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
Dec 4, 2017	2017_678680_0021	025078-17	Resident Quality Inspection

Licensee/Titulaire de permis

CVH (No. 8) GP Inc. as general partner of CVH (No. 8) LP
766 Hespeler Road Suite 301 CAMBRIDGE ON N3H 5L8

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

Seaforth Long Term Care Home
100 JAMES STREET SEAFORTH ON N0K 1W0

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

TRACY RICHARDSON (680), ADAM CANN (634)

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): November 6, 7, 8, 9 and 10, 2017.

Critical Incident System (CIS) intakes inspected concurrently during the Resident Quality Inspection:
Log #004490-17, CIS #1135-000003-17, related to falls;
Log #018172-16, CIS #1135-000002-16, related to falls.

During the course of the inspection, the inspector(s) spoke with the General Manager, the Long Term Care Consultant, the Director of Care, the Assistant Director of Care, the Resident Care Coordinator, the Resident Assessment Instrument (RAI) Coordinator, the Housekeeping Supervisor, the Food Services Manager, Registered Practical Nurses, Registered Nurses, Personal Support Workers, Health Care Aides, Housekeeping staff, Residents' Council Representative, Activity Director, family members and residents.

The inspector(s) also conducted a tour of the home and made observations of residents, activities and care, and the general maintenance and cleanliness of the home. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed. Inspector(s) observed medication administration and drug storage areas, resident and staff interactions, infection prevention and control practices, the posting of Ministry of Health and Long-Term Care Information and inspection reports.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home

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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe and secure environment for the residents.

A) In the dining room on a specific date, it was observed that the steam table was on and had been left unattended. There were three residents present in the dining room, two of those resident were sitting near the steam table.

In an interview a resident stated that they had touched that steam table a couple of times previously when it was hot.

In an interview the Director of Care (DOC) acknowledged that the steam table was on and that there were no staff present in the room at the time. The DOC stated that the steam table was not to be turned on until a staff member was in the room and that the staff member was to remain in the room while the steam table was on.

In an interview the General Manager (GM) stated that the steam table should not be turned on until a staff member was present, and that the staff member stayed in the room while the steam table was on.

B) During observations on a specified date, it was noted that a large oxygen container was located across from the stove, in the resident activity room. During the course of the inspection the oxygen tank remained in that location.

On the tank the label stated "May cause or intensify fire: oxidizer, contains refrigerated gas; may cause cryogenic burns or injury."

Review of the Medigas Oxygen Safety sheet, stated "Activities such as woodworking, metalworking, sewing, cooking, barbequing, blowing out birthday candles, and lounging in front of a fireplace can be dangerous." Further in the safety sheet it stated "do not keep or use your oxygen equipment in the same room as ignition sources or open flames

such as fireplaces, gas stoves, candles, etc."

In an interview the Activity Director acknowledged that the oxygen tanks were in the activity room and that the tanks were seven feet and two inches from the stove. The Activity Director shared that residents participate in cooking activities in the activity room two to three times per month.

In an interview the General Manager (GM) acknowledged that the oxygen tank was in the activity room and that their oxygen supplier had shared with the GM that the oxygen tanks required to be 10 feet from the stove and that the supplier was concerned that it was accessible to the residents. The GM stated that they would need to develop a plan to secure the tanks for staff use only.

In an interview Respiratory Therapist (RT) stated that the oxygen tank was a cryogenic container, and that the concern was that once staff have filled their portable tank from this container the top would be very cold and would be harmful to anyone who touched it. The RT shared that they have communicated to the GM that the concern was that anyone entering that room had access to the container.

The licensee has failed to ensure that the home was a safe and secure environment for the residents.

The severity of this issue was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of the issue was determined to be isolated. The home has a history of unrelated noncompliance. [s. 5.]

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 home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate instrument specifically designed for this purpose.

A review of the Critical Incident System (CIS) showed a report was submitted to the Ministry of Health and Long-Term Care on a specified date, stated that a specific resident had a fall on a specified date, resulting in an injury.

Review of the clinical record for the specified resident showed no documentation that a pain assessment had been completed following the fall.

Review of the home's policy titled "Pain Assessment and Management," Policy #RC-2.020 stated:
that "the client will be assessed for the presence of pain: on admission, on re-admission, quarterly, at least every shift when expressed pain is greater than 4/10, a change in condition with onset of pain, every time a dressing is changed, new or existing diagnosis of painful disease process, requesting and receiving prn pain-related medication more than 2 in a 72 hour period, resident exhibits distress related to behaviours or facial grimaces."

The home's pain "Guide to the 24 hours Pain and Symptom Management Monitoring Tool," which was part of the Pain Assessment and Management policy stated: to initiate a 24 hour pain and symptom monitoring tool when: scheduled pain medication did not relieve pain, pain remained regardless of the interventions, pain medication was changed, resident received pain related when necessary (PRN) medication for greater than 72 hours, an empiric trial of analgesics was started, evaluate breakthrough medication used in Palliative care, document detail findings in Pain management note in Point Click Care (PCC), follow up with weekly pain assessments until pain was noted as controlled.

Review of the progress notes for the specified resident showed that the resident sought medical attention.

Review of the doctors' orders for the specific resident showed the doctor had made several changes in pain medications for the specified resident during a specific time frame.

In an interview Registered Practical Nurse (RPN) stated that the specified resident had pain, and that they did not usually complain of pain verbally. The RPN stated that a pain assessment should be completed after a resident had sought medical attention, and if there was a change in pain medication. The RPN acknowledged that there was no pain assessment completed for the specific resident when the resident had sought medical attention or had a change in pain.

In an interview Registered Nurse (RN) shared that they had documented the resident's pain in the progress notes, but that an actual pain assessment had not been completed. The RN stated that a pain assessment should be completed if there was any change in condition or if there had been a change in medication.

The Director of Care (DOC) acknowledged that a pain assessment had not been completed for the specific resident. The DOC stated that a pain assessment should have been completed.

The licensee has failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate instrument specifically designed for that purpose.

The severity of this issue was determined to be a level 2 as there minimal harm or potential for actual harm. The scope of the issue was determined to be isolated. The home has a history of unrelated noncompliance. [s. 52. (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's pain was not relieved by initial interventions, the resident is assessed using a clinically appropriate instrument specifically designed for that purpose, to be implemented voluntarily.

WN #3: 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. (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).

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 has failed to ensure that a written record was kept of corrective action taken related to medication incidents.

In a review of two medication incidents involving two specific residents, the incident

report stated both residents missed a medication which should have been administered to them on a specific date.

In an interview, Assistant Director of Care (ADOC) stated that it was their responsibility to administer the medications on that specific date to the two residents. The ADOC stated that after the medication errors had occurred, they had received education from Director of Care (DOC).

In an interview Director of Care (DOC) stated that verbal education had been provided to the ADOC. The DOC stated this was the corrective action they had taken related to the two medication incidents which occurred on the same day. The DOC could not show documented evidence of verbal education for ADOC.

The licensee has failed to ensure that a written record was kept of corrective action taken related to medication incidents. [s. 135. (2)]

2. The licensee has failed to ensure that a written record was kept for the quarterly review that 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.

During the Resident Quality Inspection (RQI) a review of three medication incidents were completed involving three residents. The medication incidents had occurred in a specified month.

In an interview Director of Care (DOC) stated that a quarterly review was completed of all medication incidents that occurred in the home. The DOC stated as part of their quarterly review, all medication incidents were reviewed during their monthly best practice meeting to reduce and prevent medication incidents. The committee reviewed medication incidents which had occurred in the previous month. The DOC stated that the medication incidents involving the three residents had been reviewed in a specified month for trends and changes required. The DOC could not show documentation that the medication incidents had been reviewed during the specified month at the best practice meeting.

The licensee has failed to ensure that a written record was kept for the quarterly review that 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 severity of this issue was determined to be a level 1 as there minimal risk. The scope of the issue was determined to be a pattern. The home has a history of unrelated noncompliance. [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 a written record was kept of corrective action taken related to medication incidents, and to ensure that a written record is kept for the quarterly review that 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, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that all direct care staff were provided training in falls prevention and management.

A Critical Incident System (CIS) Report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) on on a specific date, related to a specified resident who sustained a fall with subsequent injury.

Review of the mandatory training records for falls prevention and management supplied by Director of Care (DOC) showed that in 2016, 19 out of 30 (63.3%) direct care staff had training, and 11 out of 30 (36.7%) had not received training.

In an interview General Manager (GM) stated that the records were accurate. The GM acknowledged that not all direct care staff had their training in falls prevention and management in 2016.

The licensee has failed to ensure that all direct care staff were provided training in falls prevention and management.

The severity of this issue was determined to be a level 1 as there minimal risk. The scope of the issue was determined to be a pattern. The home has a history of unrelated noncompliance. [s. 221. (1) 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 all direct care staff are provided training in falls prevention and management, to be implemented voluntarily.

WN #5: 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 has 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.136 (2) 2 states, "The drug destruction and disposal policy must also provide for the following: That drugs that are to be destroyed and disposed of shall be stored safely and securely within the home, separate from drugs that are available for administration to a resident, until the destruction and disposal occurs."

Review of the home's policy titled "Handling of Medication, Policy 5-4, Drug Destruction and Disposal" stated "All medications which are surplus, excluding Monitored Medications (Narcotics or controlled drugs), are destroyed by the team of nursing staff and one other staff member appointed by the Director of Nursing. Medications are considered to be destroyed when they are altered to such an extent that their consumption is rendered impossible or improbable. Securely store surplus medication in the designated Stericycle container in a locked area within the home only accessible by nursing staff".

During observation of a medication storage room two large stericycle containers were observed on the floor. One stericycle container was over flowing with medications which were still in their packaging. The second stericycle container had loose medications in the bottom. There were two lids sitting next to the stericycle containers on the floor.

In an interview Registered Practical Nurse (RPN) stated that the process at the home was to place drugs that were to be destroyed into the stericycle containers. The RPN stated that the drugs were not destroyed or denatured by registered staff until the pharmacist came and completed the task at which time they would denature the

medications in the staericycle containers, put the lids on, seal, sign, and date the top of the lids.

In an interview the Director of Care (DOC) and Long Term Care Consultant (LTCC) stated that the stericycle containers should have lids secured on them and that medications be added through the slot on the top of the lid.

The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

The severity of this issue was determined to be a level 1 as there minimal risk. The scope of the issue was determined to be isolated. The home has a history of unrelated noncompliance. [s. 8. (1)]

Issued on this 4th day of December, 2017

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

Original report signed by the inspector.