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 2, 2017	2017_700536_0018	024532-17	Resident Quality Inspection

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF NIAGARA
2201 ST. DAVID'S ROAD THOROLD ON L2V 4T7

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

UPPER CANADA LODGE
272 WELLINGTON STREET P. O. BOX 1390 NIAGARA-ON-THE-LAKE ON L0S 1J0

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

CATHIE ROBITAILLE (536), 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): October 24, 25, 26, 27 and 30, 2017.

During the course of the inspection, the inspector(s) spoke with residents, family members, personal support workers (PSW's), registered staff, Physiotherapist, Resident Assessment Instrument-Minimum Data Set Co-Ordinator(RAI-MDS), Director of Care (DOC) and the Administrator.

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, staffing schedules, 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
Residents' Council
Skin and Wound Care

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. 124. Every licensee of a long-term care home shall ensure that drugs obtained for use in the home, except drugs obtained for any emergency drug supply, are obtained based on resident usage, and that no more than a three-month supply is kept in the home at any time. O. Reg. 79/10, s. 124.

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs obtained for use in the home except drugs obtained for any emergency drug supply, are obtained based on resident usage, and that no more than a three-month supply is kept in the home at any time.

On October 30, 2017 Inspector and Director of Care (DOC) reviewed the home's three month drug supply. At the time of the inspection the home had 80 resident beds and two medication carts in operation. The Inspector observed the following:

i) 51 bottles of Tylenol 500 mg-100 tablets per bottle=5100 tablets
ii) 43 bottles of Tylenol 325 mg-100 tablets per bottle=4300 tablets
iii) 23 bottles of Colace 100 mg-100 capsules per bottle=2300 capsules
iv) 21 bottles of Gravol 50 mg-100 tablets per bottle=2100 tablets
v) 24 boxes Dulcolax suppositories 10 mgs-100 per box=2400 suppositories
vi) 7 bottles Senekot 8.6 mg-1000 tablets per bottle=7000 tablets.

The DOC confirmed that this was more than a 3 month supply. The home failed to ensure that drugs obtained for use in the home except drugs obtained for any emergency drug supply, are obtained based on resident usage, and that no more than a three-month supply is kept in the home at any time. [s. 124.]

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 the home has no more than a three month supply at any time, 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. (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, 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 review of the home's five "Medication Incident Report" forms from identified dates in 2017, indicated areas for the physician and the family/Subsitute Decision Maker (SDM) to be notified.

A) On an identified date in 2017, resident #010 received their specified medication at a different time than ordered by the physician. The incident report stated "no" that neither

the SDM or, the physician had been contacted in regards to the medication incident.

B) On an identified date in 2017, resident # 012 had an order that they could receive an identified medication when necessary (PRN) once every 24 hrs. The registered staff administered the medication without checking the resident's clinical record to see that they had already received the medication that same day. The incident report stated "no" that neither the SDM or, the physician had been contacted in regards to the medication incident.

C) On an identified date in 2017 , resident #013 was provided care. The Personal Support Worker (PSW) noted that resident #013 was holding pills in their hand. It was identified that the medications were from the morning medication pass. The incident report stated "no" that neither the SDM or, the physician had been contacted in regards to the medication incident.

An interview with the DOC on October 30, 2017, confirmed that in three of five medication incident involving residents that there was no documentation that these incidents were reported to the physician or the SDM. [s. 135. (1)]

2. The licensee 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).

During an interview with the DOC on October 27, 2017, it was identified that quarterly reviews are completed at the "Registered Nurses and Medication Safety Meetings" with the Pharmacist in attendance. A review was completed of the minutes provided from February 1, 2017, April 28, 2017 and July 6, 2017. Each meeting stated that "a review was completed of medication incidents, discussion of each incident and strategies to prevent reoccurrences" however, there was no further written record to address any changes and improvements identified in the review and that they were implemented.

An interview with the DOC confirmed that improvements had been made in order to reduce and prevent medications incidents however, there was no written record kept. The home failed to ensure that there was a written record kept of any changes and improvements identified in the quarterly review. [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 and ensuring any medication error involving a resident and every adverse drug reaction is reported to and follow up completed by the pharmacy service provider as per the home's medication incident report, as well as a quarterly review is 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), to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rights of residents were fully respected and promoted: Every resident had the right to have his or her personal health information kept confidential in accordance with that Act.

On two identified dates in 2017, Dementia Observation System (DOS) charting forms for residents #005 and #009 were observed hanging by a clip on the wall in a home area. The forms identified the residents name in the upper corner, and required staff to document on the resident's every 30 minutes.

Interview with PSWs #104 and #105 identified that the DOS charting forms were always hanging in the identified area for the two residents. Interview with RPN #103 identified that it was the expectation that the resident's names were covered by the clips, so that they could not be seen.

Interview with the DOC on October 26, 2017, identified that the home's expectation was that resident #005 and #009's DOS charting forms hanging in the identified area, were to be labelled as resident one and resident two, and that the binder in the nursing station would identify which resident was which. They identified that the issue had come up a week ago, and staff were directed to indicate the resident by number, not by name, on the DOS charting forms that were hung in the dining room on the home area.

The home did not ensure that resident #005 and #009's personal health information was kept confidential. [s. 3. (1) 11. iv.]

WN #4: 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 has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Resident #003 was admitted to the home with altered skin integrity on a specified date. An initial wound assessment had been completed on the altered skin integrity on the day of admission. The next wound assessment was completed on an identified date in 2017. The home was unable to identify through staff interview or corporate consultation how the weekly wound assessments had not been completed. The Resident Assessment Instrument Minimum Data Set (RAI-MDS) Co-Ordinator confirmed that the resident's wounds had not been reassessed at least weekly between two identified dates. [s. 50. (2) (b) (iv)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 116 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a Registered Dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

On October 30, 2017, a review was completed of the homes annual evaluation of the medication management program. The evaluation was completed by the Administrator and the DOC. The DOC confirmed that the evaluation did not include the: Medical Director; Pharmacy Service Provider or the Registered Dietitian. [s. 116. (1)]

Issued on this 21st day of November, 2017

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

Original report signed by the inspector.