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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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 19, 2017	2017_674610_0017	003287-17	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
5015 Spectrum Way Suite 600 MISSISSAUGA ON 000 000

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

BLENHEIM COMMUNITY VILLAGE
10 MARY AVENUE P.O. BOX 220 BLENHEIM ON N0P 1A0

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

NATALIE MORONEY (610), ALICIA MARLATT (590), HELENE DESABRAIS (615)

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): December 11, 12, 13, 14, and 15, 2017.

The following concurrent inspections were conducted during the Resident Quality Inspection related to Falls Management and Prevention:
Critical Incident Log #024287-17/CI 2695-000021-17
Critical Incident Log #025269-17/CI 2695-000024-17
Critical Incident Log #013451-17/CI 2695-000009-17

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, Associate Director of Care, Program Manager, Ministry of Correctional Services, Nurse Practitioner, Registered Nurses, Registered Practical Nurses, Personal Support Workers, families, Residents Council representative, and residents.

Inspector's also toured the resident home areas and common areas, medication rooms, spa rooms, observed resident care provision, resident and staff interactions, medication administration, medication storage areas, reviewed relevant resident clinical records, posting of required information, relevant policies and procedures, as well as meeting minutes pertaining to the inspection, and observed general maintenance and cleanliness of the home.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Residents' Council

During the course of this inspection, Non-Compliances were issued.

2 WN(s)
1 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 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 that, (a) a quarterly review was 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; (b) any changes and improvements identified in the review were implemented; and (c) a written record was kept of everything provided for in clause (a) and (b).

As part of the Resident Quality Inspection, medication incident reports were reviewed for a specified time.

In an interview with DOC shared that medication incidents were reviewed for each quarter at the Professional Advisory Council (PAC) meetings.

Review of the PAC meeting minutes on a specified date, showed documentation that the home had evaluated the root causes of the medication incidents, but provided no documentation regarding any methods implemented to reduce or prevent future medication incidents.

Review of the MediSystem Pharmacy report dated November 2017, showed no documentation to support that methods to reduce or prevent medication incidents were discussed.

On a specified date the home completed an evaluation of the Medication Management Program further review of the evaluation documentation showed:
The licensee "followed guidelines outlined within Institute for Safe Medication Practices (ISMP) Canada which speaks to analyzing medication incidents, making recommendations for the prevention of harmful medication incidents, and facilitating quality improvement initiatives. This work is done in collaboration with our respective pharmacies and brought forward at nurses' meetings, home specific and corporate Professional Advisory Council (PAC) and Pharmacy and Therapeutic (P&T) Meetings".

In an interview with the DOC they shared that an ISMP assessment was last completed in 2015 and had not been completed in 2016 and was planned to be completed in the first quarter of 2018. When asked how often the home should be completing the ISMP assessments, they shared that they should probably be completing the ISMP more often. They agreed that they had not completed the documentation and did not reflect any changes made or implemented as a result of the analysis of the medication incidents.

The licensee has failed to ensure that the quarterly review was 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, and any changes and improvements identified in the review were implemented and a written record of those changes would be provided.

The severity was determined to be a level one as there was minimal risk. The scope of this issue was wide spread during the course of this inspection. The home does not have a history of non-compliance in this subsection of the legislation. [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 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; (b) any changes and improvements identified in the review are implemented; and (c) a written record is kept of everything provided for in clause (a) and (b), to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type 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; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and where the condition or circumstances of the resident required, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

A review of the resident's specified assessment, indicated that the resident required continence care assistance.

A review of another specified assessment for the resident, indicated an increase in continence care.

A review of the home's policy #CARE2-010-01 Continence Care - Change of Continence, last reviewed July 31, 2016, stated, in part "Initiate the 3-Day Continence Diary with the change in continence status. Complete the Continence Assessment (PCC) which will include the evaluation of the 3-Day Continence diary. Review the RAPs or CAPs, assessment results, and monitoring records. Review/develop a plan of care if the resident is assessed as incontinent and/or determined a candidate for incontinence Restorative Program".

During interviews, with nursing staff and a PSW stated the resident required continence care and that the resident should have been reassessed and the plan of care should have been updated.

During an interview, the ADOC said they were aware that the resident had a change in continence care. The ADOC further said the resident had not been reassessed and that the home's expectation was that residents who experienced an increase in continence care should be monitored and a specified assessment completed.

The licensee has failed to ensure that the resident received an assessment using a clinically appropriate assessment instrument that was specifically designed for a specified assessment.

The severity was determined to be a level one as there was minimal risk. The scope of this issue was isolated during the course of this inspection. The home does not have a history of non-compliance in this subsection of the legislation. [s. 51. (2) (a)]

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Issued on this 20th day of December, 2017

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

Original report signed by the inspector.