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

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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
Sep 11, 2017	2017_607523_0014	010238-16, 013627-16, 015863-16, 016591-16, 016629-16, 017844-16, 026372-16, 031098-16, 031105-16, 031555-16, 032062-16, 033723-16, 035411-16, 006162-17, 006393-17, 011216-17	Critical Incident System

Licensee/Titulaire de permis

THE WOMEN'S CHRISTIAN ASSOCIATION OF LONDON
2022 Kains Road LONDON ON N6A 0A8

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

McCORMICK HOME
2022 Kains Road LONDON ON N6K 0A8

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

ALI NASSER (523), APRIL TOLENTINO (218), TRACY RICHARDSON (680)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): June 19, 20, 21, 22 and 23, 2017.

The following Critical Incident inspections were conducted during this inspection:
Related to prevention of abuse and neglect:
Critical Incident Log # 015863-16 / CI 2965-000010-16
Critical Incident Log # 010238-16 / CI 2965-000007-16
Critical Incident Log # 031105-16 / CI 2965-000028-16

Critical Incidents related to missing Medications:
Critical Incident Log # 006162-17 / CI 2965-000004-17
Critical Incident Log # 035411-16 / CI 2965-000034-16
Critical Incident Log # 031555-16 / CI 2965-000029-16
Critical Incident Log # 011216-17/ CI 2965-000010-17

Critical Incidents related to Transferring and Positioning:
Critical Incident Log # 032062-16 / CI 2965-000031-16
Critical Incident Log # 026372-16 / CI 2965-000022-16
Critical Incident Log # 031098-16 / CI 2965-000027-16

Critical Incidents related to Falls Prevention:
Critical Incident Log # 016591-16 / CI 2965-000012-16
Critical Incident Log # 006393-17 / CI 2965-000006-17
Critical Incident Log # 033723-16 / CI 2965-000032-16
Critical Incident Log # 016629-16 / CI 2965-000015-16
Critical Incident Log # 013627-16 / CI 2965-000002-16
Critical Incident Log # 017844-16 / CI 2965-000004-16

This inspection was completed concurrently with Complaint inspection # 2017_607523_0015
Complaint Log #016817-16 and Log #023583-16 related to care provided to the resident.

During the course of the inspection, the inspector(s) spoke with the Long Term Care Administrator, the Director of Care, 12 Registered staff members, 10 Personal Support Workers (PSWs), two Housekeeping staff members, a physician, a Nurse Practitioner, a pharmacist, two family members and 14 residents.
The inspectors also observed resident rooms and common areas, observed medication storage areas, observed medication administration, 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 and reviewed various meeting minutes.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **5 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's right not to be neglected by the licensee or staff was fully respected and promoted.

"Neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents. O. Reg. 79/10, s. 5

A) A review of a Critical Incident System (CIS) report showed that a resident had a fall on a certain date that resulted in a possible injury. The resident then had a second fall.
A clinical record review and staff interviews showed that the resident had possible injuries after each of those falls that resulted in a change in condition.

In an interview, a Nurse Practitioner acknowledged that the resident had a change in condition after the falls, and that they expected to have been notified of this change.
In an interview, a Physician acknowledged that the resident had a change in condition that required them to be notified. The Physician stated that they did not remember being notified of the resident's change in condition.
The Director of Care (DOC) stated that it would have been an expectation that the doctor be notified of any changes in the resident's condition. The DOC stated that the expectation would be to notify the physician of those changes for further direction.
The Administrator stated that with a change in condition the expectation was that a doctor be notified of those changes.

B) During the course of the inspection it was reported by the Director of Care (DOC) that a resident had a medical emergency that required immediate interventions. A few days later the resident passed away.
Clinical record review and staff interview showed that the physician was not notified of the medical emergency.
During an interview with the physician, the doctor could not recall if they had been notified of the resident's medical emergency.
During an interview, the NP said that they were not aware of the resident's medical emergency.
Director of Care (DOC) acknowledged that the resident had a medical emergency. The DOC stated that it would have been an expectation that the doctor be notified.

During the inspection this non-compliance was found to have the severity level of a minimal harm/risk or potential for actual harm/risk to residents. The scope of the non-compliance was isolated and this area of non-compliance was not previously issued. [s. 3. (1) 3.]

2. The licensee has failed to ensure that the resident's right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act was fully respected and promoted.

Observations with the Administrator showed that specific personal health information (PHI) was not being kept confidential.
The Administrator said the expectation was for the home to protect resident's PHI and keep it confidential.

During the inspection this non-compliance was found to have the severity level of a

minimal harm/risk or potential for actual harm/risk to residents. The scope of the non-compliance was isolated and this area of non-compliance was not previously issued. [s. 3. (1) 11. iv.]

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 resident's right not to be neglected by the licensee or staff and the resident's right to have his or her personal health information kept confidential were fully respected and promote, to be implemented voluntarily.

WN #2: 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months, when the resident's care needs change or care set out in the plan is no longer necessary.

A clinical record review for a specific resident's care plan showed a focus, goal and interventions related to a specific medical condition.
A review of the home's policy "Electronic Care Plan," last reviewed December 2014, stated "each resident's plan of care will be reviewed quarterly and whenever there is a change in the resident's health status, needs and abilities, an evaluation of the care given will be done."
A clinical record review and staff interviews showed the specific focus, goal and interventions were no longer necessary.
In an interview the DOC stated that the expectation was for the care plan to be revised with the quarterly updates, or any changes in condition. DOC acknowledged that the care plan had information regarding the resident that was no longer pertinent to their care.
The Administrator said that the expectation was that the care plan would be updated with changes.
The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any time that the resident's care needs change or care set out in the plan is no longer necessary.

During the inspection this non-compliance was found to have the severity level of minimal harm/risk or potential for actual harm/risk to residents. The scope of the non-compliance was isolated. This area of non-compliance was previously issued as a: Written Notification and a Voluntary Plan of Correction on October 28, 2015, under Resident Quality Inspection #2015_216144_0054. [s. 6. (10) (b)]

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 resident was reassessed and the plan of care reviewed and revised at least every six months, when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #3: 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 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 was in compliance with and implemented in accordance with all applicable requirements under the Act.

Long-Term Care Homes O. Reg. 79/10, s. 136 (3) stated that the drugs must be destroyed by a team acting together and composed of,
(a) in the case of a controlled substance, subject to any applicable requirements under the Controlled Drugs and Substances Act (Canada) or the Food and Drugs Act (Canada),
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and

(ii) a physician or a pharmacist; and
(b) in every other case,
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) one other staff member appointed by the Director of Nursing and Personal Care.

A review of medical Pharmacies policy #5-4 Drug Destruction and Disposal, dated February 2017, showed that staff would securely store surplus medication in the designated Stericycle container in a locked area within the home only accessible by nursing staff. The surplus medication container kept in the home until the licensed medical waste disposal company picks up the containers.
The DOC and an RN said that the home staff do not participate in the destruction of non-controlled substances.

During the inspection this non-compliance was found to have the severity level of minimal harm/risk or potential for actual harm/risk to residents. The scope of the non-compliance was isolated. This area of non-compliance was not previously issued. [s. 8. (1) (a)]

2. The licensee has failed 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 is required to ensure that the plan, policy, protocol, procedure, strategy or system was complied with.

A) Long-Term Care Homes O. Reg. 79/10, r. 48. (1) 4. Stated that every licensee of a long-term care home shall ensure that a pain management program to identify pain in residents and manage pain was developed and implemented in the home.

A review of the homes policy: NPC-1600-02 named Pain Management and Assessment Tools, last reviewed on December, 2014, showed that "pain is assessed/reassessed quarterly using the Quarterly Pain Assessment Tool (Appendix D) for all residents in accordance with RAI-MDS Schedule".
A clinical record review and staff interviews showed pain assessment for a specific resident was not completed quarterly.
The DOC acknowledged that the resident did not receive a certain quarterly pain reassessment
The DOC said that their expectations would be for the home's policy to be complied with and the pain reassessments be completed quarterly.

B) Long-Term Care Homes O. Reg. 79/10, s. 114 (2) stated "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, and destruction and disposal of all drugs used in the home".

i) A review of Medical Pharmacies policy #6-6, Shift Change Monitored Drug Count, Date February 2017, showed that:
Two staff (leaving and arriving), together:
a. Count the actual quantity of medication remaining.
b. Record the date, time, quantity of medication and sign in the appropriate spaces on the 'Shift Change Monitored Count' form.
c. Confirm actual quantity is the same as the amount recorded on the 'Individual Monitored Medication Record' for prn, liquid, patches or injectable.

Observations and staff interviews showed that specific controlled medication shift counts were not completed as per the home's policy.
A review of a CIS report showed a missing narcotic was identified on a certain date, and showed that a specific RN had completed the count at the end of their shift.
The RN said in an interview that at the beginning of their shift they did not complete the narcotic count as the arriving nurse.
In an interview, a Pharmacist said that the expectation was for the count to be completed at the shift change by two nurses, leaving and arriving nurse. The count would be completed and confirmed as per policy.

C) A review of Medical Pharmacies policy #9-1, Medication Incident Reporting, dated February 2017, showed that the Medical Pharmacies 'Medication Incident Report was to be completed online when a medication incident or adverse drug reaction has occurred including near miss situations.

A review of a CIS report showed that on a specific date an RPN discovered that a narcotic medication for a specific resident was missing.
In an interview, an RN and the DOC said that the online Medication Incident Report was not completed for this incident.
The DOC said that the online Medication Incident Report should have been completed, and the policy be complied with.

During the inspection this non-compliance was found to have the severity level of

minimal harm/risk or potential for actual harm/risk to residents. The scope of the non-compliance was isolated and a similar area of non-compliance was previously issued as a :
Written Notification on December 30, 2016, under Resident Quality Inspection #2016_429642_0015. [s. 8. (1) (b)]

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 Drug Destruction and Disposal was in compliance with LTCA and Reg, and the staff comply with the home's Pain Management and Assessment Tools, Shift Change Monitored Drug Count and Medication incident Reporting policies, to be implemented voluntarily.

WN #4: 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:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on an interdisciplinary assessment with respect to the resident's health conditions including pain.

Clinical record review for a resident showed that the resident had a certain pain level due a specific medical condition.
A clinical record review for the resident showed that the care plan had no pain focus, goals or interventions.
In an Interview, the DOC acknowledged that the resident's plan of care did not include a focus, goals, or interventions that would address the resident's pain level reflected in the pain assessment.
The DOC said that their expectation would be for the plan of care to be based on the pain assessment of the resident.

During the inspection this non-compliance was found to have the severity level of minimal harm/risk or potential for actual harm/risk to residents. The scope of the non-compliance was isolated. This area of non-compliance was not previously issued. [s. 26. (3) 10.]

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 plan of care was based on an interdisciplinary assessment with respect to the resident's health conditions including pain, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A) A review of a Critical Incident System (CIS) report showed that a resident had a fall on a certain date that resulted in a possible injury. The resident then had a second fall.
A review of the home’s policy titled “Pain Management and Assessment Tools” last reviewed December 2014, showed the following: “Complete pain assessment will be initiated for the following criteria: return from hospital, any change in pain medication, and any new or worsening pain.”
A clinical record review for the resident and staff interview showed that resident expressed new and worsening pain. Record review of the pain assessments and the PAINAD showed no documentation that an assessment for pain had been completed.
The Director of Care (DOC) acknowledged that the resident did not have a formal pain assessment completed or a Pain Assessment in Advanced Dementia (PAINAD) completed. The DOC said that a pain assessment should have been completed.
The licensee failed to ensure that when the resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

B) A review of a Critical Incident System (CIS) report showed that a resident had an incident on a certain date that resulted in an injury.
A review of the home’s policy titled “Pain Management and Assessment Tools” last reviewed December 2014, stated the following: “Complete pain assessment will be initiated for the following criteria: return from hospital, any change in pain medication, and any new or worsening pain.”
A clinical record review and staff interview showed that the resident expressed new and ongoing pain as a result of the injury. A pain assessment was not completed.
In an interview, the DOC acknowledged that there was not a pain assessment for the resident after the injury and they would have expected that it would be done.
The Administrator stated that the expectation was for the staff to follow the policies and complete the pain assessment for the resident.
The licensee failed to ensure that when the resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

During the inspection this non-compliance was found to have the severity level of minimum risk. The scope of the non-compliance was a pattern. This area of non-compliance was not previously issued. [s. 52. (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 when the resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

Issued on this 12th day of September, 2017

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

Original report signed by the inspector.