Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 9, 2019	2019_575214_0034	016307-19	Complaint

Licensee/Titulaire de permis

The Regional Municipality of Niagara
1815 Sir Isaac Brock Way THOROLD ON L2V 4T7

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

Linhaven
403 Ontario Street St. Catharines ON L2N 1L5

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

CATHY FEDIASH (214)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): November 8, 14, 15, 18, 19, 20, 21, 25, 2019.

Please Note: This inspection was conducted simultaneously with critical incident system (CIS) number (#) 2019_575214_0035 / 015126-19.

The following intake was completed during this complaint inspection:

-016307-19- related to prevention of abuse and neglect; plan of care; safe and secure home; dealing with complaints; medication; skin and wound.

During the course of the inspection, the inspector(s) spoke with the Administrator; Director of Resident Care (DRC); Associate Director of Resident Care (ADRC); Clinical Documentation and Informatics (CDI) Coordinator; Manager Long Term Care Facilities; Supervisor Building Services; Maintenance staff; Manager-Adult Day Program; Supervisor-Adult Day Program; Coordinator-Adult Day Program; Registered Nurses (RN's); Registered Practical Nurses (RPN's); Personal Support Workers (PSW's); residents and family members.

During the course of the inspection, the inspector(s) reviewed the complaint; home's complaint log; air temperature records; memo; resident clinical records; relevant policy and procedures; staff training records; observed administration of medications; and residents during the provision of care.

The following Inspection Protocols were used during this inspection:
Medication
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Safe and Secure Home
Skin and Wound Care

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

6 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	Légende 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 where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

In accordance with the Act, s. 8 (1) (a), the licensee was required to ensure that there was an organized program of nursing services for the home to meet the assessed needs of the residents.

1. Specifically, staff did not comply with a specified Medical Directives policy, which was part of the licensee's organized program of nursing services.

During a discussion with a family member in reference to complaint log #016307-19, they indicated that resident #002 had an identified intervention implemented when their health declined and were not aware of this intervention.

Resident #002 had been admitted to the home for a period of nine days.

Review of a progress note for an identified date and time, indicated that the identified intervention had been implemented, when resident #002's health status had declined.

A review of the specified policy indicated that the intervention had been listed on the medical directive form.

Instructions for use of the medical directive form indicated the following:

1. The substitute decision maker (SDM)/resident should complete by initialing in the column provided for each medical directive consented to and then sign the form. If they are unable to sign the Medical Directive, the nurse will complete with the SDM/Resident's input by initialing the columns that the SDM/resident has consented to and both will sign the form or the nurse will indicate consent received verbally.

2. The Medical Doctor (MD) will initial in the corresponding column for each medical directive ordered and sign the form.

3. Subsequent reviews (quarterly or re-admission) will be completed using the "Physician Order Review".

4. If the resident requires the prescribed medication for longer than outlined in the Medical Directive, the Physician will be contacted to determine the treatment required. Do not repeat the order.

5. If medication ordered routinely for example (i.e.) Tylenol, discontinue order on Medical Directives.

A review of the medical directives indicated they had been signed and dated by the MD for a previous admission to the home. Documentation on the medical directives indicated that verbal consent had been obtained by another family member, for a previous admission to the home. ADRC #103 confirmed that this was the most current medical directive form in place for resident #002 and from a prior admission at the home.

The form indicated that the SDM had not placed their initials in the column provided for each medical directive. Instead, a line, with an arrow had been drawn down the column for each medical directive.

The form had not contained the initials of the MD in the corresponding column for each medical directive.

The Administrator indicated that registered staff #113, who had admitted the resident, had reviewed the medical directive form with the family member on the resident's most current admission on an identified date, and obtained verbal consent. No documentation of this verbal consent was noted on the medical directive form.

The licensee’s policy was not complied with in relation to the initials of the SDM had not been documented for each medical directive; consent obtained verbally for the current admission had not been documented on the form; the form had not contained the initials of the MD in the corresponding column for each medical directive and as this was a re-admission to the home, the medical directives had not been completed using the Physician Order Review.

2. Specifically, staff did not comply with the licensee’s policy, titled, “Ordering and Receiving Medication”, which is part of the licensee’s organized program of nursing services.

During a discussion with a family member in reference to complaint log #016307-19, they indicated that resident #002 was admitted to the home for nine days. They indicated that the resident had an identified health condition for most of their life; however, when the resident’s health status declined, their condition worsened.

A review of the Ordering and Receiving Medication policy indicated the following:

-Physician Order Forms are intended for documenting all new prescriber orders.

-Fax/transmit the original prescriber order to Classic Care Pharmacy.

-Transcribe the new prescriber order to: the resident’s MAR/TAR sheet.

-Document that the above steps have been completed in the appropriate order processing boxes on the Physician’s Order Form ensuring that the nurse’s signature, date and time are recorded.

-Flag the resident’s chart/medical profile for a second nurse to double check the processing and transcription of the new prescriber order.

-Within 24 hours, a second nurse double-checks the processing and transcription of the new prescriber order and documents that the above steps have been completed on the Physician’s Order Form ensuring that the nurse’s signature, date and time are recorded.

A) A review of the resident’s physician’s orders for their current admission, indicated that the physician’s orders were documented electronically on a document titled, “Medication

Review Report". ADRC #103, indicated that these physician orders were generated from a report in the Point Click Care (PCC) system from the residents previous admission. The ADRC indicated that the form was faxed to the resident's physician for review to continue or make any medication changes; signed and dated and then faxed back to the home.

A review of the Medication Review Report indicated that the physician had made a change to a specified drug that the resident had been previously prescribed, on their prior admission. The physician changed the drug from a routine, daily dose to an increase in dose, daily, when needed (PRN) for an identified health condition.

A review of the resident's progress notes indicated that the resident had been assessed for the identified health condition by three different registered staff. over the course of their admission. All registered staff interviewed indicated that the identified drug had not been administered as they had not realized a PRN order was in place to assess for the health condition and administer the drug as needed. Review of progress notes and the electronic medication administration record (e-MAR) indicated that no documentation was recorded for the assessment of resident #002's identified health condition and/or PRN administration of the specified drug for six identified dates during their admission.

A review of the resident's clinical record indicated that their admission medications had not been documented on the Physician Order Forms and only listed on the electronic Medication Review Report. This report had not contained an area for the processing nurse's signature, designation; date or time and had not contained an area for a second nurse's signature, designation, date or time, indicating that they had double checked the processing and transcription of the physician's orders. A review of the e-MAR for two specified months in 2019, indicated there were three areas to document first, second and third checks. All three areas were observed to be blank.

B) Review of resident #008's clinical records indicated they had been admitted to the home for a period of five consecutive days in 2019.

A review of the resident's physician orders indicated that they were documented electronically on a document titled, "Medication Review Report". During a review of this report, a hand-written entry was made that indicated the first check and was signed by a registered nurse, with an identified date and time. Below this was a hand-written entry that indicated, second check, and was observed to have an identified date entered in this area. No signature, designation or time had been entered.

During an interview with the DRC and ADRC #102 and #103, it was indicated that with exception to faxing/transmitting the orders to pharmacy, as these resident's medications were obtained from an identified location, the licensee's policy as identified above, had not been complied with.

3. Specifically, staff did not comply with the licensee's Admission Process policy, for an identified type of admission, which was part of the licensee's organized program of nursing services.

A) During a review of complaint log #016307-19, a family member indicated that they had brought in a specified item for resident #002 and provided instruction to the home regarding it's use.

A review of the licensee's policy above, indicated that registered nursing staff were to do the following:

-Update Point of Care (POC) tasks that require individualization.

A review of resident #002's progress notes, indicated that on the date of their admission, an admission assessment progress note had been completed by registered staff #113 that indicated the resident's family member had brought in the specified item, including instructions for it's use.

Review of the POC tasks indicated that no task had been created for staff to implement the intervention.

During interviews with PSW staff #114 and #115, they indicated that they were not aware that the resident was to have the intervention implemented, as indicated, as there was no task in POC to prompt them to do this.

During an interview with PSW #116, they indicated that they were aware of the intervention and did implement it as indicated during the shifts they worked. PSW #116 confirmed that they had not documented this care they provided as there was no task in the POC system to document.

During an interview with registered staff #113, they confirmed that they had completed the admission assessment with the resident and their family member and were aware of

the specified item and instructions for it's use. Staff #113 confirmed that an individualized POC task had not been created for the intervention to be implemented and that the policy had not been complied with.

B) During a review of complaint log #016307-19, a family member indicated that on an identified date, while care was provided to resident #002, the family member observed the resident to have an alteration to their skin integrity, to a specified location.

Resident #002 had been admitted to the home for a period of nine days.

A review of progress notes indicated that on an identified date and time, registered staff #117 documented the resident had verbalized an identified complaint to a specified location on their body. It was documented that resident #002 had an alteration to their skin integrity and an intervention was put in place.

Review of progress notes indicated that documentation regarding the resident's altered skin integrity had not been documented until two days later when registered staff #120, charted the alteration to the resident's skin integrity and applied an identified intervention.

No other documentation was observed in the clinical record regarding the alteration to the resident's skin integrity, prior to the date it was first documented, or the day following.

Review of the 24-hour care plan indicated under a specified focus, that staff were to monitor skin for open areas daily during care and report any signs of skin breakdown to registered staff.

Review of the POC tasks indicated a task was in place for skin observation. The task was assigned a frequency of PRN. A review of an identified for a specified period of time, indicated that no documentation had been recorded for this task.

During an interview with ADRC #103, they confirmed that staff were to check the resident's skin daily, during care.

During an interview with the DRC and CDI Coordinator on a specified date, it was confirmed the skin observation task for resident #002, had not been individualized and the licensee's policy had not been complied with.

C) During a review of complaint log #016307-19, a family member indicated while care was provided to resident #002, the family member observed the resident to have an alteration to their skin integrity, to a specified location.

A review of the licensee's policy above, indicated that registered nursing staff were to do the following:

-Any issues or concerns follow up with family doctor.

Resident #002 had been admitted to the home for a period of nine days.

A review of progress notes indicated that on an identified date and time, registered staff #117 documented the resident had verbalized an identified complaint to a specified location on their body. It was documented that resident #002 had an alteration in their skin integrity and an intervention was put in place. Staff #117 documented that a note was left in the MD book for further assessment.

During an interview with ADRC #103, they indicated resident #002 had retained their physician in the community and were not under the care of the home's physician's.

During an interview with registered staff #117, they indicated they wrote a note in the unit's physician's book, for the physician to assess when they came to the home to complete rounds. Staff #117 confirmed that they were unaware that the resident used the services of their physician from the community and not the home's physician's. Staff #117 confirmed they had not called the resident's physician in the community to inform them of the concern of the resident's altered skin integrity. [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 to ensure that where the Act or this Regulation require the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
6. Known health conditions, including allergies and other conditions of which the licensee should be aware upon admission, including interventions. O. Reg. 79/10, s. 24 (2).

s. 24. (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 to the extent possible in the development and implementation of the resident's care plan, and in reviews and revisions of the care plan. O. Reg. 79/10, s. 24 (5).

s. 24. (9) The licensee shall ensure that the resident is reassessed and the care plan is reviewed and revised when,
(a) the resident's care needs change; O. Reg. 79/10, s. 24 (9).
(b) the care set out in the plan is no longer necessary; or O. Reg. 79/10, s. 24 (9).
(c) the care set out in the plan has not been effective. O. Reg. 79/10, s. 24 (9).

Findings/Faits saillants :

1. The licensee failed to ensure that the 24-hour admission care plan for resident #002, included, at a minimum, an identified, known health condition.

During a discussion with a family member in reference to complaint log #016307-19, they indicated that resident #002 had been admitted to the home for a period of nine days. They indicated that the resident had an identified health condition for most of their life; however, when the resident's health status declined, the identified health condition had increased. The family member indicated that the resident was transferred to a specified location on this date; diagnosed with an identified diagnoses and had passed away, on an identified date.

A review of resident #002's progress notes indicated that on an identified date and time, registered staff #113 had conducted a specified assessment. The assessment indicated

under additional notes and/or comments, an identified health concern.

A review of the resident's 24-hour care plan indicated that a focus, goals or interventions had not been included for resident #002's health concern. During an interview with registered staff #113, it was confirmed that the 24-hour care plan had not been developed to include this information. [s. 24. (2) 6.]

2. The licensee has failed to ensure that resident #002's SDM was given an opportunity to participate in the development and implementation of the resident's care plan in relation to their altered skin integrity to an identified area on their body.

During a review of complaint log #016307-19, a family member indicated that while care was provided to resident #002, the family member observed the resident to have an alteration to their skin integrity, to a specified location.

Resident #002 had been admitted to the home for a period of nine days.

A review of progress notes indicated that on an identified date and time, registered staff #117 documented the resident had verbalized an identified complaint to a specified location on their body. It was documented that resident #002 had an alteration in their skin integrity and an intervention was put in place.

During an interview with registered staff #117, they indicated they had not informed the resident's SDM in order to provide them with an opportunity to participate in the resident's care plan in relation to their altered skin integrity including interventions that had been implemented. [s. 24. (5)]

3. The licensee failed to ensure that resident #002's care plan was reviewed and revised when they demonstrated an alteration to their skin integrity.

During a review of complaint log #016307-19, a family member indicated that while care was provided to resident #002, the family member observed the resident to have an alteration to their skin integrity, to a specified location.

Resident #002 had been admitted to the home for a period of nine days.

A review of progress notes indicated that on an identified date and time, registered staff #117 documented the resident had verbalized an identified complaint to a specified

location on their body. It was documented that resident #002 had an alteration in their skin integrity and an intervention was put in place.

A review of the resident's care plan on an identified date, indicated the care plan had not contained a focus, goals or interventions in relation to the resident's altered skin integrity.

During an interview with registered staff #117, they confirmed they had not reviewed and revised resident #002's care plan to include the resident's alteration to their skin integrity or the intervention they had implemented. [s. 24. (9) (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 24 hour-admission care plan is developed for each resident and must include, at a minimum, the known health conditions and to ensure that the resident is reassessed and the care plan is reviewed and revised when the resident's care needs change, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the actions taken with respect to resident #002, were documented.

During a discussion with a family member in reference to complaint log #016307-19, they indicated that resident #002 had been admitted to the home for a period of nine days. They indicated that the resident had an identified health condition for most of their life; however, when the resident's health status declined, the health condition had worsened. The family member indicated that the resident was transferred to a specified location on this date; diagnosed with an identified diagnoses and had passed away on an identified date.

During an interview with registered staff #118, they indicated that on a specified date and time, they assessed the resident to have an identified symptom to specified areas on their body. Registered staff #118 indicated that this had occurred near the end of their shift and they asked registered staff #113 if the symptom was normal. Registered staff #118 indicated that they also informed incoming registered staff #121, of the symptom.

No documentation had been observed in the progress notes that these actions had been taken. Observation of documentation for the remainder of the identified date, had not identified any further assessment and/or interventions for resident #002's symptoms to specified areas on their body.

Registered staff #118 confirmed they had not documented their actions. [s. 30. (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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #4: 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 resident #002's drugs had been administered to them, in accordance with the directions for use specified by the prescriber.

During a discussion with a family member in reference to complaint log #016307-19, they indicated that resident #002 had been admitted to the home for a period of nine days. They indicated that the resident had an identified health condition for most of their life; however, when the resident's health status declined the identified health condition had worsened. The family member indicated that the resident was transferred to a specified location on this date; diagnosed with an identified diagnoses and had passed away on an identified date.

A review of the resident's clinical record indicated they had specified diagnoses and a progress note dated on an identified date and time, indicated that the family member had verbalized to an identified service agency, that resident #002 had another specified diagnoses.

A review of the resident's physician's orders on admission, indicated that the physician's orders were obtained electronically on a document titled, "Medication Review Report". ADRC #103, indicated that these physician orders were generated from a report in the PCC system from the resident's previous stay at the home. The ADRC indicated that the form was faxed to the resident's physician for review to continue or make any medication changes; signed and dated and the report was faxed back to the home.

A review of the Medication Review Report indicated that the physician had made a change to a specified drug that the resident had been previously prescribed, on their prior admission. The physician changed the drug from a routine, daily dose to an increase in dose, daily, when needed (PRN) for an identified health condition. During an interview with registered staff #113, they confirmed they were aware of this drug change as they processed the orders and received the drug on admission.

A) A review of resident #002's progress notes indicated that on the date of their admission, at an identified time, registered staff #113 had conducted a specified assessment. The assessment indicated under additional notes and/or comments, an identified symptom to specified areas on the resident's body.

A review of the e-MAR for the same date, indicated that no documentation had been entered for the administration of the identified drug above. During an interview with registered staff #113, they confirmed they conducted this assessment and their findings. They indicated they were aware of the prescribed drug as they processed the orders and received the drug on admission. Staff #113 indicated that they were not administering medications as the RPN had the keys for the medication cart. Staff #113 indicated when asked, that they had not informed the RPN of the resident's identified symptom to the specified areas on their body or the PRN drug prescription.

Staff #113 confirmed that resident #002 had not received this drug and should have.

B) A review of resident #002's progress notes indicated that on their third day of admission, at a specified time, registered staff #118, documented that the resident had an identified symptom to specified areas on their body and did not appear bothered by it at this time. A review of the e-MAR on this date, indicated that no documentation had been entered for the administration of the drug identified above. During an interview with staff #118, the staff member confirmed they assessed the resident for the symptom on their body. The staff member indicated when asked, that they were not aware of the identified drug prescription, as needed, for the symptom, as this prescription was PRN and was listed under a separate tab on the e-MAR. The staff member confirmed that when a health concern was identified for a resident, they were to review the entire e-MAR, and had not. The staff member indicated that they had not been aware of this prescription until the last day of the resident's admission, when the resident's health declined, and believe that it was at this time, they, along with registered staff #113, reviewed the resident's e-MAR and realized there was a PRN order for the identified drug, that was available for administration.

C) A review of a progress note dated on the resident's last day of admission during the early afternoon, indicated that registered staff #113, had documented that the resident had an identified symptom to specified areas on the resident's body, that was not new. A review of the e-MAR on this day, indicated that no documentation had been entered for the administration of the identified drug. During an interview with registered staff #113 on and identified date, they confirmed that they had not administered the drug, and

should have. They indicated they believed that prior to the end of their shift, they reviewed the e-MAR with registered staff #118 and realized there had been a PRN order for this drug.

D) A review of a progress note dated on the last day of the resident's admission during the mid day, indicated registered staff #120, had documented they assessed specified areas on the resident's body for an identified symptom that remained.

A review of a progress note dated the same day, during the early evening, indicated registered staff #120, had documented that the resident demonstrated the same symptom to the same specified areas on their body.

A review of a progress note dated the same date and eight minutes following the progress note above, indicated that the resident demonstrated the same symptom to the same specified areas on their body and that the symptom had intensified.

A review of the e-MAR on this date, indicated that no documentation had been entered for the administration of the identified drug.

During an interview with registered staff #120, the Long Term Care Home (LTCH) Inspector had asked what the staff member had meant when they documented the note on the resident's last day of admission, during the mid day and indicated that the symptom had remained. Registered staff #120 indicated they documented this statement as the specified areas on the resident's body remained the same in comparison to when the resident was admitted and that the symptom, was not new.

The LTCH inspector asked the staff if any drugs had been administered to the resident when it was identified on the last day of their admission, at the intervals identified above, that the resident had demonstrated the symptoms to the specified areas on their body. Staff #120 indicated they had not administered the identified drug as they thought the drug was administered once daily at a specified time and had not realized the prescription was to assess for the symptom and then administer the drug, if needed. Staff #120 indicated that they had not checked the e-MAR on this day, at a specified time period.

Staff #120 indicated that they spoke with registered staff #113 and then rewrote the order on the e-MAR and changed the PRN time frame to a specified time frame, so staff would be prompted to assess for the identified symptom and the need for the identified drug

administration. Registered staff #120 indicated they were trying to be clearer with the physician's order. Review of the e-MAR for a specified month and year, indicated that the rewritten order was entered onto the e-MAR on the resident's last day of admission, during the later part of the afternoon. An interview with registered staff #120 indicated they had not administered the drug on this day, in the evening hours, when they had documented that the resident had an increase in their symptom, and following the rewriting of the order, as they indicated they thought it had already been administered at a specified time, on this date.

A review of the resident's clinical record, including progress notes; assessments and the e-MAR, indicated that no documentation was recorded for the assessment of resident #002's identified symptom and/or administration of the identified drug on six identified dates during their admission.

Interviews with registered staff #113; 118 and 120, confirmed that drugs had not been administered to resident #002 in accordance with the directions 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 directions for use specified by the prescriber, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #002 received a skin assessment when they demonstrated alteration to their skin integrity.

During a review of complaint log #016307-19, a family member indicated that while care was provided to resident #002, the family member observed the resident to have an alteration to their skin integrity, to a specified location.

Resident #002 had been admitted to the home for a period of nine days.

A review of progress notes indicated that on an identified date and time, registered staff #117 documented the resident had verbalized an identified complaint to a specified location on their body. It was documented that resident #002 had an alteration in their skin integrity and an intervention was put in place.

During an interview with registered staff #117, they confirmed the documentation of their progress note and interventions implemented and confirmed that they had not completed a skin assessment, using a clinically appropriate assessment, when the resident demonstrated altered skin integrity to an identified area on their body. [s. 50. (2) (b) (i)]

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. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a response had been provided to the person who made a complaint concerning the operation of the home.

A review of complaint log number #016307-19 indicated that on an identified date, resident #002 was admitted to the home. A family member accompanying the resident at the time of admission, verbalized to staff that the room was very cold. The complainant indicated that the room was cold again, when they visited nine days later.

A review of a document titled, "Complaint Log", where the home documents complaints that cannot be addressed within 24 hours, indicated that a response had been provided to the complainant for their latter concern regarding the temperature in the home; however, no documentation was recorded for the complaint placed on the resident's admission date.

During an interview with registered staff #113, they indicated that the family member had voiced the concern to them on the resident's date of admission. While the family member was present, the staff member implemented identified interventions and completed an electronic maintenance requisition on this date, indicating to check the temperature in the room as it is cold, as per family's request.

Staff #113 indicated that they had not provided a response to the family member as they

had informed ADRC #103, during unit rounds this day, of the concern. A review of the unit rounds documentation for this date, indicated an area listed for family concerns. No documentation was present for this area. During an interview with ADRC #103, they indicated that they did not recall this conversation and had not provided a response to the family member regarding their concern.

A review of the maintenance requisition indicated that the requisition was submitted on the resident's date of admission, during the mid morning hours and was closed on the same date, later in the afternoon. An area on the requisition included an area to document notes. This was observed to be blank. During an interview with maintenance staff #107, they indicated that they received and processed this requisition. Staff #107 indicated that it was a difficult time of the year to maintain temperatures due to temperatures fluctuating during the day and night. Staff #107 indicated they had gone to the resident's room and checked the temperature but were unable to recall what the temperature was or what interventions they may have put into place. Staff #107 indicated that the requisition was marked as closed, indicating the concern had been resolved; however, they had not documented any actions taken in the notes section of the requisition, and should have.

During an interview with the Supervisor of Building Services, staff #106, they indicated the notes section on the maintenance requisition is to be completed, identifying what had been done. They indicated when a requisition is closed, the sender of the requisition receives an email to indicate that the requisition had been closed. The LTCH Inspector asked if the sender received the information that was entered in the notes section so that a response to a complaint could be completed, including actions taken. Staff #106 indicated that this information did not populate back to the sender of the requisition.

During an interview with the Administrator, they indicated that changes had been made to the requisition process to now include providing the notes entered onto the requisition, back to the sender, to identify what actions had been taken. The Administrator confirmed that a response in relation to the complaint placed on the resident's admission date, had not been provided to the complainant. [s. 101. (1) 1.]

Issued on this 17th day of December, 2019

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

Original report signed by the inspector.