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

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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
Jul 16, 2018	2018_505103_0019	007077-18	Resident Quality Inspection

Licensee/Titulaire de permis

County of Prince Edward
603 Highway 49 R.R. #2, Hallowell Township PICTON ON K0K 2T0

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

H.J. McFarland Memorial Home
603 Highway 49, R.R. #2, Hallowell Township PICTON ON K0K 2T0

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

DARLENE MURPHY (103), JESSICA PATTISON (197)

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): June 26-29, July 3-5, 2018.

The following intakes were included in this inspection:
Log #007869-18-follow-up to order,
Log #009605-18 (CIS #M556-000015-18)-controlled substance missing,
Log #009987-18 (CIS #M556-000020-18)-alleged staff to resident neglect,
Log #011675-18 (CIS #M556-000023-18)-alleged resident to resident abuse,
Log #014904-18 (CIS #M556-000026-18) and Log #013746-18 (CIS #M556-000025-18)-alleged misuse/misappropriation of resident's money.

During the course of the inspection, the inspector(s) spoke with residents, family members, Resident Council President, Family Council President, RAI coordinator, Receptionist, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Resident Quality Supervisor, Director of Care (DOC) and the Administrator.

During the course of the inspection, the inspector conducted a tour of all resident home areas, made observations related to resident care, medication administration, medication storage and infection control practices, reviewed resident health care records, applicable policies, the home's process for managing medication incidents and resident and family council meeting minutes.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

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

- **6 WN(s)**
- **5 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. 24. (1)	CO #001	2018_505103_0007	103

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. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure all doors leading to non-residential areas were kept closed and locked when not being supervised by staff.

On June 27, 2018 on or about 1015 hour, this inspector observed the main laundry room door was propped open. Upon entering the room, the inspector found no staff in the laundry room or in the vicinity at the time.

On June 28, 2018 on or about 1130 hour, this inspector observed a door labelled "storage" on the Whispering Pine's resident home area. The door was noted to be ajar and upon entering, the inspector noted the room contained a range of resident care products. At the time of the observation, there were no staff in the vicinity.

The Administrator was interviewed and stated both of these doors are to be closed and locked when staff are not present as they are non-residential areas. [s. 9. (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 all doors leading to non-residential areas are kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers and full body sponge baths.

Resident #004's current care plan indicated that the resident prefered a bath and their scheduled bath days were Mondays and Thursdays on the day shift.

Resident #005's current care plan indicated that the resident was to receive tub baths and their scheduled bath days were Tuesdays on the evening shift and Fridays on the day shift.

Resident #007's current care plan indicated that the resident prefered a bath and their scheduled bath days were Monday and Friday evenings.

Upon review of documentation in Resident #004, 005 and 007's health care records and in the Point Click Care dash board bulletin from April 1- July 5, 2018, the following was found:

Resident #004 did not receive their scheduled baths on April 19, May 7 and 10, 2018.
Resident #005 did not receive their scheduled baths on April 13, 20, May 4, 11 and July 3, 2018.
Resident #007 did not receive their scheduled baths on April 2, 13, 16, 23, 30, May 11, 14, 25 and June 18, 2018.

There was no documentation to indicate that any of these missed baths had been made up on another date.

Resident #004 indicated in an interview that they were supposed to get two baths per week, but sometimes it didn't happen due to a lack of staff. Occasionally the bath would be made up later, but most times they had to wait until the next scheduled day.

Resident #007 indicated in an interview that sometimes they only get one bath per week due to staffing.

Resident #005 could not be interviewed.

During an interview with PSW #109, they stated that they were aware that some baths were not being completed. They stated if they were able to work their full shift then the baths got done. PSW #109 indicated that at times they get pulled to cover in other areas of the home and when this happens they cannot get the scheduled baths done. They further stated that the missed baths are not always made up in the week.

The Director of Care indicated that they were aware of residents missing their scheduled baths. They stated that the home has had ongoing issues with the bath person getting pulled to cover in other areas when they are short staffed. They further indicated that the current plan is to put an extra person on the next day when this happens to make up the missed baths.

The licensee has failed to ensure that residents #004, 005 and 007 were bathed, at a minimum, twice a week by the method of their choice. [s. 33. (1)]

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 each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee responds in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

The Residents' Council Meeting Minutes were reviewed back to January 2018. The following concerns were documented as being brought forward during the meetings:

January 2018 - Would like to see everyone given the chance to go on outings and not the

same people over and over
- Want non diet drinks offered at snack pass and at events. Want aspartame free drinks. Picton water tastes like Javex - want different water.

February 2018 - Residents upset about cigarette butts littering the front entryway.
- Waiting for response to poor tasting water and aspartame free drinks.
- Staff are sometimes very loud at night while people are trying to sleep.

- Would like to know if there is some way to avoid line-ups for the nurse. Can never tell where they are or when they will be back. Having trouble with the nursing staff saying that the doctor will see them and then not getting any follow-up from the doctor.

March 2018 - Still concerned with baths being missed.
- Would like more seating in shady spots for the summer.

April 2018 - Baths being missed still a concern
- Would like an answer from Environmental services about more shady seating in the summer

May 2018 - Missed baths: Action memo written for DOC. Baths are being missed when bath staff are pulled to cover absences on the floor.
- Need more shady seating on the grounds: Action memo written for Environmental Services.
- Not happy with agency nurses. Agency nurses are sometimes mixing up medications and not asking residents what their names are.

June 2018 - Council brought forward concern regarding artificial sweeteners, specifically aspartame, in the food.

During an interview with the Residents' Council President, they indicated that the Council had brought forward a concern related to residents missing their baths and did not think that a written response to this concern had been provided.

Upon review of the Residents' Council meeting minutes, it did not appear that any written responses had been made to the Council related to any of their concerns or recommendations.

The current Residents' Council Assistant, staff #108, indicated to the inspector that they were new to the position and was not aware that a written response was required within 10 days of the Residents' Council bringing concerns or recommendations forward.

Both the Director of Care and the Administrator were also interviewed and confirmed that they had not made any written responses within 10 days to the Residents' Council related to their concerns and recommendations. [s. 57. (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 within 10 days of receiving the advice, the licensee shall respond to the Residents' Council in writing, to be implemented voluntarily.

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 secured and locked.

On June 26, 2018, during the initial tour of the home, this inspector noted that each of the four resident home areas had a medication style cart that was being used for the storage of resident medicated ointments. Each of the medication style carts were equipped with a locking device, but at the time of the observations, none of the four medication carts utilized for the storage of resident medicated ointments were locked. There were no staff observed in the area of these medication carts at the time of the observations.

On July 5, 2018, the inspector observed the medication style carts on two of the resident home areas were unlocked at the time of the observation and no staff were in the vicinity of the carts at that time. PSW staff were interviewed and stated the carts were to be locked at all times when they are not accessing the ointments.

The DOC was interviewed and stated all staff are to ensure the medication carts used to stored medicated ointments for the residents are to be kept locked at all times when not being used. [s. 129. (1) (a)]

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 drugs are stored in an area or medication cart that is secure and locked, to be implemented voluntarily.

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 in accordance with directions for use specified by the prescriber.

Resident #028's physician orders and electronic medication administration record (eMAR) for an identified month/year were reviewed and indicated the resident was ordered to receive an identified medication every twelve hours.

On an identified date, an incident identified as MEDINC26373 outlined that resident #028 was given an identified medication by the wrong route in error. The resident sustained no untoward effects as a result of the error. [s. 131. (2)]

2. The following non-compliance relates to Log #009987-18:

The home submitted a critical incident (CIS) M556-000020-18 that outlined on an identified date, resident #026 had not received an identified medication as prescribed as a result of a miscommunication between RN #106 and RPN #107.

During a review of resident #026's health care record, it was noted resident #026 was ordered to receive an identified medication. On an identified date, resident #026 missed two regularly scheduled doses and a third dose was one hour late as a result of the miscommunication.

Resident #026 was assessed by RN #106 prior to administering the identified medication.

The licensee failed to ensure resident #028 and resident #026 were administered drugs in accordance with directions for use specified by the prescriber. [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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was immediately informed, in as much detail as possible in the circumstances, of an outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.

A reportable outbreak was declared in the home on an identified date. Upon review of the information and the home's infection control practices related to the outbreak, it was noted by the inspector that there was no Critical Incident Report submitted for the outbreak.

During an interview with the Director of Care on July 4, 2018, they confirmed that they had not submitted a Critical Incident Report to inform the Ministry of Health and Long-Term Care of the outbreak. [s. 107. (1) 5.]

Issued on this 16th day of July, 2018

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

Original report signed by the inspector.