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

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

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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
Oct 22, 2015	2015_325568_0026	024283-15	Resident Quality Inspection

Licensee/Titulaire de permis

PROVINCIAL NURSING HOME LIMITED PARTNERSHIP
1090 MORAND STREET WINDSOR ON N9G 1J6

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

ERRINRUNG NURSING HOME, DIVISION OF PROVINCIAL NURSING HOME LIMITED PARTNERSHIP
67 Bruce Street P.O. Box 7069 THORNBURY ON N0H 2P0

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

DOROTHY GINTHER (568), CAROLYN MCLEOD (614), SHARON PERRY (155)

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): September 9, 10, 11, 14, 15, 16, and 17, 2015

During the course of the inspection, the inspector(s) spoke with the General Manager, Director of Care, Dietary Manager, Restorative Care Coordinator, Social Worker, Physiotherapy Assistant, Business Office Manager, Continence Program Lead, RAI Coordinator, two Registered Nurses, one Registered Practical Nurse, three Personal Support Workers, one Nurses Aide, a Family Council representative, residents and families.

The inspectors also toured the resident care areas, medication room and storage area, observed dining service, medication administration, provision of resident care, recreational activities, staff/resident interactions, infection prevention and control procedures, reviewed health care records and plans of care for identified residents, relevant policies and procedures, as well as meeting minutes pertaining to the inspection.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

8 WN(s)
5 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. 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 failed to ensure that any plan, policy, protocol, procedure, strategy or system was complied with.

The home's policy #RC - 2.010 entitled Fall Prevention and Management Program effective May 2011 identified that registered nursing staff would:

Collaborate with the resident/SDM and family to conduct the falls risk assessment on Point Click Care within 24 hours of admission, quarterly, with significant change in health status and after a resident falls.

Initiate a head injury routine if the fall was not witnessed, a head injury was noted or if the resident was on anticoagulant therapy.

Ensure staff were aware of the residents at high risk for falls - use a discreet identifier on predetermined locations.

a) Record review revealed that Resident #038 had two falls that were not witnessed. Staff interview and review of the plan of care confirmed that there was no falls risk assessment completed after one of the falls, and no head injury routine documented following both falls.

b) Record review revealed that Resident #032 had a fall that was not witnessed. The post fall incident note indicated that a head injury routine had been completed.

Documentation review failed to identify a completed head injury routine for the identified fall.

The Director of Care(DOC) acknowledged that it was the home's policy to complete a head injury routine for falls that were not witnessed and that a falls risk assessment should be completed after every fall. The DOC confirmed that these assessments had not been completed for all of Resident #038 and #032's un-witnessed falls.

c) Record review revealed that Resident #026 had a fall and there was no falls risk assessment completed at the time. Review of Resident #026's progress notes indicated that a falls risk assessment was completed four weeks after the incident. The Registered Nurse confirmed that they did not complete the falls risk assessment for Resident #026 at the time of the fall, but that it was completed four weeks later.

Interview with two Personal Support Workers and the Restorative Care Coordinator confirmed that the home used a picture of an apple to represent those at risk for falling. They indicated that the apple picture was to be on the head of the bed and on the residents mobility aide.

Observations of Resident #026's bed and mobility equipment revealed that there were no apple pictures posted. The Restorative Care Coordinator confirmed that Resident #026 was a risk for falls and was to have an apple posted on the head of their bed and mobility aide. The Restorative Care Coordinator confirmed that Resident #026 did not have an apple to identify their risk for falls on either of these locations. (155)

The licensee failed to ensure that the home's Fall Prevention and Management Program was complied with. [s. 8. (1) (a),s. 8. (1) (b)]

2. Review of the home's policy # RC - 2.020 entitled Pain Assessment and Management indicated that the client would be assessed for the presence of pain upon re-admission to the home and if there was a change of condition with onset of pain.

Record review revealed that Resident #038 had an injury. Resident #038 received a physician's order for medication to manage their pain.

Record review and staff interview with the Director of Care confirmed that a pain assessment was not completed for Resident #038. The licensee failed to ensure that the home's Pain Assessment and Management policy was complied with. [s. 8. (1) (a),s. 8.

(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 to ensure that any plan, policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails were used, steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

During observations Resident #002 was observed with a bed rail raised. When light pressure was applied to the mattress it slid laterally on the bed frame creating a gap between the bed rail and the mattress (zone three).

Record review revealed that Resident #002 utilized bed rails to re-position themselves in bed. The Bed Entrapment Assessment indicated that zones one through seven passed testing.

Staff interview with the Restorative Care Coordinator (RCC) revealed that when they test

a resident's bed they do so with the bed rails up that the resident normally uses. When the RCC was shown that Resident #002's mattress slid easily on the bed surface with gentle pressure they acknowledged that this was an entrapment risk given the gap created between the mattress and the bed rail (zone 3). The staff member indicated that when there were no mattress keepers on the bed they usually used double sided tape to secure the mattress. The RCC confirmed that the mattress was not secure on the bed frame which created a potential risk for entrapment between the bed rail and mattress. [s. 15. (1)]

2. During the inspection Resident #006 was observed on two occasions with bed rails raised. It was noted that with light pressure applied to the top of the mattress there was a gap of more than 10 centimeters between the mattress and the lowest bar of the bed rail. (zone2).

Record review revealed that Resident #006 used bed rails to assist with re-positioning in bed. The Bed Entrapment Assessment indicated that zones one through seven passed testing.

Staff interview with the Restorative Care Coordinator revealed that Resident #006 had changes made to their bed rails. The staff member believed that they had retested the bed after these changes. When shown the gap between the bottom bar of the bed rail and the mattress the staff member acknowledged that there was risk of entrapment in this area. Upon further observation the RCC noted that the bed rail was missing the bottom horizontal bar and this may be the reason for the increased space between the bed rail and the mattress. [s. 15. (1) (b)]

3. During stage one of the inspection Resident #019 was observed to have a bed rail raised. The bed rail was noted to be on a slight angle that created a space between the mattress and bed rail. The Restorative Care Coordinator confirmed that the bed rail on Resident #019's bed was not secured to the frame of the bed thus allowing it to easily shift. This created a potential zone of entrapment between the bed rail and the mattress.

The licensee has failed to ensure that where bed rails were used, steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment. [s. 15. (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 to ensure that where bed rails are used, steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment, to be implemented voluntarily.

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 were kept clean and sanitary.

During stage 1 of the inspection it was observed that the bathroom floors in ten resident rooms had a build up of dirt in the grooves / crevices of the linoleum, particularly around the perimeter of the room and the bathroom fixtures. Observations also revealed that in the tub room across from the nursing station at the north end of the home there were also areas of the floor that had a build up of dirt.

During an interview with the home's General Manager (GM) and acting lead for the housekeeping program they shared that after the last Resident Quality Inspection they had replaced the flooring in some of the resident washrooms. When shown the identified tub room and resident washrooms the GM acknowledged that there was dirt build up in the grooves of the flooring that had occurred over time. The GM indicated that they had extra roll flooring and would begin the process of replacing the floor in the identified rooms. [s. 15. (2) (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 to ensure that the home, furnishings and equipment are kept clean and sanitary, to be implemented voluntarily.

WN #4: 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 that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds has been reassessed at least weekly by a member of the registered staff.

Record review revealed that Resident #026 had altered skin integrity and was receiving treatment. The treatment administration record for Resident #026 outlined that staff were to assess the altered skin integrity on a weekly basis. Interview with the Registered Nurse (Skin and Wound Lead) confirmed that an assessment note was to be completed weekly when the review of the altered skin integrity was done.

Review of Resident #026's clinical record revealed that the staff signed the treatment administration record for Resident #026 on five out of six weeks indicating that the weekly altered skin integrity assessment was completed. Review of the progress notes indicated that the assessments were done on four out of the six weeks.

The Director of Care (DOC)acknowledged that it was the homes expectation that residents with altered skin integrity received a weekly skin assessment. The DOC confirmed that Resident #026's altered skin integrity should have been reassessed weekly and a weekly review progress note completed. [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 ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears, or wounds has been reassessed at least weekly by a member of the registered staff, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident's pain was not relieved by initial interventions, that the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Record review revealed that Resident #040 was assessed for pain in late March 2015 and not again until late June 2015. During a three week period between these dates progress notes pertaining to Resident #040, indicated that the resident was exhibiting increased behaviors suggestive of pain, however, medication was not helping.

The Director of Care confirmed that Resident #040 should have had a pain assessment completed when signs of increased pain were not relieved by initial interventions. [s. 52. (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 when the resident's pain was not relieved by initial interventions, that the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #6: 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

A review of the most recent Minimum Data Set (MDS) information submission, and the corresponding skin assessment for Resident #040, revealed inconsistent information.

The Director of Care confirmed that assessments completed by different staff involved with Resident #040's care were not consistent and did not complement one another. [s. 6. (4) (a)]

2. Review of Resident #026's skin assessment and MDS quarterly review assessment for the same period indicated that the resident had two different types of altered skin integrity.

The Director of Care confirmed that the skin and MDS assessments for Resident #026 were not consistent and did not complement each other. [s. 6. (4) (a)]

3. A review of MDS information submitted for resident #040 revealed that there had been a change in the bowel continence level between the most recent assessment and the previous assessment for this resident.

Review of the Point of Care documentation during the look-back periods associated with the two MDS submissions indicated that there was no change to the residents bowel continence level. The DOC confirmed that the bowel continence documented by the care staff was not consistent with the MDS assessment information and did not reflect the resident's true bowel continence level. [s. 6. (4) (a)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident, their SDM, if any, and any other person that either of them may direct was invited to participate in the admission and annual care conferences.

During an interview with the Substitute Decision Make (SDM) for Resident #040 they indicated that they could not recall being invited to the annual care conference for the resident.

Attendance records for care conferences held for Resident #040 indicated that the Resident and SDM attended the admission conference but had not been invited to attend an annual care conference in 2015.

Interview with the Business Office Manager, responsible for scheduling and inviting family members to care conferences, as well as a review of the documentation supporting the home's process for scheduling care conferences, confirmed that there was no invitation extended to Resident #040's SDM to attend an annual care conference in 2015. [s. 27. (1)]

WN #8: 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 ensure that controlled substances were stored in a separate locked area within the locked medication cart.

On two occasions during the inspection the area of the medication cart where controlled drugs were stored was found unlocked. The Registered Practical Nurse (RPN) confirmed that the compartment used for the storage of controlled substances in the medication cart was not locked and that it should have been locked.

The Director of Care confirmed that it was the home's expectation that the controlled substances stored in the separate area on the medication cart were to be locked. [s. 129. (1) (b)]

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Rapport d’inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Issued on this 29th day of October, 2015

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

Original report signed by the inspector.