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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 20, 2015	2015_444602_0032	O-002860-15	Resident Quality Inspection

Licensee/Titulaire de permis

CARVETH NURSING HOME LIMITED
375 JAMES STREET GANANOQUE ON K7G 2Z1

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

CARVETH CARE CENTRE
375 JAMES STREET GANANOQUE ON K7G 2Z1

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

WENDY BROWN (602), RUZICA SUBOTIC-HOWELL (548), SUSAN DONNAN (531)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): November 2 - 13, 2015

During the course of the inspection, the inspector(s) spoke with Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), the Manager of the Activity Department, the Manager of Housekeeping Services, the Environmental Services Manager, a Physiotherapy (PT) Assistant, family members, and residents.

During the course of the inspection, the inspectors conducted a full walking tour of the home, made dining room and resident care observations, observed medication administration and practices, reviewed resident health care records, observed and reviewed infection control practices, reviewed resident and family council minutes, applicable home policies, the home's staffing schedules for the nursing department, the home's duty calendar and the home's restraint education, monitoring and evaluation documentation.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Reporting and Complaints
Residents' Council
Responsive Behaviours

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

6 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. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the written policy to minimize the restraining of residents is complied with, as per O.Reg79/10:
- s.109 (b) (ii) ensuring that all appropriate staff are aware at all times of when a resident is being restrained by use of a physical device,
- s. 109 (e) how consent to the use of physical devices as set out in section 31 of the Act and the use of PASDs as set out in section 33 of the Act is to be obtained and documented;
- s. 110 (1) staff apply the physical device in accordance with any manufacturer's instructions;
- s. 110 (2) (1) that staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class;
- s. 110 (2) (6) the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician or registered nurse in the extended class attending the resident or member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances and;
- s. 110 (7) (6) every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and without limiting the generality of this requirement, the licensee shall ensure that the following are documented: .
  1. The circumstances precipitating the application of the physical device.
  2. What alternatives were considered and why those alternatives were inappropriate.
  3. The person who made the order, what device was ordered, and any instructions relating to the order.
  4. Consent.
  5. The person who applied the device and the time of application.

6. All assessment, reassessment and monitoring, including the resident's response.
7. Every release of the device and all repositioning.
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Over the course of the inspection multiple observations were made of various residents specific to restraint application. Four residents were observed on multiple occasions as having their restraints applied incorrectly; none of these residents were cognitively or physically capable of undoing the restraint on their own.

On a specified date an inspector and a staff observed a resident with an incorrectly applied restraint. The staff readjusted the restraint to fit snugly and indicated that each resident that requires a restraint is identified on a specific list and that a restraint flow sheet is completed for each of these residents.

The home provided user instructions for a specific type of restraint for their review; the procedure manual indicated that the specific restraint should fit snugly to secure the resident. The Director of Care (DOC) indicated that mandatory yearly training on the application of restraints is conducted and this procedure is to be reviewed by staff.

During record reviews two residents who had been observed with a restraint in place were noted as having no physician order and no Resident/Power of Attorney (POA) consent for the restraint, and that there was no restraint flow sheet for monitoring in place. Registered staff indicated that they were not aware that these two residents needed a restraint and that occasionally restraints are applied regardless of the order and consent requirement(s) as the restraint is standard attachment on the residents' equipment. Another staff advised that all direct care staff are informed at each shift change of those residents who require a physical device and that restraints are not be applied unless there is an order and consent.

A resident's condition must be reassessed and the effectiveness of the restraint evaluated at least every eight hours. A review of a specific resident records revealed there was no documentation of an evaluation of the effectiveness of a restraint on a Resident's Restraint Observation and Repositioning form on two occasions. At the time of the RQI registered staff were responsible for documenting their reassessment for continued use of the restraint every twelve hours vs. the legislated eight hours; this was confirmed by the Director of Care.

The home's policy titled: Restraints-Protocols, Policy #: Appendix-5, revision date: April 2015, pages 1-12 indicated that:
• a written consent must be obtained for the use of any restraint from the resident or their POA
• the device is used in accordance with any manufacturer's instructions
• that staff only apply the physical restraint that has been ordered or approved and in accordance with any specific instructions of a physician or registered nurse in the extended class
• the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every 8 hours and at any other time when necessary based on a change in the resident's condition or circumstance
• every use of a physical restraint device to restrain a resident under section 31 of the Act is documented including the following:

- The circumstances precipitating the application of the physical device.
- What alternatives were considered and why those alternatives were inappropriate.
- The person who made the order, what device was ordered, and any instructions relating to the order.
- Consent.
- The person who applied the device and the time of application.
- All assessment, reassessment and monitoring, including the resident's response.
- Every release of the device and all repositioning.
- The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

• a restraint flow sheet must be completed each shift by the RPN or HCA/PSW with the following to be monitored: hourly for release and repositioning, every 2 hours restraint removal followed by exercise and/or ambulation, every 8 hours mental emotional status and skin condition checked
• a list of resident utilizing restraint devices will be kept at each nursing station

The home was not in compliance with their policy regarding the application of restraints, the need to ensure orders and consents are in place and documented, and, the every eight hour requirement for reassessment and evaluation of resident condition and effectiveness of restraining a resident. [s. 29. (1) (b)]

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 specific to their policy of minimizing use of restraints by ensuring that all staff are aware of when a resident is to be restrained, that orders and consents are in place and documented, that restraints are applied as per manufacturer instruction and reassessed by a physician, RN(EC) or RN every eight hours with completion of required monitoring and documentation, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 86. Infection prevention and control program

Specifically failed to comply with the following:

s. 86. (2) The infection prevention and control program must include,
(a) daily monitoring to detect the presence of infection in residents of the long-term care home; and 2007, c. 8, s. 86. (2).
(b) measures to prevent the transmission of infections. 2007, c. 8, s. 86. (2).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, s.86(2)(b) in that measures were not taken to prevent the transmission of infections.

On a specified date an inspector attended the North Street tub room and observed twenty of thirty-five unlabelled nail clippers contained an aqua basin labelled "clean clippers". The bottom of the basin was covered in crumbled rust particles. The inspector subsequently observed thirty-three sets of nail clippers, two long handled clippers and a pair of toe nail scissors in the Kingsley Earl Wing (KEW) tub room's "clean clipper" supply basin; seventeen of the thirty - three nail clippers were observed as being heavily rusted. The KEW tub room "dirty clipper" basin was noted to contain multiple rusted clippers that had been used in the nail care of residents who had been bathed that day. Similar observations were made in both tub rooms on two other dates.

Multiple direct care staff indicated that nail clippers are not "dedicated" to specific

residents and are for "shared use". They explained that nail care equipment is cleaned on the night shift; the staff responsible for cleaning nail care equipment collects the clippers from the basins labelled “dirty” and is to remove those nail clippers found to be rusted or non-operational as part of the cleaning process.

A staff member was interviewed in regards to the cleaning/disinfection process used to clean shared nail care equipment and indicated that assigned staff is responsible for washing the nail clippers and removing/replacing any damaged or rusted clippers. The washed nail clippers are placed on a steel sterilization tray for sterilization. The equipment is sterilized @ 270oc for three (3) minutes. Staff indicated that there is not a written process for cleaning nail care equipment, but that the responsibility (staff / time of day) for cleaning the equipment is posted on the duty calendar.

The Assistant Director of Care (ADOC) was also interviewed regarding the cleaning, disinfection and/or sterilization process for the shared nail care equipment. The ADOC stated that the home does not have a specific policy or procedure for cleaning shared nail care equipment, however, the staff member is assigned the responsibility for washing the nail care equipment and for removing damaged or rusted clippers prior to sterilization. The ADOC confirmed that the responsibility for cleaning the equipment is indicated on the duty calendar. The DOC also confirmed that the staff is responsible for collecting, cleaning, and sterilizing nail care equipment and that the staff is expected to remove/replace rusted/non-operational clippers as part of the cleaning process each night.

Best Practices for Cleaning, Disinfection and Sterilization of Medical Equipment and Devices in All Health Care Settings, 3rd Edition, and Provincial Infectious Diseases Advisory Committee (PIDAC) is the prevailing best practice document in Ontario for the reprocessing of shared and/or re-usable resident care equipment. The document outlines that shared nail care equipment can present a high risk of infection if the equipment is contaminated and thus meticulous cleaning followed by a minimum high-level disinfection is required. Measures specific to the cleaning, disinfection or sterilization of reusable and/or shared resident equipment must be in place to prevent potential cross infection risk to residents. [s. 86. (2) (b)]

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 in the prevention of transmission of infection by ensuring that; shared nail care equipment is meticulously cleaned and followed by a minimum high-level disinfection in accordance with best practices to prevent potential cross infection of residents, and, staff who reprocess shared resident care equipment review and incorporate best practice guidelines when cleaning, disinfecting and /or sterilizing this resident care equipment, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The Licensee failed to ensure that steps are taken to ensure the security of the drug supply including the following: all areas where drugs are stored shall be kept locked at all times, when not in use.

On a specified date two inspectors observed the treatment cart in the hallway, unattended and unlocked allowing access to prescription drugs kept on the cart. A registered staff member was observed approximately twenty five feet away from the cart in a resident's room; the cart was not within the staff's eyesight.

The Director of Care (DOC) indicated that she was aware that the treatment carts were not being locked on a consistent basis. The DOC indicated that this has prompted her to provide education sessions on the importance of maintaining the security of drugs at all times and she completes spot checks of the carts.

On another specified date an inspector observed that a Medication Room door at the nursing station was unlocked and slightly ajar; there were no staff present at the station or in the immediate area. The unlocked open door allowed for access to the various prescription drugs and other medications/treatment supplies stored in the medication room. Registered staff subsequently indicated that four registered staff including the DOC have keys to the medication room. In the presence of the inspector, the staff proceeded to close the door. The staff later informed the inspector that the DOC had been informed of the incident.

As such, the License failed to ensure that steps are taken to ensure the security of the drug supply, including those areas where drugs are stored are to be kept locked at all times. [s. 129. (1) (a)]

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 in ensuring the security of drug supplies i.e. ensure areas where drugs are stored are kept locked at all times, 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:
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices. O. Reg. 79/10, s. 221 (1).

s. 221. (4) The licensee shall ensure that the training required under paragraph 4 of subsection 76 (7) of the Act includes training in the application, use and potential dangers of physical devices used to restrain residents and personal assistance services devices. O. Reg. 79/10, s. 221 (4).

Findings/Faits saillants :

1. The licensee failed to ensure with O. Reg. 79/10, s. 221 (4) that all staff who provide direct care to residents receive training provided for in subsection 76 (7) of the Act including training in the application, use, and potential dangers of physical devices used to restrain residents and personal assistance services devices.

As outlined in WN#1 staff are to be aware of when a resident is to be restrained, as well as ensure restraints are applied as per manufacturer instruction. Multiple observations specific to incorrectly applied restraints for four residents were made over the two week inspection.

Despite the home's mandatory training provided to all registered and direct care staff that includes instruction on the correct application of restraint products, as well as the need for orders and consent to use restraints, and the potential dangers of physical devices used to restrain residents; two residents were found to have no physician order or a Resident/Power of Attorney (POA) consent for their restraint(s). Additionally, multiple observations of incorrectly applied restraints were made for four different residents during the course of the inspection. The Assistant Director of Care (ADOC) provided the inspector with documentation of the training provided to direct care staff who apply physical devices and/or monitor residents restrained. Review of the In-service attendance for restraint training indicated that there was approximately twelve direct care staff that did not complete the training. The DOC advised the inspector that the homes' mandatory training is provided to all direct care staff for a seven day period of time. The DOC indicated that she is aware that several direct care staff have not completed the training and that there is no process in place to ensure that staff attend and complete this mandatory training at this time. [s. 221. (1) 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 by ensuring that all staff who provide direct care to residents receive training in the application, use, and potential dangers of physical devices used to restrain residents and personal assistance services devices, to be implemented voluntarily.

WN #5: 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The Licensee failed to ensure that the care set out in the plan is provided to the resident as specified in the plan.

A specific Resident known to have a history of falls, who requires mobility equipment and has impaired vision and balance requires supervision while mobilizing. This resident's current care plan specifies that the call bell is to be kept within reach of the Resident at all times when the resident is in his/her room.

On a specified date the Resident was observed at approximately 1100 hours to be sitting in a recliner beside his/her bed. The Resident was wearing glasses and non-skid runners. A mobility device was within reach of the Resident. It was observed that the call bell was resting on the bedside side table approximately four feet behind the Resident's recliner. While seated the Resident turned and attempted to reach the call bell and was unable to do so. It was noted there was no room for the Resident to use his/her mobility device to gain access to the call bell as there was approximately one foot expanse between the bed and recliner.

The Resident indicated that he/she does not use the call bell when he/she requires assistance and that the call bell is not beside him/her because at times staff forget to place the call bell within reach while he/she is sitting in her recliner. Registered staff indicated that the call bell should be beside the resident at all times and indicated that staff would be immediately informed that the call bell must be placed within reach of the resident. [s. 6. (7)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 13. Every licensee of a long-term care home shall ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy. O. Reg. 79/10, s. 13.

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 13 whereby every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy.

During the course of the inspection an inspector observed privacy curtains that were not sufficient to ensure privacy for residents in three separate rooms as follows:

Rm.X - Privacy curtains were not sufficient to ensure privacy for each of the two residents. The ceiling lift track obstructs the tracks. for the curtains leaving a gap of approximately one meter at each bed.
Rm.Y- No privacy curtain hung to provide privacy for the resident in bed 1.
Rm.Z - Ceiling track obstructs the track for the privacy curtains leaving a gap of two and a half meters potentially exposing the resident in one bed to the resident in the other bed.

On a specified date the Equipment and Maintenance Manager indicated that the identified privacy curtain issues will be resolved by the end of the day. [s. 13.]

Issued on this 27th day of November, 2015

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

Original report signed by the inspector.