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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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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
Sep 27, 2018	2018_650565_0011	020184-18	Resident Quality Inspection

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

MATTHEW CHIU (565), IVY LAM (646), PRAVEENA SITTAMPALAM (699), REBECCA LEUNG (726)

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): August 8, 9, 10, 13, 14, 15, 17, 20, 21, 22, 23, 24, 27, 28, 29, and 30, 2018.

During the course of the inspection, a Critical Incident (CI) intake related to a resident's identified medical condition was inspected concurrently with this Resident Quality Inspection (RQI).

During the course of the inspection, the inspector(s) spoke with the General Manager (GM), Director of Nursing (DON), Assistant Directors of Nursing (ADON), Neighbourhood Coordinators (NC), Assistant Director of Environmental Services (ADES), Registered Nurses (RN), Enterostomal Therapy Nurse (ETN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Dietary Aides (DA), Residents, and Family Members.

The inspectors conducted a tour of the resident home areas, observations of medication administration, staff and resident interactions, provision of care, dining and snack services, record review of resident and home records, meeting minutes for Residents' Council and Family Council, menus, staffing schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Reporting and Complaints
Residents' Council
Skin and Wound Care

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

5 WN(s)
4 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

During stage one of the RQI, Inspector #726 observed resident #001 having a specified injury.

Subsequent observation of resident #001 by Inspector #699 on an identified date revealed a specified description related to the above mentioned injury.

Interview with resident #001 indicated they did not report the specified injury to staff and could not recall how it occurred. Resident #001 further stated the specified descriptions of the injury.

Interview with PSW #109 indicated that they did not see the specified injury on the resident and the resident requests specified care in a particular manner as they are prone to sustaining the specified injury easily.

Interview with RN #112 indicated resident #001's specified injury was very old and healed, and stated the resident has a specified health condition and staff have to be careful when they handle the resident. RN #112 acknowledged it is the expectation that if

the resident is prone to sustaining the specified injury easily and requires care in a particular manner, it should be reflected in the resident's plan of care.

Review of resident #001's plan of care did not reveal any indication that the resident is prone to sustaining a specified injury and requires care in a particular manner.

Interview with the DON indicated if a resident was prone to sustaining a particular injury and required care in a particular manner, it should be reflected in the resident's plan of care. The DON acknowledged that the care set out in the resident #001's plan of care was not based on the resident's care needs as required. [s. 6. (2)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

During stage one of the RQI, record review and staff interview revealed resident #004 had areas of altered skin integrity.

Review of resident #004's medical records revealed the resident had developed the areas of altered skin integrity on an identified date and received an assessment the same day. Approximately two months later, another assessment indicated an area of altered skin integrity had deteriorated.

Further review of resident #004's plan of care indicated starting on an identified date, the resident should receive specified care as per an identified recommendation.

On an identified date, multiple observations during an identified period of time revealed the specified care was not provided to resident #004 on the unit.

Interview with PSW #122 indicated on the above mentioned identified date, the resident was not provided with the specified care as per the identified recommendation mentioned above the whole morning and until after the lunch meal services.

Interview with RPN #123 indicated they were aware that resident #004 was not provided with the specified care. The RPN were aware of the specified care set out in the resident's plan of care and confirmed there was no records indicating the care set out in the resident's plan of care had been revised.

Interviews with NC #124 and ADON #126 indicated that resident #004's plan of care set

out the specified care to promote healing of the areas of altered skin integrity. The staff members confirmed the care set out in the plan of care was not provided to resident #004 as specified in the plan. [s. 6. (7)]

3. The licensee has failed to ensure that staff and others who provide direct care to a resident were kept aware of the contents of the plan of care.

During stage one of the RQI, record review and staff interview revealed resident #004 had specified areas of altered skin integrity.

Review of resident #004's medical records revealed the resident had developed the areas of altered skin integrity on an identified date and received an assessment the same day. Approximately two months later, another assessment indicated an area of altered skin integrity had deteriorated.

Further review of resident #004's plan of care indicated starting on an identified date, the resident should receive specified care as per an identified recommendation.

On an identified date, multiple observations during an identified period of time revealed the specified care was not provided to resident #004 on the unit.

Interview with PSW #122 indicated on the identified date, the resident was not provided with the specified care after morning care. When reviewing resident #004's plan of care with PSW #122 during the interview, the staff member confirmed they were not aware that the plan stated the specified care.

Interview with NC #124 indicated all PSWs should have access to the plan of care using the home's tablet computers.

Interview with ADON #126 indicated the home had done education and the NCs had constantly followed up with PSWs to ensure they know how to access the residents' plans of care using tablet computers. ADON #126 acknowledged the home had failed to ensure that the above mentioned direct care staff was kept aware of the contents of resident #004's plan of care. [s. 6. (8)]

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 care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident,
- the care set out in the plan of care is provided to the resident as specified in the plan, and that
- staff and others who provide direct care to a resident are kept aware of the contents of the plan of care, to be implemented voluntarily.

WN #2: 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 a 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.

During stage one of the RQI, record review and staff interview revealed resident #004 had specified areas of altered skin integrity.

Review of resident #004's medical records revealed the resident had exhibited the specified altered skin integrities on an identified date and received an initial assessment on the same day using the Weekly Skin Observation Tool.

Review of resident #004's medical records revealed the resident had developed the areas of altered skin integrity on an identified date and received an initial assessment the same day using the Weekly Skin Observation Tool.

Review of the Weekly Skin Observation Tool indicated after the initial assessment, the identified subsequent skin assessments were not completed at least weekly for the specified areas of altered skin integrity.

Interview with RPN #123 indicated the home used the Weekly Skin Observation Tool for conducting both initial and weekly skin assessments. RPN #123 was aware of the above mentioned areas of altered skin integrity and indicated an initial skin assessment was completed on an identified date. RPN #123 stated there was no records of the required weekly skin assessment during the identified periods for the areas of altered skin integrity. RPN #123 recalled one of the areas of altered skin integrity had healed but there were no records indicating when it was.

Interview with ADON #126 indicated registered staff were expected to complete weekly skin assessments for residents with areas of altered skin integrity using the above mentioned skin assessment tool until it has healed. ADON #126 further stated when they looked at one of the resident's areas of altered skin integrity with ETN #130 on an identified date, an identified altered skin integrity was intact, but they did not know when it had healed.

ADON #126 confirmed the areas of altered skin integrity for resident #004 were not reassessed at least weekly by registered nursing staff as required. [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 a 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 #3: 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. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

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 no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident.

Review of the home's medication incidents, that occurred during an identified period, indicated an identified medication incident related to resident #019.

Review of the analysis of the medication incident report indicated that the physician ordered an identified drug to be administered during a specified period. The identified drug continued to be administered until an identified incident when it was brought to the staff's attention on an identified date.

Record review of the physician order for resident #019 indicated the order for the identified drug should be administered during the above mentioned specified period. The

order was initiated on an identified date.

Record review of resident #019’s progress notes indicated that the identified drug was started on an identified date and time until an identified incident when it was brought to the staff member’s attention. The resident had continued to receive the drug beyond the period that it was prescribed for over more than a 24-hour period. The identified drug was discontinued immediately by the RPN.

In an interview, the DON indicated that the identified drug was started and stopped on the identified dates respectively. The DON confirmed that resident #019 received the identified drug for an identified period during which it was not prescribed by the physician. [s. 131. (1)]

2. 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 medication administration observation for resident #019 with RPN #114, Inspector #699 observed that the resident was administered an identified drug not according to the specified directions for use as per physician's order.

Record review of resident #019’s electronic medication administration record (eMAR) revealed the specified directions for use.

In an interview with RPN #114, they confirmed that the specified directions for use of the identified drug should be completed prior to administering the drug to resident #019. RPN #114 stated they did not administer the medication to the resident in accordance with the specified directions for use.

In an interview with the DON, they confirmed if the physician order stated the specified directions for use, RPN #114 should have completed the specified directions prior to administration of the above mentioned medication. The DON acknowledged that the medication was not administered as specified by the physician for resident #019. [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 that:
- no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, and that
- drugs are administered to residents in accordance with the direction for use specified by the prescriber, to be implemented voluntarily.

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 was 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.

Review of the home's medication incidents, that occurred during an identified period, indicated an identified medication incident related to resident #019.

Review of the analysis of the medication incident report indicated that the physician ordered an identified drug to be administered during a specified period. The identified drug continued to be administered until an identified incident when it was brought to the staff’s attention on an identified date. There was no indication on the analysis that the physician was notified of the medication incident.

Record review of the physician order for resident #019 indicated the order for the identified drug should be administered during the above mentioned specified period. The order was initiated on an identified date.

Record review of resident #019’s progress notes indicated that the identified drug was started on an identified date and time until an identified incident when it was brought to the staff member’s attention. The resident had continued to receive the drug beyond the period that it was prescribed for over more than a 24-hour period. The identified drug was discontinued immediately by the RPN. Further review of the progress notes did not reveal any notes indicating that the physician was notified of the medication incident.

Interview with the DON indicated that they spoke with the nurse and that the physician was not formally notified of the medication incident. The DON acknowledged that the medication incident involving resident #019 was not reported to the physician. [s. 135. (1)]

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 #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the contact information of the Director, or the contact information of a person designated by the Director to receive complaints; 2017, c. 25, Sched. 5, s. 21 (1)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(g.1) a copy of the service accountability agreement as defined in section 21 of the Commitment to the Future of Medicare Act, 2004 entered into between the licensee and a local health integration network;
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)

(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(l.1) a written plan for achieving compliance, prepared by the licensee, that the Director has ordered in accordance with clause 153 (1) (b) following a referral under paragraph 4 of subsection 152 (1); 2017, c. 25, Sched. 5, s. 21 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee has failed to ensure that the copies of the inspection reports from the past two years for the long-term care home were posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations.

Observations during the initial tour of the RQI on August 8, 2018, revealed the home had posted copies of the inspection reports on the wall at the building's main entrance doorway. The last two years inspection reports #2016_541169_0019 issued on May 19, 2017, and #2017_661683_0001 issued on July 4, 2017, were not posted in the home.

Subsequent observations on August 17 and 22, 2018, indicated the above mentioned reports were not posted in the home.

Interview with the GM indicated when they received the public copies of the inspection reports, they will post them in the above mentioned location. The GM was unaware of why the above mentioned reports were missing, and confirmed they were not posted in the home as required. [s. 79. (3) (k)]

Issued on this 15th day of October, 2018

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

Original report signed by the inspector.