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
Dec 21, 2017	2017_505103_0053	024731-17	Resident Quality Inspection

Licensee/Titulaire de permis

UNITED COUNTIES OF LEEDS AND GRENVILLE
746 County Road 42 P.O Box 100 ATHENS ON K0E 1B0

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

MAPLE VIEW LODGE
746 COUNTY ROAD, 42 EAST P.O. BOX 100 ATHENS ON K0E 1B0

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

DARLENE MURPHY (103), SUSAN DONNAN (531), WENDY BROWN (602)

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): December 4-8, 11-12, 2017

The following intakes were inspected as a part of the RQI:
Log #000105-17 (alleged incident of resident to resident abuse),
Log #000949-17 (resident fall resulting in injury).

During the course of the inspection, the inspector(s) spoke with residents, family members, Resident Council representative, Family Council president, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal support workers (PSW), a maintenance worker, RAI coordinator, Support Services Supervisor, Resident Services Supervisor, Assistant Director of Care (ADOC) and the Administrator.

During the course of the inspection, the inspectors conducted a full walking tour of the resident care areas, reviewed resident health care records, applicable policies, resident activity calendars, Resident Council minutes and Family Council minutes, made observations related to resident care, observed resident dining, resident activities, medication administration, medication storage practices and the home's infection control practices..

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

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

- **5 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 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).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The following finding relates to Log #000949-17:

The licensee has failed to ensure resident #011 was reassessed and the plan of care was reviewed and revised when the resident's care needs changed.

Resident #011 was admitted to the home on a designated date and with designated diagnoses. The resident's progress notes were reviewed for a specified period of time and staff were interviewed. The staff indicated that prior to the specified review period, the resident was independent in ambulation and mobilized without the use of aides. The resident plan of care in effect at that time indicated the resident was independent with ambulation and toileting.

During a specified six week period of time, there were several entries that indicated the resident was experiencing a decrease in ability to mobilize independently. These entries described the resident as having weak spells, unsteady gait, difficulty standing from a seated position, and having increased difficulty with transfers and ambulation.

On a specified date, the progress notes indicated a physiotherapy referral was made, but there was no documented evidence of an assessment during that period of time. The resident had an unwitnessed fall approximately five weeks later and sustained an injury.

RN #100 was interviewed and reviewed the resident's health care record. The RN indicated she was unable to find any evidence to support the reassessment of the resident during the six week period of time related to the resident's decrease in ability to mobilize independently. The RN stated the home request physiotherapy to assess the residents with any change in ambulation and noted physiotherapy was asked to assess the resident, but this assessment was not completed. The RN confirmed fall prevention strategies to mitigate the resident's risk of a fall were not put into place until after the resident fell.

The licensee failed to ensure resident #011 was reassessed and the plan of care was revised when the resident's needs changed. [s. 6. (10) (b)]

2. The licensee failed to ensure different approaches were considered when the care outlined in resident #011's plan of care was not effective.

The home began using a tab alarm with resident #011 following the above noted fall to reduce the risk of falls. Resident #011 fell again five days later. The tab alarm sounded at the time of the fall, but the resident was found on the floor. Five days later, the progress notes indicated the staff had reported the tab alarm had not been effective and that the resident frequently removed the alarm prior to ambulating. The tab alarm was then discontinued.

RN #100 was interviewed and indicated the tab alarm was not an effective fall prevention measure for this resident and that the decision to discontinue the alarm was justified. The RN however, was unable to provide the inspector with any evidence to support that the home had reassessed resident #011 for alternative strategies to mitigate the risk of another fall. On a specified date, resident #011 fell and sustained another injury.

The licensee has failed to ensure different approaches were considered when the care outlined in resident #011's plan of care was not effective. [s. 6. (11) (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 resident #011 is reassessed and the plan of care revised when the resident's care needs change and to ensure different approaches are considered when the care outlined in the plan is not effective, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair;

During the course of the inspection the inspectors noted the following:

Brookside home area:

Rm 103
-multiple 1/2-1 cm drywall scraped and gouged, brown in colour, covering approx. 30 cm x 30 cm in the center of the wall to the left of resident seating area
-the ensuite bathroom, the sink outlet drain corroded on the outside
-lower bottom shelves of the vanity on both sides the bottoms are detached and hanging

Rm. 121
-glass stains on vanity
-corroded area noted on the sink outlet drain

Rm 135
--the wall to the left of the toilet bowl approximately 120 cm x 120cm the drywall is chipped with multiple small chips approximately 1 cm chips

Rm 140
-bathroom sink outlet drain corroded around the outside and on the screen

Rm. 142
-bathroom sink outlet drain corroded around the outside and on the screen

Rm 158

Common area:
Brookside tub/ shower room:
-the right lower wall of the tub area, the floor approx. 90 cm of the floor trim was damaged and detached from the wall in two approx. 8 cm from the wall, above the trim an area approximately 120 cm x 7 cm open where the ceramic tile and the drywall broken away with sharp ceramic broken edges.
-the lower shelf of the open vanity at the east end of the tub, to the left of the sink approx. 7cm x 3 cm compressed board broken away, splintered with sharp edges.
-the lower shelf to the right of the sink enlarged scaling/splintered with sharp edges

-worn, splintered, stained coffee table in the south entrance lounge

Meadowview:
-common lounge across from the nurses station, multiple drywall ceiling patches unfinished, two with brown discoloured stains resembling water stains approx. 180 x 120 cm
-ceiling in corridor across from the dining room approx. 90 cm x 120 cm drywall patch, brown stain, resembling water stain
-approx. 30 cm x 10 cm brown water stain
-ceiling across from E118 there was a approx. 120 x 150 cm unfinished drywall patch unfinished
-approx. 30 x 30 cm stain / drywall patch behind the ceiling mounted exit sign

-ceiling across from E113 multiple unfinished drywall patches, approx. 200x 200 cm, 40 x 120 cm, 90 x 120 cm and 30x 30 including brown stains resembling water stains.

On December 8, 2017 during an interview and observation tour of the homes identified areas of disrepair with the Support Services Supervisor she acknowledged the disrepair and indicated that the maintenance will be prioritized and addressed. [s. 15. (2) (c)]

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 the home, furnishings and equipment are maintained in a safe condition, to be implemented voluntarily.

WN #3: 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. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident was documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and reported to the resident, resident's substitute decision maker (SDM), if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician, or the registered nurse in the extended class attending the resident and the pharmacy service provider.

The inspector requested to review the home's medication incidents from March 1, 2017 to May 31, 2017. A total of eight incidents were provided to the inspector for that period of time.

RPN #106 and #118 were interviewed in regards to the home's process for documenting medication incidents. RPN #106 indicated the registered staff member that discovers the error documents the details of the error on a medication incident progress note on the

resident’s health record, completes a medication incident report and makes the appropriate notifications. RPN #118 indicated that the notifications to the resident's SDM and physician are to be documented in the resident's medication incident progress note. The RPN stated if the notifications were not documented then they were not notified.

One of the incidents reviewed involved resident #036 who was admitted to the home in a designated year and had designated diagnoses. On a designated date, the registered staff member discovered resident #036 had received the prescribed anti -convulsive medication two hours and fifteen minutes later than the ordered schedule. The RN instructed the registered staff member who discovered the incident to administer one tab at 1700 hour and the extra tablet from 1700 hour at bedtime. The physician had ordered the medication to be given at 0800 hour and 1200 hour and two tablets at 1700 hour. The resident’s health status and untoward effects were not assessed or documented as a result of this medication error. [s. 135. (1)]

2. The licensee has failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that occurred in the home since the last review in order to reduce and prevent medication incidents, and any changes and improvements identified in the review were implemented and a written record was kept of everything.

The inspector requested to review the home’s medication incidents from March 1, 2017 to May 31, 2017. A total of eight incidents were provided to the inspector for that period of time.

The inspector requested to review the written record of the quarterly review of the medication incidents. Upon review of the record provided there was no documentation to support a review of the home's medication incidents for that time period.

During an interview with the Assistant Director of Care, she indicated that the quarterly review had not included all medication incidents for the time period. [s. 135. (3)]

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 every medication incident involving a resident is documented together with a record of the immediate actions taken to assess and maintain the resident's health, every medication incident is reported in accordance with the legislative requirements and that quarterly reviews are undertaken of all medication incidents to reduce and prevent medication incidents and that any changes or improvements are documented, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The following finding relates to Log #000105-17:

The licensee has failed to ensure the results of the home's abuse investigation was reported to the Director (MOHLTC).

On a designated date, residents #043 and #034 were involved in a resident to resident altercation that resulted in injuries to resident #034. The home notified the after-hours pager of the incident on the date of the incident and made the appropriate notifications in accordance with the legislated requirements. A critical incident was submitted three days after the incident outlining the details of the altercation. No additional amendments to this critical incident were made.

The Director of Care was unavailable for an interview. The Administrator was interviewed and indicated the DOC would be the person responsible for investigating the incident of resident to resident abuse. She was unable to determine why the results of the abuse investigation were not completed and reported to the Director. The Administrator consulted with the DOC and later indicated that a similar incident had occurred between these same two residents on the day prior to the above noted incident. The DOC advised the Administrator that the second critical incident served as a follow up to the two incidents.

The licensee failed to report the results of the home's abuse investigation to the Director (MOHLTC). [s. 23. (2)]

WN #5: 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 drugs were administered to residents in accordance with the directions for use specified by the prescriber.

Resident #034 was admitted to the home in a designated year and had designated diagnoses. On a specified date, the registered staff discovered the resident's 0800 hour Trazadone was in the package in the medication cart at the change of shift and had not been administered to the resident. The physician had ordered this resident to receive Trazadone at 0800 hour and 1700 hour. The resident was monitored and had no untoward effect as a result of the error.

As outlined in WN #3, on the specified date, resident #036 did not receive the prescribed anti -convulsive medication in accordance with the physician's orders. The physician had ordered the resident to receive one tablet of the medication at 0800 hour and 1200 hour and two tablets at 1700 hour.

Resident #044 was admitted to the home in a designated year and had designated diagnoses. On a specified date, the registered staff member discovered that resident #044 did not receive Hydromorph contin as prescribed for pain. The omission was found during the medication count at 1400 hour. The physician had ordered Hydromorph Contin 3mg at 0800 hour and 2100 hour. [s. 131. (2)]

Issued on this 2nd day of January, 2018

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

Original report signed by the inspector.