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
Mar 8, 2016	2016_330573_0004	002443-16	Resident Quality Inspection

Licensee/Titulaire de permis

DUNDAS MANOR LIMITED
533 CLARENCE STREET P.O. BOX 970 WINCHESTER ON K0C 2K0

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

DUNDAS MANOR NURSING HOME
533 CLARENCE STREET P.O. BOX 970 WINCHESTER ON K0C 2K0

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

ANANDRAJ NATARAJAN (573), LISA KLUKE (547), PAULA MACDONALD (138), RUZICA SUBOTIC-HOWELL (548)

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): February 24, 25, 26, 29, 2016, March 01, 02, 03 and 04, 2016

Critical Incident Inspection were conducted concurrently. The following Log No: 022350-15 and 024412-15 was inspected related to critical incident the home submitted regarding abuse and Log No: 035773-15 was inspected related to a critical incident the home submitted regarding unexpected death of a resident.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care (DOC), Associate Director of Care (ADOC), RAI Coordinator, Activity Director, Maintenance Supervisor, Office Manager, Personal Support Workers Manager, Nutritional Manager (NM), Registered Dietitian (RD), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Food Service Workers, Residents and Family Members.

During the course of the inspection, the inspector(s) completed a walk through tour of all resident areas, observed medication storage areas, observed resident care, observed meal services, observed medication administration, reviewed Resident and Family Council meeting minutes, reviewed Resident health records, reviewed home's menu cycle, reviewed relevant home policies, programs, protocol and procedures.

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
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **5 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the written plan of care for each resident sets out the planned care for the resident and also give clear direction to staff and others who provide direct care to the resident.

On February 29, 2016, Inspector #573 reviewed resident #042's current written plan of care at the time of this inspection for toileting that indicates:

- "Resident is toileted routinely after breakfast, before supper and before bed"
- "Report to Registered staff any decrease in ability to toilet self hygienically, safely and appropriately"
- "Toileting – 2 persons with transfers and provide supervision and physical assist for safety"

Under urinary incontinence program, it directs staff to toilet the resident before and after every meal and also every night at bedtime. Further, the plan of care indicates that the resident will be toileted by the staff at the resident's request.

On March 01, 2016, Inspector spoke with PSW #112 who indicated that resident #042 is incontinent for both bladder and bowel. The PSW #112 indicated that the resident is toileted in the mornings, after lunch and after supper. Further PSW #112 indicated that the resident wears a brief and is totally dependent on staff for toileting.

On March 01, 2016, Inspector spoke with PSW #113 who indicated that resident #042 is incontinent for bladder and continent for bowel. The PSW #113 indicated to the inspector that resident is toileted in the mornings, after breakfast and after supper. Further the staff stated to the inspector that resident #042 would ask the staff members if she/he needs to be toileted after lunch or before supper.

On March 01, 2016, Inspector #573 reviewed resident #042 written plan of care in the presence of RAI Coordinator who indicated that resident #042 is not on a specific scheduled toileting program but needs to be toileted before and after every meal and at night before bed time. The RAI Coordinator stated to the inspector that the resident is total dependent on staff for toileting. The RAI Coordinator agreed with the inspector that the written plan of care in place does not provide clear direction to the PSW staff regarding resident's current toileting needs and further indicated to the inspector that she will update the resident #042's written plan of care.

On March 02, 2016, Inspector #573 reviewed resident #042's updated written plan of care for toileting and urinary incontinence. It directs staff to toilet the resident after breakfast, before supper and before bedtime. Further the plan of care indicates that the resident will be toileted anytime by the staff at the resident's request.

On March 02, 2016, Inspector spoke with PSW #114 who indicated that resident #042 is incontinent for bladder and continent for bowel. The PSW #114 indicated to the inspector that resident is toileted before and after every meal. Further, the PSW staff stated to the inspector that resident has dementia and she will not ask the resident if the resident needs to be toileted and because of this, the PSW #114 would follow the resident's daily toileting routine.

On March 02, 2016, Inspector #573 spoke with home's RAI Coordinator who indicated that after discussion with the PSW staff members and the registered nursing staff in the Unit, she stated that resident #042 is toileted before and after breakfast, before supper, before bed and as needed. Further the RAI Coordinator indicated to the inspector that the resident #042's urinary incontinence and toileting needs have been once again updated in the written plan of care.

The written plan of care does not set out the planned care for the resident #042's current continence care status and also does not provide clear direction regarding resident #042's current toileting needs to staff and others who provide direct care to the resident. [s. 6. (1)]

WN #2: 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 the home's policy and procedure instituted and put in place related to medication administration is complied with.

In accordance with O. Reg. 79/10, s. 114(2) every licensee of a long-term care home shall ensure that the written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

The home had a Medication Administration; Electronic Medication Administration Record System (EMAR) policy and procedure. This policy and procedure was last reviewed June 23, 2015 which was identified by the Associate Director of Care (ADOC) as the current procedure in place to direct Registered Nursing staff for all expectations related to medication administration to residents.

On page 4 of the policy, the procedure for dispensing medications identifies point #12 "that medications will no longer be administered in the dining rooms during meal service (when plates have arrived and residents are eating). This will ensure a pleasurable dining experience for all residents".

On February 24, 2016, resident #044 was observed by Inspector #138 to receive an injection while seated at the dining table with four other residents in the dining room. Resident #044 indicated to RPN #107 that she/he did not want the injection as she/he was in the middle of her/his meal however RPN #107 indicated that she/he had to receive the injection.

On February 26, 2016, resident #044 was observed by Inspector #547 to receive an

injection in the dining room while seated at the table with four other residents. Resident #044 indicated to Inspector #547 that she/he did not like to receive needle in the dining room while other residents watched.

On February 26, 2016, Inspector #547 spoke with RPN #107 who indicated that she usually gives options to the residents to choose the location for the administration of injectable medication. Further, the RPN #107 indicated to the inspector that she does not usually ask the resident's permission for the administration of injectable medication in the dining room.

On February 29, 2016, Inspector #547 interviewed the ADOC regarding the home's expectation for medication administration during meal service. The ADOC indicated that the home's policy and procedure actually indicated that no medications are to be administered to residents in the dining rooms during meal service for pleasurable dining experience and that medications should be administered before or after the meals are complete. [s. 8. (1) (b)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

On February 24, 2016, Inspector #547 observed the metal baseboard heater covers near the floor in resident care hallways at Unit #1, #2, #3 to have paint gouged, broken and the bent edges of these metal covers were exposing sharp edges. It was noted during this inspection, that several residents ambulating independently as well as residents that can propel in their own wheelchairs in these hallways.

On February 29, 2016, the Maintenance Supervisor indicated that he had started to replace the baseboard heater covers to the rounded edge heater covers in resident rooms. However he indicated that he did not realize the metal baseboard heater covers were damaged in the resident care hallways and they had not been prioritized on his preventative maintenance schedule.

On February 24, 25, 26 and 29, 2016, Inspector #547 observed that resident #018's call bell system next to the resident's bed was not functioning. Resident #018 indicated that on every occasion when the call bell system was tested, the call bell at the bed side did not function and it had been broken for a few weeks. Resident #018 further indicated to the inspector that when she/he was not feeling well a few weeks ago, and had to get up and go to the door to yell down the hall to have a staff member help her/him, as they were not responding when she/he rang from the call bell next to the bed.

On February 29, 2016 Inspector #547 interviewed the Maintenance Supervisor regarding resident #018's non-functioning call bell system. The Maintenance Supervisor indicated that resident #018's call bell system cord had already been replaced on February 26, 2016. Upon testing of this same call bell cord for resident #018, the Maintenance Supervisor noted that the call bell system was not functional in this resident's room. The Maintenance Supervisor indicated that he had not been made aware that this call system was still not functioning. [s. 15. (2) (c)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures are developed and implemented for addressing incidents of lingering offensive odours.

On February 24 and 26, 2016, Residents #014, #015 and #016 shared bathroom was noted to have lingering offensive odours.

On February 29, 2016, Inspector #547 interviewed resident #016 regarding the odours noted in the shared bathroom, and resident #016 indicated that the bathroom was always soiled with odours and residents are encouraged to ask the housekeeping staff to come back to clean the bathroom as needed. Further, the resident #016 indicated to inspector that the shared bathroom was always dirty with odours, so she/he gave up.

On March 01, 2016, Inspector #547 interviewed the home's Administrator regarding the home's policy and procedure for addressing incidents of lingering offensive odours. The Administrator indicated after review of their documents, that they did not have any policy and procedure for addressing incidents of lingering offensive odours in the home and that it would need to be developed. [s. 87. (2) (d)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (6) Where a resident of the home is permitted to administer a drug to himself or herself under subsection (5), the licensee shall ensure that there are written policies to ensure that the residents who do so understand,
(a) the use of the drug; O. Reg. 79/10, s. 131 (6).
(b) the need for the drug; O. Reg. 79/10, s. 131 (6).
(c) the need for monitoring and documentation of the use of the drug; and O. Reg. 79/10, s. 131 (6).
(d) the necessity for safekeeping of the drug by the resident where the resident is permitted to keep the drug on his or her person or in his or her room under subsection (7). O. Reg. 79/10, s. 131 (6).

Findings/Faits saillants :

1. The licensee has failed to ensure that where a resident is permitted to administer a drug to himself or herself, have written policies to ensure that the residents who do so understand the necessity for safekeeping of the drug by the resident where the resident is permitted to keep the drug on his or her person or in his or her room.

On February 24, 2016, Inspector #138 observed resident #024 had an medicated inhaler on the dinning table, shared by three other residents during the lunch observation.

On March 01, 2016, Inspector #547 interviewed resident #024 sitting at her/his bedside and noted that her/his medicated inhaler was located on the bed next to the resident. The resident indicated that she/he uses medicated inhaler on her/his own after advised by the physician. The resident indicated that she/he was not aware to keep the medicated inhaler in a safe place away from other residents. Resident #024 resides in a shared four bed room and further indicated to Inspector #547 that resident #031 from down the hall often wanders into their room. Resident #031 was known to take out items from resident rooms and residents have to call staff to ask them to redirect this resident from their rooms, so she/he could understand why medicated inhaler needed to be kept in safe keeping.

Inspector #547 spoke with the Director of Care (DOC) regarding the home's process for resident self-administration of medications and their expectations for safe storage of these prescribed medications. The DOC indicated that she currently does not have a process for this at this time and that it would need to be added to their medication administration policy and procedure. [s. 131. (6)]

Issued on this 8th day of March, 2016

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

Original report signed by the inspector.