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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 22, 2019	2018_749722_0011	030538-18	Resident Quality Inspection

Licensee/Titulaire de permis

0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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

Frost Manor
225 Mary Street West LINDSAY ON K9V 5K3

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

COREY GREEN (722), SAMI JAROUR (570)

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): November 19, 20, 21, 22, 23, and 27, 2018

No intakes were inspected concurrently during this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (A/DOC), Environmental Services Manager, RIA-MDS Coordinator, Quality Improvement and Wound Care Nurse, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Family Council President, Resident Council President, family members and residents.

During the course of the inspection, the inspectors conducted a tour of the home; observed infection prevention and control practices, medication administration, staff to resident and resident to resident interactions, and resident home areas; and reviewed clinical health records (electronic and hard copy), staff schedules, and relevant home policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **4 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	Légende 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 that the care set out in the plan of care is provided to the resident as specified in the plan.

During stage 1 of the Resident Quality Inspection (RQI), the staff interview by Inspector #560 and record review by Inspector #722 on a specified date, indicated that resident #001 had altered skin integrity at a specified location, which triggered for further inspection. Inspector #722 reviewed the skin and wound assessments for resident #001 on a specified date, which indicated that the resident has had altered skin integrity at a specified location since a specified date.

Inspector #722 reviewed the current written care plan for resident #001 on a specified date, which indicated that staff will turn the resident every two hours daily when in bed.

Inspector #722 made routine observations of resident #001 during the inspection, and observed the resident laying in bed, on their back with a light sheet or blanket covering them, with one or two pillows under their head, and in a specific position, on specified dates and times. During one of these observations, Inspector #722 observed that resident #001 was on a therapeutic mattress with specified settings. The resident was also noted to be on a bed sheet system that assisted with lifting and positioning.

On a specified date and time, Inspector #722 reviewed a worksheet that was posted on a cabinet beside resident #001's bed, which was titled "Repositioning Every Two Hours" for a specified period, and found that no initials were entered by direct care staff over specified dates and time ranges.

During separate interviews with Inspector #722 on a specified date, PSW #104 and PSW #111 indicated that resident #001 required a specified level of care for all activities of daily living. The PSWs were aware of resident #001's area of altered skin integrity, and indicated that they get the resident up in an assistive device for meals, and returned the resident to bed soon after each meal, so the resident could spend more time on the therapeutic mattress.

During the separate interviews, PSW #104 and PSW #111 indicated that there was a repositioning worksheet for specified period posted on a cabinet beside resident #001's bed, where direct care staff were to enter their initials on the appropriate date and under the appropriate hour when the resident was turned and/or repositioned. PSW #104 also indicated that there was a module within the electronic health record where PSWs checked a box at the end of each shift to indicate that the resident was turned or

repositioned every two hours. Both PSWs indicated that these tools were not completed consistently by the direct care staff.

During the interview on a specified date, PSW #111 indicated that they used to always try to turn and/or reposition the resident every two hours, but they stopped doing this when the resident started using the therapeutic mattress. PSW #111 also indicated that they were aware that they should probably be turning the resident every two hours, and confirmed that the plan of care, including the worksheet the direct care staff get each shift, indicated that the resident was to be turned every two hours. PSW #111 indicated that the resident gets turned for specified care, but indicated that they do not normally keep the resident turned on their side so they can keep the head of the bed elevated to help the resident's breathing.

On a specified date and time, Inspector #722 interviewed RN #110, who was the wound care nurse in the home. RN #110 confirmed that resident #001's care plan indicated that they were to be turned every two hours, and that the expectation would be that the resident was turned from their back to alternating sides, as tolerated, using a pillow or rolled blanket to support the resident when on their side. RPN #110 also indicated that since the resident was on a therapeutic mattress, they were not sure if the resident still needed to be turned every two hours, but acknowledged that the resident's current plan of care, including the Kardex used by the direct care staff, reflected this.

During an interview with Inspector #722 on a specified date and time, the Administrator/Director of Care (A/DOC) confirmed that resident #001's plan of care indicated that they should be turned every two hours, and indicated that turning would mean from side-to-side with a pillow or blanket to support the resident. The A/DOC was not sure if the resident needed to be turned every two hours while on the therapeutic mattress, and indicated that they would be looking into that and update and revise the plan of care as appropriate.

The licensee failed to ensure that resident #001, who is dependent on staff for repositioning, was turned every two hours as required by the resident's plan of care. [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 the care set out in the plan of care related to turning and repositioning is provided to resident #001 as specified in the plan, to be implemented voluntarily.

WN #2: 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 where the LTCHA, 2017 or O.Reg. 79/10 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.

Under O.Reg. 79/10, s. 48. (1): Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: 2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.

Under O.Reg. 79/10, s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required

under section 48 of this Regulation: 1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

The licensee's specified policies related to areas of altered skin integrity were reviewed by Inspector #722 on a specified date, and directed the following:
- Policy OTP-HLHS-4.6 (Effective date: May 2017): 2. Procedure: Specified types of altered skin integrity: The interdisciplinary team will reassess the area of altered skin integrity weekly and document assessment information as detailed in the policy.
- Policy HLHS-TP-4.7 (Effective date: April 2017): 2. Procedure: The following specified number of items shall be observed during the assessment of a specified area of altered skin integrity: assessment details as listed in the policy, and a weekly photo of the area of altered skin integrity. Each area of altered skin integrity will have the treatment plan evaluated by the registered nurse or their delegate at a minimum weekly in the specified software section in the electronic health record.

During stage 1 of the resident quality inspection (RQI), resident #001 was identified on a specified date, during the staff interview by Inspector #560 and record review by Inspector #722, as having an area of altered skin integrity in a specified location. Inspector #722 reviewed the head-to-toe skin assessments for resident #001 on a specified date, which indicated that the area of altered skin integrity was initially identified in a specified location on a specified date, and progressed over a specified period into an area of more serious altered skin integrity.

Inspector #722 reviewed resident #001's current written care plan on a specified date, which indicated that the resident had an area of altered skin integrity in a specified location; that registered staff will provide treatment as per the Healthy Living, Healthy Skin protocol; and that registered staff will provide treatment for the area of altered skin integrity as per orders. Review of the electronic treatment administration record (eTAR) for a specified period, indicated that staff will monitor the area of altered skin integrity, submit a skin integrity progress note, and complete a specified assessment with a picture every week on a specified day of the week. Inspector #722 reviewed the eTAR entries for each weekly period over a specified date range, which indicated that the weekly assessment was not delivered on specified dates. Inspector #722 reviewed the progress notes for resident #001 during this period related to the resident's area of altered skin integrity, and none of the entries included the assessment details required by Policy OTP-HLHS-4.6 and/or Policy OTP-HLHS-4.7.

Inspector #722 reviewed the specified assessments for resident #001 in the electronic medical record for each weekly period over a specified date range, which indicated that the weekly assessment was either not completed, or required assessment details were missing during specified weeks.

Inspector #722 interviewed RPN #108 on a specified date and time regarding resident #001's pressure ulcer assessments, who confirmed that a weekly assessment should be done on a specified date using the specified tool in the electronic medical record. RPN #108 reviewed some of the specified assessments in the electronic medical record for resident #001, and confirmed that some of the assessments were completely blank (i.e., assessment fields were empty and missing a photo), or they were incomplete (e.g., specified dates). RPN #108 also confirmed that registered staff may have provided assessment details in progress notes when they were providing treatment for resident #003's area of altered skin integrity, but that assessment details required as per policy were missing.

RN #110, who is the home's quality improvement and wound care nurse, was interviewed by Inspector #722 on a specified date and time related to resident #001's pressure ulcer, and indicated that the registered staff were expected to complete the specified assessment tool in the electronic medical record on a specified day every week, that included specific information, photo of the area of altered skin integrity, and any treatments as per the tool. RN #110 reviewed the specified assessments in the electronic medical record for a specified period, and indicated that the assessments were missing and/or incomplete on specified dates.

Inspector #722 interviewed the Administrator/Director of Care (A/DOC) on a specified date and time related to the specified assessments for resident #001's area of altered skin integrity. The A/DOC indicated that the expectation is that the area of altered skin integrity should be assessed weekly by the registered staff using the specified assessment form in the electronic medical record as per the home's policy.

The licensee has failed to ensure that the home's policies related to the specified area of altered skin integrity were complied with, when specified assessments using the required module in the electronic medical record were not completed on specified dates for resident #001. [s. 8. (1) (a),s. 8. (1) (b)]

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 policies related to pressure injury and wound management (OTP-HLHS-4.6) and wound assessment and documentation (Policy HLHS-TP-4.7) are complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a care conference of the interdisciplinary team providing a resident's care was held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any.

On a specified date, an interview with resident #006's Substitute Decision Make (SDM) indicated that they had not been invited to attend a six week care conference following resident #006's admission on a specified date.

Inspector #570 reviewed resident #006's health care record, both electronic and hard copy, which indicated that resident #006 was admitted to the home on a specified date. The Inspector was not able to find any indication that a care conference was held for the resident within six weeks of admission.

Inspector #570 reviewed the health care records for two other residents admitted in a specified month: resident #009 was admitted on a specified date, and resident #010 was admitted on another specified date. Inspector #570 was not able to find any indication that a care conference was held for either of these residents within six weeks of admission.

On a specified date, Inspector #570 interviewed RPN #102, who indicated that resident #006 was admitted on a specified date, and should have had an admission care conference completed at six weeks from admission. The RPN indicated that there is no documentation that a care conference was completed within six weeks following resident #006's admission. The RPN further indicated that the two other residents admitted during the specified month, resident #009 and resident #010, had no documentation that a care conference was completed within six weeks of admission.

On a specified date, during an interview with Inspector #570, the Administrator/Director of Care (A/DOC) confirmed that the six week care conferences were not held for residents #006, #009 and #010. The A/DOC indicated that care conferences were not where they should be due to recent management restructuring at the home.

The licensee did not ensure that a care conference was held within six weeks following admission for residents #006, #009 and #010. [s. 27. (1)]

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. (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 drugs were administered to resident #007 in accordance with the directions for use specified by the prescriber, when two medications that were not prescribed were administered to resident #007 on a specified date and time.

On a specified date, Inspector #722 reviewed a medication incident report for an incident that occurred on a specified date, involving resident #007 as part of the routine medication inspection during the Resident Quality Inspection (RQI). The medication incident report indicated that on a specified date, resident #007 received specified medications for a specified time of administration that were prescribed to another resident. The medication incident report indicated that RPN #105 confused resident #007 for another resident, and failed to verify the resident's identity prior to administering the medication.

The electronic medication administration record (eMAR) for resident #007 for a specified period of time was reviewed by Inspector #722 on a specified date, which indicated that resident #007 was ordered and received specified medications at a specified time on a specified date.

The progress notes for resident #007 were reviewed by Inspector #722 on a specified date, which indicated that on the specified date of the medication incident, resident #007 was mistaken for another resident by RPN #105 and was given the specified medications that were ordered for the other resident. On a specified date, Inspector #722 reviewed a letter provided to and signed by RPN #105 and the Administrator/Director of Care (Admin/DOC) on the date the incident occurred, where the RPN agreed that resident #007 was incorrectly administered another resident's medications.

On a specified date and time, Inspector #722 interviewed the A/DOC related to this medication incident. The A/DOC indicated that the RPN confused resident #007 with another resident, and that all the steps were not followed for checking the right resident. The A/DOC confirmed that RPN #105 gave resident #007 a specified number of medications that were not prescribed for them on a specified date and time as per the incident report, and indicated that there was no harm to the resident as a result of this medication incident.

The licensee failed to ensure that drugs were administered drugs in accordance with the directions for use specified by the prescriber, when resident #007 received a specified number of medications, at a specified date and time, that were not prescribed to the resident. [s. 131. (2)]

2. The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, when resident #007 received the incorrect dosage of a prescribed medication on a specified date.

During the medication observation on a specified date, Inspector #722 observed RN #106 administer the medications for resident #007 at a specified time. During this observation, Inspector #722 observed that a specified dose of a specified drug was administered to the resident; however, as described below, the dosage had recently been changed to a different dose.

On a specified date, Inspector #722 reviewed the eMAR for resident #007 for a specified period of time, which indicated that resident #007 was to receive specified medications at a specified time on the specified date of the medication observation.

On a specified date and time, Inspector #722 reviewed the latest quarterly medication review, which was signed by the physician on a specified date. The quarterly medication review indicated that the specified medication had been changed as specified in the order, when the physician wrote a different dosage over the pre-printed dosage on the quarterly medication review. The directions for use were otherwise unchanged on the quarterly medication review.

Inspector #722 interviewed RN #106 on a specified date, after observing the medication administration for resident #007, who indicated that the specified medication had been changed to a specified dosage by the physician on the quarterly medication review; that the pharmacy and reviewing nurse had not revised the eMAR accordingly; and confirmed

that resident #007 had received the previous dose of the medication at the specified date and time, rather than the new dose that was ordered by the physician on the quarterly medication review that was signed by the physician on a specified date. RN #106 identified the missed revision on the quarterly medication review, and immediately re-faxed the document to the pharmacy for correction.

The A/DOC was interviewed by Inspector #722 on a specified date and time related to this medication incident, who indicated that the wrong dose of medication had been administered to resident #007 on the specified date and time, when the resident received the previous dose of medication, rather than the new dose ordered on the quarterly medication review. The DOC confirmed that the change in the dose on the quarterly medication review was missed by the reviewing nurse, as well as the pharmacy when the document was faxed on a specified date. The A/DOC also indicated that normally the physician will strike out the old order on the quarterly medication review, and write a new order; however, because a specified number was written over top of the previous one in the dosage amount, and the directions were not revised accordingly, the increase was missed and the resident only received the previous dose of medication. The DOC also indicated that the reviewing nurse should have caught the revision and called for clarification of the order.

The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber, when resident #007 received the incorrect dose of a specified medication on a specified date and time. [s. 131. (2)]

Issued on this 30th day of January, 2019

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

Original report signed by the inspector.