Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 17, 2018	2017_700536_0025	027228-17	Resident Quality Inspection

Licensee/Titulaire de permis

THE GOVERNING COUNCIL OF THE SALVATION ARMY IN CANADA
2 Overlea Blvd. TORONTO ON M4H 1P4

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

R. H. LAWSON EVENTIDE HOME
5050 JEPSON STREET NIAGARA FALLS ON L2E 1K5

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

CATHIE ROBITAILLE (536), CATHY FEDIASH (214), LISA BOS (683)

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): December 12, 13, 14, 15 and 18, 2017.

The following inspections were completed concurrently with the Resident Quality (RQI) Inspection.

Complaint:

026366-17: pertaining to Nutrition and Hydration, Personal Support Services, Prevention of Abuse, Neglect and Retaliation

During the course of the inspection, the inspector(s) spoke with residents, family members, personal support workers (PSW's), registered staff, Physician, dietary staff, Dietary Manager, Registered Dietitian (RD), Program and Services Co-Ordinator, Maintenance Manager, Resident Assessment Instrument-Minimum Data Set Coordinator(RAI-MDS), Director of Care (DOC) and the Executive Director.

During the course of the inspection, the inspector(s) toured the home, observed the provision of care and services provided on all home areas, interviewed staff, residents and families, and reviewed relevant documents including, health care records, investigation reports, training records, meeting minutes, and relevant policies and procedures.

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

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

9 WN(s)
5 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 LTCHA, 2007 S.O. 2007, c.8, 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).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

Review of complaint log #026366-17, staff interviews and progress notes identified that on a specified date and time, resident #008 was found to have had a significant change in status. Interviews with staff identified that resident #008 had interventions in place that were not documented on their written plan of care. Interview with the Director of Care (DOC) confirmed that resident #008's did not have a written plan of care that set out all of the planned care for the resident.

The home did not ensure that resident #008's written plan of care identified all interventions in place for the resident.

PLEASE NOTE: This area of non compliance was identified during a Complaint inspection, log #026366-17, conducted concurrently during this RQI. [s. 6. (1) (a)] (Inspector #683)

2. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

A) During the Resident Quality Inspection (RQI) resident #003 triggered in stage two for altered skin integrity. A review of resident #003's quarterly Minimum Data Set (MDS) coding dated an identified date in 2017, indicated that the resident was coded as having a specific type of altered skin integrity. A review of the resident's corresponding narrative Resident Assessment Protocol (RAPs) dated on an identified date in 2017, also indicated that resident #003 had the same identified type of altered skin integrity.

A review of resident #003's MDS coding dated on an identified date in 2017, indicated that the resident was coded as having a different type of altered skin integrity. A review of the resident's corresponding narrative Resident Assessment Protocol (RAPs) for an identified date in 2017, also indicated that resident #003 had a different type of altered skin integrity.

A review of resident #003's "Skin and Wound flow sheet" in Point Click Care (PCC) dated for an identified month in 2017, conducted before and after the above MDS assessment, indicated that the resident had an area of altered skin integrity the same as was coded in MDS and the RAP.

A review of resident #003's plan of care which the home refers to as the care plan dated on an identified date in 2017, in the focus of an identified area of the care plan it stated that the resident had an identified type of altered skin integrity however, under a different area of the care plan stated that resident #003 has a different type of altered skin integrity. (Inspector #536)

B) During the Resident Quality Inspection (RQI) resident #008 triggered in stage two for

a worsening area of altered skin integrity. A review of resident#008's quarterly Minimum Data Set (MDS) coding dated in 2017, indicated that the resident was coded as having one identified type of altered skin integrity. A review of the resident's corresponding narrative Resident Assessment Protocol (RAPs) dated in 2017, also indicated that resident #008 had one identified type of altered skin integrity.

A review of resident #008's "Skin and Wound flow sheet" in Point Click Care (PCC) dated in 2017, conducted before and after the above MDS assessment, indicated that the resident had one identified type of altered skin integrity.

A review of resident #008's plan of care which the home refers to as the care plan dated in 2017, stated that resident #008 had a different type of skin integrity.

An interview with the Resident Assessment Instrument Minimum Data Set (RAI MDS)) Coordinator confirmed that these assessments as well as the care plan were not integrated or consistent with and did not complement each other for resident #008. [s. 6. (4) (a)] (Inspector #536)

3. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan was no longer necessary.

A) On an identified date in December 2017, resident #007 was observed with a safety device number one in place. On another identified date in 2017, the resident was observed with safety device number two in place.

A review of a Safety Devices Assessment in Point Click Care (PCC) dated in 2017, indicated that the resident had safety device number two in place for safety. The assessment indicated that the resident had an order for safety device number one; however, at the time, the home was trialing safety device number two and safety device number three without safety device number one.

A review of the current written care plan in place and dated in 2017, indicated under interventions to manage falls, that the resident used safety device number two, safety device number three and safety device number one when needed. A review of the Point of Care (POC) task indicated that the resident had safety device number one and safety device number two in place.

An interview with registered staff #114, confirmed that the resident only used safety device number two, at that time since an identified date in 2017. Registered staff #114 and the DOC confirmed that resident #007 was not reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan was no longer necessary. (Inspector #214)

B) During the Resident Quality Inspection (RQI) stage one of the resident observations in December 2017, resident #005's was observed wearing a safety device. During stage two of the inspection, a review of the resident's plan of care which the home refers to as the care plan dated November 2017, and the "Safety Device Assessment 2015(2)" completed on an identified date in 2017, identified that the resident was able to remove the safety device.

On an identified date in December 2017, the Inspector approached resident #005 on two different occasions and asked the resident if they could remove the safety device. The resident did not appear to understand what was being asked of them, and made no attempt to remove the safety device.

During interviews with PSW's #103, #113 and registered staff #102, the Inspector identified that resident #005 was no longer able to remove the safety device. The licensee failed to ensure that resident #005 was reassessed and the plan of care reviewed and revised when the resident's care needs changed or care set out in the plan was no longer necessary. (Inspector #536) [s. 6. (10) (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 and ensuring that there is a written plan of care for each resident that sets out the planned care for the resident, sets out clear direction to staff and others who provide direct care to the resident and that the staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complemented each other, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee failed to ensure that residents with the following weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated:
i) A change of 5 per cent of body weight, or more, over one month.

Resident #002's clinical record identified that they were on an identified diet, texture and were a specified nutrition risk. Their care plan specified an identified goal. It also identified that they were to report any significant changes to their Physician and the Registered Dietitian (RD). Review of the care plan did not identify any exemptions for the resident to the home's regular practice.

The resident's weight on three identified dates in 2017, was as specified in the resident's clinical record. This change in body weight represented a weight change of greater than five percent in less than one month.

Interview with the RD in December 2017, identified that they received referrals through e-mail or verbally for residents who experienced weight changes. On another date in December 2017, the RD confirmed that resident #002's weight change was not assessed because they did not receive a referral. (Inspector #683)

The licensee did not ensure that resident #002 was assessed using an interdisciplinary approach when they experienced a weight change of greater than five percent in an identified month in 2017.

The licensee has failed to ensure that residents with the following weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated: i) A change of 5 per cent of body weight, or more, over one month ii) A change of 7.5 per cent of body weight, or more, over three months.

Resident #007's clinical record identified that they were on an identified diet, texture and were a specified nutrition risk. Their care plan directed staff to monitor [weight] and report any significant changes to their Physician and the RD.

The resident's weight on three identified dates in 2017, was as specified in the resident's clinical record. This change in body weight represented a weight change of greater than five percent in less than one month, and greater than 7.5 percent over three months.

Interview with the RD in December 2017, identified that they received referrals through e-mail or verbally for residents who experienced weight loss. On another date in December 2017, the RD acknowledged that the home had been having some issues with the scales in the home and that the concerns were addressed by maintenance. They indicated that the November weight was likely an error. The RD confirmed that they should have received a referral for resident #007's weight change and that their weight change was not assessed in November, 2017.

The licensee did not ensure that resident #007 was assessed using an interdisciplinary approach when they experienced a weight change of greater than five percent over one month, and greater than 7.5 percent over three months. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.] (683) [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

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 and ensuring that residents with weight changes are assessed using an interdisciplinary approach and that actions are taken and outcomes are evaluated, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented: all assessment, reassessment and monitoring, including the resident's response.

A) A review of resident #007's clinical records indicated that the resident used an identified safety device. An interview with registered staff #114 confirmed that the resident was unable remove their safety device.

A review of the Point of Care (POC) documentation system task for a specified safety device was completed between identified dates in December 2017. On an identified date in December 2017, documentation indicated that the safety device was put in place at an identified time and that the resident was checked hourly and repositioned every two hours until a specified time, and then not checked or repositioned until approximately nine hours later. On another identified date in December 2017, documentation indicated that the safety device was put in place at an identified time and then not checked or the resident repositioned until approximately three hours later. Documentation the same day indicated that following the hourly check at an identified time, the resident had not been checked or repositioned until approximately six hours later. On another identified date in December 2017, documentation indicated that the safety device was put in place at an identified time and the resident was checked hourly and repositioned every two hours until a specified time, and then not checked or repositioned until approximately nine hours later.

An interview with registered staff #114 and the DOC confirmed that staff do check the resident hourly and reposition the resident every two hours; however, had not documented their actions taken with respect to the resident's specified care. (Inspector #214)

B) A review of resident #006's clinical records indicated that the resident used two different safety devices. An interview with registered staff #117 confirmed that the resident was unable to remove either device.

An interview with the DOC identified that the expectation of the home is that any resident who has any type of safety device they cannot remove, must have a restraint task created in the Point of Care (POC) documentation system. A review was completed of the assigned tasks in the Point of Care (POC) documentation system for resident #006, identified that resident #006 did not have an assigned task for their safety devices.

An interview with registered staff #117 and PSW staff #118 confirmed that staff do check the resident hourly and reposition the resident every two hours; however, that these checks were not documented and any actions taken with respect to the resident's restraint care. (Inspector #536) [s. 110. (7) 6.]

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 and ensuring that every use of a physical device to restrain a resident is documented including all assessment, reassessment and monitoring including the resident's response, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 113. Evaluation
Every licensee of a long-term care home shall ensure,
(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes or improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared.
O. Reg. 79/10, s. 113.

Findings/Faits saillants :

1. The licensee failed to ensure that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act was undertaken on a monthly basis.

An interview with the DOC confirmed that the home had not undertaken an analysis of the restraining of residents by use of a physical device, on a monthly basis. [s. 113. (a)] (Inspector #214)

2. The licensee failed to ensure that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that was necessary was done in accordance with the Act and this Regulation.

An interview with the DOC confirmed that the home had not completed an annual evaluation in 2017 to determine the effectiveness of the licensee's policy in relation to minimizing restraining of residents. [s. 113. (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 and ensuring that an analysis of the restraining of residents by use of a physical device was undertaken on a monthly basis, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that staff participated in the implementation of the infection prevention and control program.

During the initial tour of the home the inspector observed the following used, unlabeled personal items:

i) Two combs and one pair of nail clippers in the tub room
ii) One razor in the shower room
iii) One comb and two hairbrushes in the shower/tub room. Registered staff #116 confirmed the items were not labelled.

On another date in December 2017, the Inspector followed up on the unlabeled items identified on tour. The following used, unlabeled personal items were observed:

i) Three combs and one pair of nail clippers in the shower room. RPN #114 confirmed the items were not labeled and that the home's expectation was for them to be labeled.
ii) Three combs in the tub/shower room. Registered staff #102 confirmed the items were not labeled and that the home's expectation was for them to be labeled.

Interview with the DOC confirmed that the home's expectation was that personal care items including combs, brushes and nail clippers were labelled. The licensee did not ensure that staff participated in the implementation of the infection prevention and control program. [s. 229. (4)]

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 and ensuring that staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #6: 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 any plan, policy, protocol, procedure, strategy or system was complied with.

O. Reg. 79/10, s. 68 (1) (a) identifies that this section and sections 69 to 79 apply to the organized program of nutrition care and dietary services required under clause 11 (1) (a) of the Act, which identifies that every licensee of a long-term care home shall ensure that there is an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents.

A review of the home's policy titled "Nutrition Care and Hydration Program," last reviewed June 14, 2017, indicated the following:
i) A referral to the RD by registered staff shall be made when there is a significant weight change, changes in skin integrity, swallowing difficulties, and changes in fluid and food intake that affects their overall health condition.
ii) Registered staff will notify the Food Services Manager and/or the Registered Dietitian of the following weight changes:

-5 % of body weight or more over 1 month
-7.5% of body weight or more over 3 months
-10% of body weight or more over 6 months
-Any other weight change that compromises the residents health status

Resident #002's clinical record identified that they were on an identified diet, texture and a specified nutrition risk. Their care plan identified a goal to "maintain [weight] stable or slowly reach within [goal weight range]." It also directed staff to "monitor [weight] and report any significant changes to their Physician and the RD." Review of the care plan did not identify any exemptions for the resident to the home's regular practice.

The resident's weight on three different dates was as specified in the resident's clinical record . This change in body weight represented a weight change of greater than five percent in less than one month.

Interview with the RD in December 2017, identified that they received referrals through e-mail or verbally for residents who experienced weight loss. On another identified date in December 2017, the RD confirmed that resident #002's weight change was not assessed because they did not receive a referral.

The home did not ensure that their "Nutrition Care and Hydration Program" policy was complied with when resident #002's weight changed by greater than five percent in November 2017. [s. 8. (1) (a),s. 8. (1) (b)]

WN #7: 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 reassessed at least weekly by a member of the registered nursing staff if clinically indicated.

A review of resident #003's clinical record identified that they had altered skin integrity. A review was completed of the weekly wound assessments called the "skin and wound flow sheet" for a period of thirty-three weeks in 2017. The review identified that a weekly wound assessment had not been completed in eight out of thirty-three weeks in 2017. Registered staff #105 confirmed that weekly wound assessments were not completed on the dates identified. [s. 50. (2) (b) (iv)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 109. Policy to minimize restraining of residents, etc.
Every licensee of a long-term care home shall ensure that the home's written policy under section 29 of the Act deals with,
(a) use of physical devices; O. Reg. 79/10, s. 109.
(b) duties and responsibilities of staff, including,
(i) who has the authority to apply a physical device to restrain a resident or release a resident from a physical device,
(ii) ensuring that all appropriate staff are aware at all times of when a resident is being restrained by use of a physical device; O. Reg. 79/10, s. 109.
(c) restraining under the common law duty pursuant to subsection 36 (1) of the Act when immediate action is necessary to prevent serious bodily harm to the person or others; O. Reg. 79/10, s. 109.
(d) types of physical devices permitted to be used; O. Reg. 79/10, s. 109.
(e) how consent to the use of physical devices as set out in section 31 of the Act and the use of PASDs as set out in section 33 of the Act is to be obtained and documented; O. Reg. 79/10, s. 109.
(f) alternatives to the use of physical devices, including how these alternatives are planned, developed and implemented, using an interdisciplinary approach; and O. Reg. 79/10, s. 109.
(g) how the use of restraining in the home will be evaluated to ensure minimizing of restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation. O. Reg. 79/10, s. 109.

Findings/Faits saillants :

1. The licensee failed to ensure that the policy under section 29 of the Act address restraining under the common law duty when immediate action is necessary to prevent serious bodily harm to the person or others.

A review of the home's policy titled "Restraints and PASDs"; policy number: TBD; effective date: June 1, 2017 identified, that the policy did not address restraining under the common law duty when immediate action is necessary to prevent serious bodily harm to the person or others. During interview with Inspector #214, the DOC confirmed that the policy did not include this required legislation. [s. 109. (c)]

WN #9: 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).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction was (a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and (b) reported to the resident, the resident's substitute decision-maker (SDM), 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.

A) A review of a medication incident report on an specified dated in 2017, indicated that resident #013 was prescribed an identified medication daily and to administer this medication based on a required intervention. The incident report indicated that during a review of the resident's medications, it was identified that the electronic medication administration record (E-MAR) had not been set up with an area to document the identified intervention prior to the medication being administered. A review of the medication incident report and the resident's clinical records indicated that the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, or the resident's attending physician had not been made aware of this medication incident.

B) A review of a medication incident report dated on a specified date in 2017, indicated that resident #014 had not received their prescribed medication as the intact strip package was located on the next shift. A review of the medication incident report and the resident's clinical records indicated that the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, or the resident's attending physician had not been made aware of this medication incident.

C) A review of a medication incident report dated on a specified date in 2017, indicated that resident # 015 had not received their prescribed medication on an identified date in 2017. The registered staff sat the medication down and proceeded to assist the resident and had forgotten to administer the resident's medication.

A review of the medication incident report indicated that the resident had specified interventions in place in regards to their diagnosis ; however, no further actions or assessments were documented on the medication incident form or in the resident's clinical records in regards to the resident's health status in respect to specified intervention and their missed dose of medication.

The incident form and a review of the resident's clinical record identified that the resident, the resident's SDM, if any, or the Director of Nursing and Personal Care, had been made aware of this medication incident.

An interview with the DOC confirmed that this medication incident had not been documented, together with a record of the immediate actions taken to assess and maintain the resident's health and that the medication incidents above had not been reported to the required persons. [s. 135. (1)] (Inspector #214)

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

A review of a medication incident report on an identified date in 2017, indicated that resident # 015 had not received their prescribed medication on the identified date in 2017. The registered staff sat the medication down and proceeded to assist the resident and had forgotten to administer the resident's medication.

A review of the medication incident report identified that contributing factors included environmental, staffing, or workflow problem interruptions. The incident form contained an area under investigation notes for actions taken. This area was blank on the medication incident form. Review of the medication incident and the resident's clinical record had not identified any corrective action that had been taken. [s. 135. (2)] (Inspector #214)

3. The licensee has failed to ensure that, (a) a quarterly review was undertaken of all medication incidents and adverse drug reactions that had occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions and any changes and improvements identified in the review were implemented and a written record was kept of everything provided for in clauses (a) and (b).

An interview with the DOC in December 2017, confirmed that the home had not undertaken a quarterly review of all medication incidents and adverse drug reactions since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions. [s. 135. (3)]

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

Issued on this 19th day of January, 2018

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

Original report signed by the inspector.