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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

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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
Jan 21, 2019	2018_593573_0019	021723-18	Resident Quality Inspection

Licensee/Titulaire de permis

The Governing Council of the Salvation Army in Canada
2 Overlea Blvd TORONTO ON M4H 1P4

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

The Salvation Army Ottawa Grace Manor
1156 Wellington Street OTTAWA ON K1Y 2Z3

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

ANANDRAJ NATARAJAN (573), LYNE DUCHESNE (117), MEGAN MACPHAIL (551)

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 29, 30, 2018, December 03, 04, 05, 07, 10, 11, 12, 13, 14, 17, 18 and 19, 2018.

The following Complaint and Critical Incident inspections were conducted concurrently during this Resident Quality Inspection.

Complaint Log #004225 -18 related to resident care and services. Log #030401-18, a complaint related to alleged incidents of staff to resident abuse.

Critical Incident Log #020061-17, related to resident's responsive behaviours. Log #027011-18, related to alleged incident of staff to resident emotional abuse. Log #027313-18, related to resident's fall incident.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care (DOC), Assistant Director of Care (ADOC), Director of Employee Relations, Placement Coordinator, Director of Food Services, Dietitian, RAI- Coordinator, Activities Manager, PSW Supervisors, the Scheduler, Behavioural Support Ontario (BSO) champion staff, Maintenance Worker, Housekeeping Aide, Activity staff, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Chair of Family Council, President of Residents' Council, family members and residents.

During the course of the inspection, the inspector(s) completed a tour of resident areas, observed medication storage areas, observed medication administration, reviewed medication incident documentation, reviewed Residents' and Family Councils meeting minutes, reviewed resident health records, reviewed staff training records, reviewed relevant licensee's policies, protocol and procedures,reviewed home's equipment cleaning schedules and maintenance schedules.

In addition, Inspectors observed the provision of care and services to the residents, staff to resident interactions and resident to resident interactions.

The following Inspection Protocols were used during this inspection:

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

During the course of this inspection, Non-Compliances were issued.
- **7 WN(s)**
- **5 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 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 failed to ensure that care set out in the plan of care was provided to resident #023 as specified in the plan.

The physician orders on the Medication Administration Record (MAR) and the written plan of care for resident #023 listed specific interventions to address bowel function in the form of a Bowel Protocol.

A review of resident #023's health care record for two specified months in 2018 indicated that on three identified occasion specific interventions to address resident's bowel function (Bowel Protocol) was not followed.

The care set out in resident #023's plan of care with regards to bowel management was not provided as specified in the plan. [s. 6. (7)]

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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: 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 licensee is required to ensure that the policy, is complied with.

In accordance with O. Reg. 79/10, s. 52 (2). The licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

At the request of the Inspector #573, the DOC provided policy #E 34, titled Pain Management Program (revision date July 2018). The policy indicated that Registered Nursing Staff will conduct pain assessment utilizing a clinically appropriate instrument (Appendix B: Pain Assessment Tool) when pain is not relieved by initial interventions.

Resident #016's health care records indicated that the resident had a fall on a specified date and began to complain of pain. PRN pain medication was administered for seven consecutive days following the onset of the pain. Registered Nursing staff progress notes on a specified date (seventh day), indicated that resident's POA was informed that PRN pain medication was not relieving resident's pain. Further, the progress notes indicated that the resident was screaming in pain, the on call physician was notified and prescribed controlled substance medication for pain management.

On December 13, 2018, Inspector #573 reviewed resident #016's health care record and found no Pain Assessment tool that was used for resident's pain management when the pain was not relieved by PRN pain medications. No other documented pain assessment was found in the resident heath care record other than the pain scale and the effectiveness of the pain medication upon administration of the pain medications.

On December 13, 2018, the DOC confirmed that for resident #016, when the pain was not relieved by initial interventions a pain assessment utilizing the Pain Assessment tool were not conducted as per the policy. [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 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 licensee is required to ensure that the policy, is complied with, to be implemented voluntarily.

WN #3: 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 has failed to ensure that the resident who was exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received 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.

According to the DOC, the clinically appropriate assessment instrument that is

specifically designed for skin and wound is titled the Weekly Wound Assessment and is located in the assessments tab of Point Click Care (PCC).

On a specified date, an RPN charted that PSW reported that resident #026's had an altered skin integrity on a specified body part and a specific treatment was to be provided for the resident. A follow-up progress note written by the same RPN stated that the specified treatment to be continued all shifts to treat resident's altered skin integrity.

A review of the Treatment Administration Record (TAR) indicated that the specified treatment to be continued every shift until the open area has healed was added on a specified date.

A review of resident #026's health care record indicated that no initial skin assessment using a clinically appropriate assessment instrument that is specifically designed for skin and wound was found with regards to the resident's altered skin integrity. Furthermore, resident #026's health care records indicated a Weekly Wound Assessment was completed after sixteen days of the initiation of a specific treatment for the resident's altered skin integrity. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A review of resident #026's health care record indicated that on a specified date, an RPN charted that the resident had an altered skin integrity on a specified body part and a specific treatment was implemented.

The resident's skin assessments in PCC were reviewed for four specified months in 2018 and showed no Weekly Wound Assessment was completed for a nine day period in a specified month. Furthermore, no weekly wound assessments were completed over a period of 13 days and over another period of 18 days on specified months for the resident's identified area of altered skin integrity.

According to the DOC, the completion of the Weekly Wound Assessment was clinically indicated for this resident so that staff can ensure that the skin impairment does not deteriorate further. [s. 50. (2) (b) (iv)]

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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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 and the resident was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs are stored in an area or medication cart that is secure and locked.

During an initial tour of the home, on an identified unit, it was observed that the door to the medication room was ajar, and the room was vacant. Within the open medication room was the medication cart that was unlocked. There was a staff member assisting residents to eat in the dining room. No other staff members were in the vicinity.

Approximately one to two minutes later, a PSW entered the unit and closed the door which locked it, therefore making the unlocked medication cart inaccessible.

On a specified date and time, Inspector #573 observed an identified unit's medication cart which was unlocked and unsupervised by the registered nursing staff. The medication cart was located outside the unit's dining area.

On November 29, 2018, Inspector #573 spoke with the unit's RPN #104, who stated that the second drawer of the medication cart does not engage, when the lock is applied nor activated. The RPN indicated to the inspector that this had been a problem for past several months. Further, RPN #104 stated that they will inform the pharmacy immediately to resolve the medication cart locking mechanism.

On December 12, 2018, Inspector #573 spoke with RPN #104, who stated that the locking mechanism of the medication cart has been fixed by the pharmacy. [s. 129. (1) (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 drugs are stored in an area or a medication cart that is secure and locked, to be implemented voluntarily.

WN #5: 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. (4) A member of the registered nursing staff may permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical, if,
(a) the staff member has been trained by a member of the registered nursing staff in the administration of topicals; O. Reg. 79/10, s. 131 (4).
(b) the member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and O. Reg. 79/10, s. 131 (4).
(c) the staff member who administers the topical does so under the supervision of the member of the registered nursing staff. O. Reg. 79/10, s. 131 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that a staff member who is otherwise not permitted to administer a drug to a resident administered a topical without being trained by a member of the registered nursing staff in the administration of topical.

On a specified date, an RPN charted that PSW reported that resident #026's had an altered skin integrity on a specified body part.

On an identified date, resident #026's TAR indicated that the specified treatment (topical) to be continued every shift by the staff.

A review of resident #026's TAR indicated that the application of topical was coded as "12" meaning "PSW/HCA applied" 18 times on a specified month in 2018, 27 times on a specified month in 2018, 34 times on a specified month in 2018, 30 times on a specified month in 2018 and 7 times on a specified month in 2018. On the other occasions, the TAR is coded as applied by the registered nursing staff.

As per RPN #118, PSW staff apply either topical cream or spray for the resident. A review of the topical cream identified with a drug identification number (DIN).

PSWs have the option of applying topical cream that is therefore classified as a drug, and have not received the training to apply topical as per the DOC. According to the DOC, PSWs should not be applying topical that are drugs. [s. 131. (4)]

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 a member of the registered nursing staff may permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical, if, the staff member has been trained by a member of the registered nursing staff in the administration of topical, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented: 6. All assessment, reassessment and monitoring, including the resident's response.

In accordance with O.Regulation 79/10, s.110 (2) 6. The licensee shall ensure that the resident's condition has been reassessed and the effectiveness of the restraining evaluated by a physician or a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time based on the resident's condition or circumstances.

On a specified date and time, Inspector #573 observed resident #018 was sitting in their wheelchair with a lap belt in place. A review of resident #018's written plan of care indicated the use of wheelchair lap belt as a restraint. Inspector #573 reviewed resident #018's health care records for restraint which included the SDM's consent and a corresponding physician's order for the use of wheelchair lap belt as a restraint.

On December 12, 2018, Inspector #573 spoke with RPN #104, who indicated that the registered nursing staff will reassess the resident's response and the effectiveness of the restraint, every eight hours which is recorded in the Medication/ Treatment Administration Record (MAR/ TAR).

On December 13, 2018, Inspector #573 reviewed the MAR/ TAR documentation for two identified months in 2018, for resident #018 in the presence of RPN #104. Upon review it was observed that there was no documentation in the resident's MAR/ TAR to demonstrate that the residents' condition and effectiveness of the lap belt restraint had been reassessed at least every eight hours by the registered nursing staff.

On December 13, 2017, Inspector #573 spoke with the RAI coordinator, who confirmed with the Inspector that resident #018's reassessment and effectiveness of the lap belt restraint by the registered nursing staff was not documented. [s. 110. (7) 6.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 114 (3).
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policies and protocols developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

As per O.Reg. 114 (2) the policy number 4.3 "Administering and Documenting Controlled Substances", last revised June 2018, identifies the following procedure:

1) Locate the Resident's medication administration record (MAR) sheet, individual count sheet and controlled substance medication. Each controlled substance medication is individually inspected and verified for correctness against the Resident's MAR sheet, verifying competence, safety and authority.
2) The dose of controlled substance medication is documented, recording the:
a) Date and time
b) Administered quantity
c) Remaining quantity
d) Signature of the administering person
3) The controlled substance medication is administered to the Resident, as ordered.
4) The controlled substance medication is initialed as administered, on the MAR, in the correct box, immediately after administration and before the next Resident is medicated.

Resident # 021 was admitted in the home with multiple comorbities. The resident was identified as having pain and has regular and as needed pain medication.

On a specified date, RN #102 administered controlled substance medication to resident #021's pain, during a specified shift. At the end of the shift, RPN #106 and RN #107 identified, that there was a missing controlled substance medication for resident #021.

That morning, resident #021 informed RPN #016 that they had received a pain medication during the specified shift for breakthrough pain. There was no documentation in the resident's health care record, electronic Medication Administration Record (MAR) or in the controlled substance medications shift count record to indicate that the resident had been administered an as needed controlled substance medication for pain.

On December 04, 2018, RN #102 said to the inspector that they had been ill during the shift of a specified date and had not completed the documentation required with the administration of a pain medication to resident #021. RN #102 said that the home does have a policy to ensure that any administered medication is to be documented at the time of administration. The DOC said to the inspector that RN #102 had been ill during the shift of a specified date and had not completed resident #021's medication administration documentation as per their policy and prevailing practices. [s. 114. (3) (a)]

Issued on this 30th day of January, 2019

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

Original report signed by the inspector.