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 # / Registre no	Type of Inspection / Genre d'inspection
Nov 3, 2016	2016_389601_0025	020635-16, 020636-16, 020637-16	Follow up

Licensee/Titulaire de permis

TRENT VALLEY LODGE LIMITED
195 Bay Street TRENTON ON K8V 1H6

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

TRENT VALLEY LODGE LIMITED
195 BAY STREET TRENTON ON K8V 1H9

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

KARYN WOOD (601)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): September 26, 27, 28, 29 and 30, 2016.

The following log numbers were inspected:

Log #020635-16 regarding a follow up inspection to CO #001, s.8(1) related to medication administration.

Log #020636-16 regarding a follow up inspection to CO #002, s.90(2)(h)(i) water temperature greater than 49 or at least 40 degrees Celsius.

Log #020637-16 regarding a follow up inspection to CO #003, c.8, s. 15.(2)(c) furnishing maintained in a safe and good state of repair.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Pharmacist, Unit Clerk, Maintenance Supervisor, Environmental Supervisor, Clinical Care Coordinator, residents and a family member.

The inspector also reviewed the licensee's revised water temperature policy and medication policy, the licensee's education of the registered nursing staff in regards to monitoring of water temperatures and medication administration, the licensee's recorded water temperatures for the first, second and third resident floors, maintenance records and reviewed resident health care records.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Medication

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 VPC(s)**
- **2 CO(s)**
- **1 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 15. (2)	CO #003	2016_270531_0021	601

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 has failed to ensure that the licensee's policy related to medication administration was followed to ensure safe, effective administration of medication for resident #002, #003 and #004.

O. Reg. 79/10, 114. (2) states 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, destruction and disposal of all drugs used in the home.

During prior inspection number 2016_270531_0021 compliance order #001 was issued under O. Reg 79/10, s. 8(1) and O. Reg. 79/10, 114(2) related to the licensee's medication administration policy to ensure safe, effective administration of medication.

Compliance order #001 directed the licensee to educate all registered nursing staff about policy # TC-1022.2 "General Considerations Administration of Medication General Guidelines" in a formal education session and evaluate staff comprehension of the contents of the policy following the session; in particular the session and evaluation included the requirement in the policy to administer medication within one hour of the scheduled time of administration.

Compliance order #001 also directed the licensee to educate all registered nursing staff related to the College of Nurses of Ontario Medication Practice standards, including the administration of medication according to the scheduled times prescribed by the physician, the management of medication errors, and appropriate actions to be taken in response to medication errors.

During the course of this inspection, the Clinical Care Coordinator, RPN's #106, #112 and RN #117 interviewed indicated to the Inspector that the licensee's medication policy and a copy of the College of Nurses of Ontario Medication Practice standard was distributed to registered nursing staff to review and a quiz was also completed.

During an interview, RN #116 indicated to the Inspector that the required education related to medication administration had not been provided.

During an interview, the Administrator indicated to the Inspector that agency staff had been utilized for some of the registered nursing staff hours. During this interview, the

Administrator indicated that registered nursing staff had been given a copy of the medication policy #TC-1022.2 and the standards of medication administration according to the College of Nurses of Ontario Medication Practice to review. Registered nursing staff were required to sign a declaration indicating the information provided for independent study was reviewed and a quiz had been distributed for registered nursing staff to complete. The Administrator indicated that agency registered nursing staff administer medication and they did not receive the required education. The Inspector completed a record review of the agency registered nursing staff schedule for an identified twenty-five day period and identified that RN’s #121, #122, #124 and RPN’s #123, #130 had worked in the home during this time.

The licensee's "Administration of Medications - General Considerations" policy #TC-1022.2 was reviewed by the Inspector and indicated that medications are administered within one hour of the scheduled time, except medications to be given with food, or before or after meal/food orders, which are administered precisely as ordered. If there is a question about the specific time a medication should be given, consult with the consultant pharmacist or pharmacy provider. If a dose of a regularly scheduled medication is refused by the resident, document on the MAR. If more than two doses in a row are refused, follow up with the physician/prescriber.

1. Resident #002 was admitted to the home with an identified medical diagnosis.

During the course of the inspection, the Inspector reviewed resident #002’s Medication Treatment Administration Records (MTARs) for an identified twenty-six day period. It was identified that resident #002’s medications scheduled to be administered included nine identified medications at 0830 hours, one identified medication at 1230 hours, and four identified medications at 1730 hours. It was identified that the Physician had prescribed for resident #002 to receive a new medication at 0500 hour routinely on the fourteenth day of the twenty-six day period identified.

The Inspector reviewed resident #002’s progress notes for a fourteen day period and identified that resident #002's new medication regularly scheduled for 0500 hour was not administered as prescribed by the Physician on eleven occasions. RN #116, RN #122 and RN #133 had documented that resident did not receive the identified medication for different reasons.

During an interview, the Clinical Care Coordinator indicated to the Inspector that resident #002's Physician had prescribed the new medication for a specific reason. During the

same interview, the Clinical Care Coordinator indicated not being aware that resident #002 had not been receiving the new medication at 0500 hour. The Clinical Care Coordinator indicated being responsible for completing rounds with the Physician and the nurses had not communicated that resident #002 had not received the new medication at 0500 hours as prescribed by the Physician on eleven occasions.

The Inspector reviewed resident #002's MTARs for a twenty-six day period and identified that all resident #002's medications scheduled for 0830 hour were administered greater than one hour following the administration scheduled time on five identified dates ranging from six minutes to one hour and eleven minutes late.

During an interview, Pharmacist #119 indicated to the Inspector that resident #002's medications should be given according to the licensee's policy for medication administration and when a medication was ordered for three times a day the scheduled times are 0830, 1230, and 1730 hours. During the same interview, the Pharmacist also indicated that resident #002's identified medication should be given at the scheduled time due to the identified medication has a peak concentration level that is usually one to three hours after administration of the medication.

2. Resident #003 was admitted to the home with an identified medical diagnosis.

During the course of the inspection, the Inspector reviewed resident #003's MTARs for a twenty-six day period. It was identified that resident #003's medications scheduled to be administered included eight identified medications at 0830 hours, one identified medication at 1230 hours, two identified medications at 1730 hour and one identified medication at 2030 hours.

The Inspector reviewed resident #003's MTARs for a twenty-six day period and identified that all resident #003's 0830 hour medications were administered greater than one hour following the administration scheduled time on four identified dates ranging from two minutes to thirty-one minutes late.

3. Resident #004 was admitted to the home with an identified medical condition.

During the course of the inspection, the Inspector reviewed resident #004's MTARs for a twenty-six day period. It was identified that resident #004's medications scheduled to be administered included fourteen identified medications at 0830 hours, four identified medications at 1230 hours, four identified medications at 1730 hours and six identified

medications at 2030 hours.

The Inspector reviewed resident #004’s MTARs for a twenty-six day period and identified that all resident #004's 0830 hour medications were administered greater than one hour following the administration scheduled time on three identified dates ranging from five minutes to fourty-two minutes late.

The Inspector reviewed resident #004’s MTARs for a twenty-six day period and identified that all resident #004's 2030 hour medications were administered greater than one hour following the administration scheduled time on four identified dates ranging from two minutes to one hour and eight minutes late.

During an interview, Pharmacist #120 indicated to the Inspector that two of resident #004's identified medications should be given at regular intervals according to the licensee's policy for medication administration at 0830, 1230, 1730, and 2030 hours. During the same interview, the Pharmacist indicated that resident #004's identified medications was required on regular intervals to manage the symptoms of the residents medical condition.

During an interview, the Administrator indicated to the Inspector that changes had been made to the medication administration times and was not aware that resident #002, #003, and #004 had not received medication within one hour of the scheduled time, as specified in the licensee's "Administration of Medications - General Considerations" policy.

A compliance order #001 under inspection report #2016_389601_0005 was issued under O. Reg. 79/10 s. 8(1) and O. Reg. 79/10 s. 114(2).

A compliance order #001 under inspection report #2016_270531_0021 was issued under O. Reg. 79/10 s. 8(1) and O.Reg. 79/10 s. 114(2).

The history of repeated non-compliance along with the scope and risks associated with the noted medication administration practices were considered when the decision to re-issue this compliance order was made. [s. 8. (1) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were developed and implemented to ensure that immediate action was taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius.

During prior inspection #2016_270531_0021 compliance order #002 was issued related to O. Reg 79/10, s. 90. (2)(h) and s. 90 (2)(i) to update the licensee's "Water Temperature Monitoring" policy #Vll-H-10.26 to include the specific actions that will be taken when tub baths and showers cannot be completed due to low water temperatures.

Compliance order #002 also directed the home to educate all registered nursing staff and all personnel identified as responsible for addressing water temperatures outside of the acceptable range to ensure full implementation of the policy.

The licensee's "Water Temperature Monitoring" policy #VII-H-10.26 was reviewed and directs:

The water temperature of the hot water serving all tub rooms and sinks used by residents will be maintained at a temperature not below 40 degrees Celsius and will not exceed 49 degrees Celsius and will be monitored daily once per shift in selected locations where

residents have access to hot water.

Procedure:

The RN/RPN will:

1. Monitor hot water temperatures in selected resident home areas(resident bathroom and tub rooms) on each shift by running the hot water tap for five minutes, inserting the water temperature thermometer into the stream of water for fifteen seconds then reading the temperature on the dial/panel;
2. Record the water temperatures on the VII-H-26(a) Water Temperature Monitoring record attached;
3. Report all water temperatures below 40 degrees Celsius and above 49 degrees Celsius to Maintenance Personnel for adjustment and appropriate intervention and document all reports on the monitoring form;
4. When water temperatures are outside of the normal range put up signs of high or low temperatures;
5. Should the Maintenance Personnel not be available, contact the Director of Support Services or the Director of Care or the Administrator in that order;
6. Instruct all staff of the associated risks involved for use of water outside the range specified and what actions to take in the event of such an occurrence.

The PSW will:
1. Immediately report all suspicions of water outside the 40-49 degree Celsius range to the RN/RPN.

The maintenance personal will:
1. When notified or when unusual temperatures occur, adjust the hot water tanks or boiler temperature up or down depending on the water temperature readings;
2. Sign off in the book in the boiler room that the hot water tank temperature has been adjusted;
3. After the hot water tank temperature is adjusted, the water temperatures will be retaken by the following shift in the selected rooms any temperature outside of the ranges will be reported immediately and appropriate actions will be taken by registered staff.

The licensee's "Water Temperature Monitoring" policy #Vll-H-10.26 was reviewed by the Inspector. The policy did not include the specific actions that will be taken when tub baths

and showers cannot be completed due to low water temperatures as directed under compliance order #002 during inspection #2016_270531_0021.

During an interview, the Clinical Care Coordinator indicated to the Inspector that a registered staff meeting was held on an identified date to review the "Water Temperature Monitoring" policy. During the same interview, the Clinical Care Coordinator indicated that not all registered staff attended the identified meeting.

The Inspector reviewed the Agenda and Meeting Record for the registered nursing staff meeting held on the identified date. The meeting records indicated that RN's #121, #122, #124,and RPN's #106, #123, #126, #127, #128, #129, #130 who were responsible for addressing water temperatures outside of the acceptable range did not receive the required education of policy number VII-H-10.26 in relation to Water Temperature Monitoring.

The Inspector completed a record review of the "Water Temperature Check" forms for the three identified units for a twenty-five day period. The recorded water temperatures on all shifts in various locations was documented as above 49 degrees Celsius on seventeen identified shifts and there was no documentation available for record review on thirty-three identified shifts.

On five identified shifts there was no evidence of documented times that the registered nurse notified the Maintenance Supervisor regarding the water temperatures exceeding the acceptable range of 49 degrees Celsius.

On ten identified shifts there was no evidence of documented times, actions or outcome that the Maintenance Supervisor responded to the notification of the water temperatures exceeding the acceptable range of 49 degrees Celsius.

During an interview, the Maintenance Supervisor indicated to the Inspector that registered nursing staffs were responsible to take the water temperature every shift according to the scheduled rooms and were to notify the Maintenance Personnel if the water temperature was below 40 degrees Celsius or exceeded 49 degrees Celsius. The Maintenance Supervisor indicated that registered nursing staff would notify Maintenance Personnel by phone or leave a voice mail outside of regular business hours. The Maintenance Supervisor indicated that the voice mail would be checked on the following business day. The Maintenance Supervisor indicated that adjustments had been made to adjust the hot water tanks but a record was not kept indicating the date or time the action

was taken.

During the course of the inspection, RPN #106, RN’s #116 and #117 indicated to the Inspector that they are responsible for checking the water temperature every shift according to the water temperature schedule. RPN #106, RN’s #116 and #117 indicated that if the water temperature was not within the acceptable range the Maintenance Personnel were notified by phone and a voice mail was left outside of regular business hours. Registered staff would place signage at the location identified as having water temperatures outside of the acceptable range.

During an interview, the Administrator indicated that registered nursing staffs were responsible for monitoring and recording the water temperatures outside the acceptable range. The Administrator also indicated that registered nursing staff had not notified the Director of Support Services, the Director of Care or the Administrator of the water temperatures outside of the acceptable range when the Maintenance Personnel were not available as directed by the licensee’s policy. The education had been provided at a registered nursing staff meeting however not all registered nursing staffs have received the required education to ensure full understanding and implementation of the "Water Temperature Monitoring" policy.

A compliance order #001 under inspection report #2015_396103_0057 was issued under O. Reg. 79/10 s. 90(2)(h)(i). The order #001 under O. Reg. 79/10 s. 90(2)(h)(i) was complied.

A compliance order #002 under inspection report #2016_270531_0021 was issued under O. Reg. s. 90(2)(h)(i).

The history of repeated non-compliance along with the scope and risks associated with the elevated water temperature was assessed. Water temperatures that exceed 49 degrees Celsius pose a potential risk to residents from hot water scalding. The licensee has no current practice in place to immediately notify the Maintenance Supervisor outside regular business hours or residents. The scope of the risk is widespread as it affects all residents and is especially a risk for residents who can independently use the bathroom facilities without being made aware of the higher water temperatures. Due to the scope and severity of this risk, a compliance order is being re-issued. [s. 90. (2) (h)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 22nd day of November, 2016

[redacted]

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

Original report signed by the inspector.