pills inside them were laying in the drug destruction pail and not destroyed.

In an interview with a Registered Nurse (RN), they shared that medications in bottles and packages were placed in the pail and that there was not a witness that the medications had been placed in the pail.

In an interview with a Registered Practical Nurse (RPN), they stated that when they discarded medications, another staff member did not witness that the medication was placed in the pail nor was it documented as to medications being placed in the pail.

In an interview with an RPN who shared that if the bottle or container was too large to fit in the drug destruction pail place it on the floor next to the container to be destroyed. The RPN shared that they do not pour anything on top of the medications prior to or after the medications went into the pail that they were aware of.

In an interview with an RN, they stated that if they were placing medications into the drug destruction bin, that the package and the pill went into the pail. The RN was not sure of the drug destruction process as they had not been witness to this process.

In an interview with the Regional Manager of Clinical Services, they stated that staff should be removing the medication from the packages before placing them in the pail for destruction.

The licensee has failed to ensure that when a drug was destroyed, the drug was altered or denatured to such an extent that its consumption was rendered impossible or improbable.

Issued on this 6th day of February, 2018

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

Original report signed by the inspector.