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
Oct 23, 2017	2017_664602_0028	022094-17	Resident Quality Inspection

Licensee/Titulaire de permis

SHERWOOD PARK MANOR
1814 County Road #2 East BROCKVILLE ON K6V 5T1

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

SHERWOOD PARK MANOR
1814 County Road #2 East BROCKVILLE ON K6V 5T1

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

WENDY BROWN (602), DARLENE MURPHY (103)

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): October 3 - 6 and October 10 & 11, 2017

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Resident and Family Services Manager, RAI Coordinator/Infection Control Nurse, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), residents and family members.

In addition to this, the inspectors reviewed resident health care records and associated documents, relevant policies and procedures, resident and family council meeting minutes. Inspectors observed medication administration, the resident's environment, resident care and services and staff/resident interactions.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Infection Prevention and Control
Medication
Minimizing of Restraining
Residents' Council
Skin and Wound Care
Sufficient Staffing

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. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

During a review of the home's medication incidents that occurred between January 1, 2017 and March 30, 2017, the inspector noted the following:
-January 12, 2017 an incident occurred whereby a resident received the incorrect dose of a fentanyl patch,
-January 19, 2017, an incident occurred whereby a resident did not have a nitro-patch and a nicotine patch removed in accordance with the physician's order,
-January 26, 2017, an incident occurred whereby a resident did not receive an antibiotic in accordance with the physician's order,
-January 26, 2017, an incident occurred whereby a resident's 1600 hour medications were missed and therefore not given in accordance with the physician's order, and
-February 7, 2017, two incidents occurred whereby a resident did not receive narcotics in accordance with the physician's orders. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure medications are administered to residents in accordance with directions for use specified by the prescriber, to be implemented voluntarily.

WN #2: 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 has failed to ensure that every medication incident involving a resident and every adverse drug reaction was, documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and 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.

The DOC was interviewed in regards to the home's process for documenting medication incidents that have occurred in the home. The DOC stated the registered staff member, who discovers a medication error, records the details using a medication incident report. The DOC was asked to provide this inspector with all medication incidents that had occurred between January 1, 2017 and March 30, 2017. Six medication incidents were given to this inspector to review.

During a review of the six medication incidents, it was noted that zero of the six included documentation to reflect the immediate actions taken to assess and maintain the resident's health, and five of the six incidents had no documentation to reflect the required notifications. [s. 135. (1)]

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

As outlined above, this inspector requested to review the medication incidents that had occurred in the home from January 1, 2017 to March 30, 2017. Five out of the six medication incidents reviewed had no documented evidence to support an analysis was completed or that corrective action had been taken to address the errors. [s. 135. (2)]

3. The licensee has failed to ensure a quarterly review was 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.

The Administrator was interviewed in regards to the home's process for reviewing medication incidents. He indicated the home has a Pharmacy and Therapeutics committee which meet every quarter and that this meeting is attended by the DOC and pharmacists. The agenda items and the minutes of these meetings were reviewed for February 14, 2017 and June 27, 2017. The agenda included a standing item titled, "medication incidents." The minutes did not reflect any documentation to reflect a quarterly review was undertaken of all medication incidents/adverse drug reactions to reduce and prevent these incidents. [s. 135. (3)]

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 immediate actions taken to assess and maintain the resident's health are documented, to ensure there is documented evidence to support the completion of an analysis or corrective action and to ensure a quarterly review is undertaken of all medication incidents and adverse drug reactions to reduce and prevent medication incidents and adverse drug reactions, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining.

On October 3, 2017 resident #003 was observed sitting in a wheelchair with a lap-belt and a lap tray in place while at the noon meal. A review of resident #003's chart indicated a consent for a restraining lap belt at all times while in a wheelchair and a lap tray for meals was obtained from resident #003's nephew in May of 2017, however, there was no restraint order and/or no reference to an approval of the restraints by a physician or Registered Nurse in the Extended Class (RN EC) found in the electronic record or on the hard copy chart. A review of resident #003's assessment file indicated that the initial restraint assessment was completed on April 27, 2017. The lap belt and table were requested by resident #003's family due to recurrent falls and a history of injury. Alternatives to the restraints such as a medication review, footwear, bed position and physiotherapy were considered. The restraint consent was signed on May 5, 2017, however, there was no order from a physician or RN (EC) on file. A review of resident #003's chart and related documentation was competed with RN #105 who agreed there should be an order and advised that one would be obtained by week's end. [s. 31. (2) 4.]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 86. Infection prevention and control program

Specifically failed to comply with the following:

s. 86. (2) The infection prevention and control program must include,
(a) daily monitoring to detect the presence of infection in residents of the long-term care home; and 2007, c. 8, s. 86. (2).
(b) measures to prevent the transmission of infections. 2007, c. 8, s. 86. (2).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, s.86 (2) (b) in that measures are not taken to prevent the transmission of infections.

On October 3, 2017 an initial tour of the home was conducted. Observations of each of the units' tub/shower rooms were conducted and concerns specific to the home's nail care equipment cleaning sterilization process were identified. Additional tub/shower

room observations were made on each unit and detailed on October 5, 2017 as follows:
East:
o Clean container - 2 unlabeled black combs that appeared used (stray hairs and crusty residue between tines)
o Dirty container – empty
Note: 4 unlabeled black combs that appeared used laying on lower trolley shelf.
West:
o Clean container – 2 unlabeled nail scissor/clipper that appeared clean
o Dirty container – 1 unlabeled nail scissor/clipper, 1 unlabeled black comb
North tub/shower:
o Clean container - empty
o Dirty container – empty
North tub
o Clean container – 3 unlabeled black combs that appeared clean
o Dirty container – empty
South
o Clean container – 1 unlabeled nail scissor/clipper appeared clean
o Dirty container – 2 unlabeled nail scissor/clippers

On October 5, 2017 inspector #602 attended the dirty utility room on the North Unit with RAI Coordinator/Infection Control Nurse (RAI-C/IC RN) #105 and noted that there was no nail care equipment in the chemosterilant solution container and that there was no date marked on the container as to when the sterilant was last changed. RAI-C/IC RN#105 indicted that she had just been informed that the disinfectant used to sterilize nail care equipment was not the high level PREempt™ HLD5™ chemosterilant they typically use as only the low level disinfectant had been ordered. RAI-C/IC RN #105 estimated that there had been no high level disinfectant in the home for approximately one and a half months. Staff #105 further indicated that the chemosterilant in the sterilization container was likely the low level disinfectant, and thus cross contamination of the nail care equipment may have occurred.

The home's Resident Care Manual "Cleaning of Nail Equipment" policy and procedure provided by RAI-C/IC RN#105 indicated that after using nail scissors on a resident staff are to place the dirty scissors in the tub room container labelled soiled. The cleaning and sterilizing of scissors is the responsibility of PSW on Day Shift assigned to the wing. After morning baths are completed the PSW is to collect container with soiled scissors from tub room and take to dirty utility room. Scissors are to be meticulously cleaned with soap and water to ensure all organic material removed. The pre cleaned rinsed and dried

scissors are to be placed into chemosterilant (Prevention – accelerated hydrogen peroxide) and soaked for a minimum of 6 hours. The Night shift PSW removes the scissors from the chemosterilant, rinses, dries and places scissors in the "clean containers" and container/nail equipment are returned to the appropriate tub room.

Inspector #602 and RAI-C/IC RN # 105 then attended the East Unit tub room where the "dirty" container was found empty and the "clean" bin contained two used black combs. Inspector # 602 asked PSW staff #106 & 107 present in the tub room if the combs belonged to a resident. Both PSWs indicated they did not know and that it is not their practice to re-use combs when assisting residents with their tub bath. The PSW staff indicated if the resident does not have a comb with their personal care supplies they bring with them to the tub room, a new black comb would be pulled from the tub room supply, used, and then thrown out. Inspector # 602 noted a sign on the cabinet between the two bathtubs directing:

"ALL STAFF
If using combs in tub room when done,
Please place in disinfectant with nail clippers"

The RAI Coordinator/IC Nurse and PSW's 106 & 107 did not know who authored and/or posted the sign and reiterated that their practice is to discard used unlabelled combs.

RAI-C/IC RN # 105 advised that the high level PREempt™ HLD5™ Accelerated Hydrogen Peroxide chemosterilant would be ordered for delivery on October 6, 2017 and that the low level disinfectant in the sterilization container would be discarded and replaced with the high level disinfectant chemosterilant as soon as the high level chemosterilant solution arrived. RAI-C/IC RN # 105 further indicated that she would begin labelling the container with the date of the solution's replacement in order to ensure that the disinfectant is only re-used for a maximum of 14 days as indicated in the nail equipment cleaning policy. Staff #105 also indicated that the policy would be reviewed with all staff in an effort to ensure directions/procedure are followed specific to care of nail equipment and that used unlabelled combs are discarded.

On October 6, 2017, the DOC advised that he had obtained the high level PREempt™ HLD5™ chemosterilant and that the low level disinfectant was replaced with the high level chemosterilant solution, a replacement date was affixed to the chemosterilant container, all signs specific to re- use of combs were removed/discarded and that the nail care equipment cleaning and sterilization policy and procedure would be reviewed with all direct care staff at their next staff/in-service meeting. [s. 86. (2) (b)]

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 controlled substances were stored in a separate, double locked area within the locked medication cart.

During the review of the home's medication incidents, it was noted that on January 29, 2017, a controlled substance (Dilaudid) had been found in the top drawer of the medication cart by the oncoming staff. The staff member who had worked the previous shift indicated the medication had been poured for administration to a resident, but the staff member found the resident was asleep. The staff member placed the controlled substance in the top drawer of the medication cart and intended to destroy it. Upon the discovery of the medication, two registered staff members destroyed the medication.

S#104 was interviewed and stated if a controlled substance could not be given to a resident for some reason (refused or required a reattempt), it would be put into the appropriate resident medication slot until such time it could either be given or destroyed. These medication slots are located in the single locked area within the medication cart, not a double locked area as required. [s. 129. (1) (b)]

Issued on this 23rd day of October, 2017

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

Original report signed by the inspector.