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 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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Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 31, 2018	2018_723606_0023	002400-17, 005149-17, 010538-17, 011042-17, 003231-18, 010917-18	Complaint

Licensee/Titulaire de permis

Villa Forum
175 Forum Drive MISSISSAUGA ON L4Z 4E5

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

Villa Forum
175 Forum Drive MISSISSAUGA ON L4Z 4E5

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

JANET GROUX (606)

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): November 14, 15, 19, 20, 21, 22, and 23, 2018.

The following complaint intakes were inspected:
Log # 009527-17 regarding medication management system
Log #010917-18 regarding breakdown of elevators
Log #003231-18 regarding admission eligibility
Log #002400-17 regarding resident care
Log #010538-17 regarding missing resident personal items
Log #005149-17 regarding resident bill of rights
Log # 022487-17 regarding notification of resident care.

During the course of the inspection, the inspector(s) spoke with the Administrator, Co-Director of Care (DOC), Assistant Director of Care, Social Worker (SW), Environmental Service Manager (ESM), Maintenance Personnel, Registered Dietitian (RD), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Care Providers (PCP), thyssenkrupp mechanic, Urgent Care Coordinator, Toronto Central Local Health Integration Network (TCLHIN), Placement Coordinator (PC), Staff Relief Nursing Agency, Pharmacist, Housekeeping Staff, Volunteer Coordinator, Substitute Decision Makers (SDM), and residents.

During the course of this inspection, the inspectors observed resident care, observed staff to resident interaction, observed a medication administration, reviewed resident health records, meeting minutes, schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Accommodation Services - Maintenance
Admission and Discharge
Hospitalization and Change in Condition
Medication
Nutrition and Hydration
Personal Support Services
Safe and Secure Home

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's substitute decision-maker was given an opportunity to participate fully in the implementation of the resident's plan of care.

A complaint received by the Ministry of Health and Long Term Care (MOHLTC) from resident #001's substitute decision maker (SDM) alleged that the home did not notify them of resident #001's change in condition.

Resident #001's SDM revealed that they were told by the home that the resident was assessed to have a change in condition and was placed on bed rest and monitored. The SDM said that had the home notified them of the resident's change in condition, they may have recommended the resident be transferred to the hospital for further assessment. The SDM also stated that they did not have the opportunity because the home did not notify them about the resident's condition.

Resident #001's care level stated that the resident would be transferred to hospital for investigative testing and, if indicated, admission to hospital for treatments not available in the home. Staff were obliged to speak with the SDM for care for further directions related to care actions.

Registered Staff #106 stated that they had assessed resident #001 to have a change in condtion and that the resident was put on bed rest and was monitored. The registered staff stated that they did not feel this was anything new to the resident as they had often felt unwell and would be put to bed rest until they felt better. They stated that they did not notify the SDM of the resident's condition.

Registered Staff #108 stated they were not aware resident #001 was not feeling well and acknowledged that when a resident has a change in their condition, the SDM or family should be called if the resident has a expressed wishes to be transferred to the hospital.

Co-Director of Care (DOC) #101 acknowledged that when there is a significant change in a resident's condition the SDM or family should be notified based on the resident's expressed wishes.

The licensee has failed to ensure that resident #001's substitute decision-maker was given an opportunity to participate fully in the implementation of the resident's plan of care. [s. 6. (5)]

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 a resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the implementation of the resident's plan of care, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 10. (1) Every licensee of a long-term care home shall ensure that any elevators in the home are equipped to restrict resident access to areas that are not to be accessed by residents. O. Reg. 79/10, s. 10 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any elevators in the home are equipped to restrict resident access to areas that are not to be accessed by residents.

A complaint submitted to the MOHLTC reported the home's elevators frequently broke down.

An observation by the inspector noted that none of the home's three elevators were equipped to restrict residents from accessing the basement, a non residential area.

Resident #009 stated that they use the elevator often and have access to the basement.

Staff #126, #127, and #128, stated that the elevators were not equipped to restrict residents from going down to the basement if they wanted to but were told not to go.

The Environmental Services Manager (ESM), the Volunteer Coordinator, and the Administrator acknowledged that the basement was accessible to residents via elevators.

The licensee has failed to ensure that the elevators in the home are equipped to restrict resident access to areas that are not to be accessed by residents. [s. 10. (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 any elevators in the home are equipped to restrict resident access to areas that are not to be accessed by residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 120. Responsibilities of pharmacy service provider
Every licensee of a long-term care home shall ensure that the pharmacy service provider participates in the following activities:
1. For each resident of the home, the development of medication assessments, medication administration records and records for medication reassessment, and the maintenance of medication profiles.
2. Evaluation of therapeutic outcomes of drugs for residents.
3. Risk management and quality improvement activities, including review of medication incidents, adverse drug reactions and drug utilization.
4. Developing audit protocols for the pharmacy service provider to evaluate the medication management system.
5. Educational support to the staff of the home in relation to drugs.
6. Drug destruction and disposal under clause 136 (3) (a) if required by the licensee's policy. O. Reg. 79/10, s. 120.

Findings/Faits saillants :

1. The licensee failed to ensure that the pharmacy service provider participated in the development of medication assessments, medication administration records and records for medication reassessment, and the maintenance of medication profiles.

A complaint received by the MOHLTC, regarding pharmacy not providing medication to resident #002 was inspected.

Resident's #002's Medication Administration Record (MAR) for an identified month was not revised to reflect the new start date when the identified medication was received past the physician's order date.

Pharmacist #122 said that updates to the MAR that are required during business hours were completed by the pharmacy and that they should have updated the MAR to reflect the new start date of the medication.

Co-DOC #101 confirmed that updates to the MAR should have been completed by the pharmacy.

The licensee failed to ensure that the (MAR) was updated by the pharmacy when they delivered the medication after the original start date. [s. 120. 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 pharmacy service provider participates in the following activities: 1. For each resident of the home, the development of medication assessments, medication administration records and records for medication reassessment, and the maintenance of medication profiles, 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 has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A complaint received by the MOHLTC regarding the pharmacy service provider not providing newly prescribed medication to resident #002.

Registered staff #134, #135 and #136, documented in the progress notes for resident #002, that the identified medication was not in stock or available until a few days after the original start date as ordered by the physician.

Registered Staff #123, #137 and #138 had signed on the Electronic Medication Administration Record (eMAR) for resident #002 that they administered the medication on identified dates.

The Registered staff failed to ensure that the medication was administered to resident #002 in accordance with the directions; when they signed that they administered the medication to resident #002 on identified dates.

Resident #007's physician orders written on an identified date indicated instructions to add a medication in the morning and afternoon.

Observation of the medication cart during the inspection found the morning medication was still in resident #007's medication bin. Inspection of resident #007's medication bin at a later time and noted the medication was no longer there.

The eMar administration record for an identified date indicated that the Registered staff signed that they administered the morning medication to resident #007 at an earlier time however the medication was still in resident #007's medication bin after that time.

CO-DOC #101 confirmed that a Registered staff signature on a MAR indicates the

medication was administered to the resident. Co-DOC#101 reviewed the MAR for resident #002 for an identified month and confirmed the Registered staff did not follow the home's Medication Administration policy when they signed that they provided the medication to resident #002 on identified dates and thus failed to administer the medication in accordance with the directions.

Registered staff #123 on an identified date stated if they sign the MAR, it means they administered the medication. They could not account for why they signed that they administered the medication to resident #002 on an identified date and time when the medication was not delivered a few days after they signed the eMAR.

Registered staff #121 on an identified date stated they signed at an identified time that they administered the morning medication when it was not given. They signed for the medication but were unable to administer it to resident #007 because they were called to assist with an urgent issue. Registered staff #121 reported they remembered the missed dose after and administered the medication at that time.

The licensee has failed to ensure that a drug was administered to resident #002 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.

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Issued on this 2nd day of January, 2019

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

Original report signed by the inspector.