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
Nov 9, 2017	2017_556168_0034	025179-17	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

THE MEADOWS
12 TRANQUILITY AVENUE ANCASTER ON L9G 5C2

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

LISA VINK (168), JESSICA PALADINO (586)

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): November 6, 7, 8 and 9, 2017.

During this inspection, the following intakes were inspected concurrently:
Complaint
000195-16 - related to housekeeping and duty to protect

Critical Incidents
005762-17 - related to doors in a home
005477-16 - related to duty to protect and responsive behaviours
011294-17 - related to falls prevention and management
009192-17 - related to falls prevention and management
029047-16 - related to falls prevention and management.

During the course of the inspection, the inspector(s) spoke with the executive director (ED), director of care (DOC), environmental services supervisor, staff educator, resident assessment instrument (RAI) coordinator, registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), registered dietitian (RD), physiotherapist (PT), pharmacist, recreation staff, housekeeping staff, dietary staff, family members and residents.

During the course of the inspection, the inspectors observed the provision of care and services, toured the home, reviewed relevant records including but not limited to: incident reports, meeting minutes, clinical health records, policies and procedures and staff training records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

5 WN(s)
3 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 failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A. Ontario Regulation 79/10 section 48(1)3 requires the long-term care home to have an interdisciplinary program developed and implemented for continence care and bowel management, to promote continence and to ensure that residents are clean and dry.

The home had a procedure, Continence Care, LTC-E-50, revised May 2013.
This procedure identified that the nurse would "initiate the three day continence assessment on admission and /or if there is change in level of continence".
i. Resident #013 was admitted to the home in 2017.
A review of the clinical record included an admission Bowel and Bladder Continence Diary (three day).
This diary included only the resident's name, room number, the date of admission and the next two consecutive dates.
There was no information recorded on the assessment, on any of the three days, of the resident's bowel or bladder functioning or interventions of staff.
Interview with RN #106, verified that the assessment was not completed as required, was blank, and the expectation that the diary be completed as part of the admission process to assist in the development of the plan of care.
ii. Resident #015 was admitted to the home in 2017.
A Bowel and Bladder Continence Diary (three day), was included in the clinical record and was initiated the date of admission.
A review of the diary identified it was only completed for four of the required nine shifts, over the three days.
Interview with RPN #114 verified that the diary was not completed as required.

B. Ontario Regulation 79/10 section 114(2) requires that "the licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home".

The home's procedure, Medication, CARE13-O10.04, effective date August 31, 2017, identified that "In preparation for Physician/Nurse Practitioner (NP) medication review, the Nurse/Pharmacist will review the Resident's medication quarterly to evaluate medication use and reconcile any discrepancies from previous quarter. The

Physician/NP will review all orders quarterly or as per regulatory requirements. The Nurse will process any new orders after Physician/NP review".

i. Resident #030 had a Physician's Order Review, signed by the physician, on a specified date in 2017.
This Review included documentation that it was checked by two registered staff prior to the physician signing the orders and was then process by two registered staff following the physician's review the same day.
This Review provided direction to "discontinue all previous orders".
The Physician's Order Review and all orders written on the Physician's Digiorder, in the clinical record, since the review, were compared with the orders on the resident's current electronic Medication Administration Record (eMAR).
The signed Physician's Order Review identified the resident's diet to be regular diet, regular texture and regular fluids, this was the most recent diet order in the clinical record.
The eMAR identified the resident required a regular diet, regular texture with additional modifications, regular fluids and another intervention.
Interview with the RD verified that the desired diet for the resident was regular diet, regular texture with additional modifications, regular fluids and another intervention as identified earlier in 2017; however, was not consistent with the Physician's Order Review completed.

ii. Resident #013 had a Physician's Order Review, signed by the physician, on a specified date in 2017.
This Review included documentation that it was checked by two registered staff prior to the physician signing the orders; however, there were no signatures to support that registered staff processed the Review.
This Review provided direction to "discontinue all previous orders".
The Physician's Order Review and all orders written on the Physician's Digiorder, in the clinical record, since the review, were compared with the orders on the resident's current electronic Medication Administration Record (eMAR).
The signed Physician's Order Review identified the resident's diet to be regular diet, regular texture and regular fluids, this was the most recent diet order in the clinical record.
The signed Physician's Order Review included an order for a medication to be administered at a specific dosage every four hours as needed, this was the most recent order for the specific medication in the clinical record.
The eMAR identified the resident required a regular diet, regular texture, regular fluids

and special instructions for portions and provided direction regarding the specified medication to be administered three times a day as needed, which was consistent with a physician's order prior to the Physician's Order Review.
A review of the eMAR and relevant physician's orders and October Physician's Order Review with the ED, DOC and pharmacist verified that specific desired orders for the resident's diet and use of the specified medication were not accurately recorded on the current eMAR, and that the Physician's Order Review was not processed as required.

C. Ontario Regulation 79/10, section 68 requires a "a weight monitoring system to measure and record each resident's body mass index and height on admission and annually thereafter".

The home's policy, Nutritional Care and Hydration, CARE7-O10.03, last revised July 31, 2016, directed staff to measure and document each resident's height on admission and annually thereafter.

During the inspection it was identified that not all residents had their heights taken and recorded annually.
Records identified that six of six residents reviewed, who were in the home for over thirteen months, did not have their height completed on an annual basis.
Interview with RN #100, on October 6, 2017, acknowledged and confirmed that resident heights were taken on admission and on an as needed basis; however, were not done annually.

Staff did not comply with the procedures as directed. [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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure that all doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access were kept closed and locked and equipped with a door access control system that was kept on at all times.

The home had a secured courtyard, off of the ground floor gathering room, which was intended to be used by residents and family members in seasonal weather.
The door leading to this courtyard was equipped with a door access system that was closed and locked at a specific time in 2017.
On an identified date in 2017, on the request, recreation staff #116, opened the door to the courtyard, and turned off the access system. Approximately five minutes later the staff member completed a visual check of the courtyard, by walking outside. The purpose of this check was to ensure that the door could be locked and that there was no one outside. The staff member closed and locked the door, following the check, as they were not aware that anyone was in the courtyard.
A while later, resident #032, who had a history of responsive behaviours was found outside of the home.
The resident was returned to the home, safely, care was provided and changes were made to their plan of care.
According to the ED video of the incident was available and reviewed.
The video, according to the Critical Incident Report, showed that the resident left the home via the gathering room exit door, into the courtyard. The resident was in a position and an area that they could not be observed by the staff when they did their visual check.
The resident was then observed, approximately 25 minutes later, to walk through an opening in the courtyard gate, which was normally secured. The home identified that the gate was believed to be damaged or open due to a recent storm. The resident was able to leave the courtyard and walk down the side of the building, where they were seen by staff, approximately 35 minutes later.
The door leading to the outside of the home was not kept closed and locked. [s. 9. (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 all doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access are kept closed and locked and equipped with a door access control system that is kept on at all times, to be implemented voluntarily.

WN #3: 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 failed to ensure that every medication incident which involved a resident and every adverse drug reaction was reported to the resident's attending physician.

The home provided Medication Incident Reports for the past six months on request.
A review of the reports identified that resident #034 was involved in a medication incident in 2017, which was reported the same day.
A review of the Revera Medication Incident Report identified that the physician was not notified of the incident.
The incident report, from Medisystem, was approved/completed, by the team lead pharmacist, 18 days later, did not include that the physician was notified.
The incident report, from Point Click Care (PCC) Risk Management, which was revised six days after the error, did not identify that the physician was notified.
Interview with the DOC verified that based on her interview with the nursing staff the physician would have signed off on the Incident Report or made a notation on the Physician's Order Sheet if they were notified of the incident. A review of these two documents did not include any documentation by the physician as to their awareness of the incident, as confirmed by the DOC. [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 which involves a resident and every adverse drug reaction is reported to the resident's attending physician, to be implemented voluntarily.

WN #4: 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).

Findings/Faits saillants :

1. The licensee 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.

i. Resident #013 required the assistance of staff for toileting and was identified in both the July 2017 and October 2017, Minimum Data Set (MDS) Quarterly review assessments to be frequently incontinent of bladder.
The October 2017, MDS assessment also identified that the resident had a change in their urinary continence, specifically a deterioration, in urinary continence compared to the assessment completed 90 days prior, or in July 2017.
Interview with RN #106, who completed the relevant section, of the October 2017, assessment verified that the resident did not have a deterioration in their urinary continence and that the assessments were not consistent and did not complement each other.
ii. Resident #016 was observed in a chair in a specific position.
The documented plan of care identified the use of chair and position as a personal assistive services device (PASD).
RPN #103 confirmed the use of the chair as a PASD.
Physiotherapy Assessments were completed over a four month period of time in 2017, which identified that the resident did not use a PASD.
RPN #102, confirmed with the PT that the assessments did not accurately reflect the resident's current care needs and the use of the PASD.
The home did not ensure that the assessments of resident #016 were integrated, consistent with and complemented each other. [s. 6. (4) (a)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident’s hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident was bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

Resident #010 identified that they only received a bath once a week, although could not recall their bath day.
The resident shared their routine, when they were at home, was to be bathed daily and that a weekly bath was not their preference.
They also reported that they were frequently not available, on a planned basis, and that this may reason why they only received bathing once a week.
A review of the bathing schedule identified that the resident was scheduled to be bathed two times a week; however, one of the scheduled days was a day that the resident was not available.
A review of the Point of Care (POC) records indicated that during the past 30 days the resident was bathed a total of four times, was out of the home on three occasions when bathing was to be completed therefore was not bathed and refused one bath.
Interview with RN #106 and PSW #110 each verified that the resident was frequently not available on the identified day and that advanced notice was provided when they were not available.
RN #106 verified that the resident would miss the bathing on the identified day.
The ED identified that most bathing was completed during the day shift.
On November 8, 2017, the ED provided the inspector with a revised bathing schedule, following a discussion with the resident, which would accommodate the resident's availability and ensure bathing two times a week. [s. 33. (1)]

Issued on this 9th day of November, 2017

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

Original report signed by the inspector.