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 30, 2017	2017_605213_0028	025896-17	Resident Quality Inspection

Licensee/Titulaire de permis

SOUTHAMPTON CARE CENTRE INC
689 YONGE STREET MIDLAND ON L4R 2E1

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

SOUTHAMPTON CARE CENTRE
140 Grey Street P.O. Box 790 Southampton ON N0H 2L0

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

RHONDA KUKOLY (213), MELANIE NORTHEY (563)

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): November 20, 21, 22, 23, 2017

The following critical incidents were also inspected concurrently within this Resident Quality Inspection:
Log #024629-17, Critical Incident #2597-000015-17 related to falls.
Log #029746-16, Critical Incident #2597-000008-16 related to resident to resident abuse.
Log #020877-17, Critical Incident #2597-000013-17 related to resident to resident abuse.
Log #014411-17, Critical Incident #2597-000010-17 related to resident to resident abuse.
Log #025133-17, Critical Incident #2597-000016-17 related to falls.
Log #018617-17, Critical Incident #2597-000011-17 related to resident to resident abuse.
Log #011410-17, Critical Incident #2597-000008-17 related to falls.
Log #012678-17, Critical Incident #2597-000009-17 related to resident to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Co-Director of Care, the Care Services Coordinator, the Resident and Family Services Coordinator/Volunteer Coordinator, the Life Enrichment Coordinator, Registered Nurses, Registered Practical Nurses, Personal Support Workers, a Residents' Council representative, a Family Council representative, residents and family members.

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

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours

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

- **5 WN(s)**
- **1 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. 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was 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 medication incident report was completed for a resident on an identified date, related to a missed dose of medication.
The Director of Care (DOC) acknowledged that the DOC and pharmacy were notified, but that the prescriber and the resident and/or Power of Attorney (POA) were not notified. The DOC shared that follow up with family would be documented as part of the resident's progress notes in Point Click Care (PCC) and verified that there was no documented evidence that the resident's SDM was notified of the incident. Inspector #563 and the DOC reviewed the physician's book and the DOC verified that there was no notification to the prescriber of resident's medication incident.

B) A medication incident report was completed for another resident on an identified date, related to a missing medication.
The DOC verified that the incident did reach the resident, but without harm. The registered staff were unsure how long the resident was without the medication in a 24 hour period and the medication was found. Inspector #563 and the DOC reviewed the physician's book and verified that there was no notification to the prescriber and shared that there was no documented evidence that the resident and/or POA were not notified of the resident's medication incident.

C) A medication incident report was completed for another resident on an identified date, related to order times for a medication.
The DOC acknowledged that the DOC was notified and pharmacy was faxed, but that the resident/POA were not notified and there was no documented evidence in the progress notes that the resident's POA was notified.

The Silver Fox Pharmacy Medication Incidents policy 2.2 dated November 2016, was reviewed and stated "The medication incident should also be reported to the resident, the resident substitute decision-maker (SDM), if any, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident."

The Jarlette Health Services Long Term Care Division "Medication Management System - Medication Incident" policy, version 2, last revised July 20, 2017, was reviewed and stated "Upon an identification of a medication error, the individual identifying the error will report the identified medication incident to the attending physician, Director of Care, pharmacist, resident and SDM."

The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident, the resident's SDM, if any, and the resident's attending physician.

The severity of this non-compliance is minimum risk and the scope is widespread. The home does not have a history of non-compliance with this subsection of the legislation. [s. 135. (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 every medication incident involving a resident and every adverse drug reaction is reported to the resident, the resident's 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, to be implemented voluntarily.

WN #2: 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. (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 has failed to ensure 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 changed or care set out in the plan was no longer necessary.

On an identified date and time, a resident was observed and appeared physically frail. The following day at various times throughout the day, the resident’s status did not change.

Inspector #563 spoke to resident’s family member who was in the home visiting. The resident's family member shared that the resident had declined and required more assistance with care.

The current care plan in Point Click Care (PCC) was reviewed and indicated that the resident did not require the level of assistance that their family member indicated they required.

In an interview, a Registered nursing staff member shared that this resident’s health status had declined significantly and that the current plan of care did not reflect the resident’s current care needs.

The Jarlette Health Services Long Term Care Division "Resident Rights, care and Services “Plan of Care” policy last revised April 20, 2017, was reviewed and stated “The plan of care shall be reviewed and revised when the resident’s care needs change, the care set out in the plan is no longer necessary; or the care set out in the plan has not been effective”.

In an interview with the Director of Care (DOC), they stated that resident’s health status had significantly declined and that the current plan of care did not reflect the resident’s current care needs.

The licensee has failed to ensure the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed.

The severity of this non-compliance is minimal harm or potential for actual harm and the scope is isolated. The home does not have a history of non-compliance with this subsection of the legislation. [s. 6. (10) (b)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home received oral care to maintain the integrity of the oral tissue that included mouth care in the morning and evening, and the physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth.

On an identified date, a resident was observed to have residue noted along their outer lips, teeth, and tongue. The resident's tongue was very dry and their lips were stuck along the gum line. The Inspector asked the resident if they had a dry mouth and the resident replied in a very soft voice that their mouth was dry.

Inspector #563 asked a Registered Nursing staff member if the resident had received any medication, since there was residue along the resident's mouth, teeth and tongue. The staff member replied that a medication was administered earlier that day. The Inspector asked why there would be residue along the resident's lips and the staff did not have an answer.

The resident's medication administration documentation in Point Click Care (PCC) and mouth care documented in Point of Care (POC) was reviewed with Director of Care (DOC). The DOC verified that the electronic Medication Administration Record (eMAR) for resident's medication administration was documented by the registered nursing staff

member that day. The POC task documentation for mouth care twice daily was reviewed and the DOC verified that there was no documented evidence that mouth care was provided that day. In addition, at times the POC documentation indicated a response of "no" that mouth care was not given and other times there was only one documented entry for mouth care when it was scheduled twice a day.

Review of the current care plan in PCC stated oral care was to be provided twice a day for this resident.

The Jarlette Health Services Long Term Care Division "Resident Rights, care and Services "Plan of Care" policy last revised April 20, 2017, was reviewed and stated "The Personal Support Worker (PSW) will refer to the kardex to ensure that care is provided to the resident as specified in the plan of care".

The DOC stated that this resident's health status had significantly declined and the resident required total care and assistance for oral hygiene.

The licensee has failed to shall ensure that a resident received oral care to maintain the integrity of the oral tissue that included mouth care.

The severity of this non-compliance is minimum risk and the scope is isolated. The home does not have a history of non-compliance with this subsection of the legislation. [s. 34. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 117. Medical directives and orders — drugs
Every licensee of a long-term care home shall ensure that,
(a) all medical directives or orders for the administration of a drug to a resident are reviewed at any time when the resident's condition is assessed or reassessed in developing or revising the resident's plan of care as required under section 6 of the Act; and
(b) no medical directive or order for the administration of a drug to a resident is used unless it is individualized to the resident's condition and needs. O. Reg. 79/10, s. 117.

Findings/Faits saillants :

1. The licensee has failed to ensure that all medical directives or orders for the administration of a drug to a resident were reviewed at any time when the resident's condition was assessed or reassessed in developing or revising the resident's plan of care.

On an identified date, a resident was observed with residue along their outer lips, teeth, and tongue.

Inspector #563 asked a Registered Nursing staff member if the resident had received any medication, since there was residue along the resident's mouth, teeth and tongue. The staff member replied that a medication was administered earlier that day. The staff member shared that the resident’s health status had declined.

The current physician orders in Point Click Care (PCC) documented that this resident was ordered a specific medication to be administered at specified times as well as special instructions for the administration of medications: medications whole with water.

The progress notes related to altering medications for the resident stated that as early as two years prior, the resident’s medications were crushed. The three month medication reviews, handwritten orders and the hospital "Discontinued Prescriptions and Reconciliations" did not provide specific directions to crush medications. All medication orders for the administration of medications were reviewed at least every three months, and when the resident's condition was assessed or reassessed for a two year time period, the plan of care related to special instructions for crushing medications were not discussed with the pharmacy or the prescriber. There was no documented evidence that that all orders for the administration of the resident’s medications were reviewed at any time when the resident's condition was assessed or reassessed in developing or revising the resident's plan of care to reflect their need for crushed medications.

The Director of Care (DOC) shared that this resident’s health status changed several times since admission where the resident had declined and required medications crushed. The DOC acknowledged that the resident's plan of care related to the crushing of medications and the method of administration of medications was not reviewed at the times when the resident's condition was reassessed. Pharmacy was not notified that the

special instructions changed from whole medication administration to crushed medication administration.

The licensee has failed to ensure that when a resident's condition was assessed or reassessed and orders for the administration of a drug was not reviewed when revising the resident's plan of care related to crushing medications.

The severity of this non-compliance is minimum risk and the scope is isolated. The home does not have a history of non-compliance with this subsection of the legislation. [s. 117. (a)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that controlled substances were stored in a separate, double locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

On an identified date, Inspector #563 observed the narcotic count with two registered nursing staff members present. The staff entered the locked medication room and removed a locked black steel portable container stored in the refrigerator. One staff member unlocked the black box and stated there were four vials of Ativan injectable inside. The Controlled Drugs and Substances Act classified Ativan as a controlled substance.

The Jarlette Medication Management - Narcotics and Controlled Substances policy last revised October 7, 2013, was reviewed and stated "All narcotics shall be stored in a permanently affixed cabinet, under double lock at all times accessible only by a Registered Staff Member."

In an interview, the Director of Care (DOC) and Co-DOC, they acknowledged that the Ativan should be stored in a separate, double-locked stationary cupboard and that the black box was not stationary.

The licensee has failed to ensure that the controlled substance, Ativan injectable, was stored in a separate, double-locked stationary cupboard in the locked area.

The severity of this non-compliance is minimum risk and the scope is isolated. The home does not have a history of non-compliance with this subsection of the legislation. [s. 129. (1) (b)]

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Issued on this 11th day of December, 2017

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

Original report signed by the inspector.