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
Jan 11, 2018	2018_563670_0001	029484-17	Resident Quality Inspection

Licensee/Titulaire de permis

MERITAS CARE CORPORATION
567 VICTORIA AVENUE WINDSOR ON N9A 4N1

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

FRANKLIN GARDENS LONG TERM CARE HOME
24 FRANKLIN ROAD LEAMINGTON ON N8H 4B7

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

DEBRA CHURCHER (670), NANCY SINCLAIR (537), TERRI DALY (115)

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 3, 4, 5, 8, and 9, 2018.

The following Critical Incident System reports were inspected during this Resident Quality Inspection:
Log #028338-17 CIS #2602-000031-17 related to a fall with injury.

During the course of the inspection, the inspector(s) spoke with more than twenty residents, Residents' Council representative, Family Council representative, the Administrator, the Director of Care, three Registered Nurses, four Registered Practical Nurses, eight Personal Support Workers, family members, the Restorative Care Manager, the Resident Assessment Instrument Coordinator, the Activity Manager and one Dietitian.

During the course of the inspection, the inspectors toured all resident home areas, observed the general maintenance and cleanliness of the home, dining services, medication rooms, medication administration and medication count, the provision of resident care, recreational activities, staff to resident interactions, infection prevention and control practices and reviewed resident clinical records, posting of required information and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

2 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. 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.

Ontario Regulation 79/10 s. 30 (1) 1 states, "Every licensee of a long-term care home shall ensure that the following is complied with in respect of each for 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. 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."

Ontario Regulation 79/10 s. 48 (1) 2 states, "Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions."

Review of a specific resident's clinical record showed that a specific alteration in skin integrity was noted on a specific date.

Review of the home's policy titled Skin Care Management Program, last reviewed December 2017, stated, Registered Nursing Staff were to collaborate with the

interdisciplinary team including a referral to the dietician with any new pressure ulcer, skin concern or wound development.

The Inspector and Director of Care (DOC) were unable to locate a dietitian referral or any documentation from the dietitian regarding a specific resident’s altered skin integrity.

On January 9, 2018, a Registered Nurse (RN) stated that if a resident developed a specific condition a referral would be made to the dietitian by either the RN or the Registered Practical Nurse (RPN).

On January 9, 2018, the Dietitian stated that if the referral form was not in the resident's chart that a referral had probably not been completed. The Dietitian stated that they had no recollection of receiving a referral for the resident.

On January 9, 2018, the DOC stated that the Dietitian was considered part of the interdisciplinary team and a Dietitian referral should have been sent.

The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was isolated during the course of this inspection. There was a compliance history of this legislation being issued in the home on November 16, 2015, as a Voluntary Plan of Correction (VPC) in a Resident Quality Inspection #2015_216144_0063. [s. 8. (1) (a),s. 8. (1) (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 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, is complied with, to be implemented voluntarily.

WN #2: 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 every medication incident involving a resident and every adverse drug reaction was 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 were reviewed for a specific quarter, noting eight documented medication incidents. Of those incidents, one incident was noted to be related to software concerns, one incident related to communication, two related to pharmacy processing/dispensing, and four were noted to be related to medication administration, all reaching the residents.

The home’s policy titled “Medication Incidents – 4.15”, last revised August 1, 2015, stated:
“Notify the Resident or POA for any incidents reaching the resident and any follow-up actions taken.”

On January 4, 2018, two Registered Practical Nurses (RPN's) stated during interview that if a medication incident was identified, that the expectation was that they would report the incident to the Charge Registered Nurse in Charge RN in their care area. Both RPN's stated that after they had identified and reported the incident, that unless they

received instruction from the RN regarding the incident, that this was their involvement in the incident.

On January 4, 2018, a Registered Nurse (RN) stated during interview that when a medication incident had been identified and reported, that they would determine from the particular incident what the next steps would be, as far as follow up. She stated that all incidents were to be documented on the "Medication Incident/Near Miss Report", from the Pharmacy Provider. The RN stated that some of the follow up actions included notifying the physician, notifying the pharmacy by fax of the incident, notifying the Director of Care (DOC) of the incident. An RN stated that notification of the family depended on the incident, and added specifically that if the incident did reach the resident that the family was not necessarily notified, and added that it would depend on the incident.

On January 4, 2018, a Registered Nurse (RN) stated during interview that when a medication incident had been identified and reported, that they would immediately assess the incident and implement any immediate actions required as a result. The RN stated that the incident would be documented on the "Medication Incident/Near Miss Report", from the Pharmacy Provider. The RN stated that they would not call the Power Of Attorney (POA) regarding a medication incident, unless instructed to do so by the DOC, as the DOC decided which incidents were reported to the POA.

On January 4, 2018, the Director of Nursing stated during an interview that it would be expected that a medication incident that reached the resident, such as a wrong dose, medications that were not administered as per the physician orders, a missed dose, as examples, would require that the resident or POA would be notified of the incident and of any follow up actions that were required as a result of the incident. The DOC stated that they would be the person to contact the POA regarding medication incident that had reached the resident, with or without adverse effects.

The medication incident involving resident a specific resident, dated for a specific date, was reviewed with the DOC. The DOC indicated that the medication incident had reached the resident, as the resident had not received a dose of medications as per the physician's orders. DOC stated that they had not notified the residents POA of the incident.

The medication incident involving a specific resident, dated for a specific date, was reviewed with the DOC. The DOC indicated that the medication incident had reached

the resident. The DOC stated that they had not notified the residents POA of the incident.

The DOC stated that every medication incident that involved the resident should be reported to the resident, the resident's SDM, and that the medication incidents involving resident two specific residents had not been reported as required.

The severity was determined to be a level 1 as there was minimal risk. The scope of this issue was a pattern during the course of this inspection. The home does not have a history of non-compliance in this subsection of the legislation. [s. 135. (1)]

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 is 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, to be implemented voluntarily.

Issued on this 11th day of January, 2018

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

Original report signed by the inspector.