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

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

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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
Nov 15, 2017	2017_678680_0014	021937-17	Resident Quality Inspection

Licensee/Titulaire de permis

THE CORPORATION OF THE COUNTY OF LAMBTON
789 Broadway Street WYOMING ON N0N 1T0

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

NORTH LAMBTON LODGE
39 Morris Street R.R. #6 FOREST ON N0N 1J0

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

TRACY RICHARDSON (680), ANDREA DIMENNA (669)

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): September 18, 19, 20, 21, 22, 2017.

**The following intake was inspected during the Resident Quality Inspection:
Log #032767-16, Critical Incident #M559-000004-16, related to falls.**

During the course of the inspection, the inspector(s) spoke with the Administrator, two Directors of Nursing and Personal Care, the Quality Improvement Coordinator, the General Manager, the Administrative Assistant, the Nutrition and Environmental Supervisor, the Social Worker, the confidential secretary, the physiotherapist, the Comfort Trust Clerk, Cooks, Dietary Aides, Registered Practical Nurses, Registered Nurses, Personal Support Workers, Health Care Assistants, Registered Dietitian, Residents' Council Representative, family members and residents.

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

**Continence Care and Bowel Management
Critical Incident Response
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Residents' Council**

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 O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(f) is reviewed by the Residents' Council for the home; and O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's menu cycle was reviewed by the Residents' Council for the home.

During the Residents' Council interview with a specified resident as part of the Resident Quality Inspection, it was identified that Residents' Council had not reviewed the home's menu cycle.

The home's policy, Menu Planning (Index No. 4-6-4), last reviewed April 2017, stated that the menu cycle should be reviewed and approved in writing, at a minimum annually, by the Registered Dietitian. The policy continued that the approved menu should then be recommended to the Residents' Council or Food Committee.

Residents' Council meeting minutes were reviewed for each month for a year, (excluding one month, when no meeting occurred). Of the aforementioned meeting minutes, the only minutes that included discussion and approval of a menu cycle was a meeting held on a specific date, which stated the fall/winter menu cycle was discussed and approved.

Review of the Residents' Council meeting minutes showed that there were three residents who attended several meetings.

During an interview, a resident, said that Residents' Council had not reviewed the home's menu cycle this year, and only dealt with food concerns as they arose throughout the year.

During an interview, another resident stated that they had not seen a copy of the home's menu or reviewed the home's menu cycle at a Residents' Council meeting within the past year.

During an interview, a resident stated that they had not seen a copy of the home's menu

at a Residents’ Council meeting, and that they had not reviewed a menu in the past year. The resident acknowledged that they saw the daily menu posted outside the dining room, but had never seen a weekly menu or menu cycle. The resident shared that it would have been good to see an entire menu cycle and review it.

The Nutrition/Environmental Supervisor (NES) was interviewed on three occasions during the inspection, and stated that the menu cycle was reviewed and updated twice per year, but they were unsure whether or not the Residents’ Council reviewed the menu cycle. NES acknowledged that the home’s current spring/summer menu cycle was rolled out in the specified month. The Confidential Secretary was interviewed, and reviewed the Residents’ Council meeting minutes and was unable to find documentation that the menu cycle was reviewed by the home’s Residents’ Council.

The Administrator stated that if the Residents’ Council meeting minutes did not include documentation of the home’s menu cycle being reviewed, and if residents who attended the meetings said that the menu cycle was not reviewed, then the home’s menu cycle was not reviewed.

The licensee has failed to ensure that the home’s menu cycle was reviewed by the Residents’ Council for the home.

The severity was determined to be a level 1 as there was minimal risk. The scope of this issue was widespread. The home has a history of previous unrelated noncompliance. [s. 71. (1) (f)]

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 the home's menu cycle is reviewed by Residents' Council for the home, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that all areas where drugs were stored were restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator.

On a specified date, during observations in the medication room on Maple home area, A Registered Nurse (RN), shared that there was another drug storage room in the hallway that led to the kitchen, that held government stock medications. The RN stated that anyone with a master key access could enter the room and have access to the medications.

On the specified date ,the Inspector observed several types of medications stored in the separate storage room.

A list was reviewed of staff who had master key access. The list was supplied to the inspector by the Administrative Assistant. The list consisted of: Administrator, Nutrition and Environmental Supervisor, Director of Care, Maintenance, Registered staff, housekeepers and recreation and leisure staff.

The Director of Care (DOC) , and the Inspector, went to the storage room. Maintenance was called to open the door. It was observed that the maintenance person was able to

open the door with their key.

Policy titled "Medication Storage Areas," dated September 1, 2017, stated "the definition of medication storage area is any designated area inside the home intended to store medications that are administered to resident." The policy stated "access to the medication storage area must be restricted to persons who dispense, prescribe or administer medication in the home and the Administrator."

The DOC, stated that they were not aware that anyone other than registered staff could open the door, and that the room held over the counter medication.

The Administrator, acknowledged that the room was accessible to staff who should not have access to medications. The Administrator stated that they would change the room to a controlled access room for registered staff only.

The licensee has failed to ensure that all areas where drugs were stored were restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was isolated. This area of non-compliance was previously issued on October 4, 2016, as a written notification under inspection # 2016-303563-0034. [s. 130. 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 all areas where drugs are stored are restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator, 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. (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 corrective action was taken as necessary and a written record was kept of everything related to medication incidents and adverse drug reactions.

During the Resident Quality Inspection (RQI) Medication Incident Reports were reviewed for a specific time frame. There were a total of five medication incidents during this time frame.

A) A medication incident/near miss report, was reviewed for a specified resident. The incident stated that orders for a specific treatment had been faxed to pharmacy but that the orders were not processed, and that the specified treatment had not been completed. The form indicated that the Director of Care had not been notified of the incident. Sections on contributing factors and corrective action had not been completed.

Progress notes for the resident were reviewed and there were no documented notes on this incident.

In an interview the Registered Nurse (RN) stated that management had not spoken to them about this incident until just recently following the RQI. The RN stated that it was not normal practice for nurses to process orders in that manner.

The Director of Care (DOC) stated that they did not follow up as they usually would have. DOC stated that the nurse should have done a progress note for this and not written it on the order sheet.

B) A medication incident/near miss report on a specified date, was not present in the

home to review and was listed on the tracking sheet for a specific resident. The DOC had it faxed from pharmacy for the inspector to review. The resident was given a different dose of medication than prescribed. The pharmacy manager had signed the form on the front. The form indicated that there was no effect to the resident. The second page of this form was not found.

Progress notes for the resident were reviewed and there were no documented notes on this incident.

The incident report was not available in the home and the DOC had it faxed from pharmacy for the inspector to review. The DOC stated that they had taken corrective action by changing where the medications were stored. The DOC stated that family and resident were notified of this incident. There was no record of the corrective action or notifications.

The licensee has failed to ensure that corrective action was taken as necessary and a written record was kept of everything related to medication incidents and adverse drug reactions.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was a pattern. The home has a history of previous unrelated noncompliance. [s. 135. (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 (a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed;
(b) corrective action is taken as necessary; and
(c) a written record is kept of everything required under clauses (a) and (b)., to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 126. Every licensee of a long-term care home shall ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. O. Reg. 79/10, s. 126.

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs remained in the original labelled container or package provided by the pharmacy service provide or Government of Ontario until administered to a resident or destroyed.

The home's policy titled Non-Controlled Medication Destruction, dated September 1, 2013, stated "The home shall ensure that until surplus medication is destroyed and disposed of, they are stored safely and securely within the Home, separate from medication that is available for administration to a resident."

Observation of the medication cart was done on a specified date and time. It was observed that a bottle labelled discard bottle was in the medication cart with unlabelled medications in the bottle. The RN stated that any unused medications that a resident refused were placed in the bottle and discarded later.

The RN stated that it was not their practice to use the discard bottle. Two RN's were present when the bottle with medications was observed in the cart.

The following shift the bottle with unlabelled medications was still present in the medication cart in the sharps container area of the cart. The RN acknowledged that the medication was still present in the medication cart after the change of shift.

On a specified date, the DOC stated that medications were placed in the bottle during the medication pass to prevent staff from running back to the medication room during their medication pass. The DOC stated that the bottle should have been discarded at the end of the medication pass or the end of the shift.

The licensee has failed to ensure that drugs remained in the original labelled container or package provided by the pharmacy service provide or Government of Ontario until administered to a resident or destroyed.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was isolated. The home has a history of previous unrelated noncompliance. [s. 126.]

WN #5: 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 controlled substances were stored in a separate locked area within the locked medication cart.

On a specific date, in the Oak home area medication room, the Inspector observed that the medication cart was unlocked, and the narcotic box containing controlled substances was not shut all the way and was unlocked.

The home's policy titled Narcotic and Controlled Medication Lock Box, dated September 1, 2013, stated "Narcotic and controlled medication, must be kept in the lock box located in the designated drawer of the medication cart or in a separate, double locked stationary cupboard in the locked medication room. The lock box must remain locked at all times within the locked medication cart."

The Registered Practical Nurse (RPN), acknowledged that the narcotic box was unlocked, and that it was to be locked when not in use. The RPN stated that their normal practice was that the narcotic box be closed and locked.

The Director of Care stated that the narcotic box was to be closed and locked at all times.

The licensee has failed to ensure that controlled substances were stored in a separate locked area within the locked medication cart.

The severity was determined to be a level 1 as there was minimal risk. The scope of this issue was isolated. The home has a history of previous unrelated noncompliance. [s. 129. (1) (b)]

Issued on this 15th day of November, 2017

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

Original report signed by the inspector.