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
Feb 1, 2018	2018_520622_0002	000645-18	Resident Quality Inspection

Licensee/Titulaire de permis

THE CORPORATION OF THE COUNTY OF FRONTENAC
2069 Battersea Road Glenburnie ON K0H 1S0

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

FAIRMOUNT HOME FOR THE AGED
2069 Battersea Road, R.R. #1 Glenburnie ON K0H 1S0

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

HEATH HEFFERNAN (622), JESSICA PATTISON (197)

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): January 23, 24, 25, 26, 29, 30, 2018

The following logs were also inspected:
Critical Incident logs
001536-18 and 0029203-17 re: incidents with injury and hospitalization with significant change in status.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Assistant Director of Care, Nurse Practitioner (NP), the Resident Council and Family Council Chairpersons, Registered Practical Nurses (RPN), Registered Nurses (RN), Personal Support Workers (PSW), recreation staff, residents and family members.

Also during the course of the inspection the inspector(s) conducted a tour of the home, observed medication administration and written processes for handling of medication incidents and adverse drug reactions, reviewed health records, observed and reviewed infection control practices, reviewed resident and family council minutes, applicable home policies specific to falls prevention and adverse drug reactions and medication errors and reviewed the home's staffing schedules for the nursing department.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Residents' Council

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

3 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 that the plan of care sets out clear directions to staff and others who provide direct care to the resident.

Resident #017 was admitted to the home on a specified date and had multiple diagnosis including chronic pain.

Resident #017's current care plan indicated the following:

ADL Functional/Rehabilitation Potential
Toileting - Specific direction was given for the use of the commode.

Bowel Continence
To assist resident #017 with bedpan while in bed and able to stand at bed rails for commode when in wheelchair.

During an interview with PSW #105, she indicated that the resident is put on the commode in the morning and when in bed she will offer them the bedpan if the resident rings to go to the bathroom. When the resident is up in their chair, the PSW indicated she will put them on the commode.

PSW #112 indicated in an interview that staff put the resident on the commode first thing

in the morning and any other time he/she rings to go to the bathroom. When asked if staff use the bedpan for resident #017, she indicated no and because the resident does not like the bedpan.

RN #100 told the inspector that resident #017 uses the commode for toileting and that staff put him/her on whenever they need to go to the bathroom. She also stated that staff tried to use the bedpan with resident #017 at one time but they did not like it.

On a specified date, during an interview with resident #017, he/she told the inspector that they prefer to get up and use the commode when they have to go to the bathroom. Resident #017 said that they do not like the bedpan because it causes them to have pain.

The plan of care related to continence care for resident #017 does not set out clear direction to staff as it currently instructs staff to use the bedpan, even though the resident has indicated they preferred not to use it. [s. 6. (1) (c)]

2. This finding of non-compliance is related to a Critical Incident System report (CIS).

The licensee has failed to ensure that the care set out in the plan of care has been provided to the resident as specified in the plan

A review of the CIS report indicated on a specified date, resident #022 had been assisted on to the toilet by PSW #115. PSW #115 left the washroom and resident #022 fell. RN #100 assessed resident #022 and transferred the resident to the hospital. Resident #022 was diagnosed as having a specific injury.

A review of resident #022's care plan current at the time of the fall indicated that resident #022 was at risk for falls, the staff used a specified restraint in the resident's wheelchair at all times for safety and 1 staff was to assist the resident for toileting.

A review of the homes investigation interview notes with PSW #115 indicated PSW #115 had taken resident #022 to the washroom and placed them on the toilet. PSW #115 indicated she had left the washroom and resident #022 fell. PSW #115 indicated that she was aware that she should not have left resident #022 unattended on the toilet.

During separate interviews with inspector #622, Personal Support Worker (PSW) #112 and PSW #113 indicated that according to the care plan, resident #022 had a history of

falls and used a specified restraint at all times while in their wheelchair. Both PSW #112 and PSW #113 indicated that since resident #022 was at risk for falls and used the specified restraint, the expectation would have been that resident #022 should never have been left unattended on the toilet.

During an interview with inspector #622, DOC #103 indicated the care plan indicated that resident #022 was at risk for falls, used a specified restraint in their wheelchair at all times and required one staff to toilet them. DOC #103 also indicated if resident #022 had a history of falls and used a specified restraint, it would be expected that staff would not leave the resident unattended on the toilet. DOC #103 further indicated that PSW #115 was aware resident #022 was not to be left unattended on the toilet.

Therefore the licensee failed to ensure that the care set out in the 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 that there is a written plan of care for each resident that sets out the planned care for the resident; the goals the care is intended to achieve; clear directions to staff and others who provide direct care to the resident and that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: 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 drugs were administered in accordance with the directions for use by the prescriber.

On a specified date, resident #025 was administered 0.5mg of a specified medication at a specified hour in place of the ordered 0.25 mg of the specified medication. The resident received the wrong medication dosage.

On a specified date, resident #023 was ordered a specified medication four times daily. The medication administration record had been signed indicating the specified medication had been administered for five and a half days however the medication had not been given. The resident continued to have symptoms and was given the specified medication starting five and a half days later.

On a specified date, resident #024 had been administered 4.5mg of a specified medication at a specified time and was administered another dose of the same medication approximately five hours later. The medication was administered at the wrong time, the correct administration time was at a specified time.
A review of the Electronic Medication Administration Record (eMAR) dated for a specified month for resident #024 indicated the specified medication 4.5 mg was ordered every 12 hours.

The licensee failed to ensure medications for residents #023, #024 and #025 were administered in accordance with the directions for use by the prescriber. [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 that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #3: 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. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident was reported to the resident or the resident's substitute decision-maker (SDM).

The homes medication incidents were reviewed for the last quarter.

A review of the medication incident report dated a specified date, indicated resident #025 was administered 0.5mg of a specified medication at a specified time in place of the ordered 0.25 mg. There were no adverse effects to the resident, the Nurse Practitioner was informed however the report did not indicate that the resident/SDM were notified. A review of resident #025's progress notes on Mede-care dated on specified dates, indicated there was no documentation to support that the resident/SDM were notified of the medication incident.

A review of the medication incident report dated a specified date indicated resident #023 was ordered a specified medication on a specified date. The medication administration record had been signed as administered for five and a half days however the medication had not been given. The resident continued to have specific symptoms and was given the medication starting five and a half days later. During a review of this medication incident, it was noted that the resident/SDM were not notified.

During an interview with inspector #622, RN #107 indicated she could not recall if she notified resident #025 or the SDM of the medication incident dated on a specified date. RN #107 indicated if she had called the SDM, she would have marked it on the medication incident report.

During an interview with inspector #622, Assistant Director of Care #108 indicated that in the event of medication incidents the resident/SDM are to be notified. ADOC #108 also indicated that resident #023 and #025's SDMs should have been notified however the documentation indicated they were not.

During an interview with inspector #622, the Administrator indicated that the Director of Care had reviewed the documentation related to the two above mentioned medication incidents and had indicated that there was no documentation to support that the residents/SDMs had been notified of the medication incidents. [s. 135. (1)]

Issued on this 1st day of February, 2018

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

Original report signed by the inspector.