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 soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 23, 2017	2017_682549_0013	022126-17	Resident Quality Inspection

Licensee/Titulaire de permis

DEEP RIVER AND DISTRICT HOSPITAL
117 BANTING DRIVE DEEP RIVER ON K0J 1P0

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

THE FOUR SEASONS LODGE
117 BANTING DRIVE DEEP RIVER ON K0J 1P0

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

RENA BOWEN (549)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 16, 17, 20, 21, 22 and 23, 2017

Log # 025399-17 related to 24/7 RN coverage was inspected concurrently with the Resident Quality Inspection.

During the course of the inspection, the inspector(s) spoke with residents, family members, Personal Support Workers (PSW), Registered Practical Nurses (RPN), the Recreation Therapist, a member of the Residents Council, a member of the Family Council, the Food Services Supervisor, the Director of Care, the Chief Nursing Officer/Administrator and the Chief Executive Officer.

The inspector reviewed resident health care records including Medication Administration Records (MARs) and Treatment Administration Records (TARs), Registered Nurses work schedules and observed resident areas, a medication administration pass, resident to resident and staff to resident interactions and the provision of care being provided.

The following Inspection Protocols were used during this inspection:
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Residents' Council
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **3 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 O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
6. That 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 eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

s. 110. (7) 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:
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).

s. 110. (7) 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:
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).

Findings/Faits saillants :

1. The licensee has failed to reassess the resident's condition and the effectiveness of the restraining evaluated by a physician or a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and any other time based on the resident's condition or circumstances.

Resident #011 was admitted to the home on a specific date in 2017.

The resident was observed by Inspector #549 to have a restraint applied and was seated in a tilt wheelchair on several specific dates in November 2017.

Inspector #549 reviewed the resident's health care record and located an assessment for a restraint and tilt wheelchair, a physician's order dated a specific date in March 2017

prescribing the restraint and the tilt wheelchair. The resident’s health care record also contained a written consent for the restraint and tilt wheelchair signed by the resident’s SDM on a specific date in March 2017 and a specific date in June 2017.

Resident #011's health care record indicates that the restraint is used to restrict the resident’s movements when in the tilt wheelchair as a fall prevention intervention The resident is not able to undo the restraint. The tilt wheelchair is also used to restrict the resident’s movements and to change positions for skin integrity

During an interview with RPN #103 on November 21, 2017, it was indicated to the inspector that the resident's condition is reassessed and the effectiveness of the restraint is completed every week and documented in the resident’s health care record.

During an interview with the Director of Care (DOC) on November 21, 2017 it was indicated to the inspector that the expectation would be that the restraints effectiveness and the resident’s condition be documented every eight hours or any other time based on the resident’s condition or circumstances and documented in the Treatment Administration Record (TAR) or the resident s health care record.

Inspector #549 and the DOC reviewed resident #011’s health care record and TARs and where not able to locate any documentation indicating the restraints effectiveness and the resident’s condition being reassessed at least every eight hours, and any other time based on the resident’s condition or circumstances.

As such, the licensee has failed to ensure that there is a reassessment of the resident’s condition and the effectiveness of the restraint evaluated by a physician or a registered nurse of the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and any other time based on the resident’s condition. [s. 110. (2) 6.]

2. The licensee has failed to ensure the every release of the device and repositioning is documented for resident #011.

Resident #011 was observed by Inspector #549 to have a restraint and was seated in a tilt wheelchair on several specific dates in November 2017.

Resident #011's health care record indicates that the restraint is used to restrict the resident’s movements when in the tilt wheelchair a fall prevention intervention. The

resident is not able to undo the restraint. The tilt wheelchair is also used to restrict the resident's movements and to change positions for skin integrity.

During an interview with PSW #104 on November 21, 2017 it was indicated to Inspector #549 that the electronic documentation system (MEDe-care) does not include the release of the restraint or the repositioning every two hours of resident #011. The PSW also indicated that MEDe-care documentation does not include the tilt wheelchair position changes either. PSW #104 indicated that there are no other forms that are used to document the release of the restraint or repositioning of resident #011.

During a discussion on November 21, 2017 with the DOC who reviewed with the inspector the MEDe-care documentation it was noted that MEDe-care does not include the release of the restraint or the repositioning of the resident #011 every two hours. The DOC also indicated that there are no other forms used to document the release of the restraint or the repositioning of the resident.

As such, the licensee has failed to ensure that every release of the restraint and every repositioning is documented for resident #011. [s. 110. (7) 7.]

3. The licensee has failed to ensure the documentation include the removal of the device, including time of removal or discontinuance and post-restraining care.

Resident #011 was observed by Inspector #549 to have a restraint and was seated in a tilt wheelchair on several specific dates in November 2017. The resident is not able to undo the restraint.

Resident #011 is assisted back to bed after every lunch meal. The restraint is removed and the resident is transferred using a mechanical lift to bed until the supper meal, when the resident is transferred to the tilt wheelchair and the restraint is reapplied.

On November 21, 2017 the inspector and the DOC reviewed the MEDe-care documentation for the restraint and tilt wheelchair for resident #011. The DOC indicated that the MEDe-care documentation does not include the removal of the device including the time of removal.

As such, the licensee has failed to ensure that every removal of the restraint including the time of removal is documented for resident #011. [s. 110. (7) 8.]

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 resident's condition and the effectiveness of restraining is evaluated by a physician or a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hour, and any other time based on the resident's condition or circumstances. Every release of the device, every repositioning and every removal of the device including time of removal or discontinuance and post-restraining care is to be documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (3) The drugs must be destroyed by a team acting together and composed of,
(b) in every other case,
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) one other staff member appointed by the Director of Nursing and Personal Care. O. Reg. 79/10, s. 136 (3).

s. 136. (6) For the purposes of this section a drug is considered to be destroyed when it is altered or denatured to such an extent that its consumption is rendered impossible or improbable. O. Reg. 79/10, s. 136 (6).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a drug that is to be destroyed is not a controlled substance, it will be done by a team acting together and composed of: i. one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and ii. one other staff member appointed by the Director of Nursing and Personal Care.

During a medication pass observation on November 21, 2017, Registered Practical Nurse (RPN) #103 indicated to Inspector #549 that when a non-controlled drug is to be destroyed the RPN on that particular shift will put the drug in the Stericycle destruction container. The Stericycle container is kept in the locked medication room. RPN #103 indicated that there is only one registered nursing staff acting alone when putting non-controlled drugs into the Stericycle container for destruction.

During an interview with the Director of Care (DOC) on November 21, 2017 it was indicated to the inspector that she was not aware that the non-controlled drugs to be destroyed was being done by a registered nursing staff member acting alone.

As such, the licensee failed to ensure that non-controlled drugs to be destroyed is done with one member of the registered nursing staff appointed by the DOC and one other staff member appointed by the DOC. [s. 136. (3) (b)]

2. The licensee has failed to ensure that when a drug is destroyed, the drug is altered or denatured to such an extent that its consumption is rendered impossible or improbable.

During a medication pass observation on November 21, 2017, Inspector #549 inquired how non-controlled drugs to be destroyed are denatured or altered to the extent that its consumption is rendered impossible or improbable.

RPN #103 indicated that the non-controlled drugs to be destroyed go into a Stericycle container. The Stericycle container is a large white plastic container with a small opening on top where non-controlled drugs can be inserted. The Stericycle container is kept in the locked medication room.

Inspector #549 observed that the Stericycle container which is kept in the medication room was full to the top. It was also observed that the drugs to be destroyed where not denatured or altered once put into the container, they remained in their original state.

During an interview with the DOC on November 21, 2017 it was indicated to the inspector that the non-controlled drugs where not denatured or altered and remained in their original state when Stericycle removes the container from the building.

As such, the licensee has failed to ensure that non-controlled drugs to be destroyed are denatured or altered to such an extent that its consumption is rendered impossible or

improbable. [s. 136. (6)]

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 non-controlled drugs to be destroyed will be done by a team acting together and composed of i. one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and ii. one other staff member appointed by the Director of Nursing and Personal Care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are offered a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner.

Resident #007 indicated during an interview with inspector #549 that he/she is not offered a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner. The resident indicated that he/she will use his/her call bell and request a beverage which the nursing staff will bring to him/her in his/her room.

During an interview with PSW #101 and #103 on November 20, 2017 it was indicated to the inspector that not all residents are offered a between meal beverage in the morning and afternoon and a beverage in the evening after dinner.

During an interview with the DOC on November 21, 2017 it was indicated to the inspector that not all residents are being offered a between meal beverage in the morning and afternoon and after dinner.

On November 22, 2017 the Food Services Supervisor indicated that not all residents are being offered a beverage between meals in the morning and afternoon and after dinner. He also indicated that the snack and beverage menu was approved by the Residents Council on November 16, 2017 and a process is being put in place so that all residents are offered a beverage between meals in the morning and afternoon and after dinner.

As such, the licensee has failed to ensure that all residents are offered a beverage between meals in the morning and afternoon and after dinner. [s. 71. (3) (b)]

2. The licensee has failed to ensure that residents are offered a minimum of a snack in the afternoon and evening.

Resident #007 indicated to the inspector during an interview on November 16, 2017 that he/she is not being offered a snack in the afternoon and evening.

During an interview with PSW #101 and #103 on November 20, 2017 it was indicated to the inspector that not all residents are being offered a snack in the afternoon and evening.

On November 22, 2017, the Food Services Supervisor indicated to the inspector that not all residents are being offered a snack in the afternoon and evening. He also indicated during the interview that the snack menu had been approved by the Residents Council on November 16, 2017 and a process to offer a snack in the afternoon and evening to all residents is being put into place.

As such, the licensee has failed to ensure that all residents are offered a snack in the afternoon and evening. [s. 71. (3) (c)]

Issued on this 4th day of December, 2017

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

Original report signed by the inspector.