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
Jul 11, 2019	2019_575214_0021	004740-19, 012439-19	Critical Incident System

Licensee/Titulaire de permis

Shalom Manor Long Term Care Home
12 Bartlett Avenue GRIMSBY ON L3M 4N5

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

Shalom Manor Long Term Care Home
12 Bartlett Avenue GRIMSBY ON L3M 4N5

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

CATHY FEDIASH (214), KELLY CHUCKRY (611)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): June 20, 21, 24, 25, 26, 2019.

Please note: This inspection was conducted concurrently with Follow Up inspection #2019_575214_0020 / 005190-19, related to s.6 (7)- plan of care.

During the course of the inspection, the inspector(s) spoke with the Interim Chief Administrator; Interim Manager of Operations; Acting Director of Resident Care (ADRC); Resident Assessment Instrument (RAI) Minimum Data Set (MDS) Coordinator; Registered staff; Personal Support Worker (PSW) and residents.

During the inspection, the inspector(s) reviewed the Critical Incident System (CIS); resident clinical records; applicable policies and procedures; manufacturers' instructions; applicable incident reports and observed residents during the provision of care.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication

During the course of this inspection, Non-Compliances were issued.
- **4 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 and Regulation required the licensee of a long-term care home to have, institute or otherwise put any procedure in place, the procedure was complied with.

In accordance with the Act, s. 8(1) (a), and in reference to O.Reg. s. 114, the licensee was required to have a medication management system in place that ensured that written policies and protocols were 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.

Specifically, staff did not comply with the licensee's procedure entitled "Ordering Medications" (4-2), with an identified date of revision, and a second procedure entitled "Transcribing Prescriber's Orders to eMAR/MAR (electronic Medication Administration Record/Medication Administration Record) sheet" (8-3), with an identified date of revision.

A review of the home's medication management system took place during this inspection, as a result of a CIS submission #C558-000012-19. This included a review of the home's policies and procedures pertaining to the medication management system. According to the CIS submitted on an identified date, resident #004 was given the incorrect dose of an identified drug.

Upon review of the clinical health records for resident #004, the physician sent an electronic mail (email) order for this resident on an identified date and time. This included an order for the identified drug. Registered staff #115 read this order, and wrote the information onto the Prescriber's Orders form under the Orders column in the health

record. This written order did not include the signature of registered staff #115 who wrote the order.

This nurse did not transcribe the order into the eMAR. This information was relayed to registered staff #114 during report. Registered staff #114 did not initially transcribe the order into the eMAR. Resident #004 was assessed at an identified time and was administered a dose of the identified drug. Registered staff #114 referred to the Prescriber's order form as the information had not been transcribed into the eMAR. Registered staff #114 read the written order for the identified drug as having a different dose than had been prescribed. It was confirmed by registered staff #114 that the dose of the identified drug was administered before the order was transcribed into the eMAR.

The home had a policy entitled "Ordering Medications" (4-2) that was revised with an identified date. The procedure as identified in this policy indicated that the "nurse signs and dates receipt of telephone order and flags the chart for the prescriber's signature at next visit (required within 7-14 days)." The ADRC confirmed there was not a signature in the email order written on the Prescriber's Order".

The home had a policy entitled "Transcribing Prescriber's Orders to eMAR/MAR sheet" (8-3) that was revised with an identified date. The procedure as identified in this policy indicated that the nurse was to "transcribe all medication orders on the MAR". In an interview conducted by LTC Home Inspector #214 with registered staff #114, it was confirmed that the dose of the identified drug was administered prior to the order being transcribed into the eMAR and that it would have been their responsibility to complete this process.

In an interview conducted with the ADRC it was confirmed that the procedures noted above, were not complied with. [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 and Regulation requires the licensee of a long-term care home to have, institute or otherwise put any procedure in place, the procedure is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used identified systems in the home in accordance with manufacturers' instructions.

A review of CIS # C558-000003-19, indicated that on an identified date, resident #001 sustained falls. The resident was transferred to an identified location with identified injuries. The resident was also diagnosed to have other, identified diagnoses.

a) A review of the resident's fall history following the CIS, was conducted. A review of a specified assessment dated with an identified date and time, indicated that the resident had an unwitnessed fall in an identified location. The assessment indicated that an identified intervention was in place; however, had not been connected.

b) A review of a specified assessment, dated approximately two and a half months later, with an identified date and time, indicated that the resident had an unwitnessed fall in their room. The assessment indicated that an identified intervention was in place; however, had not been working as the intervention had not been connected.

A review of these interventions on an identified date, was conducted with PSW staff #104, #105 and #106. Information documented on the intervention indicated that the intervention was one year timed and warranted for one year of timed use, or two years

from receipt, whichever came first.

Observation of the identified interventions indicated an area that staff could fill in the date the intervention was put into use and another area that staff could fill in the date the intervention was replaced.

The intervention listed "Care Instructions" that indicated to:
-Test for proper function of the intervention before every use.

On observation with all three staff, it was confirmed that no date was observed to have been written on the intervention identifying when it was received or when it had been put into use.

An interview with all three staff present, indicated that they were not aware of the need to write the identified dates on the intervention. The Long Term Care Homes (LTCH) Inspector #214, asked the staff present, if the home had a procedure in place to test for proper functioning of the intervention, prior to use and if this information was documented. PSW staff #104 indicated that no actual system was in place to test the intervention prior to resident use. PSW staff #104 and #105 confirmed that no documentation was recorded that ensured this intervention was in working condition.

Manufacturers' instructions for the interventions, were provided by the home on an identified date. The ADRC communicated that the manufacturers' instructions were as listed directly on each of the interventions. The manufacturers' instructions were observed to be the same for the two identified interventions that were observed during this inspection.

During an interview with the RAI/MDS Coordinator on an identified date, they indicated that they were not aware of any test that was conducted to ensure proper functioning of the identified interventions, prior to every use and confirmed that there was no current process for documenting the outcome of the testing.

An interview with the ADRC on an identified date and time, indicated that they were not aware of any procedure to test for proper functioning of the identified interventions, prior to every use as identified in the manufacturers' instructions and confirmed that there was no current process in place to document the outcome of the testing. [s. 23.]

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 staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury. O. Reg. 79/10, s. 48 (1).
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions. O. Reg. 79/10, s. 48 (1).
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. O. Reg. 79/10, s. 48 (1).
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home implemented a falls prevention and management program to reduce incidence of falls and the risk of injury.

A review of the licensee's interdisciplinary fall prevention and management program, in response to CIS # C558-000003-19, was conducted.

During an interview with the ADRC, on an identified date, they stated that the home made a change to their fall prevention and management program on a specified date, when they replaced an identified assessment, with another identified assessment.

The ADRC stated that the RAI/MDS Coordinator was responsible for educating the registered staff for the implementation of this change in the home's fall program and had provided training to the registered staff; however, no attendance documentation had been completed that outlined when the training was provided and whom attended.

On an identified date, an interview with registered staff #107, indicated that this staff member had received training on the new assessment and that together with the RAI/MDS Coordinator, completed this new assessment for all residents that resided in the home at the time the assessment was implemented.

On an identified date, an interview with registered staff #106, #108, #109, #110 and #112, indicated that they had not received training in relation to the implementation of the new assessment.

On an identified date and time, during an interview with the RAI/MDS Coordinator, they stated that since the new assessment had been implemented, only newly hired registered staff had received training. [s. 48. (1) 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 the home implements a falls prevention and management program to reduce incidence of falls and the risk of injury, 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 failed to ensure that resident #004 was administered drugs in accordance with the directions for use as specified by the prescriber.

A review of CIS #C558-000012-19, indicated that on an identified date, resident #004, had been prescribed an identified drug. The following day, at an identified time, Registered staff #114, administered the identified drug, to resident #004. Approximately six hours later, the resident demonstrated an identified symptom and was transferred to a specified location and returned to the long-term care home the same day.

A review of the physician's order indicated that on an identified date and time, Registered staff #115, sent an email to the resident's physician, identifying the current status of resident #004. The same date, at a specified time, an email response was received by the resident's physician, and an order was received for an identified drug.

A review of a paper document, titled, "Digital Prescriber's Orders", indicated that the above physician's order had been transcribed on the same date the order was received; however, no signature of the registered staff who transcribed the order was present.

A review of a document titled, "Medication Incident Notification", dated with a specified date, indicated that resident #004, was prescribed a specified dose of the identified drug and that it had been discovered that they had been administered a different, specified dose of this drug.

A review of the resident's eMAR, dated with an identified date and time, indicated that an "X", had been documented, for the identified drug that had been administered at the specified time.

During an interview with Registered staff #114, they confirmed they worked on this specified date and shift. The staff member indicated that they had received a report regarding resident #004, at shift change, and were made aware of the resident's condition and newly prescribed drug orders. The staff member indicated that they assessed the resident at the start of their shift and observed the resident with no concerns noted. The staff member indicated that they directed staff on duty to monitor the resident and check them hourly and to call them if there were any concerns. The staff member indicated that at an identified time during the shift, they observed the resident to be in an identified state. Staff #114 indicated they asked another staff member to stay with the resident while they attended to an identified unit to access an identified drug supply. Staff #114 indicated they removed a specified drug and brought this to an identified unit, where the physician's order for this drug was located. The staff member indicated that when they came to the unit, an identified staff member, from an external resource, was present. Staff #114 indicated that the staff from the external resource had wanted to ask them some questions and while trying to answer their questions, they were also preparing the specified drug order for administration. The staff member indicated when they looked down at the drug order, they observed what they thought to be the prescribed dosage of the drug and this was the dose they prepared for administration. The staff member indicated it had been a busy night; they were concerned regarding the status of the resident; they were trying to respond to the external resource staff member and became distracted while preparing this drug. The staff member confirmed that they had not administered the specified drug in accordance with the directions for use specified by the prescriber. The staff member indicated that they had not documented the administration of the drug on the residents eMAR, as the physician's order had not been processed onto the eMAR at the time the staff member administered this drug.

An interview with the ADRC on an identified date, confirmed that resident #004, had not received their prescribed drug, 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.

Issued on this 25th day of July, 2019

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

Original report signed by the inspector.