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 8, 2017	2017_660218_0009	024076-17	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 WINSTON PARK
695 BLOCK LINE ROAD KITCHENER ON N2E 3K1

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

APRIL TOLENTINO (218), JANETM EVANS (659)

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 30, October 31, November 1, November 2, and November 3, 2017.

The following Critical Incident (CI) reports were inspected related to falls:
CI #2783-000011-15 / #2783-000012-15 Log #021136-15
CI #2783-000014-15 Log #025238-15
CI #2783-000006-16 Log #028882-16
CI #2783-000017-15 Log #001867-16
CI #2783-000004-17 Log #006161-17
CI #2783-000007-17 Log #017629-17
The following Complaint was inspected related to alleged abuse:
IL-45621-LO Log #020845-16

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Resident Assessment Instrument (RAI) Coordinator, Kinesiologist, Director of Recreational Services, and Personal Care Aides (PCA), Family and Resident Council Representatives, and residents.

The Inspectors conducted a tour of the home areas, common areas, medication rooms, and spa rooms. Observations were conducted related to resident care provision, resident/staff interactions, medication administration, medication storage areas, and general maintenance and cleanliness of the home. Inspectors reviewed relevant clinical records, posting of required information, relevant policies and procedures, as well as meeting minutes pertaining to the inspection.

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

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

3 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. 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. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

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.

A record review of the medication incidents from July to September 2017 included 12 documented medication incidents. These were comprised of one administration error, two communication/documentation errors, and nine pharmacy-related errors.

Medication incidents for resident #027, #028 and #029 were further reviewed.

Documentation of the medication incident for resident #027 showed that resident #027 was administered the incorrect dosage of a scheduled medication. Documentation stated

there was no harm to the resident. The medication incident was reviewed with the Director of Care (DOC) #102 and they acknowledged that there was no documented evidence of immediate actions taken to assess and maintain the resident's health together with the medication incident.

Documentation of the medication incident for resident #028 showed that resident #028 returned to the home from a Leave of Absence one week earlier than expected. The pharmacy was notified and medications were ordered. The medications were not delivered on time for resident #028's evening medications administration pass. Documentation of the effect on resident #028 stated that this was a harmful incident. The incident was reviewed with DOC #102 and they stated that this was a pharmacy error. They acknowledged that there was no documented evidence of the immediate action taken to assess and maintain the resident's health together with the medication incident. [s. 135. (1)]

2. The licensee failed to ensure that:
(a) all medication incidents were reviewed and analyzed.

A review of medication incidents for resident #027, #028, and #029 were completed with Director of Care #102. The DOC stated that they would only conduct an analysis of the incidents if the error occurred in the home. DOC #102 stated that pharmacy would conduct a separate analysis of the medication incident if it was related to pharmacy processing and dispensing errors. DOC #102 acknowledged that an analysis of the medication incident related to resident #027 receiving the incorrect dosage was not completed.

The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction was documented, together with a record of the immediate actions taken to assess and maintain the resident's health. The licensee also failed to ensure that all medication incidents were reviewed and analyzed.

The severity of the issue related to medication incidents was determined to be a level one with minimal risk and the scope was a pattern. The home had a history of multiple unrelated non-compliance. [s. 135. (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 every medication incident involving a resident and every adverse drug reaction is documented together with a record of the immediate actions taken to assess and maintain the resident's health and that all medication incidents and adverse drug reactions are documented, reviewed and analyzed., to be implemented voluntarily.

WN #2: 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 failed to ensure that 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 is complied with.

The Critical Incident (CI) report submitted to the Ministry of Health and Long-Term Care (MOHLTC) on an identified date in September 2016 documented that resident #026 sustained an unwitnessed fall that resulted in a significant injury.

The Long-Term Care Home's (LTCH) policy titled, "Fall Prevention and Management Program [LTC]" under section B "Post-Fall Management" for Registered Nursing Team Member in subsection four, stated "initiate the Head Injury Routine for all unwitnessed

falls and witnessed falls that have resulted in possible head injury unless otherwise indicated in plan of care".

Additionally, the LTCH's policy titled "Head Injury Routine (HIR)" documented that the Neurological/Head Injury Vital Signs Record form is to be completed for the following time periods:
- Every (Q) 15min X once if resident is stable and no abnormal changes
- Q30min X 2 hours if resident is stable and no abnormal changes
- Q1H X twice
- Q4H for 24 hours
- Q shift X2 days

A record review of the Progress Notes documented in the Goldcare Software program for resident #026 stated that the resident #026 reported to a staff member that they had fallen. Further review of the resident #026's "Falls Incident Report" documented that the fall was not witnessed. Vital signs were taken at the time of the fall once and resident #026 presented with abnormal manifestations. Resident #026 continued to exhibit declining symptoms for over one hour. Resident #026 was transferred to the hospital 30 minutes later.There was no further documentation in the home's records to demonstrate that a Head Injury Routine was initiated and continued as per policy for resident #026 after they fell with manifesting abnormal changes.

During an interview conducted on November 3, 2017, DOC #101 stated that the expectation was for staff to initiate a HIR immediately after an event of an unwitnessed fall. DOC #101 acknowledged that they were unable to provide documented evidence to show that an HIR was initiated and completed for the falls incident that occurred in September 2016.

The licensee failed to ensure that their policy and procedure related to falls prevention and management was complied with.

The severity of the issue related to the LTCH's falls policy was determined to be a level one with potential for actual harm and the scope was identified as being isolated. This area of non-compliance was issued as a Written Notification and as a Voluntary Plan of Correction on June 9, 2015, and again as a Written Notification on November 17, 2015. [s. 8. (1) (a),s. 8. (1) (b)]

WN #3: 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 failed to ensure that steps were taken to ensure the security of the drug supply and that access to these areas were restricted to persons who may dispense, prescribe, or administer drugs in the home, including the Administrator.

During staff interviews conducted on October 31, 2017, two nurses stated that individuals who had a key for access to the medication room were nurses including three other staff members. The nurses stated that the reason why an identified staff member #122 had access to the area was for administrative purposes.

On November 2, 2017, the identified staff member #122 was observed in the medication room. Nursing staff were present at the time.

During a staff interview conducted on November 3, 2017, the identified staff member #122 acknowledged that they would enter the medication room only for administrative purposes. The identified staff member #122 clarified that registered staff would give them access to the area. The identified staff member #122 stated they did not have a key to the room. DOC #102 stated that if the identified staff member #122 required access to the medication room, they would request a registered staff to let them in with their presence.

The licensee failed to ensure that all areas where drugs are stored are restricted to person who may dispense, prescribe or administer drugs in the home, and the Administrator.

The severity of this issue related to the security of drug supply was level one with minimal risk and the scope was identified as being isolated. The home had a history of multiple unrelated non-compliance. [s. 130. 2.]

Issued on this 9th day of November, 2017

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

Original report signed by the inspector.