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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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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
Jan 15, 2018	2017_577611_0029	027727-17	Resident Quality Inspection

Licensee/Titulaire de permis

859530 Ontario Inc. (operating as Jarlette Health Services)
c/o Jarlette Health Services 5 Beck Boulevard PENETANGUISHENE ON L9M 1C1

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

Royal Rose Place
635 Prince Charles Drive North WELLAND ON 000 000

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

KELLY CHUCKRY (611), YULIYA FEDOTOVA (632)

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): December 7, 8, 12, 13, 14, 2017.

During the course of this inspection inspector(s) conducted a tour of the home, observed the provision of resident care, reviewed applicable clinical health records, policies, procedures, practices, as well as conducted a medication administration observation.

During the course of the inspection, the inspector(s) spoke with residents, family members, the Administrator, Director of Resident Care (DRC), Co-Director of Care (Co DOC), Nutrition Manager, staff educators, Life Enrichment Coordinator, registered nurses (RNs), registered practical nurses (RPNs), personal support workers (PSWs), dietary aids, and housekeeping aides.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Residents' Council

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. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

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, and
(b) 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.

A review was completed of the 2017 medication incident reports. A total of 24 incidences occurred that directly involved a resident in the home. The physician(s) were not notified of documented incidences 17 times, and the resident or Substitute Decision Maker (SDM) were not notified of documented incidences 19 times.

An interview conducted with the Director of Care acknowledged that the home did not consistently report medication incidences to the resident, resident's SDM or physician. [s. 135. (1)]

2. The licensee failed to ensure that:

(a) a quarterly review was undertaken of all medication incidents and adverse drug reactions that had occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions.

The licensee failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions.

An interview conducted with the Administrator and DOC on December 13, 2017, revealed that the home did not conduct any quarterly reviews that included the 38 recorded medication incident reports that occurred in 2017.

The Administrator and DOC acknowledged that the home failed to ensure a quarterly review of medication incidents and adverse drug reactions that occurred in the home. [s. 135. (3)]

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::
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and (b) 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, and to ensure that quarterly reviews are undertaken of all medication incidences and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidences and adverse drug reactions, 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. (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).

Findings/Faits saillants :

1. The licensee 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.

On December 12, 2017, resident #007 was observed receiving an identified level of assistance with eating. On December 13, 2017, an interview with the resident and their family member indicated that the resident required the same amount of identified assistance from staff with eating.

On December 12, 2017, staff #108 was interviewed and indicated that the resident required a lower level of assistance with eating. A review of the plan of care for resident #007 (last updated in September 2017) revealed that the resident required assistance for eating but there were no details about the level of support that was to be provided. A review of Minimum Data Set (MDS) assessment (locked on November 3, 2017) contained information about the level of assistance required for resident #007 with eating.

On December 12, 2017, staff #103 and Staff Educator #2 both acknowledged that resident #007's plan of care was not based on the resident's assessment and did not contain information about the level of support for eating. The DOC further acknowledged that the records in resident #007's plan of care were not based on an assessment of the resident's needs and preferences. [s. 6. (2)]

WN #3: 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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Ontario Regulation 79/10 s. 114 (2) requires the licensee to ensure that written policies and protocols are developed for the medication management system to ensure the acquisition, dispensing, receipt, storage, administration and destruction and disposal of all drugs used in the home.

The home's pharmacy provider's policy and procedure Drug Administration:Controlled Substances #7.2 was reviewed. It included: "every change of registered staff requires a Shift Count by two registered staff members on the Controlled Substance Shift Count Record" It further included that when administering the medication registered staff are to "document on the Controlled Substance Administration Record".

The Controlled Substance Shift Count records were reviewed for December 2017. Staff signatures were not documented on twelve occasions. The Controlled Substances Administration Record sheets were also reviewed for December 2017. The date, time, amount of medication administered, amount remaining and staff signatures were not documented a total of four (4) times during this time period.

In an interview with the Administrator and Director of Care, it was acknowledged that the above noted policy was not complied with. [s. 8. (1) (b)]

Issued on this 18th day of January, 2018

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

Original report signed by the inspector.