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 3, 2017	2017_533115_0002	015966-17	Resident Quality Inspection

Licensee/Titulaire de permis

CORPORATION OF THE COUNTY OF WELLINGTON
74 WOOLWICH STREET GUELPH ON N1H 3T9

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

WELLINGTON TERRACE LONG-TERM CARE HOME
474 Wellington Road 18 FERGUS ON N1M 0A1

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

TERRI DALY (115), NUZHAT UDDIN (532), RHONDA KUKOLY (213)

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): July 24, 25, 26, 27 and 28, 2017.

The following Critical Incident intakes were completed concurrently with the RQI: Log #006490-17/CI M629-000006-17 related to falls prevention and management. Log #029435-16/CI M629-000009-16, Log #032627-16/CI M629-000010-16, Log #000164-17/CI M629-000001-17, Log #003649-17/CI M629-000004-17, related to alleged resident to resident abuse.

During the course of the inspection, the inspector(s) spoke with Administrator, Assistant Administrator, Director of Nursing, Resident Care Manager, Registered Practical Nurse/Resident Assessment Instrument (RPN/RAI) Coordinator, Nutrition Services Manager, Social Worker, Physiotherapist, Physiotherapy Assistant, Behaviour Support Ontario Registered Practical Nurse and Personal Support Worker (BSO RPN/BSO PSW), Physician, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Resident Council representative, Family Council representative, residents and families.

The inspectors also toured the home, observed medication administration, medication storage; reviewed clinical records, policies and procedures, meeting minutes, schedules, posting of required information, observed the provision of resident care, resident-staff interactions, and observed the general maintenance, cleanliness, safety and condition of the home.

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
Pain
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

1 WN(s)
0 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident was reported to the resident, the resident's substitute decision-maker, if any, the prescriber of the drug, and the resident's attending physician or the registered nurse in the extended class attending the resident.

Medication incidents for the current year were reviewed.

A medication incident involving an identified resident occurred on a specific date, where it was unsure if the resident received a dose of medication as it was not in the medication cart and staff questioned if it had been given at the wrong time, earlier in the day. The Medication Incident Report showed that the Registered Nurse was notified; however, the resident/POA, prescriber/attending physician were not checked off as notified, and on review of the resident's progress notes, there was no documentation related to that medication incident.

A medication incident involving another identified resident occurred on a specific date, where a resident's medication was found to have been administered on the wrong date. The Medication Incident Report showed that the Registered Nurse and the resident/POA was notified; however, the prescriber/attending physician was not checked off as notified.

During interviews with the Director of Care and the Resident Care Manager both said that the attending physician/prescriber of the drug were not notified of the medication incidents, and that it has been the practice of the home, at the request of the physicians, that they are not notified of medication incidents unless there was risk or a negative outcome to the resident. The Resident Care Manager also agreed that after reviewing the medication incident and the resident's health record, the substitute decision maker for the resident was not notified of the medication incident that occurred on a specific date and should have been.

The licensee failed to ensure that the substitute decision maker was notified of a medication incident involving a resident and the prescriber/attending physician was notified of medication incidents involving two residents.

The severity of this non-compliance is minimum risk and the scope is a pattern. The home does not have a history of non-compliance in this subsection of the legislation. [s. 135. (1)]

Issued on this 3rd day of August, 2017

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

Original report signed by the inspector.