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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 1, 2013	2013_103193_0005	T- 547-12, 1130-12, 1287-12	Complaint

Licensee/Titulaire de permis

UNIONVILLE HOME SOCIETY
4300 Highway #7, MARKHAM, ON, L3R-1L8

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

UNION VILLA
4300 Highway #7, Unionville, ON, L3R-1L8

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

MONICA NOURI (193)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): April 17, 18, 22 and 24/2013

the following complaint logs were inspected: T-547-12, T-1287-12 and T-133-13

During the course of the inspection, the inspector(s) spoke with residents, family members, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Nurse managers, the Education Coordinator and the Director of Nursing and Personal Care (DNPC).

During the course of the inspection, the inspector(s) reviewed residents' health records, the licensee's policies and procedures, training records, observed medication administration, and provision of care and staff resident interactions.

The following Inspection Protocols were used during this inspection:
Medication

Pain

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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).

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care for residents #1, #2 and #3 was provided to the residents as specified in their plans of care. Their plans of care indicate for staff to administer pain medication as ordered and to note the effectiveness of the medication.

Resident #2 did not receive pain medication as required by the plan of care on two identified occasions;
- on May 9 /2012 when resident #2 complained of abdominal pain as per nurse's progress notes
- on May 24/2012 when resident #2 complained of headache as per nurse's progress notes. [s. 6. (7)]

2. On April 18/2013 pain medication was not administered at 1400 to resident #2 as required by the resident's plan of care. Registered Practical Nurse (RPN) confirmed the information. [s. 6. (7)]

3. The licensee failed to ensure that the staff and others who provide direct care to resident #3 are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

Resident #3's current plan of care available for Personal Support Workers (PSWs) is kept in the care plan binder and does not indicate back pain as an issue/problem.
The revised plan of care from April 11/2013 available to staff who have computer access identifies back pain as an issue/problem.
Staff interview revealed that the revised plan of care is not immediately accessible to PSWs as they do not have access to the computer. [s. 6. (8)]

4. The licensee failed to ensure that the provision of the care set out in the resident #1's plan of care was documented on February 27/2012 for day and evening shift. [s. 6. (9) 1.]

5. On April 16, 17 and 18/2013 the administration of an identified medication for resident #3 was not documented on 3 identified occasions: April 16, 17, and 18, all for the same time, 1430.
Also, on April 18/2013 at 1430, pain medication was not documented as administered. The assigned RPN indicated the documentation was not completed due/to late administration and inability to log in the electronic Medication Administration Record (e

-MAR) after the shift is over. The RPN was attending meetings/in-services these days and returned to the unit after 1530. [s. 6. (9) 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 by ensuring that the care set out in the plan of care for resident #3 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. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The license failed to ensure that the home's Pain management program written description includes protocols for referral of resident to specialized resources where required.
The Director of Nursing and Personal Care (DNPC) confirmed during an interview. [s. 30. (1) 1.]

2. The licensee failed to ensure that any action taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

On May 4/2012 the Dementia Observation System was implemented to monitor and assess resident's #2 responsive behaviours. The intervention was not documented as required for day shifts on May 4, 5, 6/2012, from 700-1430. [s. 30. (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 any action taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's written approaches to care developed to meet the needs of the residents with responsive behaviours include identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.
DNPC confirmed during an interview. [s. 53. (1) 1.]

2. The licensee failed to ensure that the home's written strategies to care developed to meet the needs of the residents with responsive behaviours include techniques and interventions to prevent, minimize or respond to the responsive behaviours.
DNPC confirmed during an interview. [s. 53. (1) 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 the home's
- written approaches to care developed to meet the needs of the residents with responsive behaviours include identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other
- written strategies to care developed to meet the needs of the residents with responsive behaviours include techniques and interventions to prevent, minimize or respond to the responsive behaviours, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 126. Every licensee of a long-term care home shall ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. O. Reg. 79/10, s. 126.

Findings/Faits saillants :

1. The licensee failed to ensure that drugs remain in the original labeled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident.

On April 22/2013, on Box Grove unit, at morning medication administration pass, the inspector observed prepoured crushed medications without labels for 3 identified residents: resident #3, #4, #5. RPN confirmed that medication was removed from the original labeled package and crushed before the start of the morning medication pass. [s. 126.]

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 remain in the original labeled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee failed to ensure that there was monitoring and documentation of the residents' response and the effectiveness of the drugs for residents #2, #3 and #6.

On May 2/2012 at 2330, resident #3 received an identified pain medication.
On 4 identified occasions, March 3/2013 at 2 different times, March 5/2013 and April 14/2013, resident #3 received Acetaminophen for pain. [s. 134. (a)]

2. On March 3/2013 at 756, and at 1555, on March 5/2013 at 1623 and on March 14/2013 at 1017, resident #3 received Acetaminophen for pain. [s. 134. (a)]

3. On April 13/2013 at 2022 resident #6 received Acetaminophen for pain.

There was no monitoring and documentation of the residents' responses and the effectiveness of the drugs administered. [s. 134. (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 when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
4. Pain management, including pain recognition of specific and non-specific signs of pain. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee failed to provide training in pain management, including pain recognition of specific and non-specific sign of pain, to all staff who provide direct care to residents.

Through interviews with front line staff and the Education Coordinator it was determined that just 48.9% (70/143) of all direct care staff received the required training in 2012. [s. 221. (1) 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 training in pain management, including pain recognition of specific and non-specific sign of pain, is provided to all staff who provide direct care to residents annually, as required, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. On April 22/2013 at 730 and at 1144, on Box Grove, during the medication administration passes, the RPN was observed not to practice hand hygiene between residents who were administered oral medications, insulin injections and glucometer testings. [s. 229. (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 all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #1's plan of care was based on an interdisciplinary assessment of the mood and behaviour patterns, wandering, and variations in resident functioning at different times of the day.

Resident #1's plan of care did not identify the resident as a wanderer or variations in resident functioning at different times of the day. On February 27 and 28/2012 the resident was verbally and physically aggressive and wandered in the hallway and other resident rooms as confirmed by the progress notes and staff interviews. [s. 26. (3) 5.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (1) The pain management program must, at a minimum, provide for the following:
1. Communication and assessment methods for residents who are unable to communicate their pain or who are cognitively impaired. O. Reg. 79/10, s. 52 (1).
2. Strategies to manage pain, including non-pharmacologic interventions, equipment, supplies, devices and assistive aids. O. Reg. 79/10, s. 52 (1).
3. Comfort care measures. O. Reg. 79/10, s. 52 (1).
4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies. O. Reg. 79/10, s. 52 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's Pain management program provides for strategies to manage pain, including non-pharmacologic interventions, equipment, supplies, devices and assistive aids.
DNPC confirmed the information during an interview. [s. 52. (1) 2.]

2. The licensee failed to ensure that the home's Pain management program provide for comfort care measures.
DNPC confirmed the information during an interview. [s. 52. (1) 3.]

WN #10: 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 drugs are administered to residents in accordance with the directions for use specified by the prescriber.

On March 7/2013, the home's physician ordered for resident #3 to receive an identified medication, 2 times per day at 8:00 and 14:00. On April 18/2013 the resident did not receive the required dose at 1400 as directed by the prescriber.
It was confirmed by the RPN on duty that the resident received the medication at approximately 1600. [s. 131. (2)]

2. During a medication review for resident #3 it was noted a physician order from February 21/2013 which indicated to change the previous order for Tylenol from 325mg, 1-2 tablets, to 1000mg, four times per day as needed for pain/fever. The new order was transcribed to the e-MAR in addition to the old order and the medication was administered in parallel or using both orders at the same time until the home was informed by the inspector on April 22/2013 about the error. Resident's pain was not well controlled when received a lower dose of Tylenol.
Interview with the RPN on duty and DNPC confirmed this was an error and the resident did not receive the medication in accordance with the prescriber's directions. A medication incident will be completed. [s. 131. (2)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 233. Retention of resident records

Specifically failed to comply with the following:

s. 233. (2) A record kept under subsection (1) must be kept at the home for at least the first year after the resident is discharged from the home. O. Reg. 79/10, s. 233 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a document from a record of a former resident of the home was kept in the home at least for the first year after the resident was discharged from the home.

On February 27/2012, a Dementia Observation Sheet was implemented for resident #1 as per nursing progress notes. The licensee was unable to provide the document at the time of inspection as per DNPC statement. [s. 233. (2)]

Issued on this 1st day of May, 2013

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