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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

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_544527_0008	009897-17	Critical Incident System

Licensee/Titulaire de permis

CVH (No. 8) GP Inc. as general partner of CVH (No. 8) LP
766 Hespeler Road Suite 301 CAMBRIDGE ON N3H 5L8

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

Shelburne Long Term Care Home
200 ROBERT STREET SHELBURNE ON 000 000

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

KATHLEEN MILLAR (527)

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): July 5, 6 and 7, 2017.

This inspection was as a result of a Critical Incident, Log #009897-17 and was related to medication management.

During the course of the inspection, the Long Term Care Home (LTCH) Inspector reviewed the residents' clinical records, internal investigative notes, policies and procedures; toured the home; and observed resident care.

During the course of the inspection, the inspector(s) spoke with the General Manager (GM), the Director of Care (DOC), the Behavioural Support Ontario Personal Support Worker (BSO PSW), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), residents, and families.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Medication
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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 where the Act or this Regulation required 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 was required to ensure that the plan, policy, protocol, procedure, strategy or system, (b) was complied with.

In accordance with Long-Term Care Homes Act (LTCHA) 2007, s. 114 (2), which required the licensee to ensure 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.
The home's nursing policy called "Permission to Leave Premises and be Responsible for Medication of Resident", number NA-4.210, and effective September 1990, directed staff that residents "must have a Physician's Order to leave the premises with medication. Acceptance of Responsibility for Resident During Leave and for Resident's Medication(s) Form must be signed before leaving."
In addition, the home's MediSystem pharmacy policy called "Leave of Absence (LOA) - Residents on Leave from the Home", and last reviewed January 2017, directed staff that "the physician must authorize the leave of absence of the resident by a written or verbal order which can be found in the Physician's Order Form or the Physician's Order Review."

(i) In March 2016, resident #001 went on a leave of absence with their family member. There was no acceptance of responsibility for the resident during leave and there was no medication form signed by the family member and/or in the resident's clinical record. There was no documentation in the medication administration record (MAR) to reflect that the resident was administered their medication, and there was no documentation in the resident's progress notes to indicate the resident was administered their medication while on a LOA or when they returned to the home.

(ii) In June 2017, resident #001 went on a leave of absence with their family member. There was no acceptance of responsibility for resident during leave and no medication form signed by the family member and/or in the resident's clinical record. There was no documentation in the medication administration record (MAR) that the resident was administered their evening medication while on a LOA or when they returned to the home.

The clinical record for resident #001 was reviewed and there was no physician's order for

the resident to go on a leave of absence with their medications. During the record review there was also no "Acceptance of Responsibility for Resident During Leave and for Resident's Medication(s)" found on resident #001's clinical record.
During an Interview with RN #116, #117 and RPN #114, they indicated that when a resident goes on a leave of absence with medications that they were expected to ensure the Acceptance of Responsibility for Resident During Leave and for Resident's Medication(s) form was signed by the responsible person, such as a family member, and copy the medication card would be attached to the form and then placed in the resident's clinical record. The staff were unable to find any forms completed for resident #001 and they were unable to locate a physician's order that the resident could go on a leave of absence with medication(s).
The Director of Care (DOC) confirmed that a physician's order was required when a resident went on a leave of absence with medication(s) and the form should be signed by the responsible person, such as a family member and filed in the resident's clinical record, as per the home's policy and procedure.
The home failed to ensure that the nursing and pharmacy policy and procedures were complied with related to resident #001 going on a leave of absence with medications.

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 plan, policy, protocol, procedure, strategy or system, (b) is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that, for each resident demonstrating responsive behaviours, (b) strategies were developed and implemented to respond to these behaviours, where possible.

Resident #001 was experiencing responsive behaviours and based on the assessments by the interdisciplinary team, a specific intervention to manage resident #001's behaviour was to be developed and implemented.
In May and July 2017, resident #001 was observed by PSW #119, #120 and #121, not complying with the strategy to manage their behaviours.
The clinical record was reviewed; however the Long Term Care Home (LTCH) Inspector #527 was unable to find the intervention in the resident's plan of care.
The BSO, RN #116, RPNs #100, #103, #104, #114 and PSWs #110, #111, #112 and #113 were interviewed and confirmed that they had discussed implementing a specific strategy to manage the responsive behaviour for resident #001. The BSO also confirmed that they were unable to find this intervention for managing the resident's responsive behaviour on the plan of care.
The DOC was interviewed and confirmed the specific strategy to manage the resident's responsive behaviour should have been developed and implemented on the plan of care.
The staff failed to ensure that a specific intervention was developed and implemented consistently to respond to resident #001's behaviours.

2. The licensee failed to ensure that, (c) actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

Resident #001 was exhibiting responsive behaviours and as a result the interdisciplinary team had implemented monitoring to assess the frequency and pattern of the resident's behaviour. The DOS monitoring was started in April 2017, and was discontinued five days later by RN #118.
The home's policy called "Responsive Behaviour Management", number RC-6.020, and last revised in August 2012, directed staff to conduct the monitoring for seven to fourteen days.
The clinical record was reviewed and it was identified that RN #118 discontinued the monitoring within five days of it being initiated with no consultation with the interdisciplinary team and no documentation as to the reason why the monitoring was cancelled. In addition, the documentation related to the monitoring for behaviours was inconsistently documented by the Personal Support Workers (PSWs).
Interview with the BSO confirmed that the resident's monitoring was initiated and should have continued for at least seven days. The BSO would then conduct a huddle with the interdisciplinary team to determine if an additional seven days of monitoring was required or not. In addition, the BSO confirmed that the monitoring by the PSWs was inconsistently documented on Point of Care (POC) in the electronic health record.
The DOC was interviewed and confirmed that RN #118 discontinued the monitoring prematurely and that the documentation of the resident's behaviours was inconsistently documented in POC.
The home failed to ensure that actions were taken to respond to the needs of resident #001, including the assessment and documented responses.

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, for each resident demonstrating responsive behaviours, (b) strategies are developed and implemented to respond to these behaviours, where possible; and (c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented, to be implemented voluntarily.

Issued on this 1st day of September, 2017

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

Original report signed by the inspector.