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 23, 2018	2018_617148_0013	001402-18	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

Garden Terrace
100 Aird Place KANATA ON K2L 4H8

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

AMANDA NIXON (148), LINDA HARKINS (126)

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 13, 17- 20, 23-16, 2018

This inspection included a complaint (log #001789-18) related to skin and wound, medication administration, nutrition and hydration for an identified resident.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, both Directors of Care (DOC), Nutritional Care Manager (NCM), Resident Assessment Instrument (RAI) Coordinator, Clinical Care Coordinator, Life Enrichment Coordinator, Registered Dietitian, Physiotherapist, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Food Service Workers, Cook, PSW Students, family members and residents.

The inspectors reviewed resident health care records, documents related to the medication management system, dietary information used at the point of meal service and information pertaining to the Resident and Family Councils. In addition, the Inspectors toured resident care areas in the home and observed infection control practices and medication administration, staff to resident interactions and resident to resident interactions.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Residents' Council
Skin and Wound Care

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

- **3 WN(s)**
- **3 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

The licensee has failed to ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident.

During observations of resident #009, the resident was observed to remain in bed past the schedule breakfast meal service. Inspector #148 spoke with PSW #104, RPN #105 and Cook #106, who all reported that the resident prefers to sleep and does not usually rise for the breakfast service. PSW #104 and RPN #105 both reported that the resident usually rises after 1000 hours when the morning nourishment is passed. In discussion with PSW #104 it was noted that a labelled snack is provided by the kitchen and is provided to the resident at the morning nourishment pass and/or when the resident rises. This labelled snack was confirmed with the home's NCM #109.

The intake records for the last two months document the intake at breakfast as refused or sleeping. The plan of care for resident #009 was reviewed and indicated that the resident's preference was to rise at a specific hour prior to 1000 hours. The plan of care did not reflect the pattern of attendance at the breakfast meal service as demonstrated by staff interviews and record review.

As it relates to both the sleeping pattern and provision of three meals a day, the plan of care for resident #009 did not indicate the need or preference for late rising nor the resident's attendance the breakfast meal.

2) The plan of care for resident #010 indicated that the resident requires supervision or cueing; described as limited assistance.

The resident was observed at the breakfast meal on April 19, 2018, to be provided

assistance including verbal and physical encouragement and physical assist with the task of eating.

The Inspector reviewed the flow sheets whereby the level of assistance required by resident #010 is documented. The flow sheets indicated that the resident requires extensive to total assistance for eating at meals. The most recent assessment by the home's Registered Dietitian was conducted with the Minimum Data Set (MDS) assessment. The Resident Assessment Protocol (RAP) completed by the home's RD, indicated that the resident required extensive assistance. The Inspector spoke with PSW #104, who is familiar with the resident's care, who stated that resident #010 can be confused by the task of eating. PSW #104 stated that the resident requires extensive to total feeding assist and only minimally participates in the activity. The Inspector spoke with PSW student #108, who was providing direct care to residents, who stated that the Kardex at the nursing station would be the resource to reference to identify the needs of the resident. The Inspector reviewed the Kardex for resident #010 and noted that it was the same as the plan of care as described above.

As it relates to resident #010's need for assistance with eating, the plan of care was not based on the assessment or needs of the resident.

3) RPN #121 indicated that resident #020 has altered skin integrity that requires a specific treatment and a specific intervention. RPN #105 and RPN #114 and PSW #113 and PSW #120 indicated that they were aware that resident #020 requires an identified intervention to improve skin integrity.

The plan of care did not indicate the skin condition of resident #020 nor the need for a specific interventions.

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 plan of care is based on an assessment of the resident and the needs and preferences of that resident, 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 :

The licensee has failed to ensure that drugs are administered to a resident in accordance with the directions for use specified by the prescriber.

On a specified date, resident # 048 was to receive a pain medication four times during the day. On the following morning, at the beginning of the day shift, RPN #124 found two tablets of the pain medication in a small paper cup in resident #048's medications bin.

Resident #048 did not received the pain medication in accordance with the directions for the use specified by the prescriber, on a specified date

2) On a specified date, at the breakfast meal service, RPN #126 administered the medications prescribed for resident #049 to resident #010. Resident #049 did not suffer any adverse reactions.

Resident #049 did not received the medications in accordance with the directions for the specified prescriber.

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 a resident 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. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

The licensee has failed to ensure that (a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; (b) corrective action is taken as necessary; and (c) a written record is kept of everything required under clauses (a) and (b) of O.Reg., s.135(2).

During the inspection, Inspector #126 reviewed the medications quarterly review for the period of December 2017 to April 2018. It was noted in the report that there was two incidents on a specific date documented as "unaccounted controlled substances" for two different types of narcotics. These two narcotics were not delivered on a specific evening. The next morning, two internal Medications Incidents Notification Reports (MINR) were completed.

On the identified evening, RPN # 122 noted that two different types of narcotics were not delivered. RPN #122 documented on the "Shift to Shift Report", dated the next day, that the two different types of narcotics were not received on the evening and that the day charge RN #123 was to follow up.

The MINRs were reviewed and it was noted that the Pharmacist for the home was contacted by RN #123 and informed the RN that the two types of different narcotics were processed and that they were not at the pharmacy. The Pharmacist was to send new narcotic cards on the emergency run that day.

On the MINRS, there was a note that a discussion was held with the Pharmacy indicating that the driver had accidently left a bag behind at the pharmacy when making the delivery. This note was without a signature, date, time and without the name of the pharmacy staff that was spoken to.

Discussion held with DOC #118, who indicated to Inspector #126 that the DOC could not recall the date and time of the note but suspected that it was the morning after the narcotics were not delivered.

Discussion held with RPN #122, who indicated to Inspector #126 that if there was a problem with the medications delivery, the nurse usually writes a note for the day RN to follow up the next day because the pharmacy is closed on evening.

Discussion held with RN #123, who indicated that the pharmacy was contacted related to the two types of narcotics not received. The Pharmacist indicated that the narcotic medications were processed and to make sure they were not in the home.

In the documentation provided to Inspector #126, it was noted that the medication incidents related to the two narcotic medications were not analyzed and corrective action was not taken to prevent this incident from reoccurring. On April 24, 2018, the home initiated an analysis into the incident to review the medication management system as it relates to the delivery of medications.

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 all medication incident and adverse drug reactions are documented, reviewed and analyzed, corrective action is taken as necessary and a written record is kept, in accordance with O.Reg., s. 135(2), to be implemented voluntarily.

Issued on this 25th day of May, 2018

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

Original report signed by the inspector.