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

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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 24, 2018	2018_536537_0009	005623-18	Resident Quality Inspection

Licensee/Titulaire de permis

The Corporation of the County of Lambton
789 Broadway Street WYOMING ON N0N 1T0

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

Lambton Meadowview Villa
3958 Petrolia Line, R.R. #4 PETROLIA ON N0N 1R0

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

NANCY SINCLAIR (537), ALICIA MARLATT (590), HELENE DESABRAIS (615), TERRI DALY (115)

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 3, 4, 5, 9, 12, 11, and 12, 2018

The following intakes were completed within the RQI:

Related to allegations of abuse to a resident:
Log #029702-16/CIS M547-000016-16
Log #005336-17/CIS M547-000010-17

Log #004975-18/CIS M547-000019-18

Related to missing or unaccounted for controlled substances;
Log #006624-17/CIS M547-000011-17
Log #002547-17/CIS M547-000005-17
Log #000022-17/CIS M547-000020-16
Log #033135-16/CIS M547-000018-16
Log #009783-17/CIS M547-000014-17

Related to Injury that Results in Transfer to Hospital and which results in a Significant Change
in Status:
Log #017162-16/CIS M547-000008-16
Log #024565-17/CIS M547-000022-17
Log #003614-17/CIS M547-000008-17
Log #029203-16/CIS M547-000010-16
Log #018056-17/CIS M547-000017-17
Log #029301-16/CIS M547-000013-16
Log #019283-16/CIS M547-000004-16
Log #000098-17/CIS M547-000021-16

Related to improper/incompetent or neglectful care of a resident:
Log #002684-17/CIS M547-000007-17
Log #021279-17/CIS M547-000020-17
Log #028619-16/CIS M547-000012-16

Related to family concerns in follow up to an allegation of abuse of a resident:
Log #003605-18/IL-55596-LO

Follow up to CO #001 and #002 related to the failure to immediately report and investigate allegations of resident abuse:
Log #000785-18
Log #000787-18

The following intake was inspected concurrently with the RQI and can be found in a separate report:
Log #002883-18/IL-55406-LO related to multiple care related concerns.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing and Personal Care (DONPC), Registered Dietitian (RD), Comfort Trust Clerk, Quality Improvement/Resident Assessment Instrument Coordinator (QI/RAI), four Registered Nurses (RN), seven Registered Practical Nurses (RPN), five Personal Support Workers, (PSW), Resident Council representative, Family Council representative, Residents and Families.

The inspector(s) also conducted a tour of all resident areas and common areas, observed residents and care provided to them, meal service, medication passes, medication storage areas, reviewed health care records and plans of care for identified residents, reviewed policies and procedures of the home, meeting minutes and observed the general maintenance and cleanliness of the home.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **4 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 23. (1)	CO #001	2017_566669_0028	537
LTCHA, 2007 S.O. 2007, c.8 s. 24. (1)	CO #002	2017_566669_0028	537

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. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC), documenting improper care of a resident.

Review of the resident's progress notes showed a note that documented an area of skin impairment on two occasions that was not assessed using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Review of the homes policy titled "Skin and Wound Care - 3-5-19-6", last reviewed November 3, 2017, stated in part, if a resident had been identified as having a new pressure/stasis ulcer, new rash/excoriation resulting in break in skin, change in skin issue, a Comprehensive Skin Assessment was to be completed in Point Click Care (PCC).

Review of the resident's completed assessments showed that a Comprehensive Skin Assessment had not been completed or documented in PCC until eight days after the area of skin impairment was initially identified.

In an interview with Quality Improvement Coordinator #102, they shared that when an area of skin impairment was reported to registered staff, the registered staff should complete an assessment on the home's assessment tool in Point Click Care (PCC) as soon as possible.

In an interview with Administrator #100, they acknowledged that the resident should have had a skin assessment completed when the area of impaired skin integrity was first identified, using the home's Comprehensive Skin Assessment in PCC.

The licensee has failed to ensure that an assessment using a clinically appropriate assessment instrument was completed when a resident was identified as having an area of altered skin integrity. [s. 50. (2) (b) (i)]

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 a resident experiencing altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report included the description of the individuals involved in the incident and the names of any staff members or other persons who were present at or discovered the incident.

a) A Critical Incident System (CIS) report submitted by the home stated a resident reported that a staff member refused to assist them to perform a task the resident could not complete independently. The CIS report did not include the name of the staff person identified in the incident.

During an interview, Administrator #100 stated they contacted their Human Resources representative and the Union representative and no one knew or recalled the staff's name since it was not documented.

b) A CIS report submitted by the home indicated that a resident had verbalized a concern to a Personal Support Worker (PSW) while they were being provided care. The resident reported that the PSW did not seriously consider their verbalized concern, left the room and did not return. The CIS report did not indicate the description or name of the PSW identified in this incident.

During an interview, Administrator #100 stated that the Administrator and the Director of Nursing and Personal Care (DONPC) at the time of the incident were no longer employed by the home. Administrator #100 stated that the CIS report had been completed by the former DONPC of the home and that since there was no documentation of the incident found other than the CIS report, they did not know the name of the PSW involved in the incident.

The licensee has failed to ensure that the report to the Director regarding the alleged, suspected or witnessed incident of abuse of residents included the description of the individuals involved in the incidents and the names of any staff members or other persons who were present at or discovered the incidents. [s. 104. (1) 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 in making a report to the Director under subsection 23 (2) of the Act , the licensee shall include in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report, a description of the individuals involved in the incident, including names of any staff members or other persons who were present at or discovered the incident, to be implemented voluntarily.

WN #3: 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 residents in accordance with the directions for use specified by the prescriber.

Medication incidents reported in the home were reviewed for the time period of October 2017, November 2017, and December 2017. There were eight medication incidents, including one in October, five in November and two in December.

The medication incidents included the following incidents:

A medication incident reported that a registered practical nurse (RPN) discovered medications prescribed for a specified resident on a specific date to be in medication drawer beyond the required date of administration.

A medication incident reported that a medication for an identified resident was signed in the electronic Medication Administration Record (eMAR) as being administered; however a registered staff member found the medication remained in the package and that the count card was not signed as given to the identified resident.

A medication incident reported that an identified resident had an order for the administration of a specific medication over a specified number of day; however registered staff found some of the medication still in the vial after the date that the last dose was to be given.

The Remedy’s RX Pharmacies policy titled "Medication Administration and Documentation", dated September 1, 2013, revised March 1, 2016, was reviewed and stated, under Medication Administration
“3. All medication must be administered to residents according to the directions for use specified by the Prescriber.”

In an interview with Administrator #100, they said that previously the home did not have appropriate processes in place and that medications should be administered as prescribed by the physician.

The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber when residents did not receive medications as ordered. [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 #4: 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 :

1. The licensee has failed to ensure that all medication incidents and adverse drug reactions were documented, reviewed and analyzed, and that corrective action was taken as necessary.

Medication incidents reported in the home were reviewed for the time period of October 2017, November 2017, and December 2017.

There were 8 medication incidents, including one in October, five in November and two in December.

The medication incidents included the following incidents:

A medication incident reported that a resident had an order for the administration of a specific medication over a specified number of days, however registered staff found

some of the medication still in the vial after the date that the last dose was to be given. The report did not include information completed on the home's Remedy's Rx Medication Incident/Near Miss Report form under the heading:
Identify factors (Root Cause) contributing to this incident and Corrective Action to prevent similar occurrences in the future.

The Remedy’s RX Pharmacy policy titled "Medication Administration and Documentation", dated September 1, 2013 revised January 29, 2018, was reviewed and stated, under Procedure:
"6. The Director of Care or Pharmacy Manager, as appropriate, investigates the medication incident, identifying factors contributing to the incident and documents findings on the Medication Incident/Near Miss form.
7. The Director of Care or Pharmacy Manager, as appropriate, determines corrective actions to be taken to reduce the risks of similar incidents occurring in the future."

During an interview with Registered Practical Nurse #121, they said that when a medication incident occurred it was discussed, causes were looked at, and how the home would correct the incident to ensure that it did not happen again.

Director of Nursing and Personal Care (DONPC) #118 said that when incidents were brought to their attention they followed up with causes, things to do to mitigate risk, and then processes were reviewed with the nurse related to medication administration and the College of Nurse's Medication administration requirements were reviewed with the registered staff involved.

The licensee has failed to ensure that all medication incidents were analyzed and corrective action taken for an incident involving a resident. [s. 135. (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 every medication incident involving a resident and every adverse drug reaction is documented, reviewed and analyzed; corrective action is taken as necessary; and a written record is kept of everything required under clauses (a) and (b), to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where there was a written policy that promoted zero tolerance of abuse and neglect of residents that the policy was complied with.

A review of a Critical Incident System (CIS) report submitted by the home to the Ministry of Health and Long Term Care, alleged neglect by a staff member to an identified resident when a staff member refused to assist a resident when requested.

A review of the home's addendum to policy #2-8-18, "Abuse (reported and/or suspected)-Process Checklist", dated October 25, 2017, stated in part: "Immediately call the on call supervisor. Provide details. If this constitutes abuse, immediately call the MOHLTC at 1-800-268-6060 (after business hours) or 1-519-675-7685 (DURING BUSINESS HOURS) to: report the allegations, advise them that an investigation has been started, advise that a follow up CIS will be submitted with details".

During interviews, Registered Nurse (RN) #109, Registered Practical Nurses (RPN) #108 and #116 stated that they would immediately report suspected abuse or neglect of residents to their supervisor.

During an interview, RPN #108 stated that a staff came to them and told them that the identified resident was upset regarding a staff. RPN #108 spoke to the resident and reported the alleged neglect to the Administrator of the home at the time.

During an interview, Administrator #100 stated that at the time of the incident, other persons were the Administrator and DONPC of the home and that the CIS report was completed by the DONPC at that time. Since there was no documentation of the incident found other than the CIS report, they did not know if the DONPC and Administrator knew of the alleged neglect on the date as specified, but it would be expected that the CIS report should have been completed at that time.

The licensee has failed to ensure the home's policy regarding the reporting of alleged abuse was complied with when a resident and RPN #108 reported and incident to the former Administrator. [s. 20. (1)]

Issued on this 5th day of June, 2018

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

Original report signed by the inspector.