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 prévue le Loi de 2007 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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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jun 22, 2018;	2018_605213_0007 (A2)	004202-18	Resident Quality Inspection

Licensee/Titulaire de permis

Meadow Park (London) Inc.
c/o Jarlette Health Services 5 Beck Boulevard PENETANGUISHENE ON L9M 1C1

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

Meadow Park (London)
1210 Southdale Road East LONDON ON N6E 1B4

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

Amended by RHONDA KUKOLY (213) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

A request was received from the licensee on June 22, 2018 to the London Service Area Office for extension of the compliance date from June 25, 2018 to July 23, 2018.

Issued on this 22 day of June 2018 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Amended by RHONDA KUKOLY (213) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): May 4, 7, 8, 9, 10, 11, 14, 15, 16, 2018.

The following intakes were inspected concurrently while in the home completing the RQI:

Log #017478-17 Critical Incident #2643-000033-17 related to alleged staff to resident abuse.

Log #017495-17 Critical Incident #2643-000032-17 related to alleged resident to resident abuse.

Log #022880-17 Critical Incident #2643-000037-17 related to falls.

Log #026648-17 Critical Incident #2643-000041-17 related to falls.

Log #017786-17 Complaint related to alleged resident abuse/neglect.

Log #021742-17 Complaint Infoline #IL-52863-LO related to alleged resident to resident abuse.

Log #000147-18 Complaint Infoline #IL-54809-LO related to care concerns.

Log #002568-18 Complaint Infoline #IL-55304-LO related to care concerns.

Log #025136-17 related to a follow up to Compliance Order #001 issued in Resident Quality Inspection #2017_606563_0014 regarding O. Reg. 79/10 50(2)(b)(i) skin & wound management.

Log #025137-17 related to a follow-up to Compliance Order #002 issued in Resident Quality Inspection #2017_606563_0014 regarding O. Reg. 79/10, s. 114 (1) related to medication management.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Co-Director of Care, the Staff Educator, the Resident Assessment Instrument Coordinator, the Environmental Services Supervisor, the Life Enrichment Coordinator, the Food Services Supervisor, the Resident and Family Services Coordinator, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Behavioural Supports Ontario Personal Support Worker, Dietary Aides, an Administrative Assistant, family members and residents.

The inspector(s) also conducted a tour of the home and made observations of residents, activities and care. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed. Inspector(s) observed meal and snack service, medication administration and drug storage areas, resident/staff interactions, infection prevention and control practices, the posting of Ministry information and inspection reports and the general maintenance, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Sufficient Staffing

During the course of the original inspection, Non-Compliances were issued.
- **5 WN(s)**
- **1 VPC(s)**
- **1 CO(s)**
- **1 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
O.Reg 79/10 s. 114. (1)	CO #002	2017_606563_0014	563

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,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).
(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).
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and O. Reg. 79/10, s. 50 (2).
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff upon any return of the resident from hospital; that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (i) 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, (ii) received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required, (iii) was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; and any resident who was dependent on staff for repositioning was repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load.

Ontario Regulation 79/10, s. 50(3) defines altered skin integrity as the potential or actual disruption of epidermal or dermal tissue.

The home's policy "Skin and Wound Program", revised July 20, 2017, stated in part:
• A resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff upon return from hospital.
• A resident exhibiting altered skin integrity receives immediate treatment and interventions to reduce or relive pain.
• A resident exhibiting altered skin integrity 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 and is reassessed at least weekly by a member of the registered nursing staff if clinically indicated.
• Any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required.
• A resident with actual alteration in skin integrity has a completed wound assessment and treatment record completed with initiation of impaired skin integrity and with any change in treatment.

a) A review of documentation, including progress notes and skin/wound assessments in Point Click Care (PCC), over an identified twelve week period of time, for resident #018, showed that the resident had a number of areas of altered skin integrity. The progress notes and assessments in PCC also showed that a skin assessment was not completed upon a return from hospital and that initial wound assessments and weekly wound assessments were not completed as required, for all of the areas of impaired skin integrity.

In an interview, the Director of Care (DOC) said that the expectation was that skin assessments upon return from hospital, initial and weekly wound assessments should have been completed for resident #018.

In an interview, the Resident Assessment Instrument (RAI) Coordinator said that the resident should have had a head to toe skin assessment completed when they returned from the hospital and did not. They also acknowledged that all required wound assessments had not been completed for resident #018.

b) A review of documentation including progress notes and assessments in PCC, over an identified six week period of time, for resident #026 showed that the resident had a number of areas of altered skin integrity with pain. The progress notes and assessments in PCC also showed that a skin assessment was not completed upon a return from hospital and that initial wound assessments and weekly wound assessments were not completed as required, for all of the areas of impaired skin integrity. Additionally, there were no pain assessments completed for pain related to a wound and there were no immediate treatments/interventions to reduce or relieve pain and/or to promote healing.

Further review of the plan of care for resident #026 showed that the resident was dependent on staff for repositioning, and the plan of care did not provide for repositioning every two hours or more frequently as required.

In an interview, the RAI Coordinator acknowledged that when resident #026 returned to the home from hospital exhibiting altered skin integrity, they were to receive 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. They said the resident should have received treatment to reduce or relieve pain and that resident #026, who was dependent on staff for repositioning was to be repositioned every two hours or more and that this would be part of the plan of care.

In an interview, Administrator said that the expectation was that weekly wound assessments would be completed using a clinically appropriate assessment tool for a resident with impaired skin integrity, and that this had not been completed for resident #026.

c) A review of documentation including progress notes and skin assessments in Point Click Care (PCC), over an identified five week period of time, for resident #023, showed that the resident had a number of areas of altered skin integrity. The progress notes and assessments in PCC also showed that that initial wound assessments and weekly wound assessments were not completed as required, for all of the areas of impaired skin integrity.

The treatment orders and the electronic Treatment Administration Record (e-TAR) for resident #023 were also reviewed for a two month period of time and showed several orders and directions did not provide direction related to the area to receive the ordered treatment. In addition, several ordered treatments did not have documentation showing that the treatment was provided as planned for resident #023.

In an interview, the Administrator said that treatment orders for wounds were ordered by the physician and that the registered staff were to sign for treatments in the e-TAR. They said if the documentation was incomplete on the e-TAR, the treatment would not have been completed, and should have been for resident #023. The Administrator also acknowledged that the treatment areas were not always specified on the e-TAR and did not provide clear direction for staff.

The licensee has failed to ensure that residents who were at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff upon any return from hospital; that residents 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 and reassessed at least weekly by a member of the registered nursing staff if clinically indicated, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment; that residents received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required; and that residents who were dependent on staff for repositioning were repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load. [s. 50. (2)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A2)The following order(s) have been amended:CO# 001

DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #2: 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. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

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 no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident.

A Medication Incident Form was completed for resident #037. Resident #037 was administered the wrong medication strip that included two medications. The incident type was documented as "incorrect patient" and "incorrect drug" with no harm to the resident as confirmed by monitoring and intervention.

In an interview, the Director of Care (DOC) #102 acknowledged that resident #037 was administered resident #039's medications for an identified date and time.

The licensee has failed to ensure that no drug was used by or administered to resident #037 unless the drug had been prescribed for the resident. [s. 131. (1)]

2. The licensee has failed to ensure that drugs were administered to residents in

accordance with the directions for use specified by the prescriber.

A Medication Incident Form was completed for resident #036. An identified medication was not included in the strip pack for an identified date and time. The incident type was documented as an omission that reached the resident, but without harm.

The progress notes in Point Click Care stated that the specific medication was not available and not found in the medication strip. The electronic Medication Administration Record (eMAR) for that month, documented a code of "9", which indicated "Other / See Nurse Notes".

In an interview, the Director of Care (DOC) #102 stated that pharmacy packaged the medication for the 0800 hour medication pass, but the order was documented in the eMAR for administration at 2000 hours. The medication was not given at 0800 hours, it was removed from the package and then the medication was not available for the 2000 hour time for administration. The DOC acknowledged that the resident did not receive the medication on two dates at 2000 hours as prescribed.

The licensee has failed to ensure that medication was administered to resident #036 on two identified dates at 2000 hours in accordance with the 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 that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident and that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care
Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident related to bathing.

The Ministry of Health and Long-Term Care received a complaint which included a concern related to bathing for resident #024.

Documentation, including the plan of care, the task list in Point Click Care (PCC), documentation in Point of Care (POC), and the paper bath schedule in the bath book at the nursing station, was reviewed for resident #024. The three different areas of documentation all showed three different directions for bathing including different days and preferences.

The home's documentation of bathing completed was reviewed in PCC by Inspector #689. Given the understanding that resident #024 expected to have two baths per week, documentation of resident baths over a four week period showed for three out of eight opportunities (38 per cent), there was no bath documented.

The home's paper documentation of bathing were reviewed and showed ten baths were documented (55.5 per cent) over a nine week period for resident #024.

In an interview with a staff member, Inspector #689 asked the staff how they determined when a resident's bath was. The staff said they would look at the bath schedule in the bath book. When asked where staff look to find the residents' bath type and preferences, the staff said resident preferences were not in the bath book and they would ask registered staff for the information, who would let staff know about resident's care preferences. The staff stated that they would sometimes look at the Kardex on Point of Care (POC), which reflected the care plan, but it was not always up to date. When asked who updated the care plan, the staff said that registered staff updated the care plan, and that they had issues with the care plan being reflective of usual care. The staff stated that if a resident bath was missed, they would report it to the registered staff. They said that the information regarding baths, including refusal, was not relayed back to the staff. The staff said that if a bath needed to be completed, they heard it verbally from the registered staff. They said that the problem was that the bath schedule did not relay what information was on POC for baths and the POC did not have updated resident information.

In an interview with the DOC, the Inspector asked what the expectation was regarding documentation for baths. The DOC said that if a resident refused, it was marked as refused in PCC and in the bath log book. The DOC said they would periodically check the log book and ask what is going on. They stated that three or four weeks ago, the home was short staffed and some baths were missed at that time. The inspector asked if there was a new employee, where were they expected to look for a bath schedule for a resident. The DOC said the staff would look in the bath schedule sheets and then look at the list in the bath book. They said that each shift would write down which resident needed a bath to be done and write it on their list. The Inspector asked why resident #024's bath schedule showed one bath day on the bath schedule. The DOC said that the resident took one bath per week now, and that's why they were on the schedule for the one day. When asked if they would expect that this resident was offered two baths per week, the DOC said yes. The Inspector and the DOC reviewed the task list in PCC and the Kardex/Care Plan with the DOC, which showed different preferences and days, when asked by the Inspector why the difference, the DOC said it was on a particular day of the week because a staff member had the most success for giving the resident a bath on that day. The DOC said resident #024 was offered on two different days of the week.

In an interview with a registered staff member, Inspector #689 asked the staff where staff looked to find the residents' bath type and preferences. The staff said that preferences were in the care plan. When asked what resident #024's bath schedule was, the staff reviewed the care plan on their computer and stated that the resident was scheduled for a bath on two specified days. When asked who updated the care plan for bathing, the staff said that they did not update the schedule, that the managers changed the bath schedule. When asked what the process was if a resident refused a bath, the staff stated that the PSW will offer the bath the next day after reviewing the bath log book.

In an Interview with another staff member, Inspector #689 asked the staff where staff looked to find the resident's bath type and preferences. They said they would look at the bath schedule in the bath book, or if the resident was vocal the resident would let the staff know. When asked who updated the care plan if there was a change in the bath schedule, the staff said they would let the registered staff know and changes would be made to the bath schedule. When asked what the process was if a resident refused a bath, they stated that the information was documented in POC and the information was passed onto registered staff.

A review of the home's policy entitled "Resident Rights, Care and Services – Nursing and Personal Support Services – Bathing" with no revision date, stated under procedures the following:
"The Registered Staff Member will:
- Ensure that the resident's plan of care provides a documented and accurate reflection of the individual personal care needs of the resident, with care and consideration.
- Ensure the resident's plan of care provides a documented and accurate reflection of the:
 - the resident's preferred method of bathing.
 - the preferred day of the week of bathing
 - the preferred time of day of bathing
 - the resident's current state of health and well-being
 - the weather
 - the policies and procedures of the long term care home"

"The PSW will:
 - Follow the documented resident's plan of care, to ensure the provision of bathing in keeping with:
 - the resident's preferred method of bathing.

- the preferred day of the week of bathing
- the preferred time of day of bathing
- the resident's current state of health and well-being
- the weather
- the policies and procedures of the long term care home
- Follow the current schedule of bathing, in keeping with the set standard of the long term care home."

The licensee has failed to ensure that there was a written plan of care for resident #024 that set out clear directions to staff and others regarding the resident's bathing schedule. [s. 6. (1) (c)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Silver Fox Pharmacy Drug Destruction: Controlled Substances Policy 9.2 was complied with.

Ontario Regulation 79/10 s. 114 (2) states: "The licensee shall ensure that written

policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home."

Ontario Regulation 79/10 s. 136 (4) states: "Where a drug that is to be destroyed is a controlled substance, the drug destruction and disposal policy must provide that the team composed of the persons referred to in clause (3) (a) shall document the following in the drug record:
1. The date of removal of the drug from the drug storage area.
2. The name of the resident for whom the drug was prescribed, where applicable.
3. The prescription number of the drug, where applicable.
4. The drug's name, strength and quantity.
5. The reason for destruction.
6. The date when the drug was destroyed.
7. The names of the members of the team who destroyed the drug.
8. The manner of destruction of the drug. O. Reg. 79/10, s. 136 (4).

The Silver Fox Pharmacy "Drug Destruction: Controlled Substances" Policy 9.2 last revised May 2018, stated: "The following information must be documented on the Controlled Substance Administration Record for every controlled substance: the prescription number, the date the drug was dispensed, the name of the resident, and the medication name, strength, directions and dosage form." The policy also stated: "When removing the controlled substance from active supply, 2 registered staff members must indicate the reason for removal/destruction, the remaining quantity, and sign/date accordingly on the Controlled Substance Administration Record; and document the removal on the shift count (sign/date/quantity removed)."

Inspector #563 and the Director of Care (DOC) reviewed the controlled substance administration records that had missing information required by the legislation and the DOC verified there were 17 records of drug destruction that were missing required information documented on the forms including dates of destruction, reason for destruction, not signed, name of medication, and prescription numbers. The DOC acknowledged there was missing information on the controlled substance administration records for the identified drug destruction.

The Silver Fox Pharmacy Drug Destruction: Controlled Substances Policy 9.2 was not complied with. There were 17 out of 96 (17 per cent) of the LTC Controlled Substance Administration Records missing documentation required, as stated in

the Ontario Regulation 79/10, s. 136(4). [s. 8. (1) (b)]

WN #5: 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. (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 every medication incident involving a resident and every adverse drug reaction was reported to the resident, the resident's Substitute Decision Maker (SDM), if any, and the prescriber of the drug.

A Medication Incident Form for resident #036 indicated that a medication for a

specified date and time was not included in the strip pack. The incident type was documented as an omission that reached the resident, but without harm. The medication incident form did not document the notification of the prescriber of the drug or the resident and/or SDM. The form also documented that the incident was a pharmacy error related to dispensing / delivery.

In an interview, the Director of Care (DOC) acknowledged the medication incident involving resident #036, was also a nursing error since the resident did not receive the medication as prescribed. The DOC acknowledged that resident #036's SDM was to be notified that the medication was absent from the strip and the physician should have notified that the resident did not receive the medication.

The licensee has failed to ensure that every medication incident involving resident #036 was reported to the resident's SDM and the prescriber of the drug related to the omission of the medication. [s. 135. (1) (b)]

2. The licensee has failed to ensure that all medication incidents and adverse drug reactions were documented, reviewed and analyzed, corrective action was taken as necessary, and a written record was kept of everything.

A Medication Incident Form for resident #036 indicated their for a specified date and time was not included in the strip pack. The incident type was documented as an omission that reached the resident, but without harm. The form also documented that incident was a dispensing / delivery error by pharmacy. The medication incident form did not document the actions, comments, recommendations or improvement strategies implemented as corrective action.

In an interview, the Director of Care (DOC) acknowledged the medication incident involving resident #036 was also a nursing error since the resident did not receive the medication as prescribed. The DOC acknowledged that there was no follow up with the registered staff member involved. The DOC stated that the incident was treated as a pharmacy error and should have also been investigated as a nursing error with the appropriate corrective action taken. The DOC shared that they were responsible for following up with the staff involved and it did not occur for this incident.

The licensee has failed to ensure that the medication incident related to resident #036 was analyzed and corrective action was taken with the registered staff member to reduce and prevent future medication incidents. [s. 135. (2)]

Issued on this 22 day of June 2018 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de soins de longue durée

London Service Area Office
130 Dufferin Avenue, 4th floor
LONDON, ON, N6A-5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130, avenue Dufferin, 4ème étage
LONDON, ON, N6A-5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : Amended by RHONDA KUKOLY (213) - (A2)

Inspection No. / No de l'inspection : 2018_605213_0007 (A2)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 004202-18 (A2)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Jun 22, 2018;(A2)

Licensee / Titulaire de permis : Meadow Park (London) Inc.
c/o Jarlette Health Services, 5 Beck Boulevard, PENETANGUISHENE, ON, L9M-1C1

LTC Home / Foyer de SLD : Meadow Park (London)
1210 Southdale Road East, LONDON, ON, N6E-1B4

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Michelle Priester

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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To Meadow Park (London) Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2016_419658_0015, CO #001; 2017_606563_0014, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(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;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

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Order / Ordre :

(A1)
The licensee must be compliant with O. Reg. 50(2).

Specifically, the licensee will:
a) Review and revise the Skin and Wound Log/Audit to include treatment completed and documented as well as follow-up completed (date, person responsible, etc.). Implement the audit tool, including complete the tool as outlined, document the results and the follow up.
b) Identify the registered staff who should have completed skin/wound assessments for resident #018, #023 and #026 and provide those staff with re-training on when to complete skin assessments, including upon return from hospital or leave of absence, on admission, upon the presence of new altered skin integrity and weekly, as well as, the definition of impaired skin integrity.
c) Complete skin assessments for all residents within 24 hours of admission, upon return from hospital and upon return from an absence of greater than 24 hours.
d) Complete initial and weekly skin/wound assessments using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment for residents #018, #023, #026 and all other residents with impaired skin integrity as appropriate.
e) Complete treatments as planned for residents #018, #023, #026 and all other residents with impaired skin integrity, for all treatments, as specified in the plan of care and/or as ordered.
f) Document treatments completed as planned for residents #018, #023, #026 and all other residents with impaired skin integrity, for all treatments, as specified in the plan of care and/or as ordered.
g) Assess and create a plan of care related to repositioning, as well as implement the plan of care related to repositioning for residents #018, #023, #026 and all other residents with impaired skin integrity and those at risk for impaired skin integrity, who cannot reposition themselves as appropriate.
h) Assess pain, create a plan of care related to pain management and implement the plan of care to manage pain for residents #018, #023, #026 and all other residents with impaired skin integrity as appropriate.

Grounds / Motifs :

1. The licensee has failed to ensure that a resident at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff upon any return of the resident from hospital; that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (i) 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, (ii) received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required, (iii) was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; and any resident who was dependent on staff for repositioning was repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load.

Ontario Regulation 79/10, s. 50(3) defines altered skin integrity as the potential or actual disruption of epidermal or dermal tissue.

The home's policy "Skin and Wound Program", revised July 20, 2017, stated in part:
• A resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff upon return from hospital.
• A resident exhibiting altered skin integrity receives immediate treatment and interventions to reduce or relive pain.
• A resident exhibiting altered skin integrity 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 and is reassessed at least weekly by a member of the registered nursing staff if clinically indicated.
• Any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required.
• A resident with actual alteration in skin integrity has a completed wound assessment and treatment record completed with initiation of impaired skin integrity and with any change in treatment.

a) A review of documentation, including progress notes and skin/wound assessments in Point Click Care (PCC), over an identified twelve week period of time, for resident #018, showed that the resident had a number of areas of altered skin integrity. The progress notes and assessments in PCC also showed that a skin assessment was not completed upon a return from hospital and that initial wound assessments and weekly wound assessments were not completed as required, for all of the areas of

impaired skin integrity.

In an interview, the Director of Care (DOC) said that the expectation was that skin assessments upon return from hospital, initial and weekly wound assessments should have been completed for resident #018.

In an interview, the Resident Assessment Instrument (RAI) Coordinator said that the resident should have had a head to toe skin assessment completed when they returned from the hospital and did not. They also acknowledged that all required wound assessments had not been completed for resident #018.

b) A review of documentation including progress notes and assessments in PCC, over an identified six week period of time, for resident #026 showed that the resident had a number of areas of altered skin integrity with pain. The progress notes and assessments in PCC also showed that a skin assessment was not completed upon a return from hospital and that initial wound assessments and weekly wound assessments were not completed as required, for all of the areas of impaired skin integrity. Additionally, there were no pain assessments completed for pain related to a wound and there were no immediate treatments/interventions to reduce or relieve pain and/or to promote healing.

Further review of the plan of care for resident #026 showed that the resident was dependent on staff for repositioning, and the plan of care did not provide for repositioning every two hours or more frequently as required.

In an interview, the RAI Coordinator acknowledged that when resident #026 returned to the home from hospital exhibiting altered skin integrity, they were to receive 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. They said the resident should have received treatment to reduce or relieve pain and that resident #026, who was dependent on staff for repositioning was to be repositioned every two hours or more and that this would be part of the plan of care.

In an interview, Administrator said that the expectation was that weekly wound assessments would be completed using a clinically appropriate assessment tool for a resident with impaired skin integrity, and that this had not been completed for resident #026.

c) A review of documentation including progress notes and skin assessments in Point Click Care (PCC), over an identified five week period of time, for resident #023, showed that the resident had a number of areas of altered skin integrity. The progress notes and assessments in PCC also showed that that initial wound assessments and weekly wound assessments were not completed as required, for all of the areas of impaired skin integrity.

The treatment orders and the electronic Treatment Administration Record (e-TAR) for resident #023 were also reviewed for a two month period of time and showed several orders and directions did not provide direction related to the area to receive the ordered treatment. In addition, several ordered treatments did not have documentation showing that the treatment was provided as planned for resident #023.

In an interview, the Administrator said that treatment orders for wounds were ordered by the physician and that the registered staff were to sign for treatments in the e-TAR. They said if the documentation was incomplete on the e-TAR, the treatment would not have been completed, and should have been for resident #023. The Administrator also acknowledged that the treatment areas were not always specified on the e-TAR and did not provide clear direction for staff.

The licensee has failed to ensure that residents who were at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff upon any return from hospital; that residents 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 and reassessed at least weekly by a member of the registered nursing staff if clinically indicated, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment; that residents received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required; and that residents who were dependent on staff for repositioning were repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load.

The severity of this issue was determined to be a level 3 as there was actual risk/harm to the residents and the area of non-compliance is a Key Risk Indicator. The scope of the issue was a level 3 as it related to three of three residents

reviewed. The home had a level 4 history of on-going noncompliance with this section of the Act that included:
- October 6, 2017 (2017_606563_0014) Compliance Order #001
- August 24, 2017 (2017_536537_0030) Written notification
- May 25, 2017 (2016_419658_0015) Compliance Order #001

(610)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Jul 23, 2018(A2)

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 22 day of June 2018 (A2)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by RHONDA KUKOLY - (A2)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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Service Area Office / Bureau régional de services : London