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

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 22, 2017	2017_505103_0040	019093-17	Complaint

Licensee/Titulaire de permis

THE CORPORATION OF THE COUNTY OF LANARK
P.O. Box 37 Sunset Blvd. PERTH ON K7H 3E2

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

LANARK LODGE
115 Christie Lake Road, R. R. #4 Lot 27, Concession 2 PERTH ON K7H 3C6

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

DARLENE MURPHY (103)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): September 18-21, 2017

Log #019093-17 (complaints related to resident care).

During the course of the inspection, the inspector(s) spoke with Personal support workers (PSW), Registered Practical Nurses (RPN), the Registered Dietitian (RD), the RAI Coordinator, the Assistant Director of Care and the Administrator.

During the course of the inspection, the inspector observed resident care including dining, reviewed the resident health care record including the progress notes, physician's orders, weight monitoring records, medication administration records and the resident plan of care, applicable policies and the home's complaint process.

The following Inspection Protocols were used during this inspection:
Dining Observation
Hospitalization and Change in Condition
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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 resident #001's substitute decision maker (SDM) was given the opportunity to participate fully in the development and implementation of the resident's plan of care.

Resident #001 was admitted to the home on a designated date and was noted to have identified diagnoses. The resident's health care record was reviewed including the resident's progress notes and bowel continence records. On an identified date, the staff documented the resident had two episodes of loose stools and throughout that same identified month, the resident was documented as having had a total of twenty-two loose bowel movements.

Staff were interviewed and stated the resident's usual bowel pattern was either normal or constipated and that the episodes of loose stools were unusual for this resident.

Resident #001's spouse and power of attorney (POA) visited the resident on a regular basis and was not made aware of this change in condition until approximately three weeks after the onset of the loose stools. [s. 6. (5)]

2. The licensee has failed to ensure resident #001 was reassessed and the plan of care was reviewed and revised when the resident's care needs changed.

As outlined above, resident #001's bowel habits over the identified month demonstrated

a change in the resident’s condition and care needs. The resident's electronic medication administration records were reviewed. Resident #001 received seven doses of a medication used to treat loose stools during the identified month. Six out of the seven doses administered had the effectiveness of the medication documented as “unknown”.

The RAI coordinator was interviewed and indicated alerts are built into the home’s electronic documentation system (point click care) which flag a variety of changes in resident’s care needs. The alerts are generated from the documentation entered into the system by the personal support workers. Alerts are sent to the dashboard of the documentation system and registered staff can then review the alert and take action. When the action or reassessment is completed, the staff member would then clear the alert.

The RAI coordinator indicated one of the alerts is for residents that have three or more loose bowel movements in a twenty-four hour period of time. The alerts for the identified month were reviewed for resident #001 and there had been a total of four alerts sent. The resident health care record had no documentation to support the reassessment of this resident in response to these alerts.

During the identified month, there were no documented assessments to support the reassessment of this change in care needs. Resident #001's loose stools continued throughout the identified month and the following month. On an identified date, RN #100 noted in the progress notes that the resident had been having loose stools over the past month and at that time, the physician and dietitian were asked to assess the resident for possible causes of the loose stools.

The licensee failed to ensure resident #001 was reassessed and the plan of care reviewed and revised when the resident's care needs changed. [s. 6. (10) (b)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 117. Medical directives and orders — drugs
Every licensee of a long-term care home shall ensure that,
(a) all medical directives or orders for the administration of a drug to a resident are reviewed at any time when the resident's condition is assessed or reassessed in developing or revising the resident's plan of care as required under section 6 of the Act; and
(b) no medical directive or order for the administration of a drug to a resident is used unless it is individualized to the resident's condition and needs. O. Reg. 79/10, s. 117.

Findings/Faits saillants :

1. The licensee has failed to ensure no medical directive or order for the administration of a drug to a resident is used unless it is individualized to the resident's condition and needs.

As outlined in WN #1, resident #001 began having loose stools on an identified date and continued to have loose bowel movements throughout the period of two identified months. The resident electronic medication administration records were reviewed. The inspector noted an identified medication used to treat diarrhea was included on the resident medication administration records as an "as required" medication since the resident had been admitted to the home. During a review of the monthly medication administration records, it was noted that the resident had not required or received this "as required" medication for a period of approximately eight months.

When the resident began have bouts of loose stool again on the identified date, the medication was once again administered by the registered staff and was given a total of seven times during the identified month.

The Administrator of the home was interviewed in regards to the inclusion of this medication on the resident medication administration record. She indicated all "as required" medications which have been unused for twelve weeks or longer are to be discontinued. She stated during the three month medication reviews, the registered staff are responsible to check on the "as required" medications and to discontinue all that

have not been used during the previous three month period of time. The Administrator confirmed the identified medication should have been discontinued since resident #001 had not required the medication for more than a twelve week period of time. At least two, three month medication reviews would have been completed since that time.

The Administrator did provide this inspector with a copy of the directive titled, "Discontinuing Held or Unused Medications". The directive indicated: where resident medications remain on hold or where prn (as required) treatments or prn (as required) medications have been unused for twelve weeks or longer, this medical directive shall serve as an order to discontinue the medication. A completed copy of this page will be faxed to pharmacy to ensure the medication treatment/medication administration record remains current. Further use of the medication will require re-ordering from the resident's physician.

The licensee has failed to ensure no medical directive or order for the administration of a drug to a resident was used unless it is individualized to the resident's condition and needs. [s. 117. (b)]

Issued on this 27th day of September, 2017

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

Original report signed by the inspector.