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

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Inspection de sions de longue durée

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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 18, 2016	2016_396103_0014	002466-16	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

DARLENE MURPHY (103), AMBER MOASE (541), HEATH HEFFERNAN (622), JESSICA PATTISON (197), 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): March 9-11, March 14-17, 2016.

During the course of the inspection, the inspector(s) spoke with Residents, Family members, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), RAI coordinator, Activity Director, Director of Care (DOC) and the Administrator.

During the course of the inspection, the inspectors conducted a full walking tour of the home, observed dining, medication administration, and resident care, reviewed resident health care records, the home's infection control practices and applicable policies.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

6 WN(s)
2 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. 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 good state of repair.

The following observations were made during the inspection:

Infirmary A: There are gouges in wall behind bedside table.

Room 1: 1 tile in bathroom is partially missing. Resident's bathroom has a rusted grab bar above toilet and baseboard heater is rusted on end by the sink.

Room 18D: Paint is chipped/scraped off baseboard heaters in room and bathroom, paint chipped off door frame into bathroom .

Room 2A: The wall tiles behind and around the sink are painted with a grey substance, a wall tile chipped above the towel rack behind the door, the plaster on the wall is very rough and painted over extending from the corner behind the door to the mirror above the sink. There are two holes drilled in the wall above the soap dispenser.

Room 3: The door frames into bathroom heavily scraped/no paint.

Room 5: The baseboard is completely detached from wall by door; closet -baseboard is missing with deep gouges in the surface of the wall and metal strapping evident; bathroom door has paint missing on bottom edge of door/door frames are missing paint

to metal; water stain on bathroom ceiling above toilet.

Room 6: bathroom door and frame are scraped.

Room 7: grab bar above toilet is rusting

Room 9B: The wall by closet is gouged; baseboard detached with rough wall edge exposed; bathroom door and frame scraped; walls under window and at end of bed is scraped.

Room 10: Both sides of bathroom door are scraped and have paint chipping off. Door frame also has paint chips missing. The bottom of the wall leading into the washroom has chips and marks, the paint is chipped from the bottom one foot of the door on both sides. The wall leading into the room behind the residents easy chair is noted to have been damaged, there is plaster applied, not sanded and not finished. The wall behind the head of the bed was damaged and had been rough plastered but not finished.

Rm 12: Paint is scraped off bottom of bathroom door and around door frame into bathroom.

Room 15: Some scratches on closet door and on the bottom left side the metal strapping is visible. In shared bathroom there is a tile missing on wall where one end of towel bar was. Surface of back of bathroom door and door frame scarred/scraped. Wall across from the bottom of resident's bed is gouged/scraped.

Room 17: The base of bathroom door and the door frame is scraped and is missing paint.

Room 18: The paint chipped/scraped off baseboard heaters in room and bathroom, paint chipped off door frame into bathroom.

Room 22: There is a broken tile approximately 3 inches by 5 inches to the left of the doorway just inside the first corner of the wall next to bed one. Cable lines had been attached to the tile using tie straps and they are pulled away from the floor with the tile. The wires are loose from the wall/floor approximately 3 inches from the wall.

Room 23: The privacy curtain track for bed B has pulled away from the ceiling next to the outside wall and is hanging from the ceiling approximately 8 inches.

Inspector #541 interviewed the Administrator who states she oversees maintenance in the home. Administrator was able to show inspector the home's preventative maintenance schedule which indicates preventative painting is done bi-annually in May and October each year. The Administrator confirmed with Inspector #541 that all resident bathroom doors and door frames would have been painted October 2015. [s. 15. (2) (c)]

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 the home is maintained in a good state of repair, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure resident #014's altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was reassessed at least weekly by a member of the registered nursing staff.

Resident #014 had identified diagnoses and the current plan of care indicated the resident was at risk of skin breakdown.

The residents' wound care records were reviewed and the current treatment book indicated the resident had an identified wound that required dressing changes every 3-5 days. The residents' health care record was reviewed from February 18 to March 17, 2016 and there were no weekly assessments found during this time to reflect the status of this wound.

This inspector also found treatment sheets in the health care record that indicated the resident had a second identified wound. The treatment record was reviewed from February 16 to March 17, 2016 and during that time, the resident was noted to have two documented assessments completed on February 25, 2016 and March 6, 2016.

An additional treatment sheet indicated the resident had another identified wound. The resident health care record was reviewed from February 25, 2016 to March 17, 2016. On February 26 and March 3/16, there were documented assessments of the area, but there were no additional documented assessments found between March 3 and March 17, 2016.

The DOC was interviewed and indicated the home had previously been using the wound tracker system in mede-care for the documentation of all wound assessments. The system was found to be compromised in mid-February and the home switched the documentation of all wound assessments to paper treatment sheets. The DOC indicated the registered staff were unhappy with this system and the home was investigating other options. The DOC did agree the weekly wound assessments were not being completed for this resident and that the lack of assessments made it difficult to determine if treatments were effective or if additional measures were required. [s. 50. (2) (b) (iv)]

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 weekly wound and skin assessments are completed by registered staff for all residents exhibiting altered skin integrity, to be implemented voluntarily.

WN #3: 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. As required under O. Reg s. 8 (1), where the Act or 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 the plan, policy, protocol, procedure, strategy or system is in compliance with and is implemented and complied with all applicable requirements under the Act.

O. Reg 79/10, s. 89 (1)(a)(iv) indicates as a part of the organized program of laundry services, the licensee shall ensure there is a process to report and locate residents' lost clothing and personal items.

The staff bulletin board behind the nursing desk indicated resident #041 was missing an article of clothing and staff should keep an eye in co-resident's closets. This resident was interviewed and indicated the clothing had been missing for approximately two weeks and that it had been reported to staff. The resident further indicated the clothing was still

missing and that no one had any answers. The resident stated they told the staff they should check other resident's closets, but to their knowledge no one had done this. The resident further indicated they had lost clothing in the past that was never found.

Staff was interviewed in regards to the home's process. PSWs #109 and #101 indicated when a resident reports missing clothing, they check the laundry room and then report the items to the registered staff. RN #110 was interviewed and indicated the items would be documented in the resident progress notes and put into the shift report which goes to the main office. The RN further indicated, a note may be posted on the bulletin board so staff would be aware the items are missing.

The Administrator was interviewed in regards to the home's process for locating missing resident clothing. She provided this inspector with a book that she stated was kept in the laundry room. The book had many pages of missing items listed, but there was no indication if any of the items had been located. In addition, the laundry area was found to contain several large storage containers with unclaimed clothing.

The Administrator provided the inspector with policy, 4.1.8 "Procedure for reporting of Missing articles" last reviewed on February 2006. The procedure indicated, "when a resident or family reports an article of missing clothing, the nurse shall report it on the lost items form located at the nurses' station; the form is then taken to the laundry department and the Laundry Aide shall post it on the bulletin board in the folding room until the item is found. When the article is found, the report slip and article are returned to the nurse in charge of the unit. The Administrator stated the home has not been following this process. [s. 8. (1)]

2. The licensee has failed to comply with O. Reg. 79/10 r. 8. (1) (b) whereby the medication administration policy and procedures were not complied with.

O. Reg. 79/10, s. 114(2) states the licensee shall ensure that 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's Organizational Policy and Procedure manual Section 4A "External Services" Medication Administration procedure for drug administration references use of the "The Medical Pharmacies Policy & Procedure Manual". In Section 3, Policy 3-6, of the Pharmacy Manual, "The Medication Pass" directs that "all medications administered are

listed on the resident MAR. Each resident receives the correct medication in the correct prescribed dosage at the correct time by the correct route". The procedure indicates specifically in 8. "Administer medications and ensure they are taken".

During the 0800 hour medication pass on March 16, 2016 RN #107 was observed providing resident #007 with their medications. Resident #007 began taking the medications but the RN left before the resident had finished. Resident #007 was not in view of the RN for several minutes. When the RN returned to the dining room, she became aware the resident had spilled some of the medication and may not have received the entire dose.

In a subsequent interview with the Director of Care regarding medication administration, the DOC advised that the expectation is that registered staff stay to supervise each resident taking all of their medication as provided e.g. in the dining area, in their room, wherever the medications are provided. [s. 8. (1) (b)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that annual dental assessments and other preventative dental services are offered to residents.

On March 15, 2016, the DOC advised that Health Unit mobile screening visits to the home were discontinued in 2011. The DOC shared that since then the home has made an effort to alert residents and families who no longer have a dentist to mobile options for assessments and other preventative services at admission and then at least yearly via their monthly newsletter/activity calendar. A review of the January 2013 - February 2016 newsletter/activity calendars revealed one reference to dental health, oral care mobile services included in March 2015 in the form of an attached brochure: re Mobile Dental Hygiene Services brochure. There was no reference to services or whether screening services would be arranged.

In a subsequent interview, the DOC acknowledged that this is likely the only offer /reference to dental assessments and services made to residents since the Health Unit discontinued its mobile program in 2011, other than the brochure contained in the admission package. [s. 34. (1) (c)]

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:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that proper techniques were used to assist residents with eating, including safe positioning of residents who require assistance.

On March 9, 2016 Inspector #197 observed the lunch meal service in the dining room. PSW #113 was observed standing while feeding resident #003 and #018, who require total feeding assistance.

Proper techniques were not used to assist residents #003 and #018 with eating. [s. 73. (1) 10.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure a documented record is kept in the home that includes the nature of each verbal or written complaint.

During the inspection, resident #012 stated a piece of jewelry went missing about three weeks ago. The resident indicated a family member had reported it to a staff member.

The Administrator was interviewed and asked how the home monitored missing personal items such as jewelry. The Administrator indicated the complaint would be brought forward by means of a shift report and the documented record should reflect the missing property.

The documented record was reviewed and there were no entries for 2016. The Administrator reviewed the shift reports, stated there were no entries to indicate the resident was missing the jewelry and indicated no one had been advised of the missing jewelry.

This inspector advised the Administrator that a staff member must have been notified as a note was currently posted on the bulletin board behind the nursing desk dated March 1, 2016 which indicated the resident was missing this piece of jewelry.

The Administrator stated the home will need to review with staff the process for ensuring all verbal complaints are brought forward. [s. 101. (2)]

Issued on this 18th day of March, 2016

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

Original report signed by the inspector.