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
Oct 23, 2017	2017_505103_0046	022092-17	Resident Quality Inspection

Licensee/Titulaire de permis

DIVERSICARE CANADA MANAGEMENT SERVICES CO., INC
2121 ARGENTIA ROAD SUITE 301 MISSISSAUGA ON L5N 2X4

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

PERTH COMMUNITY CARE CENTRE
101 CHRISTIE LAKE ROAD R. R. #4 PERTH ON K7H 3C6

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

DARLENE MURPHY (103), HEATH HEFFERNAN (622)

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 16- 20, 2017

During the course of the inspection, the inspector(s) spoke with residents, family members, Resident Council President, Family Council President, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Registered Dietitian, Maintenance Supervisor, Director of Resident Services, (DRS), Director of Care (DOC), and the Administrator.

During the course of the inspection, the inspector(s) conducted a full walking tour of the home, made observations related to the home's infection control practices, medication administration, and a storage area for narcotics, reviewed resident health care records, and applicable home policies.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure required policies under the Nutritional care program were complied with.

O. Reg 79/10, s. 68 (2) (e) states, a licensee of a long term care home shall ensure that the program includes a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter,
(ii) body mass index and height upon admission and annually thereafter.

During a review of resident health care records, it was noted that several residents did not have regular monthly weights recorded. RPN #108 was interviewed and stated the PSW's are to weigh each resident when taking the resident to a have a bath or shower. This RPN stated she is the usual person to enter the weights into the documentation system.

Resident #017's weight record was reviewed. The resident had the last documented weight completed on August 4, 2017. The documented weight for the month prior had been completed on July 30, 2017. There was a discrepancy of eighteen kilograms between these two weights.

The Registered Dietitian #107 was interviewed and indicated monthly weights are not always being done on a regular basis and rarely prior to the tenth day of the month. The Dietitian had requested a re-weigh of resident #017 on August 14, 2017 and to date there had been no re-weigh documented. #107 further stated that to date (October 19, 2017), she had only forty-nine weights out of the one hundred and twenty one residents living in the home.

The DOC was asked to provide a copy of the home's policies related to weight records. Policy # DS-III-025, "Weight monitoring and Evaluation" was provided to the inspector. Under Procedure, the policy indicated the RN/RPN will:

-record monthly weights or re-weighs from PSW documentation tool into the weights and vitals system of the electronic documentation system by the tenth of every month.
-Request the PSW to reweigh the resident if there is an unanticipated weight change (loss or gain) or a two kilogram difference in the resident's previous month.

The licensee failed to ensure the policy related to the monthly monitoring of resident weights was complied with.

During the review of resident health care records, inspectors #103 and #622 both noted resident heights were not being completed on an annual basis. Some resident heights dated back to 2014. The DOC was asked to provide a copy of the home's policy related to height measurement. Policy #LTC-RCM-G-20.90, "Height Measurement" was reviewed. The policy indicates a resident's height will be taken upon admission and annually to determine the ratio between height and weight as related to dietary requirements.

The licensee failed to ensure the policy related to the annual monitoring of resident heights was complied with. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the home's policy regarding monthly weights, re-weighs and heights are complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

On October 16, 2017, during the initial tour of the home, inspector #622 observed the doors leading to the Maintenance Wing had a mag-lock, a key pad and signs stating they led to a restricted staff area which would be unlocked by fire alarm. Inspector #622 noted the doors opened when pushed and sounded an alarm. A staff member in the area indicated the door was not locked but had been set with an alarm to notify staff if someone entered without using the keypad. The unlocked doors leading to the maintenance area allowed resident's access to tools in the hallway and the exit door to the outside in stairwell "B". The exit door in stairwell "B" was noted to be unlocked, a staff member leaving the door indicated it was supposed to be locked. The green light on the touch pad did not change to red signifying it had locked and no alarm sounded after the staff left.

On October 16, 2017 at approximately 1410 hours, inspector #103 observed a resident entering the maintenance hallway while mobilizing with a walker. The resident was noted to pull the doorway open that led to the maintenance hallway and the alarm sounded. Inspector #103 observed an Activation staff member leave her office, look through the window in the door and walked away from the area. The Activation staff member indicated to inspector #103 that it was ok, the resident was going to look at the lost clothing. The Activation staff member further indicated residents have access to the maintenance hallway, this has been longstanding and allows the residents to check with the laundry to see if they can find missing items.

On October16, 2017 during a team meeting at approximately 1500 hours, inspector #103

observed another resident with a walker who was accompanied by a family member, enter the maintenance hallway, the alarm sounded and was turned off by a passing staff member.

During an interview with inspector #622 on October 16, 2017, Maintenance Supervisor #105 indicated the doors leading to the maintenance wing were supposed to have both a mag-lock and an alarm. The Maintenance Supervisor #105 also indicated the exterior door in stairwell "B" had an alarm only and was not locked as the doorway leading to the maintenance wing was supposed to be. The Maintenance Supervisor #105 indicated that he had gone to assess the exterior doorway in stairwell "B" and the alarm had been set to bypass. The Maintenance Supervisor #105 further indicated he had reset the door keypad at the time.

During an interview with inspector #622 on October 17, 2017, Maintenance Supervisor #105 indicated he received the parts for the Maintenance Wing doors and the mag-locks were functioning.

The licensee failed to ensure that all doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by residents, and those doors had been kept closed and locked when they were not being supervised by staff. [s. 9. (1) 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 all doors leading to non-residental areas are kept closed ad locked when not being supervised by staff, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure resident #017's personal assistance services device (PASD) was included in the resident plan of care.

A PASD is defined as a device used to assist a person with a routine activity of living. A PASD may have the effect of limiting or inhibiting a resident's freedom of movement if the resident is not able, either physically or cognitively to release themselves from the PASD.

Resident #017 was admitted to the home on an identified date and had identified diagnoses. The resident was observed to be seated in a tilted wheelchair and had a front closing lap belt in place.

The resident was interviewed in regards to the tilt chair and the lap belt. The resident stated they were unsure why either was being used, but they were very comfortable in the wheelchair and was agreeable to both being used . The resident indicated he/she was not able to undo the lap belt and that he/she would be unable to get out of the chair when tilted even if the lap belt was not being used.

Resident #017's plan of care was reviewed and there was no documentation related to the use of the lap belt or tilt wheelchair.

The Director of Resident Services (DRS) was interviewed and stated the resident had previous incidents of slipping out of the wheelchair. She stated the resident had received a new wheelchair about one month ago and that the lap belt and tilt function of the chair was being used for positioning and to prevent further incidents of sliding out of the wheelchair. The Occupational therapist had approved the tilt wheelchair and the lap belt. The DRS agreed the resident was being restrained by both the lap belt and the tilt function of the wheelchair and was unable to find any documentation related to the use of the lap belt or tilt wheelchair in the resident plan of care. [s. 33. (3)]

WN #4: 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 is reported to the resident, the resident's SDM, if any, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class.

Three medication incident reports occurring over an identified period of time were reviewed. The resident and/or substitute decision maker(s) (SDM) were not notified of the medication incident in two of the three reports and the Physician was not notified in the three reviewed.

A review of the Medication Incident – Final Report with an identified date indicated there had been a medication omission error related to resident #023. The nurse finding the error documented that at the start of their shift, they found resident #023's 1400 hour medication was not given. The Medication Incident – Final Report did not indicate if the SDM or physician had been notified.

A review of the Medication Incident – Final Report with an identified date indicated there had been a medication error related to resident #016. The description of the incident indicated the morning dose of an identified medication was not available from pharmacy. The RPN substituted the evening dose of the medication, but the evening dose was 1 mg

instead of the ordered 0.5 mg and the resident received the wrong dose. The Medication Incident- Final Report indicated the family were notified, however the physician notification was blank.

A review of the Medication Incident – Final Report with an identified date indicated there had been a medication omission error related to resident #024.The resident's prescribed medicated patch was not applied on the morning of an identified date. The nurse on the evening shift had attempted to remove the patch at the scheduled time and noted it had not been applied. The Medication Incident – Final Report did not indicate the SDM or physician had been notified.

During an interview with inspector #622 on October 18, 2017, the DOC reviewed resident #023, #016 and 024's hard copies of their charts including the progress notes, the physician's progress notes, the physician's orders and the electronic chart progress notes. The DOC indicated she could not find documentation that the physician had been notified for all three of the medication incidents reviewed and, for the incidents related to resident's #023 and 024, she could not find documentation indicating the SDM had been notified. The DOC further indicated that all medication incidents should be reported to the SDM and the physician. She stated it would be presumed that the SDM and physician were not notified if there was no documentation. [s. 135. (1)]

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.