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
Oct 26, 2017	2017_527665_0010	021539-17	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
5015 Spectrum Way Suite 600 MISSISSAUGA ON 000 000

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

MACKENZIE PLACE
52 GEORGE STREET NEWMARKET ON L3Y 4V3

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

JOY IERACI (665), THERESA BERDOE-YOUNG (596)

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): October 2, 3, 4, 5, 6, 10, 11, 12 and 13, 2017.

The following Complaint Intake Log #010524-15 was inspected concurrently with the Resident Quality Inspection (RQI) related to Residents' Bill of Rights, accessibility of 24 hour nursing care and choices at meal service.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Resident Assessment Instrument (RAI) Coordinator, Classic Care Pharmacist (CCP), Recreation Manager (RM), Associate Director of Care/Wound Care Chamption (ADOC/WCC), Director of Care (DOC) and the Executive Director (ED).

The inspectors also conducted a tour of the home including resident home areas, medication administration observations, dining observations, staff and resident interactions, provision of care observations, reviewed clinical health records, reviewed meeting minutes, staffing schedules, relevant home policies and procedures and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

4 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	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. (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).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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 staff and others involved in the different aspects of care of the resident collaborate with each other 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.

The Continence and Bowel Management inspection protocol (IP) triggered from stage one of the Resident Quality Inspection (RQI) for resident #002.

Record review of the resident #002's Minimum Data Set (MDS) assessment on an identified date in 2017, indicated the resident's bowel and bladder status. Record review of the resident's written care plan and kardex revealed specific interventions for toileting.

Interviews with Personal Support Workers (PSWs) #109 and #127 revealed resident #002's care interventions for toileting was different from the resident's written care plan and kardex. PSW #127 stated that he/she had always provided a specific intervention to resident #002 related to toileting since an identified month in 2016, which was different from the written care plan and kardex.

Observation of the resident's identified over bed logo indicated a specific intervention for transfers, which was different from the resident's written care plan and kardex.

PSW #109 stated that he/she should have informed the registered staff about resident #002's interventions for toileting was not as the kardex and care plan indicated so that the resident's care plan would have been updated by the nurse. PSW #109 admitted that this was missed.

According to Registered Practical Nurse (RPN) #122 and Registered Nurse (RN) #123, they were not aware that the care resident #002 required with toileting reflected differently in the written care plan and kardex from the logo above the resident's bed. RN #123 stated that it was the registered staff's responsibility to update the resident's plan of care, but was not informed of the change in status by the PSW staff. RN #123 later informed the inspector that they spoke with the PSW staff and changed the resident's care plan and kardex to reflect the specified interventions for toileting.

2. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

During observation of a medication pass on an identified date and time with RPN #103, and review of the double locked narcotic drawer of the medication cart, the inspector observed the following identified narcotic medications for residents #013 and #019:

-the identified narcotic medication card belonging to resident #013, contained 11 capsules
-the identified narcotic medication card belonging to resident #019, contained five tablets

Record review of resident #013's Narcotic and Controlled Drug Administration Record (NCDAR) revealed a count of 12 capsules of the identified narcotic at 0700 hrs on the identified date in October 2017, and review of resident #019's NCDAR revealed a count

of six tablets of the identified narcotic on the same date.

Interview with RPN #103 revealed that the medication counts documented on the NCDARs for both residents were incorrect, as he/she had administered the above mentioned medications to residents #013 and #019 at 0800 hrs as ordered, but did not sign off on their respective NCDARs after administering the medications. RPN #103 acknowledged that he/she should have signed off on both residents NCDARs immediately after administering the narcotics, and stated that he/she would do it right away.

Record review of the home’s Medisystem pharmacy policy titled "Narcotic and Controlled Substances Administration Record", last reviewed January 17, 2017, stated that all entries must be made at the time the drug is removed from the container.

Interview with the Director of Care (DOC) revealed that the provision of care was not documented. The home’s expectation is that the above mentioned registered staff should have signed off on resident #013 and #019’s NCDARs immediately after administration of their narcotic medication.

3. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan was no longer necessary.

The Continence and Bowel Management IP triggered from stage one of the RQI for resident #006.

Record review of the resident #006's MDS assessment on an identified date in 2017, indicated resident’s bowel and bladder status.

Record review of the resident's written care plan identified specific interventions for toileting.

Interview with PSW #119 revealed that he/she has not provided resident #006 with one of the specified interventions for toileting in the past two to three months, due to a change in resident status. The PSW reported the kardex and care plan needed to be revised to reflect this.

Interview with RPN #120 revealed the same information about resident #006 as

mentioned above by PSW #119. The RPN told the inspector he/she will update the resident's care plan and kardex.

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:
- staff and others involved in the different aspects of care of the resident collaborated with each other 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.

- the provision of the care set out in the plan of care is documented.

- the plan of care is reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan was no longer necessary., to be implemented voluntarily.

WN #2: 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 a resident exhibiting altered skin integrity, including pressure ulcers 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.

Resident #004 was triggered from stage one for prevalence of an identified altered skin integrity through MDS and staff interview.

Record review of resident's MDS assessment on an identified date in 2017, revealed resident #004 had an area of altered skin integrity which resolved on an identified date in 2017. A progress note on two identified dates in 2017, revealed resident #004's identified altered skin integrity reoccurred and received treatment.

Interviews with RPN #103 and RN #116, indicated when an altered skin integrity is discovered on a resident, it is the home's policy and expectation for three identified assessments to be completed by the registered staff. The RPN and RN indicated when an identified altered skin integrity resolves and reoccurs, it is the expectation that the identified assessments be initiated and completed upon discovery. The registered staff reviewed resident #004's assessments and indicated the assessments were not completed when resident #004's alteration in skin integrity reoccurred on an identified

date in 2017. Both registered staff acknowledged resident #004 did not receive a skin and wound assessment when the alteration in skin integrity reoccurred as per home's expectation.

Interview with the home's Associate Director of Care/Wound Care Champion (ADOC/WCC), indicated it is the home's expectation that the three identified assessments be completed upon discovery of an identified altered skin integrity. The ADOC/WCC reviewed the progress notes and assessments for resident #004 and indicated that a skin and wound assessment was not carried out by the registered staff when the identified area of altered skin integrity on resident #004 reoccurred and was discovered on an identified date in 2017. The ADOC/WCC acknowledged that the home did not follow the home's expectation regarding completion of a skin and wound assessment for resident #004.

2. Resident #006 was triggered from stage one for prevalence of an identified altered skin integrity through MDS.

Record review of resident's MDS assessment on an identified date in 2017, revealed resident #006 had areas of altered skin integrity. On an identified date in 2017, a progress note indicated the discovery of the identified areas of altered skin integrity on the resident.

Review of the assessments revealed two identified assessments were completed on two identified dates in 2017. The inspector did not locate a third identified assessment for skin and wound in resident #006's clinical records.

Interviews with RPN #103 and RN #116, indicated that when a specified altered skin integrity is discovered on a resident, it is the home's policy and expectation for three identified assessments be completed by the registered staff. RN #116 reviewed resident #006's clinical records and indicated that an identified assessment was not completed upon discovery of the identified areas of altered skin integrity as per home's expectation.

Interview with the home's ADOC/WCC, indicated it is the home's expectation that the identified assessment be completed upon discovery. The ADOC/WCC reviewed the progress notes and assessments for resident #006 and indicated that the identified assessment was not completed by the registered staff when the identified areas of altered skin integrity were discovered on an identified date in 2017. The ADOC

acknowledged that the home did not follow the home's expectation regarding completion of a skin and wound assessment for resident #006.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 116 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, met annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

Record review of the home's 2016, Medication Management Program Evaluation dated June 13, 2017, and the Support Office Summary report dated March 28, 2017, did not list the Medical Director as a participant in the evaluation.

Interview with the Executive Director (ED) revealed that that the Medical Director participated in the Medication Management Program Evaluation during the quarterly professional advisory meetings so his/her name was not included as a participant in the annual evaluation. The ED stated that there was change in the Medical Director in 2017, and neither one participated in the home's 2016, annual evaluations on March 28 and June 13, 2017.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area or a medication cart that was used exclusively for drugs and drug-related supplies, that was secure and locked.

On an identified date in October 2017, during observation of a medication administration pass the inspector observed a small transparent plastic bag that contained personal items, in the double-locked section of the medication cart containing narcotics.

During an interview with RPN #103, he/she stated that he/she did not know which resident the personal items belonged to and they should not be stored in the narcotics drawer.

Interview with the DOC revealed only narcotics should be stored in the double-locked section of the medication cart containing narcotics.

Issued on this 1st day of November, 2017

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

Original report signed by the inspector.