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
Jul 14, 2017	2017_363659_0011	009531-17	Resident Quality Inspection

Licensee/Titulaire de permis

CORPORATION OF THE COUNTY OF HURON
77722A London Rd R R 5 CLINTON ON N0M 1L0

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

HURONVIEW HOME FOR THE AGED
R. R. #5, LOT 50, CON 1 MUNICIPALITY OF HURON EAST CLINTON ON N0M 1L0

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

JANETM EVANS (659), MARIAN MACDONALD (137), 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): May 18, 19, 23, 24, 25, 26, 29, 30, 31 and June 1, 2017.

The following follow up and intakes were completed within this Resident Quality Inspection:
Critical Incident Log # 025706-16 CIS # M541-000014-14 related to a resident fall
Critical Incident Log # 032770-16 CIS # M541-000014-16 related to a resident fall
Critical Incident Log # 010979-16 CIS # M541-000004-16 related to a resident fall
Critical Incident Log # 010302-16 CIS # M541-000003-16 related to a resident fall
Critical Incident Log #028788-16 CIS # M541-000009-16 related to a resident fall
Critical Incident Log # 007064-17 CIS # M541-000004-17 related to a resident fall
Critical Incident Log # 026732-16 CIS # M541-000008-16 related to a resident fall
Critical Incident Log # 028797-16 CIS # M541-000010-16 related to a resident fall

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Assistant Director of Care, Nutrition Manager, Manager Environmental Services, Program and Social Services Manager, Behavioural Support Nurse, the RAI Coordinator, Registered Nurses, Registered Practical Nurses, Maintenance staff, Personal Care Providers, Dietary Aides, Physiotherapy Assistant, Administrative staff the Resident Council Representative; Family Council Representative and Residents and Family members.

The inspector(s) conducted a tour of the home, and reviewed clinical records and plans of care for relevant residents, pertinent policies and procedures, Residents' and Family Council minutes. 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 storage areas and required Ministry of Health and Long-Term Care postings.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

- **7 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	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. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents who required assistance with eating or drinking were only served a meal when someone was available to provide the assistance.

During observations made on four days in two of dining rooms it was observed that food and fluids had been placed on tables prior to residents being at the tables or prior to staff being able to assist residents who were seated at the tables. A resident was observed to put an unwrapped fruit spread in their mouth and Inspector #680 notified the registered practical nurse (RPN) who removed it from the resident's mouth and threw it away.

Review of policy "Pleasurable Dining" dated August 2009 stated "Residents requiring assistance wait no longer than 5 minutes after their meal is served prior to receiving assistance."

In an interviews, two Dietary Aids, a PSW and an RPN acknowledged that food or fluids was placed on tables of those residents requiring assistance before staff are available to assist the resident to eat.

In an interview the Nutrition Manager (NM) stated that at breakfast, staff put food and fluids out as it makes things smoother. They stated that the hot foods and cereal should not be on the table until the nurses are there to assist the residents who require assistance. The NM acknowledged that yogurt and fluids would be at the tables of those residents requiring assistance prior to staff arriving to assist.

The Administrator stated that the expectation was that food not be on the table prior to staff attending to assist those requiring assistance.

The licensee has failed to ensure that residents who required assistance with eating or drinking were only served a meal when someone was available to provide the assistance. On three separate observations food was present at the tables of those residents requiring assistance and no staff to assist them were present at the table.

The severity of the issue was determined to be potential for harm and the scope of the issue was isolated. The home had a history of unrelated noncompliance. [s. 73. (2) (b)]

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 no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (6) The licensee shall ensure that the information gathered under subsection (5) is analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks. O. Reg. 79/10, s. 229 (6).

Findings/Faits saillants :

1. The licensee has failed to ensure that the information that was gathered on every shift about the residents' infections, analyzed daily to detect the presence of infection and was reviewed at least monthly to detect trends for the purpose of reducing the incidence of infections and outbreaks.

On an identified day, a specified resident developed a fever and a dry cough. The resident was placed on isolation precautions and medications were ordered to treat the symptoms. The resident was added to the respiratory line list and then removed from the line as "not a case".

Review of the nursing calendar for a specified date in that home area showed that a specified resident was placed on medications to treat symptoms and required a specimen be collected; further on the page it noted that the resident was placed in isolation. Two days later, the resident was on the isolation list. The Registered Nurse (RN) stated that everyone documented information in the calendar differently. The RN was unable to verify that when the calendar book was open to a specified date, which page the associated isolation list would appear.

During interviews with four RNs, one stated that the nurses use to receive the lab report which they could look to review infections monthly but that they have not seen that report in a couple of years. The RN stated that in order to know how many infections they had in a month they would have to look back in everyone's chart to view the lab reports. The second RN stated that there was no tracking list for infections on a daily or monthly basis. If a specimen was needed it was marked in the calendar and staff documented in the progress notes. The third RN stated that the staff previously kept track of infections daily but that practice stopped and was unsure of how long ago; residents in isolation were placed in the calendar for tracking. The RN stated that the nurses use to have a monthly tracking infection sheet but there was not a tracking form any more.

In interviews with Registered Practical Nurses, they stated that staff do not have a monthly or daily tracking sheet to monitor how many residents would have infections in a month, staff document in the resident's clinical record. If there was more one than one resident with signs of illness the staff would start a line listing for them, but infections were not tracked daily.

In an interview with Assistant Director of Care (ADOC), it was stated that the calendar was used more for courtesy than for actual tracking, and that if the line listing was not available, staff would not have access to know who was in isolation. The ADOC stated that staff documented specimen collections in the calendar and the information should be charted in the progress notes.

In an interview with the Director of Care (DOC), they stated that there was no documentation of a daily monitoring for infections on residents. The DOC also stated there was no monthly analysis of infections for the home completed.

The Administrator stated that the home used to monitor all infections for tracking purposes but that process had stopped. They also stated there has been no analysis monthly for infections within the home.

The licensee has failed to ensure that the information that was gathered on every shift about the residents' infections, were analyzed daily to detect the presence of infection and were reviewed at least monthly to detect trends for the purpose of reducing the incidence of infections and outbreaks.

The severity of the issue was determined to be potential for harm and the scope of the issue was isolated. The home had a history of unrelated noncompliance. [s. 229. (6)]

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 with ensuring that the data gathered related to symptoms and signifying the presence of infection is analyzed daily to detect the presence of an infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks, to be implemented voluntarily.

WN #3: 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that care set out in the plan of care was based on an assessment of the resident and the resident's needs and preferences.

In interviews with a specified resident, the resident stated that their preference would be to have their bath at an alternate time. The resident stated that they had asked staff to change their bath time and was told the home could not accommodate this request.

Review of the bath schedule showed that the resident was documented as having one

bath during the weekday and one bath on the weekend.

Review of the clinical record for the resident showed that the resident's customary routines and preferences related to bathing were not what was documented in their plan of care for related bathing.

In interviews Personal Support Workers (PSWs) stated that if a resident requested a change for the bath schedule that it would have to reviewed with the registered staff. Registered Practical Nurses (RPN) stated that preference for bathing was taken into consideration but was based on availability of the tub room.

The Director of Care (DOC) stated that the team gathered information related to the residents preferences i.e. baths or showers. Notes were made in the care plan and communication book. The expectation was that if a resident requested to switch times for bathing then the home accommodated the resident's request.

The licensee failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences.

2. The licensee has failed to ensure that the resident, the SDM, if any, and the designate of the resident / SDM had been provided the opportunity to participate fully in the development and implementation of the plan of care.

In a family interview the family member stated that they had not received calls about changes in medications for the resident. The family member later stated that they were not concerned about being called.

Record review showed that the resident's dosage of a specified medication had been increased and a second specified medication was discontinued. There was no documentation of the family notification in the residents progress notes.

Review of policy titled "Patient Counseling" dated January 2014 stated:
Residents and/or their Substitute Decision Maker (SDM) will be informed and educated about all new medication orders or changes in medication dose.

Procedure:
1. The resident and/or SDM will be counseled about any new medication orders and

changes in medication dose by the nurse. The physician and pharmacist may provide educational counseling as needed upon request.
3. Document counseling of the resident or SDM in the progress notes of any unsuccessful attempts to contact the SDM.

In an interview the RN stated that nurses obtain annually, a consent to treatment form which covers the dosage changes and medications for the treatment of the items listed on the form. If it was a medication to treat infections, staff would call the family because it was treatment for a specific diagnosis, if it was a medication for pain, the family would be notified. The RN stated if it was typically in the same group of medications they would not have to call the family or resident. They were informed of this at the annual care conference.

A Registered Practical Nurse (RPN) stated not all medication changes were called to the family; staff tend to know the families that like to know about changes. The RPN stated that families were called for major changes or if it was a family that required more information.

The Assistant Director of Care (ADOC) acknowledged that all changes in medications be reported to families or resident as per the policy but acknowledged that this was not the practice. Expectation was that staff follow these policies from pharmacy. The ADOC acknowledged that the older version of the pharmacy policy on patient counseling showed the same directions as the new policy on patient counseling.

The Director of Care (DOC) stated that in the past staff have contacted families for new medications or changes to existing medication orders. The DOC stated that the new pharmacy policies had not been educated to staff and therefore not expected they would be followed.

The licensee has failed to ensure that the SDM had been provided the opportunity to participate fully in the development and implementation of the plan of care.

The severity of the issue was determined to be minimal risk and the scope of the issue was isolated. The home had a history of unrelated non compliance. [s. 6. (5)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The Licensee has failed to ensure that there was a written description of the personal support services program that included the following:
• goals and objectives
• methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources.

In an interview, Administrator stated that the home did not have a written description of the personal support services program. The Administrator stated that the mandatory programs have had goals and objectives and analysis completed but that the personal support program on its own had not been evaluated. Administrator stated that policy reviews for nursing had been completed. There were no goals and objectives for the nursing department at this time but something they need to pull together in the future.

The Licensee has failed to ensure that there was a written description of the personal support services program that included the following:
• goals and objectives
• methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources.

The severity of the issue was determined to be minimal risk and the scope of the issue was isolated. The home had a history of unrelated noncompliance. [s. 30. (1) 1.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was offered an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident/SDM if payment was required.

In a family interview for a specified resident, the family member stated that they do not remember being offered dental services when the resident was admitted and were not aware that the home provided this service. The family member stated that they were present for the admission.

During record review there was no documentation that this service was offered in the chart.

During an interview with the Director of Care (DOC), they stated that the families were given the information regarding dental care on admission, the families, if they wish this service, fill out the form and send it to the dentist or the staff will assist them to fax the information to the dental service. The DOC stated that the families were not offered this service annually and that it was only offered again if the families come forward with request for dental service. The DOC acknowledged there was no written documentation to show that the service was offered on admission but that the paperwork to complete for obtaining this service is within the admission package for families to review.

The licensee has failed to ensure that residents were offered an annual dental assessment and other preventative dental services.

The severity of the issue was determined to be minimal risk and the scope of the issue was isolated. The home had a history of unrelated noncompliance. [s. 34. (1) (c)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record was kept in the home that includes:
(a) the nature of each verbal or written complaint
(b) the date the complaint was received
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions that were taken and any follow-up action required
(d) the final resolution, if any.

In a family interview it was stated by the family member of an identified resident that jewelry they had purchased had gone missing. They had reported the concern and stated that there had been no follow up from the home regarding the missing jewelry.

Record review of the communication book on the resident care area where the identified resident resided an entry was seen that the resident was missing jewelry.

Review of the policy titled "Complaint Procedures", dated July 2015, stated "any team member, volunteer or service provider who receives a complaint must notify a supervisor or manager of the home immediately. The complaint must be recorded using the appropriate form (See Appendix B: Complaint reporting tool- currently using Resident and Family Concern Form)." The policy also stated "in every complaint situation, a response must be made to the person who made the complaint, including what the home has done to resolve the complaint."

Review of the complaint log showed no documentation of the missing jewelry on a Resident and Family Concern form.

In interviews a Registered Nurse (RN) stated that missing items were usually in the communication with a description so that everyone was aware. The RN was not aware that jewelry was missing for the identified resident.

Health Care Aide (HCA) stated that when they are told about a missing item they would tell the charge nurse and document it in their charting.The HCA was not aware of the missing jewelry.

The Administrator stated for any concern there was a 10 day return on a response to the family. Missing items do not always get to the concern form unless the families state they are concerned. The Administrator was unable to locate a concern form regarding the missing jewelry. The Administrator stated that this was something they need to look at in order to have follow up with families.

The licensee has failed to ensure that a documented record was kept in the home that includes:
(a) the nature of each verbal or written complaint
(b) the date the complaint was received
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions that were taken and any follow-up action required
(d) the final resolution.

The severity of the issue was determined to be minimal risk and the scope of the issue was isolated. The home had a history of unrelated noncompliance. [s. 101. (2)]

WN #7: 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).

Findings/Faits saillants :

1. The Licensee has failed to ensure that medication incidents that involved 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.

A review of eight medication incident reports that occurred during February 2017 to April 2017 was completed. There were three medication incident reports with no documentation to support that a physician had been notified and three incidents with no documentation to support that the resident or family had been notified of the incident.

In review of the progress notes there was no documentation to support that physician and family or resident had been notified.

In review of the policy "Medication Incident Reporting" dated February 2017 stated "Every medication incident and adverse reaction involving a resident (excluding near miss) is to be reported to the resident or the resident's substitute decision-maker, the Director of Nursing and Personal Care, the resident's attending physician and the pharmacy/Clinical Consultant Pharmacist." The policy also stated "every medication incident and adverse drug reaction involving a resident directly (i.e. excluding near miss) will require a designate from the home to notify the resident or the resident's substitute decision-maker that an incident reached the resident."

In interviews, the Assistant Director of Care (ADOC) stated that there was no documentation to support that the families/residents, and physician had been notified of three of the incidents.

The Administrator stated that it was an expectation that every medication error be reported to families/residents and physicians. The Administrator stated they were working with pharmacy to ensure that this was completed with each error that required notification.

The Licensee has failed to ensure that medication incidents that involved 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
There were three out of eight medication incidents that were not reported to families/residents and physicians.

The severity of the issue was determined to be minimal risk and the scope of the issue was isolated. The home had a history of unrelated noncompliance. [s. 135. (1)]

Issued on this 14th day of August, 2017

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

Original report signed by the inspector.