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
Aug 15, 2017	2017_552531_0022	014832-17	Resident Quality Inspection

Licensee/Titulaire de permis

LAND O'LAKES COMMUNITY SERVICES
12497A Hwy 41 PO Box 92 Northbrook ON K0H 2G0

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

PINE MEADOW NURSING HOME
124 Lloyd Street P.O. Box 100 Northbrook ON K0H 2G0

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

SUSAN DONNAN (531), CATHI KERR (641), DARLENE MURPHY (103)

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): August 8, 9, 10, 11 and 14, 2017

The following logs were inspected concurrently with this inspection
Log #009461-17 related to fall prevention

During the course of the inspection, the inspector(s) spoke with residents, Residents Substitute Decision Makers (SDM), Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN) the President of the Resident Council, the President of the Family Council, the Support Services Manager (SSM)
a Physician, the Director of Care (DOC), and the Administrator.

During the course of the inspection the inspectors conducted a tour of the home, reviewed resident health care records, observed resident care and services, reviewed medication administration and practices, reviewed resident and family council minutes, reviewed maintenance audits, the fall prevention program and staffing plans.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Personal Support Services
Residents' Council

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **1 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. 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 drugs were administered to resident #009 in accordance with the directions for use specified by the prescriber.

On a specified date on or about 1730 hour, resident #009 had been transferred to hospital for assessment. The resident returned to the home from hospital eight hours later. During that time, the resident had been prescribed to receive medication treatments at 2000hr:

The resident's progress notes were reviewed and indicated the resident had demonstrated moaning and facial grimacing with movement upon return to the home on a specified date on or about 0230 hour. No treatments were administered at that time. On the following morning the resident was assessed as having pain and administered a treatment for breakthrough pain with effect.

During morning care on a specified date, the resident demonstrated pain and anxiety. The registered staff became aware the resident's treatment that had been scheduled for replacement upon return from hospital had not been applied as prescribed and applied the treatment at that time. Resident #009 was assessed as having pain on the same date at 0859 hour and was administered a breakthrough treatment with effect.

The DOC was interviewed and indicated the staff are not required to check for the presence of treatment patches between the prescribed scheduled administrations. [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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #2: 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure the care set out in resident #003's plan of care was provided to the resident as specified in the plan.

On a specified date, resident #003 was found on the floor beside the bed.

Resident #003's plan of care related to falls was reviewed and included the following interventions to reduce the number of falls:

-bed alarm applied on bed,
-ensure common items are within reach,
-fall mat on the floor,
-good fitting footwear, and
-participate in exercise program to build/maintain strength.

RN #103 was interviewed and stated she assessed the resident post fall. She stated the resident was found on the fall mat on the floor. The RN stated the resident had been previously sleeping and she felt the resident had been attempting to get to the bathroom. The RN indicated at the time of this fall, a bed alarm was not in use.

The licensee failed to ensure the care set out in resident #003's plan of care was provided to the resident as specified in the plan. [s. 6. (7)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with the LTCH Act 2007, c. 8, s. 15 (2) whereby the home, furnishings and equipment are not maintained in a safe condition and good state of repair.

The following observations were made during the course of the inspection and constitute potential risk related to resident safety:
Rm. 213 shared accommodation
-left lower corner of the entrance wall approx. 3x3 inch of drywall noted to be broken, exposing steel bead with sharp edges.
-right lower 12 inches of the right entrance wall noted as heavily scarred, black marks and 12 inch area of multiple drywall chips.
-lower 12 inches of the wall between the bathroom and the closet was scarred with multiple drywall chips lower 12 inches
-6 inch round unfinished drywall patch, (dark grey colour, appearance of being wet), area above resident's head of bed
-resident #040 indicated the area had been there over a year, the colour becomes darker when it is wet outdoors.
-the shared bathroom sink drain outlet corroded, enamel worn off
-multiple bleach stains on the vanity.

Rm 210 shared accommodation
-right lower corner, next to the bathroom the drywall is gouged and missing, x 10 inches, exposing steel bead with sharp jagged edges.
-trim in this area also ill fitting, semi detached from the wall.
-lower 12-14 inches of the right wall from the entrance x 12' the drywall is heavily scarred, with gouged areas, and heavy black marks along the length of the wall.

Rm. 211 shared accommodation
-left lower corner approximately 2x4 inch drywall missing with exposed steel bead frame, sharp edges.

Rm. 209 shared accommodation
-lower 12-14 inches of the right wall, heavily scarred, drywall damaged, gouged and torn left lower
-left corner next to the bathroom the drywall was gouged and broken, sharp edges exposing entire corner steel bead.
-approx. 24 inches of the outside edges of the door kick plate were shattered, splintered with sharp edges.
-sink outlet drain enamel worn

Teal and Rose Home Area open lift storage area
-the Rose storage area the lower 6 " of the left wall heavily scarred and gouged
-the top 4' of the Teal storage area the drywall was heavily scarred and gouged.

Entrance hall between the activation lounge and Administration office there is 28 inch circular unfinished aged ceiling drywall patch
The top 4' of the door to the non residential service area in this hall is heavily scarred with black areas, the paint chipped exposing the steel frame.

The Support Services Manager was interviewed on August 10, 2017 and indicated that the housekeeping staff are responsible to complete room audits and report the areas of disrepair for maintenance to addressed.

On August 10, 2017 during an interview and observation tour of the homes identified areas of disrepair with the Administrator and the Support Services Manager they acknowledged the disrepair and indicated that the maintenance will be prioritized and addressed. [s. 15. (2) (c)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (3) Every licensee of a long-term care home shall ensure that the equipment, supplies, devices and assistive aids referred to in subsection (1) are readily available at the home. O. Reg. 79/10, s. 49 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that equipment, supplies, devices and assistive aids for falls prevention and management program were readily available in the home.

RN #103 was interviewed and indicated the home does not always have a supply of bed alarms available. The RN indicated at times, the staff need to borrow an alarm from a resident who is considered to be lower risk of falls in order to provide an alarm for a resident that requires it more urgently. The RN showed the inspector the location where alarms are kept and there were no alarms currently available in the home.

The DOC was interviewed and stated she tries to keep one alarm on site to be used in the case of an emergency. The DOC was unaware there were currently no alarms on site for the purpose of fall prevention. [s. 49. (3)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure all areas where drugs are stored were kept locked at all times when not in use.

During the initial tour of the home, inspector #641 found a room labelled "storage room" to be unlocked. The room was located on the Teal wing of the home where residents reside. When the inspector entered the room, it was found to contain the home's supply of government stock medications. This inspector noted that the door was equipped with a lock that was required to be manually locked each time the room was accessed.

The inspector informed RN #101 who indicated the room should be closed and locked at all times when not being attended by registered staff. The RN locked the door and posted a sign on the door which stated, "remember to lock door".

The DOC was interviewed and stated the staff are expected to check the status of all doors that are required to be locked upon leaving the room.

The licensee has failed to ensure all areas where drugs are stored were kept locked when not in use. [s. 130. 1.]

WN #6: 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. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure all medication incidents and adverse drug reactions are documented, reviewed and analyzed, corrective action is taken as necessary and a written record is kept of everything required.

The DOC was interviewed in regards to the medication incident involving resident #009 as outlined in WN #1. She stated that upon becoming aware of the incident, she spoke with the RN who had worked on the evening of the specified date. She stated she discussed with the RN that a time reminder should have been set in the resident's electronic medication administration record to alert oncoming staff that medications needed to be administered upon the resident's return to the home. The DOC indicated she also discussed the error with the RN who worked the night shift the resident returned from the hospital to ensure the RN reviewed the resident medications upon return to the home for any omissions.

The DOC felt the error was the result of poor communication between the shifts. The inspector requested the written record of the DOC's actions taken in regard to this error, but the DOC indicated she did not have records to reflect the corrective action, the review and the analysis of the medication incident. [s. 135. (2)]

2. The licensee has failed to ensure that a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; any changes and improvements identified in the review are implemented and a written record is kept of everything.

The DOC was interviewed in regards to the medication incident involving resident #009 as outlined in WN#1. She indicated the medication incidents may be discussed at the Medical Advisory Meetings which are held on a quarterly basis and include the pharmacist and the medical director.

The DOC stated that depending on the error, the incidents are not always discussed or analyzed for trends and that the home may only have one medication error each quarter. The DOC reviewed the meeting minutes and stated she believed this error was not discussed during the June 2017 meeting. There was no written documentation to reflect any changes or improvements made to reduce and prevent the medication incident. [s. 135. (3)]

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Issued on this 15th day of August, 2017

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

Original report signed by the inspector.