Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Oct 4, 2021	2021_916168_0008	013694-21	Critical Incident System

Licensee/Titulaire de permis

Schlegel Villages Inc.
325 Max Becker Drive Suite. 201 Kitchener ON N2E 4H5

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

Hamilton Continuing Care
125 Wentworth Street South Hamilton ON L8N 2Z1

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

LISA VINK (168)

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): September 28 and 29, 2021.

This Critical Incident System inspection was conducted for log 013694-21 related to plan of care.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the former Director of Care, registered nurses, registered practical nurses, housekeepers, a screener, agency staff and residents.

During the course of the inspection, the inspector observed the provision of care, toured the home, reviewed relevant records including, but not limited to, clinical health records, procedures and investigation files.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Infection Prevention and Control
Medication

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	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 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 failed to ensure procedures included in the required Medication Management System were complied with.

In accordance with O. Reg. 79/10, s. 114 (1) the licensee was required to develop an interdisciplinary medication management system and in accordance with O. Reg. 79/10, s. 114 (2) the licensee was required to ensure that policies and protocols were developed for the accurate dispensing of all drugs used in the home.

The home's procedure, from MediSystems Pharmacy, Prescriber's Order Reviews, under Part D Medications, identified in part that staff would compare the newly printed Prescriber's Order Review against the resident's current Medication Administration Record (eMAR), recent prescriber's orders, and the last Prescriber's Order Review to ensure the new review was up to date before the prescriber reviewed it.
Additional clarification was provided by the ED who confirmed that the top of the Prescriber's Order Review included the statement "discontinue all previous orders" and that once the review was signed by the physician only those orders included on the form were current orders.

i. A Resident had an order for a supplement change on the Physician's Digiorder.
The resident's Prescriber's Order Review was checked by two registered staff three days later, was signed by the physician seven days after the order was written, and processed by nursing staff the same day.
The Prescriber's Order Review did not include the order for the supplement, although the treatment remained on the eMAR and continued to be administered.
The procedure related to Prescriber's Order Reviews was not complied with when staff did not include the order for the supplement on the form.

Sources: A review of Physician's Digiorder, eMAR and Prescriber's Order Review for a resident, a review of procedure Prescriber's Order Reviews and interviews with staff.

ii. A resident had an intervention in place as documented in their clinical record.
An order was received related to the intervention, as recorded on the Physician's Digiorder.
The following month additional orders were received related to the intervention.
The Prescriber's Order Review was checked by two registered staff prior to the second order related to the intervention; however, was signed by the physician the day following the second order, and processed by nursing staff the same day.
The Prescriber's Order Review did not include any orders related to the intervention, although the intervention remained on the eMAR and continued to be in place.
A second Prescriber's Order Review was checked by two registered staff approximately three months later, was signed by the physician, and processed by nursing staff the same day.
The Prescriber's Order Review did not include any orders for the intervention, although the intervention remained in place.
The procedure related to Prescriber's Order Reviews was not complied with when staff did not include the orders for the intervention on the form.

Sources: A review of Physician's Digiorder, eMAR and Prescriber's Order Review for a resident, a review of procedure Prescriber's Order Reviews and interviews with staff. [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 where the Regulation requires the licensee to put in place any procedure that the procedure is complied with, 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of a resident so that their assessments were consistent with and complemented each other related to continence care and bowel management.

A resident had an intervention in place as documented in the clinical record.
The Minimum Data Set (MDS) assessment completed related to Continence In The Last 14 Days did not include the intervention.
The Resident Assessment Protocol (RAP) for Urinary Incontinence noted the intervention.
Interview with staff following a review of the documentation confirmed that the assessments were not consistent with each other and that the intervention was not identified in the MDS assessment in error.

The assessments were not consistent with and did not complement each other.

Sources: Assessments and progress notes for a resident and interviews with staff. [s. 6. (4) (a)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a required program including interventions and the resident's responses to interventions, were documented.

According to the eMAR a resident was to have an intervention completed on an identified date.
The eMAR for for the specific date was coded as "9" or "other see nurses notes".
The progress notes for that day included that the following day the intervention would be completed and that a reminder was set.
There was no documentation on the eMAR or in the progress notes from the planned date of the intervention until the end of the month that the intervention had been completed.
Interview with a staff member identified that to their recall they supported staff with the completion of the intervention; however, they could not recall when this occurred but confirmed that they did not document this intervention.
The intervention nor the resident's response to the intervention was documented as required.

Sources: Review of a resident's eMAR and progress notes and interviews with staff. [s. 30. (2)]

Issued on this 4th day of October, 2021

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

Original report signed by the inspector.