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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## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jan 5, 2017 | 2016_463616_0023 | 026783-16 | Resident Quality Inspection |

### Licensee/Titulaire de permis

North of Superior Healthcare Group
20B Cartier Road TERRACE BAY ON P0T 2W0

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

WILKES TERRACE
208 Cartier Road TERRACE BAY ON P0T 2W0

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

JENNIFER KOSS (616), SHEILA CLARK (617)

### Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Resident Quality Inspection inspection.**

**This inspection was conducted on the following date(s): September 12, 13, 14, 15, and 16, 2016.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Chief Nursing Officer (CNO), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Community Program Manager (CPM), Maintenance Manager, Dietary Aides (DAs), residents and family members.**

**The Inspectors directly observed the delivery of care and services to residents, resident to resident interactions, conducted a tour of resident home areas, reviewed resident health care records, various home policies, procedures, and programs.**

**The following Inspection Protocols were used during this inspection:**
**Family Council**
**Medication**
**Minimizing of Restraining**
**Nutrition and Hydration**
**Pain**
**Residents' Council**

**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<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. (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 shall ensure that the provision of the care set out in the plan of care was

documented.

Resident #001 triggered during stage one of the inspection regarding nutrition and hydration risk.

Inspector #616 reviewed the resident's plan of care related to nutrition and hydration. A nutrition assessment was completed by the Registered Dietitian (RD) in March 2016 that identified the resident's preference not to receive any dietary interventions. The most recent nutrition assessment completed by the RD in August 2016, identified a nutritional goal to meet the resident's needs.

During an interview the resident stated to the Inspector that it was their choice not to have received any nutrition interventions.

On September 14, 2016, RPN #104 stated to the Inspector that food and fluid intake for each resident was documented daily on the Point of Care (POC) electronic system by either the PSW or registered staff. During an interview with PSW #108 on September 15, 2016, they stated that staff entered the resident's intake as food percentage and fluid volume on the POC. The PSW also stated that staff documented on the POC when a resident refused a meal, was sleeping, or was on a leave of absence (LOA) during the meal.

The Inspector reviewed a POC Dietary Report of three meals per day for this resident over a 12 day period and found that eight out of the 12 days, documentation was missing for 17 meals.

The Inspector also reviewed progress notes during this same 12 day period related to any documentation of meal refusals or other reasons for missing a meal. There were no progress notes found related to meals during this period. The Inspector also reviewed the home's LOA binder for the dates of missed meals above. It was documented that on two of these resident #001 was away during a meal service.

During an interview with RPN #106 and the Chief Nursing Officer (CNO) on September 15, 2016, the RPN stated this resident was known to refuse a meal. However, the CNO stated there should have been documentation to indicate the reason for the missed meal on the POC. The CNO stated that staff were expected to have documented all food and fluid intake on the POC for each resident as per the home's current policy "Recording Food and Fluid Intake". They also stated that on the above days, the provision of food

and fluid was not documented as it should have been, including the days the resident was on leave of absence, or refused meals. [s. 6. (9) 1.]

2. Resident #006 triggered during stage one of the inspection regarding nutrition and hydration risk.

Inspector #616 reviewed the resident’s plan of care related to nutrition and hydration. A nutrition assessment was completed by the RD in July 2016, in which the resident's nutritional risk level was identified. The goals in this assessment were identified in the resident’s current care plan and that staff were to monitor their intake.

On September 13, 2016, during an interview with PSW #100 and RPN #103, they stated this resident was known to have variable food and fluid intake at meals which was recorded by the RPN or PSWs in the POC. RPN #103 stated there should have been documentation on the POC when they refused or were sleeping.

The Inspector reviewed a POC Dietary Report of three meals per day for this resident from over a 12 day period and found that on seven of the 12 days, documentation was missing for 11 meals.

The Inspector also reviewed progress notes during this same 12 day period related to any documentation of meal refusals or other reasons for missing a meal. There were no progress notes found related to the missed meals during this period. The Inspector also reviewed the home’s LOA binder for the dates of missed meals above. There were no absences during the meals listed above. [s. 6. (9) 1.]

3. Resident #007 triggered during stage one of the inspection regarding nutrition and hydration risk.

Inspector #616 reviewed the resident’s plan of care related to nutrition and hydration. A nutrition assessment was completed by the RD in September 2016, in which the resident's nutritional risk level was identified. The goals in this assessment were identified in the resident’s current care plan and that staff were to monitor their intake.

On September 14, 2016, during an interview with RPN #104, they stated this resident was known to have variable food and fluid intake at meals. They stated intake was recorded by the RPN or PSW in the POC. They also stated there should have been documentation in the POC when they refused or were sleeping.

The home's policy "Recording Food and Fluid Intake", last revised June, 2015, #B3.9, indicated that nursing staff will record fluid and food intake at all meals and snack times using the POC electronic chart in the medecare system.

The Inspector reviewed a Dietary Report from POC for three meals per day for this resident over a 12 day period and found that on six of the 12 days, documentation was missing for 10 meals.

The Inspector also reviewed progress notes during this same 12 day period related to any documentation of meal refusals or other reasons for missing a meal. There were no progress notes found related to the missed meals during this period. The Inspector also reviewed the home's LOA binder for the dates of missed meals above. There was no absences during the meals listed above.

During an interview with the CNO on September 15, 2016, they stated that staff were expected to document all food and fluid intake on the POC for each resident as per the home's policy "Recording Food and Fluid Intake". They also stated that on the above days, the provision of food and fluid was not documented as it should have been. [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 to ensure that the following are documented: 1. The provision of the care set out in the plan of care, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails**

**Specifically failed to comply with the following:**

**s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,**
**(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).**
**(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).**
**(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that where bed rails were used, the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.

A review of the home's policy titled "Bed Entrapment" revised July 2014, indicated that all beds at the home had short locking bed rails in place at the head of the bed, and the risk assessment for the bed rails consisted of Zones One, Two, Three, and Four. The four Zones were to be inspected yearly to ensure that they met the requirements and no changes were made to the components of the bed in question. Any incidents of entrapment were to be immediately documented and given to the CNO. The CNO would maintain all records of the incident, bed evaluation, corrective actions taken and communicate with the nursing team the results and any changes made.

Resident #003's bed rails were observed to be used by Inspector #616 on September 12, 2016, and by Inspector #617 on September 15 and 16, 2016.

Inspector #617 interviewed resident #003 who reported that they used bed rails to help them with an activity of daily living and that they preferred them in the guard position.

A review of resident #003's Health Care Record indicated that they used bed rails for safety, and identified the level of physical assistance from staff for this activity of daily living.

Inspector #617 interviewed PSW #108 who confirmed that resident #003 used bed rails to help with an activity of daily living.

On September 15, 2016, Inspector #617 interviewed the CNO, who confirmed that the nursing department had not yet tested the bed rails used for resident #003 to determine risks in Zones One, Two, Three, and Four. On September 15, 2016, Inspector #617 interviewed the Maintenance Manager, who explained that the maintenance department had not yet completed assessments of all residents' bed systems in the home. [s. 15. (1) (a)]

2. Resident #004's bed rails were observed to be in use by Inspector #616 on September 12, 2016, and by Inspector #617 on September 15 and 16, 2016.

Inspector #617 interviewed resident #004 who reported that the bed rails in use did not hinder their activity.

A review of resident #004's HCR indicated the use of bed rails, and no physical assistance required from staff. A review of resident #004's plan of care identified bed rail use as a personal preference.

Inspector #617 interviewed PSW #108 who confirmed that resident #004's bed rails were in the guard position. The PSW reported that resident #004 did not use the bed rails.

On September 15, 2016, Inspector #617 interviewed the CNO, who confirmed that the nursing department had not yet tested the bed rails used for resident #004 to determine risks in Zones One, Two, Three, and Four. On September 15, 2016, Inspector #617 interviewed the Maintenance Manager, who explained that the maintenance department had not yet completed assessments of all residents' bed systems in the home. [s. 15. (1) (a)]

3. Resident #005's bed rails were observed to be used by Inspector #616 on September 12, 2016, and by Inspector #617 on September 15 and 16, 2016.

Inspector interviewed resident #005 who reported that the bed rails were used.

A review of resident #005's HCR indicated that they used bed rails.

Inspector #617 interviewed PSW #108 who confirmed that resident #005's bed had

particular bed rails in the guard position. The PSW reported that resident #005 used a bed rail when staff assisted them.

On September 15, 2016, Inspector #617 interviewed the CNO, who confirmed that the nursing department had not yet tested the bed rails used for resident #005 to determine risks in Zones One, Two, Three, and Four. On September 15, 2016, Inspector #617 interviewed the Maintenance Manager, who explained that the maintenance department had not yet completed assessments of all residents' bed systems in the home. [s. 15. (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 bed rails are used, the resident and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident, to be implemented voluntarily.***

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**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. (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. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident.

Inspector #616 reviewed the Medication Administration Record (MAR) for resident #001 related to as needed (PRN) pain medications for a six months period in 2016. The MAR for each month listed a specific PRN analgesic, and it was documented on the MAR that the resident had received this PRN analgesic on three instances approximately one month apart.

In the resident’s health chart, the Inspector located Medication Reviews for three past quarterly periods. The Inspector noted that missing from each of the Medication Reviews, was a physician's order for the PRN analgesic.

During an interview with RPN #106 on September 15, 2016, they verified to the Inspector that they were unable to locate an order for the PRN analgesic, and they verified this medication was not included on the quarterly Medication Review. In an interview with the CNO also on this date, they verified to the Inspector that they had reviewed resident #001’s archived health record dating back to the resident's admission and was unable to locate a physician's order for the PRN analgesic as noted on the MAR and documented as administered to the resident. [s. 131. (1)]

2. The licensee has failed to ensure that no resident administered a drug to himself or herself unless the administration had been approved by the prescriber in consultation with the resident.

On a day in September 2016, Inspector #617 observed resident #009's medication placed on the resident's bedside table with a Pharmacy prescription label with administration instructions.

During this time of inspection, the Inspector interviewed resident #009 who reported that they had been administering their own medication for a long time. Resident #009 reported that they had received instruction from the registered staff on the application of the medication and felt very independent with the task. Resident #009 reported that the registered staff confirmed with them that they had self-administered the medication.

During an interview with RPN #104, it was confirmed to Inspector #617 that resident #009 self-administered their medication. RPN #104 stated that the registered staff confirmed with resident #009 that they had administered the medication and then the registered staff documented the self-administration on the resident’s MAR.

A review of the home's policy titled "Medication Administration-C1" last revised on

February 2014, indicated that any resident who has permission to administer medications to his/her self were to follow the steps outlined in the policy on self-administration of medications. A review of the Pharmacy medication administration policy titled, "Self Administration of Medication" (undated), indicated that a physician's order must be obtained when a resident administered medications.

A review of resident #009's care plan located at the nursing station indicated that staff were to provide this particular medication to the resident and ensure that they administered the medication properly.

Inspector #617 reviewed resident #009's original physician's order, the current Medication Review, and the current MAR for the medication prescription. It was noted that authorization from the physician was missing for resident #009 to self-administer this particular medication.

In an interview with RPN #106, it was confirmed to Inspector #617 that they had reviewed resident #009's chart and did not find a physician's order for the resident to self-administer this particular medication.

On September 15, 2016, Inspector #617 and the CNO together reviewed resident #009's physician's order, the current Medication Review, and the two policies regarding resident self-administration of medication. The CNO confirmed to the Inspector that the physician's order for resident #009 to self-administer this particular medication was missing and was required for safe practice of resident self-administration of medication. [s. 131. (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 no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, and that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident, to be implemented voluntarily.***

**WN #4: 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 has failed to ensure that when a resident was taking any drug or combination of drugs, including psychotropic drugs, there was monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

During stage one of the inspection, resident #002 triggered for having pain.

Inspector #616 interviewed the resident on a day in September 2016, who stated they experienced pain in a specific area. On September 14 and 15, 2016, the Inspector interviewed RPN #104 and PSW #107 respectively, who both stated that the resident was known to experience pain in this specific area for which they received a PRN medication.

The Inspector reviewed the resident's MAR for a recent past month related to PRN pain management which included a particular analgesic as a "Medical Directive Order Set". The Inspector noted that the documentation on the MAR indicated that the resident had received this analgesic on three instances during the month reviewed, however the dose of the analgesic could not be determined by the Inspector.

The Inspector reviewed progress notes linked to the administration of this medication on

the three dates. On two consecutive days, the reason for the pain medication administration was identified, along with a note “no follow up required” related to the effectiveness of the medication. A progress note for the medication administration on the third instance, documented the reason the pain medication was administered, that the resident's response and the effectiveness of the pain medication was required, and scheduled for one hour later. There was no documentation regarding the resident's response or the effectiveness of the medication.

The home's Pain Management Program, last revised September 2012, indicated that a pain assessment will be conducted on each resident when pain medication or PRN analgesia is initiated, and all interventions will be documented and evaluated to ensure the plan is effective in relieving the pain.

The Inspector interviewed the CNO on September 15, 2016, who stated that with any administration of a PRN pain medication, staff documented the response/effectiveness in the MAR which created a follow up progress note. There should not have been an instance where staff had documented "no follow up required" when PRN pain medications had been administered. [s. 134. (a)]

2. During stage one of the inspection, resident #001 triggered for having pain.

Inspector #616 interviewed the resident on a day in September 2016, who stated their pain was experienced in a specific area. On September 14, 2016, the Inspector interviewed RPN #104 who stated that the resident was known to experience pain in this specific area for which they received a PRN medication as one of their pain management interventions.

The Inspector reviewed the resident’s MAR related to PRN pain management. PRN analgesia had been administered on one occasion.

The Inspector reviewed the progress note linked to the administration of this medication on that particular occasion where it was documented “no follow up required” related to the effectiveness of the PRN medication.

During interviews with RPN #104 on September 14, and RPN #106 on September 15, 2016, they both stated to the Inspector that when PRN analgesics were administered, a follow up note related to the effectiveness of the medication was required by staff. They further stated that the electronic system prompted a follow up note one hour after

administration that linked with a progress note.

The home's Pain Management Program, last revised September 2012, indicated that a pain assessment will be conducted on each resident when pain medication or PRN analgesia is initiated, and all interventions will be documented and evaluated to ensure the plan is effective in relieving the pain.

The Inspector interviewed the CNO on September 15, 2016, who stated that with any administration of a PRN pain medication, staff documented the response/effectiveness in the MAR which created a follow up progress note. There should not have been an instance where staff had documented "no follow up required" when PRN pain medications had been administered. [s. 134. (a)]

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**Issued on this 9th day of January, 2017**

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

**Original report signed by the inspector.**