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
Jan 8, 2018	2017_619550_0027	021408-17, 024293-17	Critical Incident System

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
5015 Spectrum Way Suite 600 MISSISSAUGA ON 000 000

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

MONTFORT
705 Montreal Road OTTAWA ON K1K 0M9

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

JOANNE HENRIE (550)

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): December 6, 7, 8, 11, 12, 13 and 18, 2017.

This Critical Incident Inspection is related to a critical incident the home submitted related to a fall resulting in a transfer to hospital and another critical incident related to allegations of neglect to a resident.

During the course of the inspection, the inspector(s) spoke with the home's Executive Director, the Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and a family member.

In addition, the inspector reviewed two Critical Incident Report (CIS), incident investigation reports, residents health care records and policies related to the Medication Management System.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **2 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. 42. Every licensee of a long-term care home shall ensure that every resident receives end-of-life care when required in a manner that meets their needs. O. Reg. 79/10, s. 42.

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident receives end-of-life care when required in a manner that meets their needs.

This inspection is related to Log #021408-17.

A Critical Incident report (CIS) was submitted to the Director on a specified date in 2017 reporting allegations of neglect to resident #003 which occurred on the day before. It was reported that on a specified date, the DOC completed the viewing a video footage for a specified shift on a specified date in 2017 on a specified unit in the home for an unrelated incident. During her viewing of the video, she noted that RN #100 was not observed going into resident #003's room until approximately one hour before the end of her shift. Resident #003 was palliative care and was to receive regular pain medication at two specified hours during that shift.

Inspector #550 reviewed resident #003's health care records and noted that on a specified date, the resident was placed on palliative care by the physician after a discussion with the resident's family member.

On December 7, 2017, during an interview the DOC indicated to the inspector that when a resident is determined to be palliative, this is communicated to the Personal Support Workers at the beginning of each shift by the registered nursing staff to ensure the resident gets the appropriate care.

The progress notes were reviewed by the inspector. A progress note for the specified shift on the specified date by RN #100 at approximately one half hour before the end of the shift indicated that the resident was calm but congested, two specified medication were administered with good effect and that the resident had received care. The RPN for the following shift documented at the start of her shift that the resident was received in bed sleeping in a specified position. An hour and a half later, the resident was repositioned and a marked redness was observed to the resident's specified body part. An hour and a half later, the resident was found with no vital signs.

The physician's orders were reviewed for the date the palliative care was initiated and included the following:
-Discontinue all meds by mouth except for a specified medication.
-a specified medication at a specific dosage to be administered every 4hrs regularly and the same medication at a lower dosage to be administered every hour as required for the management of pain
-a specified medication to be administered every four hours as required for specific symptoms.

It was documented in the medication administration records (MAR) the day of the incident that a specified medication was signed as having been administered twice as

scheduled. There was no signature for the administration of another specified medication for that date. The inspector reviewed the medication administration historic report for the date in question which indicated the specific time a medication was signed for in the MAR computer system. The report showed that the first dose of a specified medication which was to be administered at a specific time was signed six hours later as having been administered at the scheduled time with the date manually edited to indicate the following day. The other scheduled time for the administration of the same medication which was scheduled to be administered four hours later signed one hour later as having been administered at the scheduled time on that day.

The resident's plan of care dated a specified date in 2017 indicated that the resident was palliative and required to be repositioned every two hours with the assistance of two staff.

The inspector viewed the video footage for the first three hours of the specified shift on the specified date for a specified unit in the home; the hallway where the resident was residing. The video footage for the rest of the shift was not available for the inspector to view. During that period of time, the inspector did not observe RN #100 going into resident #003's room or in that hallway.

During an interview on December 8, 2017, RN #100 indicated to the inspector being aware that resident #003 was palliative, was required to receive a specified medicatiom for the management of pain at two specific times and that the resident was to be repositioned every two hours. RN #100 indicated that she did not inform PSW #102 who was the PSW responsible for that unit, that resident #003 was palliative and required to be repositioned every two hours because she wanted to care for the resident herself. She told the inspector that she had repositioned the resident every two hours on her own and that she did not request the assistance of any other staff member despite being aware that the care plan indicated that two staff were required to reposition this resident. The resident was not heavy and she was able to reposition the resident on her own. RN #100 was not able to explain to the inspector why the video camera from the specified unit's hallway had not capture her when she went to resident #003's room every two hours to reposition the resident or when she went to administer the medication.

The home's internal investigation report revealed that because PSW #102 was not informed that resident #003 was palliative, PSW #102 had not repositioned the resident during the the specified shift and she did not verify the resident except for the time she changed the resident's incontinence product.

As evidenced above, resident #003 did not receive the appropriate end-of-life care in a manner that met the resident's needs. PSW #102 was not informed by RN #100 that resident #003 was palliative on that specified shift. The video footage from a specified unit in the home on a specific date for the first three hours of the shift shows that the resident was not provided with the pain control medication at the specified scheduled time as prescribed and the resident was not repositioned every two hours with the assistance of two staff members as per the plan of care. Interview with RN #100 confirms that she did not inform PSW #102 that resident #003 was palliative and that she did not request the assistance of staff to reposition the resident. [s. 42.]

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 residents receive the appropriate end-of-life care in a manner that meets their needs, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 114 (3).
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Findings/Faits saillants :

1. As per O. Reg. s. 114 (2), the licensee shall ensure that written policies and protocols are developed for the medication management system to ensure accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

O. Reg. s. 114 (3) indicates that the written policies and protocols must be (a) developed, implemented, evaluated and updated in accordance with evidence based practices and, if there are none, in accordance with prevailing practices.

This inspection is related to Log #021408-17.

Inspector #550 reviewed a critical incident report that was submitted to the Director on a specified date reporting allegations of neglect to resident #003. It was noted documented in the report that on the day before, RN #100 had failed to do the narcotic count and the wastage of a narcotic at the end of her shift with another registered nursing staff.

The home's internal investigation report was reviewed by the inspector. It was observed documented that during an interview with the DOC, RN #100 indicated she did not do the narcotic count or waste the controlled substance with another registered nursing staff member as RPN #103 was arriving late and RPN #104 was busy. Inspector #550 was not able to interview RN #100 for this matter.

Inspector #550 reviewed resident #003's health care records. On a specified date, resident #003 was prescribed a specified medication at a specific dosage to be administered every 4hrs regularly and the same medication at a lower dosage to be administered every hour as required for the management of pain.

This medication was scheduled to be administered at two specified times for the shift in question as regular administration time. Because this medication was supplied in a concentration higher than what was prescribed, the nurse was required to waste some of the medication at the end of her shift.

The narcotic and controlled drug administration record for resident #003 for the specified medication was reviewed by the inspector. It was observed documented on the date the incident occurred at a specified time (the end of that shift) a specific dosage had been wasted and initialed by RN #100. There were no other staff initials to indicate that the wastage had been done by two registered staff members. During an interview on December 8, 2017, RPN #104 indicated to the inspector that on that specific date she was in the medication room on another unit at the start of her shift when RN #100 came to see her. RN #100 informed her that RPN #103 had called to inform her she would be arriving late for her shift. RN #100 indicated she could not stay and wait for RPN #103 to

arrive as she had to leave. The RN gave RPN #104 the keys to the specified unit's medication cart and left the facility. RPN #104 told the inspector that she did not do the narcotic count or wastage with RN #100 on that specific date at the end of her shift as the RN gave her the keys to the medication cart and immediately left.

RPN #103 who was the RPN working the following shift on the specified unit on that day told inspector #550 that she called RN #100 to inform her that she would be arriving late for her shift that day. When she arrived on the unit twenty five minutes after the start of the shift, RN #100 was already gone and had signed the narcotic and controlled drug administration record. RPN #103 went to get the medication cart keys from RPN #104 and did the narcotic count with her. RPN #103 signed the narcotic and controlled administration record beside RN #100's signature. RPN #104 who did the narcotic count with RPN #103 did not sign the narcotic and controlled administration record as RN #100 had already signed it and the count was accurate.

The home's policy on management of narcotic drugs and controlled substances, policy number LTC-F-80, revised August 2012 was reviewed by the inspector. On page 2, procedures 7 indicated that the narcotic count is to be done at each shift change by two registered nursing staff; the registered nursing staff ending the shift and the nursing staff who is starting the shift. Both registered nursing staff will do the count of the narcotics and controlled substances and document on the narcotic count sheet. During the count, the vials and the blister packs packaging are to be verified to ensure the exact count. Procedure 9 indicated that the wastage of all narcotics such as half a vial of Morphine has to be observed and attested by signature from two registered nursing staff. The unused portion of the medication had to be discarded in a biohazards waste container or a container for sharp objects.

During an interview on December 7, 2017, the Director of Care indicated to inspector #550 that RN #100 did not follow the licensee's policy on the management of narcotic drugs and controlled substances by not completing the narcotic count at the end of her shift with another registered nursing staff member and by not performing the wastage of the specified narcotic with another registered nursing staff member. [s. 114. (3) (a)]

Issued on this 7th day of February, 2018

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

Original report signed by the inspector.