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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 5, 2018	2018_752627_0017	021660-18	Resident Quality Inspection

Licensee/Titulaire de permis

Foyer Hearst - Mattice - Soins De Sante
67-15th Street P.O. Box 1538 HEARST ON P0L 1N0

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

Foyer Des Pionniers
67 15th Street P.O. Box 1538 HEARST ON P0L 1N0

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

SYLVIE BYRNES (627), TIFFANY BOUCHER (543)

Inspection Summary/Résumé de l'inspection

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

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

This inspection was conducted on the following date(s): August 28-30, 2018.

The following intakes were inspected during this Inspection:

**One critical incident system (CIS) report related to falls; and,
one CIS report related to medication administration.**

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Dietary Manager (DM), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), family members and residents.

The Inspectors also conducted a tour of resident care areas, observed the provision of care and services to residents, staff to resident interactions, reviewed relevant health care records, policies and procedures.

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
Residents' Council

During the course of this inspection, Non-Compliances were issued.
- **3 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. 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 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 #543 reviewed a medication incident report which identified that resident #008 was administered incorrect medication.

Inspector #543 reviewed the home's "Administration of Medication" (05-02-03) policy, with a review date of June 2018. The policy indicated that staff would use the basic rules of drug administration: correct resident, correct medication, correct dosage, correct time and correct route.

The Inspector reviewed resident #008's medication administration record, which indicated that the resident was ordered a specific medication.

Inspector #543 interviewed the Administrator who verified that resident #008 was not administered the specific medication as ordered by the physician and that they had received another medication instead. [s. 131. (1)]

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

A critical incident system (CIS) report was submitted to the Director, related to a medication error. According to the CIS report, resident #007 was not provided with a specific intervention.

Inspector #543 reviewed the home's investigation notes which revealed that the staff neglected to intervene at a specific time, and neglected to do the specific intervention for a period of 12 days.

The Inspector reviewed the resident's physician orders, which indicated that resident #007 was to receive the specific intervention daily, and consequently, may have received another intervention.

Inspector #543 reviewed resident #007's documentation which indicated that the resident was not provided with the specific intervention for a total of 12 days.

Inspector #543 interviewed the Administrator who verified that the registered staff had not provided resident #007 with the specific intervention for a period or 12 days, as ordered by the physician. [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 #2: 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 there was a written plan of care for each resident that set out;
a) The planned care for the resident;
b) The goals the care was intended to achieve; and
c) Clear directions to staff and others who provided direct care to the resident.

Resident #003 was identified as having pain in their minimal data set (MDS) assessment.

Inspector #627 interviewed resident #003 who stated that they had pain which affected their ADLs occasionally.

Inspector #627 reviewed the resident assessment protocol (RAP) for the MDS assessment which indicated that the care plan was to be updated with specific goal to prevent the development of complications, resident #003 was to be comfortable and pain free.

Inspector #627 reviewed the resident's care plan in effect at the time of the inspection, and the resident's archived care plan, and could not identify a focus for to address resident #003's pain management.

Inspector #627 interviewed Registered Nurse (RN) #104 who stated that a pain assessment was completed on admission and quarterly when the MDS assessment was completed. The RN stated that care plans were updated by RNs, the Director of Care (DOC) and the Administrator. The RN who completed the RAP was responsible to create or update the care plan. The RN acknowledged that resident #003's pain should have been addressed in the written care plan.

Inspector #627 interviewed the DOC who stated that pain management was to be addressed in the resident's care plan with goals and interventions when a resident exhibited pain. Upon a review of resident #003's written care plan, they acknowledged that resident #003's pain management was not addressed in the resident's written plan of care. [s. 6. (1)]

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

Resident #002 was identified as having pain in their MDS assessment.

Inspector #627 interviewed resident #002, who stated that they had pain. The resident stated that they were not asked by the staff if they had pain and they had not wanted to bother the staff to make them aware of their pain.

Inspector #627 reviewed resident #002's care plan which indicated for the focus of comfort, an intervention which indicated a specific intervention in regards to the resident's pain.

Inspector #627 reviewed the home's policy titled "Pain Assessment and Procedure" which indicated that a pain assessment was to be conducted and documented for residents who rated their pain serenity at a four or greater on a zero to ten pain scale.

Inspector #627 interviewed Registered Practical Nurse (RPN) #102 who stated that they assessed resident #002's pain level in the morning by looking at their physical appearance. The RPN further stated that resident #002 had not voiced complaints of pain. The RPN indicated that they had never asked resident #002 to rate their pain on a pain scale. The RPN further indicated that the home utilized pain assessment tools, however, it was more for residents who demonstrated responsive behaviours, and could not verbalize having pain and that a pain assessment tool had not been initiated for resident #002.

Inspector #627 interviewed RN #104 who stated that a pain assessment was completed on admission and quarterly with the MDS. If a RAP was triggered, the care plan would be adjusted by the RN who completed the RAP. RN #104 acknowledged that no further assessment of the resident's pain had been completed.

Inspector #627 interviewed the Administrator who stated that when a resident's MDS assessment indicated moderate daily pain, a "Pain Management Monitoring Flow Sheet" was to be initiated and analyzed to ensure that the resident's pain was addressed. The Administrator indicated that a specific intervention had been added to the care plan. The Administrator acknowledged that the intervention had not been completed. [s. 6. (7)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that all areas where drugs were stored were restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator.

On a specific date, Inspector #543 observed a Maintenance staff enter the locked medication room.

Inspector #543 interviewed the DOC and the Administrator verified that the maintenance staff had had access to the medication room. [s. 130. 2.]

Issued on this 5th day of September, 2018

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

Original report signed by the inspector.