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
Jul 10, 2018	2018_577611_0012	012187-18	Resident Quality Inspection

Licensee/Titulaire de permis

Rykka Care Centres II GP Inc.
3760 14th Avenue Suite 402 MARKHAM ON L3R 3T7

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

Pine Villa Nursing Home
490 Highway #8 STONEY CREEK ON L8G 1G6

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

KELLY CHUCKRY (611), AILEEN GRABA (682), JESSICA PALADINO (586)

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 13, 14, 15, 18, 19, 20, 21, 25, 2018.

One complaint intake was completed during this RQI inspection. This was Log # 000418-18, pertaining to a safe and secure home.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care (DOC), Food Service and Nutrition Manager, the Director of Environmental Services, the Manager of Recreation and Leisure, Registered Dietitian (RD), Registered staff, Personal Support Aides (PSA), housekeeping staff, maintenance staff, residents and families.

During the course of this inspection inspector(s) conducted a tour of the home, observed the provision of resident care, observed medication administration, reviewed medication incidents, applicable clinical health records, policies, procedures, practices, meeting minutes, and education material.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

5 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. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident.

A. In June 2018, resident #025 was interviewed in their shared room. During this interview, it was observed that resident #025 had oral medications in their room.

After a review of resident #025's Medication Administration Record (MAR) it was determined that the medication left in the pill cup included identified medications. A review of the clinical health record for this resident indicated that they did not have approval from the prescriber to self administer these medications.

During an interview in June 2018, registered staff #101 acknowledged that they leave resident #025 to self administer their medication. In an interview with the DOC in June 2018, it was acknowledged that registered staff are expected to stay with residents, including resident #025 while taking their medication. It was further acknowledged by the DOC that resident #025 did not have approval by the prescriber to self-administer drugs.

B. In June 2018, resident #025 was observed to have two (2) identified medications in their room.

Registered staff #101 confirmed that resident #025 had self-administered medications, and they did not have a physician order in place for the administration of these medications.

The DOC confirmed in June 2018, that resident #025 did not have an order for the identified medication, and did not have approval by the prescriber to self-administer these drugs. [s. 131. (5)]

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 resident administered a drug to himself or herself unless the administration was approved by the prescriber in consultation with the resident, to be implemented voluntarily.

WN #2: 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 failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was assessed by a dietitian who is a member of the staff of the home, and any changes made to the residents plan of care relating to nutrition and hydration were implemented.

A clinical record review indicated that resident #026 developed an area of altered skin integrity in September 2017. A further review indicated resident #026 was assessed by a physician in November 2017, and subsequently started this resident on an intervention. A progress note dated in November 2017, indicated that resident #026 was referred to a dietitian and assessed in November 2017.

During an interview in June 2018, registered staff #110 stated that the dietitian referral is completed when altered skin integrity is identified and confirmed that they did not refer to the dietitian when the resident exhibited altered skin integrity in September 2017. During an interview in June 2018, registered staff #105 confirmed that resident #026 was not assessed by the registered dietitian for an identified period of time after the resident initially exhibited altered skin integrity. [s. 50. (2) (b) (iii)]

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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is assessed by a dietitian who is a member of the staff of the home, and any changes made to the residents plan of care relating to nutrition and hydration were implemented, to be implemented voluntarily.

WN #3: 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 failed to ensure that 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, (b) is complied with.

In accordance with O. Reg. 79/10 s.114 (3) (a), the licensee was required to ensure that written policies related to the medication management system, must be, developed, implemented, evaluated and updated in accordance with evidence- based practices and, if there are none, in accordance with prevailing practices.

The home had a policy in place titled Medication Administration, 3-7. This policy was from the Pharmacy Policy and Procedure manual. In this policy, under the procedure section, it indicated that registered staff must "check the identify of the resident before giving the medication, and remain with the resident until the medication is taken."

In June 2018, resident #025 was interviewed in their shared room. During this interview, it was observed that resident #025 had oral medications in their room.

After a review of resident #025's Medication Administration Record (MAR) it was determined that the medication left in the pill cup included identified medications.

During an interview in June 2018, registered staff #101 stated they leave resident #025 to take their medication on their own. In an interview with the DOC in June 2018, it was acknowledged that registered staff are expected to stay with residents, including resident #025 while taking their medication. Registered staff #105 stated that registered staff are to remain with residents while they take their medication.

In an interview with the DOC in June 2018, it was confirmed that registered staff #101 did not comply with the above noted Medication Administration policy. [s. 8. (1) (b)]

2. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

In accordance with O. Reg. 79/10 s.114 (3) (a), the licensee was required to ensure that written policies must be, developed, implemented, evaluated and updated in accordance with evidence based practices and, if there are none, in accordance with prevailing practices. Specifically, registered staff did not comply with the licensee's policy in the Resident Care and Services manual regarding Admissions, transfers and discharges - Admission of a resident, Index I.D. RCS B-05, updated April 22, 2015, and the licensee's Medication Management System that directs registered staff to obtain consent for the specified medication. The policy stated, the medication "is administered once consent is obtained from the resident/substitute decision maker (SDM)". According to the home's medication incident documentation system and resident's #038 clinical record, they were administered medication in January 2018, by registered staff #106. Further clinical record review indicated that on an identified date in 2017, resident's #038 substitute decision maker (SDM)) declined consent for the administration of this medication. During an interview in June 2018, registered staff #105 confirmed that the SDM did not provide consent for the administration of the medication to resident #038.

During an interview in June 2018, the DOC stated that the home did not have a specific policy regarding consent for the medication, and that the home's procedure for obtaining consent for this medication was the same as another consent for an identified medication. During an interview in June 2018, registered staff #105 indicated that the physician had ordered the medication for all residents and the pharmacy dispensed the medication for all residents in January 2018. The DOC stated that according to their internal investigation, registered staff #106 was administering the medication to resident #038, they did not access the appropriate consent information. They were not aware that resident's #038 SDM did not consent to the administration of this medication.

Registered staff #105 and the DOC stated that registered staff #106 did not comply with the admission of a resident policy which is part of the licensee medications system. [s. 8. (1) (b)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A. The licensee's policy, 'Resident Weight Monitoring' (index I.D. RCS C-25, last reviewed June 1, 2018), indicated the following,
"If a therapeutic supplement such as Resource/Med Plus 2.0 is recommended and ordered, it must be entered in the care plan under the nutrition risk section by the dietitian and on the electronic Medication Administration Record (E-MAR). The Registered staff document consumption on the E-MAR…If a resident refuses a therapeutic supplement inform the FSM or Dietitian".

Resident #026's documented plan of care included an order for an identified intervention initiated in August 2017. The former RD (#109) increased the frequency of this intervention in response to significant weight loss the resident experienced in February 2018.

Review of the resident's e-MAR included this intervention; however, did not require sign-off from registered staff. There was no documentation of the resident's acceptance or refusal of this intervention since February 2018.

A progress note written by the home's current RD (#107) in May 2018, indicated that the intervention was taken poorly, and further noted there was no documentation re: acceptance on eMARs. In an interview with the RD in June 2018, they indicated that they were unable to appropriately assess the effectiveness of this intervention due to lack

of documentation.

According to the DOC during an interview in June 2018, when the dosage changed in February, the e-MAR was not appropriately updated; therefore, the resident's acceptance or refusal had not been documented since February 2018. The DOC confirmed this intervention was to be signed off on the e-MAR; however, this was not being done as per the licensee's protocol.

B. According to resident #026's health record, they had experienced significant weight loss from January to February 2018, and former RD #109 increased an intervention. The resident continued to have significant weight loss in March 2018, and further non-significant weight loss in April 2018. In an interview with RD #107 in June 2018, they indicated that during the quarterly assessment of the resident, registered staff informed them that the resident often refused an identified intervention. During this assessment, RD #107 wrote a progress note indicating that follow up would take place.

In an interview with RPN #101 in June 2018, they indicated that the resident almost always refused the identified intervention.

A review of the resident's health record in June 2018, did not identify any follow up by the RD in regard to alternatives for this intervention. The resident's weight declined further in June 2018. In an interview with RD #107, they indicated that they had approached the resident on multiple attempts in May and June 2018 to assess the resident and explore alternate dietary interventions with them; however, the resident was sleeping each time and they were unable to speak with the resident. The RD confirmed that they had not documented these attempts to follow up with the resident. The home did not ensure that any actions taken with respect to resident #026 were documented. [s. 30. (2)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures are developed and implemented to ensure that all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks

During four (4) observations in June 2018, two (2) resident bathrooms, one in which was shared with other residents, were observed to have significant black dried debris around the base of the toilets. During an interview in June 2018, housekeeping staff #112 stated that they have been trying to manage the black debris surrounding the toilets for an unidentified period of time but were unable to effectively address them. A review of the Environmental/equipment policy Index I.D. HS-J-80 revised February 1, 2017, from the Health and Safety Manual indicated: "other than emergency or hazardous situations requiring maintenance all requests from maintenance or repairs for equipment, etc. must be completed using maintenance care electronic requisitions".

During an interview in June 2018, maintenance staff #113 stated that issues regarding caulking surrounding the toilet needed to be reported either verbally to them or by using the electronic requisition for maintenance. Housekeeping staff #112 stated that they had not implemented the home's procedures and did not follow the licensee policy for maintenance of caulking surrounding the toilet in the identified bathrooms as they had not reported the black debris to the environmental service manager (ESM) either in person or through the home's electronic maintenance reporting system. [s. 90. (2) (d)]

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Issued on this 25th day of July, 2018

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

Original report signed by the inspector.