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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

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
Jun 11, 2018	2018_722630_0010	008864-18	Resident Quality Inspection

Licensee/Titulaire de permis

Vision '74 Inc.
229 Wellington Street SARNIA ON N7T 1G9

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

Vision Nursing Home
229 Wellington Street SARNIA ON N7T 1G9

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

AMIE GIBBS-WARD (630), ALICIA MARLATT (590), AMANDA COULTER (694), DEBRA CHURCHER (670), ZINNIA SHARMA (696)

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): May 28, 29, 30 and 31, June 1, 4, 5, 6, 7 and 8, 2018.

The following Critical Incident intakes were completed within this inspection:
Critical Incident Log #004213-18 / CI 2659-000001-18 related to falls prevention;
Critical Incident Log #012193-18 / CI 2659-000003-18 related to prevention of abuse and neglect;
Critical Incident Log #012196-18 / CI 2659-000004-18 related to prevention of abuse and neglect.

The following Complaint intake was completed within this inspection:
Complaint Log #003322-18 / IL-55523-LO related to responsive behaviours.

Nancy Sinclair (Inspector #537) was also present during this inspection.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), the Administrator, the Director of Care (DOC), the Nurse Manager, the Registered Dietitian (RD), Resident Assessment Instrument (RAI) Coordinators, Registered Nurses (RN), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), a Housekeeper, a Cook, family members and over forty residents.

The inspectors also observed resident rooms and common areas, observed medication storage areas, observed medication administration, observed meal and snack service, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, reviewed policies and procedures of the home, reviewed the written staffing plan of the home, reviewed various meeting minutes and also reviewed written records of program evaluations.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **4 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

During a stage 1 interview and a follow-up interview for the Resident Quality Inspection (RQI) an identified resident told an inspector that they had concerns about a specific area of care.

During an interview with identified staff members they said that they thought this resident required a specific type of care and that they would look in the plan of care to find out about a resident's care needs.

During an interview with another identified staff member they said that this resident's care needs had fluctuated since their admission to the home and that this resident was aware of what care they required from staff. This staff member said there were specific interventions in place for this resident. This staff member said that the plan of care did not reflect this resident's current care needs related to this specific concern. This staff member and an inspector reviewed the chart for for this identified resident and the staff member acknowledged that there had been no assessment of this specific issue since the time of admission.

The clinical record for this identified resident showed there had been changes in their care needs since admission related to this issue. The plan of care showed that the resident had a specific status related to this care. This plan of care did not provide direction regarding the concerns that had been expressed by the resident related to this type of care. There was no documented assessment related to this care area in the resident's chart apart from a specific assessment tool completed at admission.

During an interview the Director of Care (DOC) said that usually a resident's care needs would be assessed at admission using a specific assessment tool. The DOC and an inspector reviewed the assessments and the plan of care for this resident and the DOC acknowledged that this resident had changes in their care needs after admission. The DOC said that this resident had been assessed by the interdisciplinary team but acknowledged there had not been a reassessment of this specific issue after admission. The DOC said it was the expectation in the home that this resident's plan of care should have been based on an assessment and the resident's needs and preferences. (630) [s. 6. (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 care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident, to be implemented voluntarily.

WN #2: 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 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, was in compliance with and was implemented in accordance with all applicable requirements under the Act.

A) Ontario Regulation 79/10 s.129 (1) (b) states "Every licensee of a long-term care home shall ensure that (b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart."

The home's policy titled "Safe Storage of Medications", policy number 4.8, dated July 2014, indicated in part that "medications requiring refrigeration are to be stored in a refrigerator in the medication room or in a locked box in a refrigerator. Controlled

substances are stored in a stationary narcotic box in a medication cart or in a stationary narcotic cupboard or box in the medication room."

On a specific date inspectors observed that there was a glass vial stored in a locked metal box in the refrigerator in the medication room that an identified registered nursing staff member removed and counted during the shift change narcotic and controlled substance record count. This staff member stated that the vial was Ativan, and was in the locked box in the refrigerator and then behind the locked medication room door, providing a double lock for the storage of the vial. The Ativan was in a locked box inside the fridge, and the fridge did not have a lock on it and the fridge was not secured to be stationary. This staff member explained there were no residents specifically prescribed the injectable Ativan, it was a medication for the palliative program and was stored in this medication room fridge. This staff member stated that this was the only home care area that this medication was stored.

During an interview the Director of Care (DOC) acknowledged to the inspectors that the Ativan was stored in a lock box which was provided by the home's pharmacy provider and instructions that were provided to them as per the policy. The DOC further added that they understood that the Ativan should have been double-locked in the medication room within a stationary lock box and refrigerator. The DOC stated the home followed the direction of the pharmacist and polices from the pharmacy, and acknowledged the policy did not meet the requirements of the legislation.

The licensee has failed to ensure that their policy on Safe Storage of Medications was in compliance with all applicable requirements under the Long-Term Care Home Act (696) (694).

B) Ontario Regulation 79/10 s. 48 (1) states "Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable."

Ontario Regulation 79/10 s. 51 (2) (a) and (b) states "Every licensee of a long-term care home shall ensure that (a) each resident who is incontinent receives an assessment that includes the identification of causal factors, patterns, types of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of

incontinence; (b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented."

Specifically the home's policies for their required continence care and bowel management program did not include protocols or procedures for assessing residents with changes in bowel continence using a clinically appropriate assessment instrument after the initial admission assessment was completed. The policies also did not include protocols or procedures for updating the residents' plans of care based on reassessments of bowel continence.

During an interview with an identified staff member they reported that an identified resident had experienced a change in their bowel continence status and that there had not been an assessment completed. This staff member said that the plan of care for this identified resident did not reflect their current care needs related to bowel continence.

The clinical record for this resident showed changes in their bowel continence since admission based on the Resident Assessment Instrument Minimum Data Set (RAI MDS) assessments. The plan of care for this resident related to bowel continence had not been revised since it had been initiated on admission. There was no documented bowel continence assessment in apart from the assessment tool completed at admission.

During an interview the Director of Care (DOC) said that usually a resident's bowel continence would be assessed at admission using the "Bladder and Bowel Tracking Record." The DOC said that if a resident's bowel continence changed after admission then staff would assess based on nursing knowledge, make referrals to interdisciplinary team members and document these assessments in a progress note. The DOC and an inspector reviewed the RAI MDS coding and the plan of care for an identified resident and the DOC acknowledged that resident had changes in their bowel continence after admission and there had not been a reassessment of their bowel continence after admission. The DOC said that they had reviewed all the home's policies related to their "Bowel and Bladder Management" program and did not find a policy regarding assessments for bowel continence apart from the direction for the admission assessment using the "Bladder and Bowel Tracking" record. The DOC said that they were in the process of revising the policies and procedures in the home for assessing bladder continence but these changes did not include bowel continence assessment.

Based on these interviews and record review the licensee has failed to ensure that their

policies for the required continence care and bowel management program included the required protocols or procedures. Specifically the home's program did not include protocols or procedures for assessing residents with changes in bowel continence using a clinically appropriate assessment instrument after the initial admission assessment was completed or for updating the residents' plans of care based on reassessments of bowel continence. (630) [s. 8. (1) (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 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 ensures that the plan, policy, protocol, procedure, strategy or system, is in compliance with and is implemented in accordance with applicable requirements under the Act, to be implemented voluntarily.

WN #3: 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.

During a review of medication incidents from January 1 to March 31, 2018, the following was identified:

A) A review of a medication incident indicated that on a specific date an identified resident was given the wrong dose of an as needed (PRN) medication.

B) A review of a another medication incident indicated that on a specific date an identified resident did not receive their scheduled medication. A review of the electronic Medication Administration Record (eMAR) showed that this resident did not receive this medication as prescribed by the physician.

C) A review of another medication incident indicated that on a specific date an identified resident did not receive their scheduled medication. A review of the eMAR showed that this resident did not receive this medication as prescribed by the physician.

D) A review of a medication incident report completed for another identified resident showed they received an incorrect dose of a medication on a specific date.

E) A review of a medication incident report completed for another identified resident showed they received an incorrect dose of a medication on a specific date.

During an interview the Director of Care (DOC) recalled each of the incidents and confirmed to the inspectors that the five incidents occurred when the residents received prescribed medication, but all received incorrect doses. The DOC stated that drugs should be been administered to residents in accordance with the directions for use specified by the prescriber.

The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber. (694) (696) [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.

WN #4: 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 and every adverse drug reaction was reported to the resident and the resident's Substitute Decision Maker (SDM).

A review of a medication incident indicated that on a specific date an identified resident did not receive their scheduled medication. The physician's orders showed that resident was to receive a specific dose of a medication at a specific time. A review of the resident's electronic Mediation Administration Record (eMAR) showed that this resident did not receive this medication as prescribed by the physician.

There was no documentation on reporting of the medication incident to the resident or their SDM in the resident's progress notes, the home's "Medication Incident Report & Analysis Form" or the risk management document in Point Click Care.

During an interview the Nurse Manager stated that they themselves did not inform the resident's SDM of the incident and had no documentation to support if they were informed.

During an interview and inspector spoke with the resident's SDM and they stated that they were not informed of the medication incident.

In an interview with the Director of Care (DOC) they acknowledged that the resident or their SDM had to be notified after medication incidents had occurred.

The home failed to ensure that the medication incident involving this resident had been reported to the resident and the resident's SDM (696) [s. 135. (1)].

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

Issued on this 12th day of June, 2018

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

Original report signed by the inspector.