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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## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Sep 11, 2015 | 2015_347197_0030 | O-002517-15 | Resident Quality Inspection |

### Licensee/Titulaire de permis

KEAY NURSING HOMES INC
10-112 Red Pine Road P.O. Box 21 GRAND BEND ON N0M 1Z0

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

E. J. MCQUIGGE LODGE
38 Black Diamond Road P.O. Box 68 Cannifton ON K0K 1K0

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

JESSICA PATTISON (197), AMBER MOASE (541), WENDY BROWN (602)

### 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): August 31, September 1-4, 8, 9, 2015**

**During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Food Service/Environmental Supervisor, the RAI Coordinator(s), Activity Director, a member of Resident's Council, the Physiotherapist, Registered Nurses, Registered Practical Nurses, Personal Support Workers, a Food Service Worker, Housekeeping staff, family members of Resident's and Residents.**

**The following Inspection Protocols were used during this inspection:**
**Accommodation Services - Housekeeping**
**Continence Care and Bowel Management**
**Dining Observation**
**Family Council**
**Hospitalization and Change in Condition**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Nutrition and Hydration**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Recreation and Social Activities**
**Residents' Council**
**Responsive Behaviours**
**Skin and Wound Care**
**Sufficient Staffing**

**During the course of this inspection, Non-Compliances were issued.**
- **6 WN(s)**
- **5 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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 comply with LTCHA 2007, s. 5 in that the lounge is not a safe and secure environment for residents.

On September 1, 2015 at approximately 1100 hours, Inspectors #197 and #541 were in the resident lounge and noted that the hairdresser was doing Residents' hair and had a hot curling iron, scissors and a razor on a table within reach of residents while she was not present. At the time there was a cognitively impaired resident by the table, however, the resident did not try to touch the tools while inspectors were observing. The hairdresser was gone for approximately five minutes. When she returned, she indicated to Inspectors that she comes in every Tuesday to do hair. She said no one has ever been injured by touching her tools, but she recognized the risk and said she would work with management to come up with a solution.

Inspector #541 spoke with the Director of Care (DOC) and asked what her expectations are around the hairdressing tools and the DOC stated the hairdresser is in the room the entire time. Inspector #541 informed the DOC that this was not the case and that the hairdresser was not present and a cognitively impaired resident was wandering around the table where hairdressing tools were present, including a hot curling iron. The DOC stated this is not usually the case but because they are short one person today this may be why the hairdresser left the lounge.

Later the same day at 1442 hours, the hairdresser was observed by Inspector #541 to leave the lounge again for approximately 7 minutes leaving her tools unattended, curling iron on and within reach of residents in the lounge.

It was also noted by Inspectors that the hairdresser washes Residents' hair in a room around the corner from the lounge and out of sight of her hairdressing tools. [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 lounge is a safe and secure environment for residents, 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. (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 has failed to comply with LTCHA 2007, s. 6(7) in that the care set out in the plan of care for a resident was not provided to the resident as specified in the plan.

The current care plan for Resident #41 states the following with respect to eating:
- the resident requires feeding assistance and nursing will allow sufficient time to consume meals
- provide a peaceful and unhurried atmosphere during meals
- the resident is at high nutritional risk and receives a texture modified diet
- resident should be fed in a specified way

Resident #41 was observed during two lunch meals, August 31 and September 8, 2015.

On August 31, 2015, Resident #41 was provided with feeding assistance not in accordance with instructions in the care plan. At times the PSW was feeding the Resident very quickly and was not pausing between spoonfuls to allow the resident sufficient time to swallow. Resident #41 was observed to cough frequently during this meal.

On September 8, 2015, Resident #41 was fed by a PSW, again not in accordance with instructions in the care plan. The Resident tolerated the meal well and had minimal coughing. The PSW began assisting the resident at 1250 hours and at 1310 hours got up and left the dining room while Resident #41 still had half of dessert, one third of a cup of thickened juice and half a serving of vegetables left. Another PSW entered the dining room a few minutes later and took Resident #41 out of the dining room without offering the remainder of the meal. [s. 6. (7)]

***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 care set out in in the plan of care for a resident related to eating and providing feeding assistance is provided as specified in the plan, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance**

**Specifically failed to comply with the following:**

**s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,**
**(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).**
**(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).**
**(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).**
**(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).**
**(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).**
**(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).**
**(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).**
**(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to comply with LTCHA 2007, s. 20(2) in that they did not ensure that the policy to promote zero tolerance of abuse and neglect of residents contains an explanation of the duty under section 24 of the Act to make mandatory reports.

Inspector #541 asked the DOC for a copy of the home's policy to promote zero tolerance of abuse and neglect. Inspector was provided with the Resident Information Package which contains section IV. titled Zero Tolerance Policy on Abuse and Neglect.

Under the heading Reporting Abuse or Neglect, the policy directs any person who has reasonable grounds to suspect abuse has occurred or may occur to report the information immediately to their supervisor. Under the heading Reporting to the Ministry of Health and Long-Term Care the policy indicates the Administrator or designate shall report any suspected abuse or neglect to the MOHLTC inspector or Regional Office within 24 hours via telephone.

The policy does not contain an explanation of the duty under section 24 of the Act which requires a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident.
3. Unlawful conduct that resulted in harm or risk of harm to a resident.
4. Misuse or misappropriation of a resident's money
5. Misuse or misappropriation of funding provided to a licensee under this Act of the Local Health System Integration Act, 2006.

On September 9, 2015 during an interview with the Administrator, she confirmed the policy to promote zero tolerance of abuse and neglect provided to inspector is the most up to date policy in the home. The Administrator confirmed with inspector that the policy does not contain an explanation of the duty under section 24 of the Act to make mandatory reports. [s. 20. (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 the policy to promote zero tolerance of abuse and neglect of residents contains an explanation of the duty under section 24 of the Act to make mandatory reports, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services**

**Specifically failed to comply with the following:**

**s. 31. (3) The staffing plan must,**
**(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).**
**(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).**
**(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).**
**(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).**
**(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).**

**Findings/Faits saillants :**

1. Re: Log #O-000481-15:

The licensee has failed to comply with O. Reg. 79/10, s. 31(3) in that the staffing plan did not contain all of the following components:
(a) provides for a staffing mix that is consistent with residents' assessed care and safety needs
(b) sets out the organization and scheduling of staff shifts
(c) promotes continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident
(d) includes a back-up plan for nursing and personal care staffing that addresses situations when staff cannot come to work? (including 24/7 RN coverage)
(e) gets evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices?

On September 9, 2015 the Administrator was asked to provide the home's staffing plan. Inspector was provided with policy titled Night Shift Coverage, policy titled Resident Services as well as a document titled Human Resource Plan 2012-2015.

The staffing plan does not provide for the following:
- A staffing mix that is consistent with residents' assessed care and safety needs.
- The organization and scheduling of staff shifts.
- Evaluations and updates at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

During an interview with the Administrator on September 9, 2015, she confirmed this information is not provided in the home's staffing plan. [s. 31. (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 the home's staffing plan contains all components as listed under O. Reg. 79/10, s. 31(3), to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service**

**Specifically failed to comply with the following:**

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).**

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).**

**s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to comply with O. Reg. 79/10, s. 73(1)8 in that two lunch meals were not served course by course.

On August 31 and September 8, 2015 during the lunch meal observation, Inspectors #197 and #541 noted that some Residents were not served their meal course by course.

On August 31, 2015, Resident #27 was served an entree while still eating soup. The entree was left out of reach and a co-resident had to pass it to Resident #27 when the resident was ready.
During the same meal, Residents #3, 4, 6, 35, 41, 42 and 43 were served their dessert while still eating their main course.

On September 8, 2015, Residents #2, 11, 21, 41, as well as all residents at tables #7, 10 and 11 were all served their dessert while still eating their main course.

An interview was conducted with the Food Service Supervisor on September 9, 2015. She stated that this is not the home's normal practice and that dessert should not be served to residents until they have finished their meal. [s. 73. (1) 8.]

2. The licensee has failed to comply with O. Reg. 79/10, s. 73(1)10 in that proper techniques were not used to assist residents with eating, including safe positioning of residents who require assistance.

On August 31, 2015 the lunch meal was observed.

Resident #41's current care plan states that the Resident requires feeding assistance. During the meal it was noted that the PSW feeding Resident #41 was instructing the resident to raise an arm and hold it up above his/her head while providing feeding assistance. The Resident would drop the arm down but the PSW continued to have the resident raise the arm back up. The PSW was also sitting on a stool and had to bend down to feed the resident. A hi/lo stool was available in the dining room, but was not used by the PSW.

The Physiotherapist, RN #S104, the Food Service Supervisor and the Administrator were all interviewed related to Resident #41 and positioning at meals. All stated that they were not aware of and had not witnessed the positioning techniques used by this PSW at the lunch meal. The FSS and Administrator stated that raising Resident #41's arm above his/her head during meals is not part of the Resident's care plan. The PSW who fed Resident #41 did not work again in the home during the inspection period and could not be interviewed.

Resident #13's care plan dated September 8, 2015 states that the Resident requires assistance with meals.
On September 8, 2015, a PSW was observed to stand three times while providing assistance to Resident #13 with dessert and a drink.
Standing above a Resident while feeding can cause hyperextension of the neck which opens the airway and increases the risk of aspiration. [s. 73. (1) 10.]

3. The licensee has failed to comply with O. Reg. 79/10, s. 73(2)(b) in that a resident who requires assistance with eating and drinking was served a meal before someone was available to provide assistance.

The current care plan for Resident #41 indicates that the resident requires feeding assistance by staff.
On September 8, 2015, Resident #41 was provided with a hot entree at approximately 1245 hours. Resident #41 was not provided with feeding assistance until 1250 hours. [s. 73. (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 to ensure that residents are served course by course unless otherwise indicated, that proper techniques are used to provide feeding assistance to residents and that no resident is served a meal until someone is available to provide the required assistance, to be implemented voluntarily.***

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**WN #6: 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 has failed to comply with O. Reg. 79/10, s. 129(1)(a) in that drugs were not stored in compliance with manufacturers instructions (e.g. expiration date). Observation of the medication fridge located in the Home's pharmacy/medication room on September 4, 2015 revealed 2 packages of Humulin insulin that had expired effective August 2015. S#104 was alerted to the expired medication packages and acknowledged that the medication had expired. The Staff suggested that this had likely occurred as the resident no longer requires Humulin insulin as blood sugar control had improved. S#104 advised that the packages would be discarded and the pharmacy contacted for replacement immediately. A second observation conducted on September 8, 2015 revealed that the medication had been discarded and replaced (expiry date in 2016). [s. 129. (1) (a)]

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**Issued on this 11th day of September, 2015**

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

**Original report signed by the inspector.**