Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 14, 2020	2020_659189_0008	018553-19, 024222-19, 001818-20, 002858-20	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

NICOLE RANGER (189)

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): March 5, 6, 9, 10, 11, 12, 13, 2020 onsite; May 29, June 3, 5, 8, 10, 11, 18, 26, 2020 offsite.

Log #002858-20 related to medication administration
Log #018553-19 related to prevention of abuse and neglect
Log #001818-20 related to falls prevention
Log #024222-19 related to responsive behaviours.

During the course of the inspection, the inspector(s) spoke with the Assistant General Manager (AGM), Director of Nursing Care (DNC), Assistant Director of Nursing Care (ADNC), Director of Clinical College, Kinesiologist, Neighborhood Coordinator (NC), Resident Assessment Instrument Minimum Data Set (RAI MDS) coordinator, registered nurse (RN), registered practical nurse (RPN), agency registered practical nurse, student registered practical nurse, and personal support workers (PSW).

During the course of the inspection the inspector conducted tour of floors in the home, observed staff to resident interactions, observed medication storage areas, reviewed residents' health records, reviewed home's investigation notes, and any relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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	Légende 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

The home submitted a Critical Incident System (CIS) report to the Ministry of Long Term Care (MLTC) related to an injury incurred by resident #003.

Resident #003's fall history was identified on their admission documents, and on an initial Falls Risk Assessment conducted upon admission to the home. A review of the home's policy entitled "Fall Prevention and Management program LTC" reviewed May 14, 2019, indicated that the Kinesiologist should assess residents who have been referred and appropriate strategies should be implemented based on that assessment. The assessments and strategies should be shared with the team.

A review of the clinical record indicated that the Resident Assessment Instrument Minimum Data Set (RAI MDS) coordinator #120 sent a referral to program for active living (PAL) services, for the Kinesiologist to asses resident #003's transfer status and fall prevention strategies based on the results of the falls assessments.

Interview with the RAI MDS coordinator #120 indicated the referral should be checked by the PAL team members and completed accordingly.

Interview with the Kinesiologist indicated their role is to assess the transfer method and

review fall preventions strategies for residents. The Kinesiologist indicated that they assessed resident #003's transfer status, however acknowledged that they did not assess the fall prevention strategies for the resident. [s. 6. (4) (a)]

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.

The home submitted a CIS report to the MLTC related to an incident of visitor to resident abuse.

According to the CIS, during a meal service, a visiting family member observed resident #002's family member feeding the resident in an inappropriate manner and yelling at the resident. The visiting family member voiced their concerns to management.

A review of resident #002's written plan of care indicated that the family member may be present for meals, but they are not to be involved in feeding the resident. They can provide verbal prompting only.

Interview with RN #108 identified that during an identified meal service, they had been feeding resident #002, but was called away by another staff member. When they returned they found resident #002's meal nearly completed. RN #108 reported that the family member had continued to feed the resident.

Interview with PSW #110 and RPN #111 also confirmed that they have witnessed resident #002's family member feeding the resident on multiple occasions prior to the incident that occurred.

Interview with the Assistant General Manager (AGM) identified that resident #002's plan of care included the restriction of family member to assist with resident feeding and that staff were aware of this. By not taking measures to prevent resident #002's family member from feeding them, the home failed to follow resident #002's plan of care. [s. 6. (7)]

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 staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a post-fall assessment, using a clinically appropriate assessment instrument, specifically designed for falls, was conducted for resident #003.

The home submitted a CIS report to the MLTC related to an injury incurred by resident #003.

A review of the home's fall investigation records identified that the resident #003 had sustained a previous fall on an identified date, however no post fall assessment or any documentation related to that fall was completed. A review of the homes policy entitled "Fall Prevention and Management program LTC" reviewed May 14, 2019, indicated that all resident falls are to be documented by registered staff using the post falls assessment and completing a falls incident report.

Interview with PSWs #116 and #117 revealed that they witnessed the resident fall and that RPN #123 was made aware of the fall by the staff. Contained in the home's investigation is confirmation that RPN #123 was made aware of the witnessed fall by the PSW staff.

During an interview with the AGM, it was confirmed a post-fall assessment, using a clinically appropriate assessment instrument, specifically designed for falls, was not conducted for resident #003, for the fall. [s. 49. (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 when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #3: 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 drugs were stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies.

During observations of three home area medication carts on an identified date, the inspector noted various non drug-related items stored in the medication carts. These items included money, dental crown, broken glasses, broken hearing aids, and keys to a resident's closet door.

During interviews with the Director of Nursing Care (DNC) and the Assistant General Manager (AGM), they confirmed that only drug and drug related supplies should be stored in the medication cart [s. 129. (1) (a)]

2. 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.

The home submitted a CIS reported to the MLTC related to missing narcotics for resident #001.

Review of the home's policy entitled "Drug Distribution, Delivery and Receipt of Medications" last reviewed January 16, 2017, indicated that when the pharmacy delivers medications to the home, it will be delivered to a centralized location in the home and

picked up by a nurse. All medications received from pharmacy are to be kept in a secure location until opened, and that all narcotics and controlled substances must be placed in a double locked container for safe and secure storage.

Staff interview identified that RPN #102 had received a pharmacy delivery of two bags containing medications.

RPN #102 opened one of the bags and signed for receipt of the medications in that bag. RPN #102 did not identify the contents of the other bag, and left it on the on top of the medication cart.

The bag was seen by RPN #104 who worked that night, but they did nothing with it. The following day shift RPN student #109 identified there was missing narcotic medications for resident #001, and that prompted RPN #101 to contact the pharmacy. The pharmacy confirmed the delivery of narcotic medications to RPN #102 the previous evening.

During interviews with the AGM and the DNC, they reported the home's procedure for receiving medication from pharmacy, directs the staff once narcotics are received, two registered staff are to open and count the narcotic medication, sign off on the narcotic count record, and place the narcotics in the double locked container in the medication cart. RPN #102 failed to follow this procedure. The inspection revealed the process for receipt of pharmacy medications had not been followed . [s. 129. (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 drugs are stored in an area or a medication cart that is used exclusively for drugs and drug related supplies; and 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, to be implemented voluntarily.

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 (4.1) A member of the registered nursing staff may permit a nursing student to administer drugs to residents if,
(a) the licensee has verified with the university or college that offers the nursing educational program in which the nursing student is enrolled that the nursing student has received education or training about the administration of drugs as part of the program;
(b) the nursing student has been trained by a member of the registered nursing staff in the written policies and protocols for the medication management system referred to in subsection 114 (2);
(c) the member of the registered nursing staff who is permitting the administration is satisfied that the nursing student can safely administer drugs; and
(d) the nursing student who administers the drugs does so under the supervision of the member of the registered nursing staff.

Findings/Faits saillants :

1. The licensee has failed to ensure that a member of the registered nursing staff may permit a nursing student to administer drugs to resident if, (b) the nursing student has been trained by a member of the registered staff in the written policies and protocols for the medication management system referred to in subsection 114 (2); and (d) the nursing student who administers the drugs does so under the supervision of the member of the registered nursing staff.

The home submitted a CIS report related to missing narcotics for resident #001.

Interviews with RPN #101 identified that it was their practice to give the medication room keys to the RPN student #109, and to allow them access to medications including narcotics without supervision.

RPN student #109 confirmed that they had been given unsupervised access to the medication room keys and had conducted the narcotic count unsupervised on many occasions.

Review of the College Practical Nursing Program Clinical Guidelines for Pre Graduate Clinical, undated, states the preceptor is to monitor the students when doing any medication administration.

During interviews with the AGM and the DNC, they confirmed the registered staff are to conduct narcotic counts together with the nursing student, and to follow the college guidelines related to medication administration. The home failed to ensure that the registered nursing staff followed the policy regarding the medication management system, and that the nursing student was supervised by the registered staff when administering drugs. [s. 131. (4.1)]

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 a member of the registered nursing staff may permit a nursing student to administer drugs to a resident if the nursing student has been trained by a member of the registered staff in the written policies and protocols for the medication management system; the nursing student who administers the drugs does so under the supervision of the member of the registered nursing staff, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to ensure the security of the drug supply, including all areas where drugs are stored shall be kept locked at all times, when not in use.

The home submitted a CIS report to the MLTC related to missing narcotics for resident #001.

During interview with RPN #101, they reported that on an identified date, they arrived for their shift and found the medication room door open. The medication room contained the medication cart with medications. RPN #101 stated that they were informed by PSW#105, who worked on the identified date, that the medication room door was open throughout the shift.

Interview with PSW #105 confirmed that they observed the medication room door open, and that the PSW had informed RPN #104 that the medication room door should be closed at all times.

During interviews with the AGM and the DNC, they confirmed that all areas where drugs are stored shall be kept locked at all times when not in use. [s. 130. 1.]

Issued on this 28th day of July, 2020

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

Original report signed by the inspector.