Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 8, 2017	2017_601532_0013	020497-17	Resident Quality Inspection

Licensee/Titulaire de permis

PARKWOOD MENNONITE HOME INC.
726 New Hampshire Street WATERLOO ON N2K 4M1

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

PARKWOOD MENNONITE HOME
726 New Hampshire Street WATERLOO ON N2K 4M1

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

NUZHAT UDDIN (532), APRIL TOLENTINO (218), NATALIE MORONEY (610)

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 7, 8, 11, 12, 13, 14 and 15, 2017.

The following concurrent inspections were conducted during the Resident Quality Inspection (RQI):
Complaint Log #003863-17 related to abuse;
Complaint Log #024199-16 related to care issues.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Clinical Coordinator (CC), Program Director (PD), Resident Assessment Instrument (RAI) Coordinator, Restorative Care Coordinator (RCC), Nurse Practice Consultant, Behaviour Support Ontario Staff (BSO), Registered Nurses, Registered Practical Nurses, Personal Support Workers, Family and Resident Council Representatives, and over forty residents.

Inspectors also toured the resident home areas and common areas, medication rooms, spa rooms, observed resident care provision, resident/staff interaction, dining services, medication administration, medication storage areas, reviewed relevant residents clinical, records, posting of required information, relevant policies and procedures, as well as meeting minutes pertaining to the inspection, and observed general maintenance and cleaning of the home.

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

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

- **3 WN(s)**
- **2 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. 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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Ontario Regulation 79/10, s. 49 (1) states in part that every licensee of a long term home shall ensure that there is an organized program of falls prevention and management and the program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids.

Falls Prevention and Management Program policy, stated under roles and responsibilities on near fall/post fall that "registered nursing staff were to initiate Head Injury Routine (HIR) for all un-witnessed falls and witnessed falls that resulted in a possible head injury or if the resident was on anticoagulant therapy according to Parkwood Mennonite Home Head Injury Routine."

Head Trauma policy, under purpose stated "to conduct a thorough and frequent neurologic assessment following an injury to the head". Under procedure the policy indicated that "a neurologic assessment of a resident with trauma shall include a H.I.R. (Head Injury Routine)."

Review of the HIR form indicated that the vital signs and a neurological assessment was to be completed at the following frequency:

Every half hour- four times
Every hour - four times
Every two hours- four times
Day two - once
Day three- once

a) Review of plan of care for an identified resident stated that the resident was at moderate risk of falls.

Record review of the post fall assessment identified a number of falls for the resident.

Record review indicated that the Head Injury Routines (HIR) were initiated for a specified number of falls however, the HIRs were incomplete and were not conducted as per the frequencies outlined in the HIR following the un-witnessed falls.

b) Record review indicated that another identified resident had a number of falls.

Review of plan of care identified that the identified resident was at moderate risk of falls.

Record review indicated that the Head Injury Routines (HIR) were initiated for a specified number of falls.

Record review further indicated that all of the HIRs that were initiated were missing the above assessments and were not completed as per the frequencies outlined in the HIR.

In an interview, Registered Practical Nurse (RPN) stated that as part of their roles and responsibilities they were to ensure that if there was an un-witnessed fall than the resident was assessed and a HIR was completed.

In an interview the Director of Care (DOC) verified that a HIR was to be completed with any un-witnessed fall.

In an interview the DOC was shown the HIR for the two identified residents and they acknowledged that the expectation was that the HIRs were conducted thoroughly following an injury to the head or following an un-witnessed fall. They acknowledged that this was not done for either of the identified residents.

The licensee has failed to ensure that the head injury routines with respect to the

identified residents were completed thoroughly and frequently as stated on the HIR.

The severity of this area of non-compliance was minimal harm or potential for actual harm. The scope was determined to be a pattern and there was a history of previous unrelated non-compliance. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #2: The licensee has failed to ensure the written policies and protocols related to the medication management system were developed, implemented, evaluated and update accordance with evidence-based practices and, if there were none, in accordance with prevailing practices. O. Reg. 79/10, s. 114 (3)(a).

Findings/Faits saillants :

The licensee has failed to comply with O. Reg. 79/10, s. 114 (3)(a), to ensure that the written policies and protocols related to the medication management system were developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

Inspector observed the medication cart in an identified home area and noted that there were medications in a medication can in the bottom drawer. As the medications were in a can, medications were not in individual labeled packages and as such, there was no identifying information connecting the resident to the medications in the cans to identify who was to receive the medications. As a result, the medications were in the medication can for an unknown time, and were not stored in a secure, designated area within the home, separate from medications that were to be administered to the residents.

Further observation showed that the medication cart on an identified home area also had medications in a can within the medication cart that required drug destruction and was not in a secure, designated area within the home, separate from medications that were to be

administered to the residents.

A Registered Practical Nurse (RPN) said that medication in the can are medication that have been refused by the resident. That the can with the medication would be emptied only when the can was full. Then the medication would be placed into the white non-controlled drug destruction bins.

A RN said that the home had started this practice a few months ago, and that the medication would remain in the can till ready for drug destruction.

The Inspector interviewed the DOC who said that the licensee utilized a pharmacy service provider and their policy titled Medication Destruction, Non Controlled Medication, stated in part that:

- All Medication to be destroyed are prepared for disposal by removing any excess packaging and placing medication in the Drug Destruction Container which is supplied by the Pharmacy.
- Medication is secured in the medication rooms, and these medications are kept separate from medications available for resident administration.
- Remove excess packaging and placing the medication in the drug destruction container.

Nurse Practice Consultant said that the expectation when a medication was required to be destroyed and disposed of that the medication would remain in the original packaging, until after the medication pass when the medication can be placed in to the drug destruction bin.

The DOC acknowledged that the licensee was not following the policy and procedures for the medication destruction of non-controlled drug substances, and the staff were not implementing the drug destruction policy correctly.

The licensee failed to ensure that policy on the disposal and destruction of non-controlled substances that was based on evidence-based and prevailing practices, was implemented as medications were not placed in white buckets, medications awaiting destruction were not stored in a secure, designated area within the home separate from medications to be administered to residents, unused or wasted medication was not stored away from active medication.

The severity of this area of non-compliance was minimal harm or potential for actual harm.

The scope was determined to be a pattern and there was a history of related non-compliance being issued dated October 12, 2016, in a Resident Quality Inspection 2016_216144_0077 as a Voluntary Plan of Correction (VPC). [s. 126.] (610)

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 to ensure that the written policies and protocols related to the medication management system were developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A skin and wound assessment stated that an identified resident had altered skin integrity.

Plan of care for the identified resident, stated under skin that the identified resident had altered skin integrity and that the registered staff were to monitor the known area daily as per Treatment Administration Record (TAR) and wound nurse to assess weekly.

In an interview the identified resident shared that they seemed to be doing okay and pain was manageable.

Resident observation showed that the identified area was reddened.

Record review of the skin and wound assessment indicated that there was no weekly assessment documented for the identified dates.

RN acknowledged that the identified resident did have altered skin integrity. They were asked to show and demonstrate if the assessments were documented for the identified dates, either in the progress notes or under assessment. The RN checked the documentation and acknowledged that the weekly assessments were not documented for the above dates.

In an interview the Director of Care verified with the wound tracking record and the Treatment Administration Record (TAR) and shared that weekly wound assessments were not done for the identified dates. They shared that since there were not a lot of wounds in the home the expectation was that weekly assessment for this resident was done.

The licensee failed to ensure that the identified resident with altered skin integrity was assessed at least weekly by a member of the registered nursing staff.

The severity of this area of non-compliance was minimal harm. The scope was determined to be a isolated and there was an history of previous related non-compliance being issued dated September 28, 2015, in a Resident Quality Inspection 2015_258519_0032 as a Voluntary Plan of Correction (VPC). [s. 50. (2) (b) (iv)]

Issued on this 9th day of November, 2017

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

Original report signed by the inspector.