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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 20, 2015	2015_285546_0001	O-000464-14 X O-000694-14 X O-001368-14	Critical Incident System

Licensee/Titulaire de permis

THE CORPORATION OF THE CITY OF CORNWALL
1900 Montreal Rd. CORNWALL ON K6H 7L1

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

GLEN-STOR-DUN LODGE
1900 MONTREAL ROAD CORNWALL ON K6H 7L1

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

SUSAN WENDT (546)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 12, 13, 14, 15, 16, 21, 22, 23, 26, 27, 2015

For the following logs:
O-000464-14
O-000694-14
O-001368-14

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing, the Staff Educator, one registered practical nurse, Personal Support Workers, and one resident.

In addition, the inspector reviewed several CI reports, reviewed identified residents' health records (including care plans, medication administration records, flowsheets, hospital discharge summaries), observed resident care and services, reviewed the posted Residents' Bill of Rights, reviewed several medication incident reports and investigative notes taken by the Home, reviewed Employee Orientation agenda and checklists, employee confidentiality agreement, Policy acknowledgment, acknowledgment of mandatory training received for one registered staff, post-orientation questionnaire quizzes, Pointclickcare software training agenda and checklist and, pharmacy orientation inservice for registered staff. Reviewed the Home's following policies and procedures :
• Administering Routine Medications (Policy #4.2 -last revision July 2014)
• Administering and Documenting Controlled Substances (Policy #4.3 – last revision July 2014)
• Administering PRN Medications (Policy #4.4 – last revision July 2014)
• Medication Audits (Policy #5.2 – last revision July 2014)
• Falls Prevention Program (Policy #DM3-0509-07 – last revision Nov 2012)
• Falls Prevention Program (Policy #DM3-0509-18 – last revision Nov 2012)
• Falls Prevention Program (Policy # DM3-0509-__ to Reference Policy #DM3-0509-07 – last revision Nov 2012).

The following Inspection Protocols were used during this inspection:

Falls Prevention
Hospitalization and Change in Condition
Medication
Reporting and Complaints
Responsive Behaviours

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

- **4 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 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 comply with O. Reg. 79/10, s. 8 (1)(b) in 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, is complied with. [Log O-000694-14]

In accordance with O. Reg. 79/10 s. 114 (2) and (3), the licensee shall ensure that written policies and protocols are developed for the medication management system to ensure that accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home; the written policies and protocols must be implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

In January 2015, the inspector conducted an inspection for a Critical Incident whereby controlled substances were missing or unaccounted for. During the course of the visit, the inspector interviewed the Director of Nursing (DON) who provided her investigative handwritten notes, as well as copies of the incident reports.

During an interview with the inspector, the Staff Educator gave the inspector a copy of the Policies and Procedures of the Home's medication administration manual, as well as a copy of the registered staff's orientation in-service training for medication administration at the Home and signed attestion for the mandatory training.

A review of 3 critical incidents and the interviews conducted by the Home surrounding these incidents in the breach of controlled substances revealed that one registered staff had failed to have the destruction of unused controlled substances witnessed and/or co-signed by another registered staff, as per the Home's policy and evidence-based / prevailing practice. Following the extensive investigation by the Home, the registered staff was subsequently suspended from duties and reported to the appropriate authorities.

As such, a registered member of the Home did not follow the established medication administration policies and procedures, therefore the Home's medication administration, destruction and disposal policy did not comply with the Act. [Log O-000694-14] [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 all registered staff comply with the Act by following the Home's established medication administration policies and procedures, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a falls risk assessment was completed as part of the resident's plan of care.

On a specific date in January 2015, the Inspector reviewed a critical incident report for a resident who had sustained a fall and was sent to hospital.

According to the electronic progress notes, the resident fell in the bathroom on a specific date in November 2014 and sustained a periorbital laceration, a skin tear and pain; a late entry in the progress notes indicated that vital signs were taken and head injury routine was initiated. The resident was sent to hospital for full assessment and to rule out fractures. The resident returned from hospital with the diagnoses of fractures, which were immobilized. The resident presented with a periorbital hematoma; the resident denied any issues with vision and pupils were equal and reactive to light. The resident complained of pain and was medicated with relief.

A review of the resident's plan of care revealed no falls risk assessment tools in hard copy or electronic form, thereby not identifying fall risk levels for this resident. When interviewed in January 2015, S#101 confirmed that the resident had a history of multiple falls, but could not confirm whether this resident ever had a falls risk assessment completed.

The resident's care plan, dated November 2014, indicated that the resident was at risk for falls and numerous interdisciplinary measures were documented.

In a discussion with the inspector on a specific date in January 2015, the Director of Nursing (DON) informed the inspector that it was her expectation that the registered staff conduct a fall assessment for all residents on admission and quarterly thereafter, as indicated in the Falls Prevention Program's Policy #DM3-05-09-07 (effective 2007 April, with a review date of 2012 Nov). Later on the same day, the DON confirmed there was no falls risk assessment tools completed as per policy. [s. 26. (3) 10.]

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 residents receive a falls risk assessment at admission and quarterly thereafter, according to the Home's policy, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident received a post-fall assessment using a clinically appropriate assessment instrument, specifically designed for falls.

On a specific date in January 2015, the Inspector reviewed a critical incident report for a resident who sustained a fall and was sent to hospital.

According to the electronic progress notes, the resident fell in the bathroom on a specific date in November 2014 and sustained a periorbital laceration, a skin tear and pain; a late entry in the progress notes indicated that vital signs were taken and head injury routine was initiated. The resident was sent to hospital for full assessment and to rule out fractures. The resident returned from hospital with the diagnoses of fractures, which were immobilized. The resident presented with a periorbital hematoma; the resident denied any issues with vision and pupils were equal and reactive to light. The resident complained of pain and was medicated with relief.

Upon review of the plan of care, the inspector found no post-fall assessments. When interviewed in January 2015, S#101 indicated there was no post-fall assessment tool used.

In a discussion with the inspector on a specific date in January 2015, the Director of Nursing confirmed there was no post-fall assessment instrument used as they did not have those tools or processes in place. [s. 49. (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, when residents fall, the staff use a clinically appropriate post-fall assessment in a consistent manner, to be implemented voluntarily.

WN #4: 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was reviewed and revised upon the resident's return from hospital.

Upon review of a deceased resident's archived plan of care (both hard copy and electronic record), the inspector observed no updates in the care plan identifying the resident's care needs change for palliative care, other than oral medications were discontinued.

Progress notes indicated that on a specific date in May 2014, the resident sustained a fall with injury and was transferred to hospital. While in hospital, the resident was assessed as having aspiration pneumonia which did not respond to antibiotic therapy. Following a discussion with the family, it was decided by the attending physician that the resident should be on palliative care and transferred back to the Home for palliative care. The resident returned to the Home and died shortly thereafter.

On a specific date in January 2015 during a discussion with the inspector, the Director of Nursing confirmed that the plan of care had not been updated to reflect the resident's declining change in health status upon return from the hospital, where he was discharged for palliative care at the Home. The existing written care plan did not provide clear directions to frontline staff in regards to end of life comfort measures and care. [s. 6. (10) (b)]

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Issued on this 6th day of March, 2015

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

Original report signed by the inspector.