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

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
May 8, 2018	2018_554541_0003	007079-18	Resident Quality Inspection

Licensee/Titulaire de permis

Carveth Nursing Home Limited
375 James Street GANANOQUE ON K7G 2Z1

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

Carveth Care Centre
375 James Street GANANOQUE ON K7G 2Z1

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

AMBER LAM (541), CATHI KERR (641), HEATH HEFFERNAN (622), WENDY BROWN (602)

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): April 17, 18, 19, 20, 23, 24, 25, 26 and 27, 2018

As part of this inspection, the following two intakes were inspected:
- a critical incident related to resident transfers
- a complaint related to medication administration and resident transfers

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Assistant Director of Care, the Maintenance Supervisor, the Food Service Supervisor, the Activity Director, the Registered Dietitian, the RAI Coordinator, Registered Nurses, Registered Practical Nurses, Personal Support Workers, the President of the Family Council, the President of the Resident Council and residents.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **2 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. 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 any policy instituted or otherwise put in place is implemented in accordance with all applicable requirements under the Act, and complied with.

O. Reg. 79/10, s. 8 (1) indicates 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 is complied with.

O. Reg. 79/10, s. 50 (1) indicates the skin and wound care program must, at a minimum, provide for the following:
1. The provision of routine skin care to maintain skin integrity and prevent wounds.
2. Strategies to promote resident comfort and mobility and promote the prevention of infection, including the monitoring of residents.
3. Strategies to transfer and position residents to reduce and prevent skin breakdown and reduce and relieve pressure, including the use of equipment, supplies, devices and positioning aids.
4. Treatments and interventions, including physiotherapy and nutrition care.

The licensee's Treatments Policy and Procedure supplied by the Policy and Program Development staff #121 on April 26, 2018 which included "Wound and Skin Care Assessment and Management" on page two and three indicated;

1. A skin and wound care assessment using the "Skin Assessment Tool" and Braden Scale will be completed by registered staff for all residents on the initial sign of any skin breakdown.

2. If a wound and or skin tear is noted, then a "Wound/Skin Care Assessment Checklist" is to be initiated and the checklist item to be followed through on and completed. This Checklist is essentially a registered staff action plan to ensure that all wound protocols have been initiated and documented correctly.
- Wound/skin tear documentation will be completed weekly (preferably Saturday, Sunday) and will cover location of the wound, size, dressings, drainage, undermining/tunneling, Character of the wound, staging of the wound.

A review of resident #044's health records indicated they had a wound on an identified area. There were no documented initial "Skin Assessment Tool", Braden Scale or "Wound/Skin Care Assessment Checklist" completed.

A review of the progress notes on specified dates did not include documentation for assessment or when resident #044's wound opened. The first documentation related to resident #044's wound was noted to be on a date stating that the dressing had been changed. A life lab report on a specified date indicated a swab was taken of the area on that date.

A review of the weekly "Skin Assessment Tools" completed for resident #044 indicated there were no assessments documented until 13 days after the initial progress note. A review of the resident's health record including the electronic record, the resident file, the treatment administration record and the wound care binder did not contain a completed "Wound/Skin Care Assessment Checklist" or Braden scale related to resident #044's wound.

On April 26, 2018 at approximately 1010 hours, inspector #622 interviewed Registered Practical Nurse (RPN) #108 who was the designated lead for the home's wound care program. RPN #108 indicated they were unsure when resident #044's wound opened. RPN #108 reviewed the documentation along with the licensee's policy/procedure. RPN #108 stated a skin and wound care assessment using the weekly skin assessment tool had not been completed when the wound initially opened, the Wound Care Assessment Checklist was not completed and no assessments had been documented in the progress notes for resident #044's wound for a specified two month time period.

On April 26, 2018 at approximately 1300 hours, inspector #622 interviewed the Director of Care (DOC) #100 who reviewed the licensee's policy and procedure regarding Wound and Skin Care Assessment and Management. DOC #100 stated that a resident's wound is to be assessed using the weekly skin assessment tool at the initial sign of any skin

breakdown, a Braden scale should be completed and a “Wound/Skin Care Assessment Checklist" is to be initiated. DOC #100 stated they were not aware of when resident #044’s wound opened. DOC #100 said they reviewed the health records for resident #044 and could not find documentation for the initial weekly "Skin Assessment Tool", Braden scale or the "Wound/Skin Care Checklist" being completed.

Therefore, the licensee failed to ensure that the "Wound and Skin Care Assessment and Management" policy was complied with. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee 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, (b) is complied with.

O. Reg. 79/10, s. 114 (2) indicates that every licensee of a long-term care 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.

The Pharmacy Manual “Hunt’s Pharmacy” Long-term Care Facilities revised October 2014 p. 21 “Refusal to Fill an Order” policy indicates that if a situation arises where the pharmacy refuses to fill a prescription, the Registered Nurse (RN), Physician and Director of Care (DOC) will be contacted. An explanation for refusal will be given and an alternative will be suggested.

During a review of the home’s medication incidents that occurred over a three month specified time period, the inspector noted the following:

On a specified date, resident #024’s physician contacted the home to advise that resident #024 had a specified medical condition. Verbal orders were provided at that time for a specified medication. As is current practice, the medication was obtained from the Emergency Stock Box (ESB) for the first dose on the date the order was placed and again for the next dose in the morning the following day. On the date the second dose was given, RN #120 received a telephone call from the pharmacy asking why the specified ESB medication had been utilized. RN #120 advised they received orders to start the specified medication for resident #024’s condition the day prior. The pharmacy indicated that they left a voicemail message for an RN on the date the medication was ordered outlining that the specified medication interacted with another of resident #024’s

medications, could cause a health concern and that an alternative must be considered.

RN # 120 immediately alerted resident #024's physician following contact with the pharmacy and an alternate medication was ordered for the resident's specified medical condition. The resident's vitals were monitored for the next forty eight hours with no ill effects noted.

During the subsequent investigation, the pharmacy explained they had left a message on "a desk phone" for an RN, sent a fax to the DOC, that was not received until the day after the medication was ordered, and no contact was made with the physician regarding the refusal to fill the order due to the possible drug interaction. The DOC spoke with the pharmacy to outline that communication needs to be direct vs. voicemail. The concern will be further reviewed at the next Physician/Pharmacy Committee Meeting.

The licensee failed to comply with the "Refusal to Fill an Order" policy in that the Registered Nurse, Physician and Director of Care were not contacted by the pharmacy to provide an explanation for the refusal and suggest an alternative, when the pharmacy refused to fill a prescription. [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 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, is (b) is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #007 with the following weight changes was assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month

Resident #007 had a significant weight loss of 7.0 kg (7.3%) during a 1 month period. The resident’s weight for the following month was completed and demonstrated a similar weight to the month prior, confirming a significant weight loss. Resident #007’s quarterly nutritional assessment was completed on a specified date by Food Service Supervisor #111 and it stated that resident’s weight was well maintained. Food Service Supervisor #111 confirmed during an interview on April 23, 2018 that resident #007's significant weight change was not assessed at the time the quarterly assessment was completed.

At the time of the significant weight change, resident #007 was identified as being at a moderate nutrition risk.

The Food Service Supervisor #111 stated during an interview with Inspector #541 that significant weight changes are assessed by the home’s Registered Dietitian (RD). The RD is made aware of the weight change either by referral from nursing, the Food Service Supervisor or by the RD’s own review of the weight exception report. The home’s RD #119 confirmed during an interview that the RD is notified of significant weight changes by a referral or by the RD's own review of the weight exception report. RD #119 indicated being unfamiliar with resident #007 as there are two RDs for the home and this resident is not on RD #119's assignment. RD #119 did indicate that a re-weigh should have been completed for resident #007 and that the weight change should have been assessed and documented.

The home failed to ensure that resident #007’s significant weight change of 7.3% over one month was assessed using an interdisciplinary approach. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

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 residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated: 1. A change of 5 per cent of body weight, or more, over one month, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

On April 17, 2018 at approximately 0907 hours, during the initial tour of the home, inspector #622 observed the following concerns related to doors leading to non-residential areas;
1) The storage room door situated at the left side of the entrance to the North East resident home area opened when the latch was turned allowing inspector #622 access. A sticker was on the door which indicated; "when using this door, please pull shut and ensure that it is locked". No staff were in the immediate area at the time of observation and the door was in a busy corridor with residents ambulating past. The storage room contained dressing and wound care supplies, catheters, nail care supplies, suture removal kits, mouth care supplies, and a thermopatch clothing labeler. Personal Support Worker (PSW) #101 stated the storage room door was not for resident access and should have been kept locked at all times.

2) The back entrance doorway to the tub room situated at the entrance to the West resident home area was unlocked and could be opened. A sticker was on the door which indicated; "when using this door, please pull shut and ensure that it is locked". Inside the room was the old shower, old tub area, two oxygen concentrators, a walker, clothing hanging on a rack and the doorway leading into the tub room which was open. When inspector #622 closed the door it locked, there were no staff or residents in the area at the time of the observation. Director of Care (DOC) #100 stated the doorway was not for resident access and should have been kept locked at all times.

During an interview with inspector #622 on April 23, 2018 at approximately 1115 hours, maintenance supervisor #107 stated the doors to the storage room on the North East resident home area and the back entrance to the tub room at the entrance to the West resident home were not locking properly so the locksets have been changed. The Maintenance Supervisor #107 also stated that these doors were not to be accessible to residents and were to be kept locked at all times.

The licensee has failed to ensure that all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and those doors are kept closed and locked when they are not being supervised by staff. [s. 9. (1) 2.]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the physical device applied in accordance with the manufacturer's instructions.

On April 18, 2018 Inspector #541 observed resident #045 being pushed out of the dining room in a wheelchair. Resident #045 had a four point seat belt applied that was sitting loosely on the resident's thighs. The seat belt could be pulled away from the resident. Resident #045 was unable to tell the inspector the reason for the belt nor was the resident able to undo the belt when asked.

According to a restraint summary progress note on a specified date in resident #045's chart, the resident requires the use of a four point seatbelt when up in adaptive seating to maintain proper hip positioning, and for a feeling of safety and security.
The manufacturer's instructions for the four point seat belt (identified in the instructions as a "pelvic support belt") were obtained from the home and state:
"This support belt must be worn tightly fitted across the lower pelvis or thighs at all times. A loose seat belt can allow the user to slip down and create a risk of strangulation."

Inspector spoke with RPN #102 on April 18, 2018 regarding resident #045's seat belt. RPN #102 confirmed the belt was loose and that it could not be tightened therefore a note was left for Motion Specialities to fix the belt.

Resident #045's four point seat belt was not applied in accordance with the manufacturer's instructions when it was observed on April 18, 2018 sitting loosely on the resident's thighs. [s. 110. (1) 1.]

WN #5: 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 medications were administered to resident #021 in accordance with the directions for use specified by the prescriber.

During a review of the home's medication incidents that occurred over a specified three month time period, the inspector noted the following:

Resident #021 contracted a specified illness during an outbreak at the home on a specified date. A medication incident occurred on two dates during a specified month. Resident #021 was administered a specified medication, one capsule twice on two specified dates. The physician's order stated: a specified medication one capsule daily x 5 days however it was transcribed as: if affected with the specified illness, two times daily for the specified illness for 5 days.

During an interview with Inspector #602 on April 26, 2018 the DOC indicated that the medication incident had occurred as in an effort to transcribe the multiple orders received during the outbreak, the once daily order was mistakenly transcribed as twice daily. The resident, POA, staff responsible, the physician and the pharmacy were notified. The physician's response was to continue one tablet daily for the final two days. Documentation on the incident report and in the progress notes indicated the resident had been assessed with no noted ill effects. [s. 131. (2)]

Issued on this 28th day of May, 2018

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

Original report signed by the inspector.