Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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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 11, 2018	2018_505103_0022	010987-18	Resident Quality Inspection

Licensee/Titulaire de permis

Lennox and Addington County General Hospital Association
8 Richmond Park Drive NAPANEE ON K7R 2Z4

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

Lennox and Addington County General Hospital
8 Richmond Park Drive NAPANEE ON K7R 2Z4

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

DARLENE MURPHY (103)

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): August 2-3, 7-10, 13-15, 2018.

Log #010540-18 (CIS #7089-000002-18) -resident fall that resulted in an injury.

During the course of the inspection, the inspector(s) spoke with residents, Personal Support workers (PSW), a Registered Practical Nurse (RPN), Registered Nurses (RN), the Occupational Therapist (OT), the Physiotherapist (PT), and the Unit Coordinator (UC).

During the course of the inspection, the inspector conducted a walking tour of all resident areas, reviewed resident health care records including resident progress notes, plans of care, medication administration records (MAR), treatment administration records (TAR) and physician orders, made observations related to infection control practices, resident activities, staff to resident interactions, medication administration and medication storage.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Responsive Behaviours
Skin and Wound Care

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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure the care specified in resident #017's plan of care was provided to the resident as specified in the plan.

Resident #017 was admitted to the convalescent care unit on a specified date and had identified diagnoses. The resident had skin impairment on two identified areas of the body and was assessed as at risk of skin breakdown with a Braden score of 17. The resident utilized a wheelchair as the primary mode of ambulation.

Resident #017's physician orders were reviewed for a specified period of time in regards to the treatment for the skin impairment. The resident's electronic treatment administration record (eTAR) and progress notes were reviewed for the same identified period of time. Gaps were identified.

Unit Coordinator, RN #101 was interviewed and reviewed resident #017's eTAR and progress notes. The RN indicated there was no evidence the treatments had been completed as prescribed in the resident plan of care.

The licensee has failed to ensure the care specified in resident #017's plan of care was provided to the resident as specified in the plan. [s. 6. (7)]

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 resident wound and skin treatments are completed as specified in the plan of care, to be implemented voluntarily.

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 are used, the resident is assessed and their bed system is evaluated in accordance with evidence-based practices and, if there are none, prevailing practices, to minimize the risk to the resident.

On August 21, 2012, a notice was issued to Long-Term Care Home Administrators from the Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch identifying a document produced by Health Canada (HC) titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008" (HC Guidance Document). In the notice, it was written that this HC Guidance Document was expected to be used "as a best practice document".

The HC Guidance Document characterizes, where bed rails are used, the body parts at risk for entrapment (head, neck, chest), identified the locations of bed openings that are potential entrapment areas (Zones 1-7), recommended dimensional limits for the gaps in some of the potential entrapment areas (Zones 1-4), and prescribed testing methods for assessing gaps in bed systems. The HC Guidance Document also included the titles of two additional companion documents by the Hospital Bed Safety Workgroup (HBSW) established by the Food and Drug Administration (FDA) in the United States. One of the companion documents was titled “Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings”. (Companion Document) (HBSW, US FDA, 2003). This document provided necessary guidance in establishing a clinical assessment where bed rails were used.

In the Companion Document, it was recommended that any decision regarding the use of

bed rails be made within the context of an individualized resident assessment, in order to assess the relative risk of using bed rails compared with not using bed rails for each individual resident. The assessment was to be conducted by an interdisciplinary team taking into consideration numerous factors including (but not limited to) alternative interventions trialed, the resident's medical needs, cognition, mobility, sleep habits and patterns, sleep environment, resident comfort in bed, and potential safety concerns. The document indicated there must be clear documentation of this risk-benefit analysis in the residents' health care record. The decision to use bed rails was to be approved by the interdisciplinary team and the effectiveness of the bed rail was to be reviewed regularly.

On August 2, 2018, this inspector noted during an initial tour of the home, that all residents on the unit had two quarter rails up on either side at the head of the bed. This remained unchanged throughout the inspection period. Resident #005, #015 and #017 bed systems were inspected. All three of these residents were observed to have two quarter rails up.

Residents #005, #015 and #017's health care records were reviewed and there was no documentation found to support the completion of an individualized resident assessment to assess the risk of using the bed rails or that the bed systems belonging to resident #005, #015 and #017 had been evaluated in accordance with prevailing practices, in order to minimize risk to the resident.

RN #100 was interviewed and stated the two quarter rails are routinely used on the unit as they have both the bed controls and the call bell built into the rails. The RN stated they were unaware of any individualized resident assessment completed or if the bed systems were assessed with the use of bed rails.

OT #105 was interviewed in regards to the use of bed rails. The OT stated that due to the rehabilitative nature of the unit, all residents were encouraged to use the quarter rails to assist them in getting into and out of bed. The OT indicated the unit did not utilize a formalized resident assessment related to the use of bed rails. OT #105 indicated their role would be focused to ensure residents were safely using the quarter rails.

OT #105 indicated the unit was currently in the process of replacing some of the mattresses. They indicated they were only involved in bed system assessments when a resident required a low air loss mattress. The OT stated they would visually be looking for gaps that may be a safety issue for residents and recommend ways to address the gap. OT #105 stated they were unaware of any testing methods for assessing gaps in

bed systems being completed on the bed systems on this unit.

PT #106 was interviewed and stated two quarter rails were consistently used with every resident on this unit. PT #106 indicated, in regards to the use of bed rails, they assessed each resident on admission to ensure they were properly using the bed rails relative to the injury that brought them to the unit to avoid further injury. The PT indicated the unit was not currently completing resident assessments related specifically to the use of bed rails.

Unit Coordinator (UC) #101 was interviewed in regards to resident use of bed rails and the assessment of resident bed systems. UC #101 indicated the residents generally liked the two quarter rails to be up as it assists them in getting into and out of bed and allows them to be more independent. UC #101 indicated they felt bed entrapment risk was low for the population of the unit as many of the residents had a high level of mobility and cognition. Unit Coordinator #101 was unaware of the HC guidance document and the companion documents related to the use of bed rails. UC #101 upon further investigation into the matter was able to confirm, the unit currently does not complete resident assessments specific to the use of bed rails and does not complete bed system assessments.

The licensee has failed to ensure that where bed rails are used, the resident is assessed and their bed system is evaluated in accordance with evidence-based practices and, if there are none, prevailing practices, to minimize the risk to the resident. [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, residents are assessed and their bed system evaluated in accordance with evidence based practices, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure a resident exhibiting altered skin integrity including pressure ulcers was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

As outlined in WN #1, Resident #017 was admitted to the convalescent care unit on a specified date and had identified diagnoses.

RN #103 was interviewed in regards to the home's practice in regards to wound and skin assessments. The RN stated a weekly wound assessment is completed every week and would be found under the assessment tab in the home's electronic documentation system. They indicated the wound and skin care team from the hospital assess the wounds on the unit and make recommendations in regards to treatment, pressure relief etc. and indicated their assessments would be found in the progress note section. The RN further indicated additional assessment information would be made by the registered staff completing the treatment for this resident's wounds in the progress notes.

The resident health care record was reviewed in regards to the wound and skin assessments. The inspector noted under the assessment tab, the staff had been documenting the location of the resident's skin impairment and that each of the weekly assessments indicated the stage of the wounds. There was no additional assessment information found in this area and there were no additional assessments found in the resident progress notes.

The Unit Coordinator, RN #101 was interviewed in regards to the expectations around documented weekly assessments. They indicated resident #017 was at risk due to their diagnosis and impaired mobility and was able to confirm the wounds had shown little improvement since admission to the unit. The RN also indicated the wound and skin champions from the hospital came to the unit every two weeks to assess the wounds for this resident. The documentation was reviewed with the Unit Coordinator, RN #101 and they indicated the expectation would be to complete a full wound and skin assessment at least weekly that would include measurements of the wounds, documentation related to the amount and character of the drainage and any other pertinent information such as signs and symptoms of infection or healing.

The licensee has failed to ensure resident #017's pressure ulcers were assessed weekly by a member of the registered nursing staff. [s. 50. (2) (b) (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 residents exhibiting altered skin integrity are reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, 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. (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 failed to ensure no drug was used by or administered to a resident unless the drug was prescribed for the resident.

On an identified date and time, the RPN administered an identified medication to resident #022. Following the administration of the identified medication, it was determined there was no physician’s order in place at that time.

RN #100 was interviewed and stated resident #022 had previously resided on the convalescent care unit. At the time of this error, residents being readmitted to the unit had all previous physician orders still visible on the eMAR. As a result, the RPN in error administered the identified medication in accordance with physician orders that had been in place during the previous admission. RN #100 stated as a result of the error, the unit now deletes all previous physician orders upon discharge to prevent a recurrence. Resident #022 was monitored as a result of the error and there were no untoward

outcomes as a result of the error.

The licensee failed to ensure no drug was used by or administered to resident #022 unless the drug was prescribed for the resident. [s. 131. (1)]

2. The licensee has failed to ensure drugs were administered to residents in accordance with the directions for use specified by the prescriber.

Resident #024 had a physician's order to receive an identified medication three times a day following breakfast, at 1400 hour and at 2100 hour. On a specified date, it was noted by the registered staff member administering medications at 1700 hour, that resident #024's 1400 hour dosage was still in the strip packaging and the electronic medication administration record (eMAR) was red, indicating the medication had not been given for that time. The resident sustained no untoward outcome as a result of the missed dose.

Resident #023 had a physician's order to apply a specified medicated patch every morning at 0800 hour and to remove the patch every evening at bedtime. On an identified date, resident #023 was found to have two medicated patches in place. Upon investigating the error, it was determined the physician's order had been incorrectly transcribed in that it did not reflect the need to remove the patch at bedtime. There were no untoward effects to the resident as a result of the error.

The licensee failed to ensure drugs were administered to residents #024 and #023 in accordance with the directions for use. [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 no drug was used by or administered to a resident unless the drug was prescribed for the resident and to ensure drugs were administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #5: 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. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure a quarterly review was undertaken of all medication incidents that occurred in the home since the time of the last review in order to reduce and prevent medication incidents, any changes and improvements identified in the review are implemented and a written record was kept of everything.

RN #100 was interviewed in regards to the home's process for reviewing medication incidents. The RN indicated all medication incidents are reviewed during the quarterly Professional Advisory Committee (PAC) meetings. The RN stated that during the review of the incidents, there is discussion of actions already taken to address the error and additional discussions to address possible ways of reducing and preventing similar incidents. The RN was able to provide this inspector with examples of changes made to the medication system in response to previous medication incidents. The home's PAC meeting minutes were reviewed by this inspector, but there was no documentation to support the actions implemented in response to the medication incidents.

RN #101 was interviewed and indicated similar information in regards to the review of medication incidents during the quarterly PAC meetings. RN #101 indicated there is no written documentation to support the discussions in regards to reducing and preventing similar medication incidents.

The licensee has failed to ensure a written record was kept of all changes and improvements identifed in the quarterly medication review. [s. 135. (3)]

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 a written record is kept of all changes and improvements identified in the quarterly medication review, to be implemented voluntarily.

Issued on this 11th day of October, 2018

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

Original report signed by the inspector.