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 # / No de registre	Type of Inspection / Genre d'inspection
Oct 20, 2017	2017_552531_0025	021270-17	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
5015 Spectrum Way Suite 600 MISSISSAUGA ON 000 000

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

HALLOWELL HOUSE
13628 LOYALIST PARKWAY PICTON ON K0K 2T0

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

SUSAN DONNAN (531), CATHI KERR (641)

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): September 5, 6, 7, 8, and 11, 2017

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Associate Director of Care (ADOC), a Registered Dietician (RD), the Recreational Manager (RM), the Environmental Services Manager (ESM), the RAI Coordinator, Registered Practical Nurses (RPN), Personal Support Workers (PSW), a Physiotheray Assistant (PA), the President of the Resident Council (RC) and Family Council (FC), residents' Substitute Decision Makers (SDM) and residents.
The inspectors also conducted a walking tour of the home areas, reviewed residents' health care records, observed residents' care and services, reviewed medication administration records, reviewed Resident and Family Council minutes, observed infection control practices and reviewed relevant medication policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Dignity, Choice and Privacy
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Residents' Council

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 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 LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. 1. The licensee has failed to comply with the LTCH Act 2007, c. 8, s. 15 (2) whereby the home, furnishings and equipment are not maintained in a safe condition and good state of repair.

The following observations were made during the course of the inspection:

Willow home area:
- In the main hall, approx. 90 cm x 120 cm area of flooring tile that the tiles had heaved, and the edges are cracked and broken, edges filled with a dark brown debris.

Sunset Court home area:
North hall :
- Approx. 4 ceiling tiles 120 cm x 120 cm area of dark brown water stains with gray coloured circumference resembling a wet surface
- Approx. 60 cm circular area encompassing ceiling tile above the nurses station, dark brown water stain with gray centre and circumference resembling a wet surface
- Approx. 30 cm area of ceiling tile dark brown water stain with gray shade circumference resembling a wet surface
- Rm 128 three dark brown water stains above bed two measuring approx. 45 cm, 10 cm and 8 cm, with gray coloured centre resembling wet area
- the shared resident washroom in the vicinity the sink outlet drain was corroded
- approx. 240 cm x 120 cm the south wall of the resident common washroom located in the north hall, south of the lounge, multiple areas of aged; discoloured; unfinished drywall patches
- Approx. 12.5 cm x 12 cm of the corner floor trim was detached from the wall, with sharp edges of the lower left doorway leading to outside sitting area.
Sunset lounge:
- Large wooden activity table multiple stained; worn wood top, chipped splintered wooden legs, and sharp broken splintered area back of two of the chairs
- 180 cm x 15 cm ceiling mounted frosted covered light fixture was non-functioning
- The ceiling mounted frosted covered light fixtures in the centre of the ceiling aged, yellow with dead insects.
- Approx. 15 cm x 12 cm area of the large brown leather chair the leather on the back rest was peeled exposing cream base cloth
- -there was approx. 30 cm x 1 cm area along the wall next to the chair, the wallpaper was torn, drywall gouged

West hall:
- Rm 128 three dark brown water stains above bed two measuring approx. 45 cm, 10 cm and 8 cm, with gray coloured centre resembling wet area
- the shared resident washroom in the vicinity the sink outlet drain was corroded
-approx. 60 cm x 15 cm area of ceiling tile above the east exit sign, dark brown stain, with gray coloured centre and circumference resembling a wet surface

-sunset dining area:
-approx. 20 cm dark brown water stain in the centre of the ceiling; in the vicinity of table 1, next to the main lounge.

Main lounge:
-two large red leather type lounge chairs with approx. 20 cm worn, torn areas on on the arms and back of the chairs, exposing cream base material.
-matching sofa approx. 12-15 cm area lower right corner leather worn and torn.
-approx. 300 cm x 25 cm electric baseboard heater, the heat shield was scarred and the paint chipped

Main dining room:
-two 300cm x 25 cm electric baseboard heaters, the heat shields semi-detached and ill fitting, with 3-5 cm dented areas
-the ceiling light approx. 120x 150 cm fixture in this area was non-functioning.
-north east section small dining room, there was approx. 60 cm water stained ceiling tile with gray circumference resembling a wet surface.

Restorative Care room, there was a 75cm bulging water stained ceiling tile, grey centre and circumference resembling a wet surface.

Maple Oak home area hall:
The ceiling tile across from room 135, 134 and 137 black soot like substance encompassing the HVAC vents as well as dark water stains on the ceiling tiles in the same surface area
Rm 132 the lower left corner of the door kick plate approx. 25 cm detached, splintered with sharp edges.

-the flooring tiles in hallway between Oak and Maple units – in the vicinity of the ChitChat room – 30cm square patch with broken/ indented areas;

-in the vicinity of room 137 – open area 5 cm x 7cm;
-6 chips in floor by sitting area in front of room 134;
-flooring tiles broken indented area in front of room 132.

Rm 138 the sink outlet drain was corroded and rusted.
RM 140 the sink outlet drain was corroded, enamel worn/rust
Rm 136 the sink outlet drain was corroded, enamel worn

Main entrance vestibule, an area approx. 360 cm x 360 the flooring tile was removed exposing the concrete .

On September 7, 2017 during an interview and tour of the homes identified areas of disrepair with the Support Services Manager he acknowledged the disrepair and indicated that the maintenance would be prioritized and addressed. [s. 15. (2) (c)]

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 the home, furnishings and equipment are maintained in a safe condition and good state of repair, to be implemented voluntarily.

WN #2: 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. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

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 has failed to ensure that no drug was administered to resident #026 unless the drug had been prescribed for the resident.

Inspector #641 reviewed the licensee's medication incident log for a three month period.

An incident occurred on specified date related to resident #026 receiving a medication that was not prescribed for the resident.

The DOC indicated that a medication incident occurred on the specified date where resident #026 was administered a medication that was not prescribed for the resident .

The DOC indicated that RPN #109 had copied an order for resident #027 onto the digital physician's order sheet that had been labelled at the top with resident #026's name, but then crossed out with a non-digital pen and resident #027's name added. Because resident #027's name had not been put on the sheet with the proper pen, when the order was transmitted to the pharmacy, it appeared to be for resident #026 instead of for resident #027 as it was intended.
The DOC indicated that the proper procedure for labelling the digital order sheets had not been followed when the names had been changed. The DOC indicated that resident #026 received this medication that was not prescribed for the resident [s. 131. (1)]

2. The licensee has failed to ensure that resident #027 was administered medications in accordance with the directions for use specified by the prescriber.

On a specified date resident #027 was not administrated a medication in accordance with the directions as specified by the prescriber.

The DOC indicated that RPN #109 had copied an order to alternate a medication dose for resident #027 onto the digital physician's order sheet that had been labelled at the top with resident #026's name, but then crossed out with a non-digital pen and resident #027's name added. Because resident #027's name had not been put on the sheet with the proper pen, when the order was transmitted to the pharmacy, it appeared to be for resident #026 instead of for resident #027 as it was intended. The DOC indicated that the proper procedure for labelling the digital order sheets had not been followed when the names had been changed.

The ADOC indicated that the order for resident #027 indicated the resident was to recieve an alternate dose on the specified date, but because the order hadn't been change on the resident's MAR the resident was administered the medication according to the previous order. The ADOC indicated that this was a medication incident that should have been followed up on. [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 no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident was documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and reported to the resident's SDM and the resident's attending physician.

On a specified date resident #027 was not administered a medication as prescribed for the resident on that day.

The DOC indicated that RPN #109 had copied an order for resident #027 onto the digital physician's order sheet that had been labelled at the top with resident #026's name, but then crossed out with a non-digital pen and resident #027's name added. Because resident #027's name had not been put on the sheet with the proper pen, when the order was transmitted to the pharmacy, it appeared to be for resident #026 instead of for resident #027 as it was intended. The DOC indicated that the proper procedure for labelling the digital order sheets had not been followed when the names had been changed, which contributed to the medication error.

Resident #027's MAR for the specified date indicated that the resident had not received the medication as the new order had indicated.

The ADOC reviewed the MAR for resident #026 and for resident #027 for the specified date and the physicians order sheet for resident #027. The ADOC indicated that the order for resident #027 indicated the order hadn't been processed properly, the resident was administered the medication according to the previous order. The ADOC indicated that this was a medication incident that should have been followed up on but no incident report had been completed and no one had been notified of this incident.
The licensee failed to ensure that the medication incident on the specified date related to resident #027 was documented including a record of action taken to assess the resident and reported to the resident's SDM and his physician as required. [s. 135. (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 every medication incident involving a resident and every adverse effect is documented together with a record of the immediate actions taken, reported to the resident, the resident's substitute decision maker, and the physician, to be implemented voluntarily.

Issued on this 20th day of October, 2017

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

Original report signed by the inspector.