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
Aug 7, 2018	2018_484646_0007	029399-17, 029514-17	Critical Incident System

Licensee/Titulaire de permis

Schlegel Villages Inc.
325 Max Becker Drive Suite. 201 KITCHENER ON N2E 4H5

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

The Village of Erin Meadows
2930 Erin Centre Boulevard MISSISSAUGA ON L5M 7M4

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

IVY LAM (646), DEREGE GEDA (645)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): May 1, 2, 3, 4, 7, 8, 9, 10, 11, 14, 15, 16, 17, 18, 22, and 23, 2018.

During the course of the inspection, the inspector(s) spoke with Acting General Manager (AGM), Acting Director of Nursing (DON), Assistant Directors of Nursing Care (ADNC), Neighborhood Coordinators (NC), Personal Expression Resource Team (PERT) Lead, Resident Assessment Instrument – Minimum Data Set (RAI-MDS) Coordinators, Skin and Wound Lead, Physician (MD), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Physiotherapist (PT), Kinesiologist (KIN), Physiotherapy Assistant, Recreation Aide, Residents, Family Members, Power of Attorneys (POA), and Substitute Decision-Makers (SDM).

During the course of this inspection, inspectors conducted a tour of the home, observed residents' care, staff to resident interactions, resident to resident interactions, reviewed resident health care records and home's records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **4 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. 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, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

This inspection was initiated for resident #016 related to Critical Incident System (CIS) report #2881-000029-17, related to an incident where the resident had returned to the home on an identified date after an identified medical procedure. Resident #016 was assessed by physician (MD) #129, the next day, who made an identified order to be completed on another identified date.

Review of skin assessments done for resident #016 showed that an identified assessment was completed on the day that the resident returned to the home from the medical procedure. However, no Weekly Skin Observation Tool that assessed the identified alteration of skin integrity was completed and documented until thirteen days later.

Interviews with the Skin and Wound Lead/ ADNC #107 and the Acting Director of Nursing Care #127 indicated that it is the home's expectation for the weekly skin assessment to be done weekly for residents with an identified alteration of skin integrity until the skin is healed and that this was not done for resident #016, for the week after the resident returned to the home. [s. 50. (2) (b) (iv)]

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 the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, 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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The following is further evidence to support the order issued on March 28, 2018, during Resident Quality Inspection (RQI) 2018_544527_0001 to be complied April 27, 2018.

The licensee has failed to ensure that when resident #050 was reassessed and the plan of care was revised because the care set out in the plan had not been effective, different approaches were considered in the revision of the plan of care.

A review of a Critical Incident System (CIS) report #2881-000028-17, submitted to the Ministry of Health and Long-Term Care (MOHLTC), indicated that resident #050 had an unwitnessed fall resulting in an identified injury and hospitalization.

A record review indicated that the resident had a fall on four separate identified dates prior to the fall on the CIS report. The resident's plan of care was updated with fall prevention interventions after the first fall incident. Further record review indicated that the plan of care was not updated, and no new interventions were implemented on the three subsequent fall incidents.

An interview with the Assistant Director of Nursing (ADNC) #107 and Neighbourhood Coordinator (NC) #130 indicated that when a resident has a fall, registered staff are expected to reassess the resident, develop interventions to prevent falls and update the care plan. In the event where the resident continues to fall, staff are to continuously develop different approaches to prevent the fall from happening again and modify the plan of care with new interventions. During the interview NC #130 reiterated that recurring falls are the result of unmet or ineffective interventions and requires reassessment to prevent further fall incidents and injuries. During the interview, both the ADNC and NC stated that registered staff neither used a different approach, nor implemented different interventions to prevent the recurring falls.

An interview with the Acting General Manager (AGM) also confirmed that when a resident had frequent falls, the fall prevention interventions need to be reassessed, registered staff are to change interventions and update the plan of care as needed. [s. 6. (11) (b)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The following is further evidence to support the order issued on March 28, 2018, during RQI 2018_544527_0001, to be complied April 27, 2018.

The licensee has failed to ensure that residents were free from neglect by the licensee or staff in the home.

In accordance with the definition in subsection 2 (1) of the Act "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, including inaction or a pattern of inaction that jeopardizes the health or safety of one or more residents.

This inspection was initiated for resident #016 related to CIS report #2881-000029-17, related to an incident where the resident had returned to the home on an identified date after an identified medical procedure. On the following day, resident #016 was assessed by physician (MD) #129, who ordered an identified procedure to be completed for the resident on an identified date. The home complete this order until six days after the day the procedure was ordered to be completed.

During the course of the inspection, the following issues were identified:

I. Medication was not administered to the resident as per the directions for use specified by the prescriber:
Hospital discharge notes an identified date, included an identified medication order for resident #016 for an identified period of time.

Review of the electronic medication administration record (eMAR) indicated that Registered Practical Nurse (RPN) #116 had entered the medication order, but had put

the stop date for the identified medication that was stopped one day earlier than the identified order date. RPN #116 stated during interview with the Inspector that they had miscalculated the end date. RPN #116 and ADNC #107 stated that based on their calculations, the medication should have been stopped one day after the date entered on eMAR and the resident was not administered the complete course of the identified medication as specified by the prescriber.

II. Identified medical procedure was not done for resident #016 on the date ordered by MD #129, and an identified condition was observed on resident #016's identified part of the body when the procedure was completed by the nurse practitioner six days after the ordered date.

Review of resident #016's Physician's Digiorder showed that on an identified date, MD #129 assessed resident #016 and put in an order with multiple instructions, including an identified medical procedure for resident #016 on an identified date. The Physician's Digiorder also showed that RPN #128 signed that the order was processed but did not process the complete order, and no entry was made on the Treatment Administration Record (TAR) regarding the instructions for the identified medical procedure. Further, the Physician's Digiorder showed that RPN #124 had signed for the second check.

In an interview, RPN #128 stated that two days after the resident returned to the home from the planned medical procedure in hospital, the Substitute Decision-Maker (SDM) of resident #016 had inquired about an identified test for resident #016, at which point RPN #128 saw the order was not processed, and processed the identified test portion of the physician's order and signed in the 'processed by' box. RPN #128 stated that their thought was that the next registered staff would process the remainder of the order. However, it was not communicated to the next RPN that the order was only partially processed.

In an interview, RPN #124 stated that they saw that RPN #128 had signed for having processed the order. RPN #124 stated that they had co-signed the order without checking if the order was completely processed, because they had assumed that RPN #128 had processed the complete order correctly.

Therefore, no order was entered into the TAR for the identified medical procedure ordered by MD #129, and it was not identified that the identified medical procedure was not done for the resident until four days after the date that the procedure was ordered when RPN #124 asked RPN #125 if the procedure was completed. The procedure was

completed six days after it was ordered by MD #129.

III. Weekly reassessment of resident #016 who an identified alteration of skin integrity was not done:

Review of skin assessments done for resident #016 showed that an identified assessment was completed on the day that the resident returned to the home from the medical procedure. However, no Weekly Skin Observation Tool that assessed the identified alteration in skin integrity was completed and documented until thirteen days later.

Interviews with the Skin and Wound Lead/ ADNC #107 and the Acting Director of Nursing Care #127 indicated that it is the home's expectation for the weekly skin assessment to be done weekly for residents with an identified alteration of skin integrity until the skin is healed and that this was not done for resident #016, for the week after the resident returned to the home.

IV. Resident #016 who had exhibited altered skin integrity did not receive immediate treatment and interventions to promote healing and prevent infection as required.

Review of resident #016's TAR in an identified month showed the order for an identified care of the alteration of skin integrity was not done until fifteen days after the resident returned to the home.

Review of the resident's record and staffing records showed that between the resident's return to the home and the time the identified medical procedure ordered by MD #129 was done, fourteen different registered staff members worked with the resident, but none noticed or notified the physician that there was no treatment order for resident #016 regarding identified care for the resident that would accompany residents who have this identified alteration of skin integrity.

Review of resident #016's progress notes showed that the identified care was done three times in the thirteen-day period between the resident's return to home to the completion of the identified medical procedure:

- RPN #126, who was identified to have done the identified care for the resident once, stated in an interview that that they had done the care that day as the PSW notified the care was needed for the resident, but the RPN did not look at the care plan for

instructions, and did not look at the TAR to see if there were any orders placed for the resident for the identified care. The RPN stated that it is their normal process to review the TAR prior to providing care, but they did not do so that day. The RPN further stated that if they had looked in the TAR and saw there was no order, they would have called the MD for the order.
- On another identified date, RPN #141 documented the identified care was provided for the resident there were signs that the resident required this care.

- On another identified date, the progress notes showed RPN #123 provided the identified care for resident #016. Interview with RPN #123 showed that the RPN was informed from the previous shift and RPN #123 observed that the resident required this identified care.

- No other documentation of the identified care was identified the day when the identified medical procedure was done for the resident, six days after the original date it was to be done. Review of NP's documentation showed there was signs of an identified health condition on an identified area of the resident's body when the identified medical procedure was done.
Interview with Skin and Wound Lead / ADNC #107 stated that the identified care should be done at an identified interval of time as per the home's practice. This was not done for resident #016.

V. Equipment was not readily available as required to for the resident's identified care.

Review of resident #016's progress notes showed that the identified date when the RPNs #124 and #125 recognized the identified medical procedure as ordered by MD #129 was not done for resident #016, they were unable to locate the identified equipment needed for the procedure. The Resident Assessment Instrument – Minimum Data Set (RAI-MDS) coordinator #142 who was on call was notified, but was not able to follow-up until the next day, and was not able to find the identified equipment. ADNC #108 was also notified on the following day, eventually found the equipment in an identified area in the home.

In an interview with the Inspector, ADNC #107 and the skin and wound lead stated that the incomplete processing of the order after the resident returned to the home, led to a chain reaction where the order was not checked but was signed for, no treatment order for the identified medical procedure was done, and the treatment order for the identified care for resident #016 with alteration of skin integrity was not done as per the home's practice.

In an interview with the Inspector, ADNC #108 stated that this CIS was submitted under neglect, as it was a series of incompetency that pointed toward neglect.

Interview with the Acting Director of Nursing Care #127 stated that neglect included passive unintentional failure. The Acting Director of Nursing Care #127 further stated that an identified procedure was an error of omission that was not followed up on and was not removed on the date as per the physician's order. There was no specific treatment in the TAR regarding the identified procedure or care of the skin impairment, and the detail of attention that should be paid to resident #016 who returned from the home with an identified alteration of skin integrity was missing.

The series of issues identified above constitute neglect, as there was a series of inaction where the treatment and care required for resident #016's health and well-being were not provided for the resident. [s. 19. (1)]

WN #4: 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.

Hospital discharge notes an identified date, included an identified medication order for resident #016 for an identified period of time.

Review of the electronic medication administration record (eMAR) indicated that Registered Practical Nurse (RPN) #116 had entered the medication order, but had put the stop date for the identified medication that was stopped one day earlier than the identified order date. RPN #116 stated during interview with the Inspector that they had miscalculated the end date. RPN #116 and ADNC #107 stated that based on their calculations, the medication should have been stopped one day after the date entered on eMAR and the resident was not administered the complete course of the identified medication as specified by the prescriber. [s. 131. (2)]

Issued on this 14th day of August, 2018

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

Original report signed by the inspector.