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

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 10, 2014	2014_288549_0028	O-000511-14	Resident Quality Inspection

Licensee/Titulaire de permis

ARNPRIOR (THE) AND DISTRICT MEMORIAL HOSP.
350 John Street North, ARNPRIOR, ON, K7S-2P6

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

THE GROVE, ARNPRIOR AND DISTRICT NURSING HOME
275 IDA STREET NORTH, ARNPRIOR, ON, K7S-3M7

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

RENA BOWEN (549), ANANDRAJ NATARAJAN (573), MEGAN MACPHAIL (551), WENDY PATTERSON (556)

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): June 23, 24, 25, 26, 27, 30, July 2, 3, 2014

Critical Incident Log #O-000382-14 was included as part of this inspection.

During the course of the inspection, the inspector(s) spoke with several residents, the President of the Family Council, the President of the Residents' Council, several Family members, the Director of Care(DOC), the Assistant Director of Care (ADOC), the Infection Control Practitioner(IPAC), the RAI Coordinator, the Activity Program Manager, the Medical Director, the Pharmacist, the Maintenance Supervisor, several Registered Nurses (RN), several Personal Support Workers (PSW), several Registered Practical Nurses (RPN), several Activity Aides, several Housekeeping Aides, the Business Office Manager and the Chief Executive Officer (CEO).

During the course of the inspection, the inspector(s) completed a walk through tour of all resident areas, reviewed resident health care records, ambulatory equipment cleaning schedule, Resident Council meeting minutes and the Family Council meeting minutes, relevant home policies, the home's staffing schedule, observed Infection Prevention and Control practices, resident dining, resident medication administration, medication storage areas and resident care being provided.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing
Trust Accounts

Findings of Non-Compliance were found during this inspection.

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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007, c. 8, s. 6 (10) (b) in that the

licensee did not ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change.

Resident #001 was admitted to the home on a specified date in 2008. His/Her medications included an analgesic twice a day. A Daily Pain Assessment was ordered by the physician.

PSW #S114 was interviewed and reported that it was normal for Resident #001 to rub his/her left arm between the wrist and forearm to say "ah" when it was moved. PSW #S114 worked the 7am-3pm shift on a specified date in April 2014 as a PSW. PSW #S114 stated that after the provision of care, Resident #001 said "ah" loudly when he/she lifted his/her left arm to place a pillow under it. PSW #S114 suspected that Resident #001 was in pain and reported this at the end of shift report. "(L) arm sore" is noted on the Daily Report for the day shift.

PSW #S119 was interviewed and stated that he/she worked the 5pm-10pm shift on a specified date in April, 2014 as a PSW. PSW #S119 reported that Resident #001's left arm felt loose where it was normally stiff and that the resident screamed out in pain. PSW #S119 stated that after the provision of care, he/she reported to the Registered Nursing Staff that there was something wrong with Resident 001's arm. "C/O sore (LT) arm" is noted on the Daily Report for the evening shift.

PSW #S120 was interviewed and stated that he/she worked the 7am-3pm shift on a specified day in April, 2014 as a PSW. PSW #S120 reported that when putting Resident #001 to bed after lunch, the resident said "it doesn't feel" but did not elaborate further and that this was reported at the end of shift meeting. "C/O sore Lt) arm" is noted on the Daily Report for the day shift.

PSW #S121 was interviewed and stated that he/she worked the 3pm-11pm shift on a specified date in April 2014 as a PSW. PSW #S121 reported that Resident #001 initially complained of a sore elbow, then shoulder. PSW #S121 stated that Resident #001 cried out and looked to be in pain. PSW #S121 states that he/she reported this to the Registered Nurse. "sore (Lt) are" is noted on the Daily Report for the day shift.

A review of Resident #001's health care record shows that on a specified day in April, 2014, Resident #001's daily pain assessment was "4/10 lt arm" whereas it was previously 0/10 since March, 2014.

RN #S123 was interviewed and stated that when he/she completed the daily pain assessment, he/she determined that the pain level was 4/10 based on Resident #001's face and that Resident #001 grimaced when the left arm was raised and that Resident #001 "was protecting it too". The resident was not assessed further.

RN #S123 stated that at end of shift report, it was brought to his/her attention that Resident #001 had complained of a sore left arm. RN #S123 stated that he/she did not assess Resident #001 at that time but did pass on the report of pain to the next shift.

PSW #S114 worked the 11pm-7am shift on two specified consecutive days in April, 2014. PSW #S114 reported that after the provision of care, bruising was noted on Resident #001's left arm and shoulder area and that the RN was notified.

There is a progress note entry for the specified day in April,2014 by RN #S134 stating "Resident's left upper arm is bruised and sore".

On a specified day in April, 2014 at 07:30 RN #135 described Resident #001's condition as " Left upper arm very bruised. Whole extremity atonic and resident yells out when attempt made to move limb".

An As Needed order for a analgesic every four hours was obtained and given to Resident #001 at 0750. Resident #001 was sent to hospital on a specified day in April, 2014 and diagnosed with a fractured left humerus. Resident #001 passed away.

Resident #001 first complained of pain on the day shift on a specified day in April,2014. On a specified day in April, 2014 at 17:04 his/her pain scale was 4/10, but was not assessed further. On the same day in April, 2014 at the end of 3pm-11pm shift, the RN stated that it was brought to his/her attention that Resident #001 had complaints of pain but that he/she did not reassess Resident #001. Resident #001 received a regularly scheduled doses of an analgesic twice a day. Resident #001's plan of care needs related to the Lt arm pain was not reviewed and revised until 2 days later when an order was obtained for Tylenol 500mg every four hours as needed at which time Resident #001 was sent to the hospital and diagnosed with a fractured left humerus.[Log# O-000382-14] [s. 6. (10) (b)]

2. A review of Resident #002’s health care record indicated he/she was at a high risk for falls.

The care plan was reviewed and it stated that Resident #002 was to wear hip protector pads at all times over his/her clothes.

PSW #S113 stated that the hip protectors looked like a wide black belt with plastic sections that looked like holsters that went over the resident's hips. About 2 months ago the hip protectors disappeared, PSW #113 thinks it was because they were uncomfortable, or unsuitable for Resident #002. PSW #S113 further stated that Resident #002 does attempt to get out of the chair and/or bed and is still at a high risk for falls.

PSW #S114 stated that one day Resident #002 was wearing the hip protectors and the next time he/she came in to work the hip protectors weren't there anymore, but he/she doesn't know why they were discontinued for Resident #002, or exactly when.

RPN #S112 stated that Resident #002 will attempt to get out of the chair and/or bed on his/her own and remains at a high risk for falls.

In an interview the ADOC stated that she is unaware of who made the decision to stop using the hip protectors for Resident #002 but they weren't staying in the proper position and a different type of hip protector should have been implemented when the belt type hip protectors were stopped.

Inspector #556 observed Resident #002 on four separate days and the Resident was not wearing hip protector pads over his/her clothing during any of the observations.

As such, there was no evidence to indicate that Resident #002 was reassessed and the plan of care reviewed and revised when the resident’s care needs changed. [s. 6. (10) (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 when a resident's care needs change the plan of care is reviewed and revised, to be implemented voluntarily.

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 failed to comply with O. Reg 79/10, s. 8 (1) (b) in that the licensee did not ensure that where the Act or this Regulation requires the licensee of a long-term care 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 is complied with.

The Pain Management Program (policy # VI-G-10.54; date revised February, 2011) was reviewed and states "Each resident must have a formal pain assessment on admission and be reassessed on readmission, quarterly and at significant condition changes…"

Resident #001 was admitted to the home on a specified date during the month of August 2008. A Daily Pain Assessment was ordered by the physician.

Resident #001's daily pain scale was reviewed for a period between March and April, 2014. The daily pain scale is documented as being 0/10 or "no pain" 32/35 days, including a specified date in April, 2014. The following day Resident 001's pain scale

was "4/10 lt arm".

The DOC was interviewed and asked if a change of a pain scale rating from 0/10 to 4/10 in a twenty four (24) hour period would merit a formal pain assessment, and she stated that her expectation was yes. Resident #001's health care record was reviewed, and there is no documentation to support that a formal pain assessment was completed when Resident #001's pain scale changed significantly in a 24 hour period.

A formal pain assessment was not conducted on Resident #001 when he/she experienced a significant change in her condition as shown by her pain scale changing from 0/10 to 4/10 in a 24 hour period.[Log# O-000382-14] [s. 8. (1) (a),s. 8. (1) (b)]

2. Ontario Regulation 79/10, s. 136 (1) states that every licensee of a long-term care home shall ensure, as part of the medication management system, that a written policy is developed in the home that provides for the ongoing identification, destruction and disposal of drugs; and Ontario Regulation 79/10, s. 8. (1) (b) states that 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, is complied with.

The licensee has failed to comply with Ontario Regulation 79/10, s. 8. (1) (b) in that the licensee failed to ensure that the home's drug disposal policy was complied with.

A review of the home's policy entitled Inventory Control - Drug Disposal, Index Number: 02-06-20 last reviewed Oct 1, 2012 regarding the disposal of discontinued/expired medications states that "each nursing station will have a clearly marked storage area for discontinued or outdated medications that is separate from drugs that are available for administration. Discontinued narcotics are to be stored in a double-locked storage area."

In an interview RPN #S100 and RPN #S103 both stated that the narcotic drawer of the medication cart is where the discontinued narcotics are stored while they await destruction, and that drawer is also where the narcotics are stored that are currently being administered to residents. As such the controlled substances that are to be destroyed and disposed are not stored in a double-locked storage area separate from

any controlled substance that is available for administration to a resident. [s. 8. (1) (b)]

WN #3: 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. The licensee has failed to comply with Ontario Regulation 79/10, s. 31 (3) (e) in that the licensee did not ensure that the staffing plan for the organized program of nursing services required under clause 8 (1) (b) of the Long Term Care Homes Act was evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Resident #006 stated during the stage one RQI interview that when he/she rings the bell he/she has to wait a long time for staff to come and help.

Resident #005 stated during the stage one RQI interview that he/she requires the assistance of 2 staff to toilet and sometimes he/she has to wait a long time to get off the toilet.

Resident #004 stated during the stage one RQI interview that sometimes he/she has to wait up to 2 hours for staff to come when he/she rings the bell. Resident #004 further stated that it is worse on week-ends, and often the home works short of staff.

#S105 RPN stated that sometimes they have to work short.

Inspector #556 reviewed the home's staffing plan with the DOC, who stated that the staffing plan has not been evaluated since 2007.

A review of the evaluation of the staffing plan validated that the evaluation was conducted in February 2007, as such the licensee has not ensured that the staffing plan was evaluated and updated at least annually. [s. 31. (3) (e)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85 (3), whereby the licensee did not seek the advice of the Residents' Council in developing and carrying out of the Satisfaction survey.

On June 30th, 2014 Inspector #573 spoke with the Resident Council President, who indicated that the licensee did not seek the advice of the Residents' Council regarding the development of home's annual Satisfaction Survey.

Inspector #573 reviewed the minutes of the Resident Council meetings from February 2013 to April 2014 and this review indicated that the Residents' Council advice has not been requested in developing the Satisfaction Survey. Inspector #573 interviewed the Activity Programs Manager on June 30th, 2014 and the manager stated that the Resident Council had not been consulted with respect to the resident Satisfaction survey.

On July 2nd, 2014 LTCH Inspector #573 spoke with the CEO who confirmed that the licensee did not seek the advice of the Residents' council in developing and carrying out the home's annual Satisfaction survey. [s. 85. (3)]

WN #5: 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).

Findings/Faits saillants :

1. The licensee has failed to comply with Ontario Regulation 79/10, s. 136 (3) (b) (ii) in that the licensee has failed to ensure that non controlled drugs and substances were destroyed by a team acting together and composed of one member of the registered nursing staff appointed by the DOC and one other staff member also appointed by the DOC.

RPN #S103 and RPN #S100 both stated that when non controlled drugs and substances are to be disposed of, the registered staff responsible for the resident whose medication is being destroyed puts the medication in the designated disposal container in the medication room. RPN #S103 and RPN #S100 further stated that two staff are only involved in the process if the drug is a narcotic, but for non controlled drugs and substances one nurse acting alone discontinues the medication and disposes of it. [s. 136. (3) (b) (ii)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 229 (2) (d) in that the licensee did not ensure that the Infection Prevention and Control Program is evaluated and updated at least annually.

On June 25, 2014 during an interview with Inspector #549 the Infection Control Practitioner stated the Infection Prevention and Control Program was not evaluated and updated at least annually.

On June 26, 2014 the Director of Care confirmed to Inspector #549 that there have been some Infection Prevention and Control policy updates but there has not been an annual evaluation and update of the Infection Prevention and Control Program. [s. 229. (2) (d)]

Issued on this 11th day of July, 2014

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