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
291 King Street, 4th Floor
LONDON, ON, N6B-1R8
Telephone: (519) 675-7680
Facsimile: (519) 675-7685

Bureau régional de services de London
291, rue King, 4iém étage
LONDON, ON, N6B-1R8
Téléphone: (519) 675-7680
Télécopieur: (519) 675-7685

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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
Nov 28, 2013	2013_171155_0049	L-000900-13	Other

Licensee/Titulaire de permis

HANOVER NURSING HOME LIMITED
700 19TH AVENUE, HANOVER, ON, N4N-3S6

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

HANOVER CARE CENTRE
700-19TH AVENUE, HANOVER, ON, N4N-3S6

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

SHARON PERRY (155), REBECCA DEWITTE (521)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct an Other inspection.

This inspection was conducted on the following date(s): November 5 and 6, 2013.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Activity Director, 2 Registered Practical Nurses, Physio Assistant, 4 Personal Support Workers/Health Care Aides, Resident Council Representative, and 8 Residents.

During the course of the inspection, the inspector(s) toured resident living areas; observed dining room service during lunch; observed residents; observed staff interacting with residents; reviewed relevant policies; observed and tested call bells; reviewed registered staff schedule; checked medication storage areas; reviewed employee immunization records; and reviewed resident clinical records.

The following Inspection Protocols were used during this inspection:
Critical Incident Response

Dining Observation

Infection Prevention and Control

Medication

Minimizing of Restraining

Residents' Council

Safe and Secure Home

Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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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. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. On November 5, 2013 when inspectors entered the home there was not a registered nurse on duty. Review of the schedule for the period October 20, 2013 to November 6, 2013 a registered nurse was on duty and present in the home 6/35 shifts (17% of the time).
This was confirmed by the Administrator. [s. 8. (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 at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

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1. The licensee failed to ensure that the policy to minimize the restraining of residents is complied with. Review of the home's Least Restraint Policy (#60-10) states the following:
- When a restraint is being considered as a long term intervention, a "Restraint Documentation Form" will be completed by the multidisciplinary team.
- Orders for the restraint are faxed to the pharmacy so that they will be printed on the next months MAR and 3 month medication review
- Written consent for the use of the restraint will be obtained from the Power of Attorney for Personal Care.
- Residents who are restrained will be checked every hour and repositioned every two hours
- Documentation of these checks will be completed by the Personal Support Worker on the "Hanover Care Centre Restraint Record"
- The need for the restraint will be reviewed every eight hours by the Registered Nursing Staff and will be documented on the "Physical Restraint Reassessment Form".

There is no documented evidence that these measures were in place for:
-3/3 residents reviewed wearing restraints.
This was confirmed by the Director of Care. [s. 29. (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 the policy to minimize restraining of residents is complied with, to be implemented voluntarily.

WN #3: 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).

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. An interview with a Resident Council Representative revealed that the home did not seek the advice of the Residents Council in developing and carrying out the satisfaction survey and acting on the results.
This was confirmed by the Activity Director and Administrator. [s. 85. (3)]

2. An interview with the Resident Council Representative revealed that the licensee did not ensure that the results of the survey are documented and made available to the Resident' Council to seek their advise.
This was confirmed by the Activity Director and Administrator.
The copy of the survey provided to the inspectors stated "McVean Lodge" (the retirement home section of the building). The Administrator was not able to provide the inspectors with the results of the survey and actions taken as a result of the survey. [s. 85. (4) (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 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; and the licensee shall ensure that the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to be implemented voluntarily.

WN #4: 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:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).

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:
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.) 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:
4. Consent. 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:
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.
During the inspection, a resident was observed to be wearing a restraint while seated in their wheelchair.
There was no order by the physician or the registered nurse in the extended class for the resident to have the restraint.
This was confirmed by the Director of Care. [s. 110. (2) 1.]

2. The licensee failed to ensure that the resident is released from the physical device and repositioned at least once every two hours.
An identified resident was observed during the inspection wearing restraints.
On November 6, 2013 the licensee failed to produce evidence that the resident's restraints were released and that the resident was repositioned every two hours.
This was confirmed by the Director of Care. [s. 110. (2) 4.]

3. The licensee shall ensure that consent for use of a physical device to restrain is documented.
3/3 (100%) residents observed restrained did not have documented consent for the use of the physical devices.
This was confirmed on November 6, 2013 by the Director of Care. [s. 110. (7) 4.]

4. The licensee failed to ensure that for every use of a physical device to restrain a resident that there is documentation of the person who applied the device and the time of application.
During the inspection an identified resident was observed wearing a restraint. There was no documentation for this resident that included the person who applied the restraint and the time of the application.
This was confirmed by the Director of Care. [s. 110. (7) 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 where a resident is being restrained by a physical device that the staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class; that the resident is released from the physical device and repositioned at least once every two hours; that every use of a physical device to retrain a resident is documented including consent and the person who applied the device and the time of the application, to be implemented voluntarily.

WN #5: 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 did not ensure that the home is a safe and secure environment for its residents. On November 5, 2013 at 1100 hours the fire alarm pull station at the end of the long hall resident care area was covered by two pieces of 8.5 x 11 inch white paper that was taped to the wall. Two staff informed inspectors that it was covered as a resident kept pulling the fire alarm pull station.
During interview the Administrator confirmed that she was aware that the fire alarm pull station had been covered since last week as resident had been pulling the pull station causing the alarm to sound. The Administrator indicated that she should remove the paper so that it is not covered.
The Administrator confirmed at the end of the day that she had ordered a proper alarm cover box for the fire alarm pull station. [s. 5.]

WN #6: 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. (2) Where the Act or this Regulation requires the licensee to keep a record, the licensee shall ensure that the record is kept in a readable and useable format that allows a complete copy of the record to be readily produced. O. Reg. 79/10, s. 8 (2)

Findings/Faits saillants :

1. The licensee failed to ensure that the home's policy and procedure regarding Tray Service (policy #160-440) was complied with.
Review of the Tray Service Procedure states that the nursing staff will remain with the resident to provide assistance and/or supervision for the entire time the tray is in their room.
On November 5, 2013 at noon meal seven residents received tray service in their rooms. Four residents were given their trays and no staff remained with them. This was confirmed by a Personal Support Worker.
On November 6, 2013 during noon meal a resident was observed to have their meal tray in their room and were eating. No staff were present in the room. This was confirmed by a Personal Support Worker. [s. 8. (2)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that is available in every area accessible by residents.
There is no resident-staff communication and response system available in the activity room, small lounge across from nursing station and large lounge.
This was confirmed by the Activity Director. [s. 17. (1) (e)]

2. The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that, in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff.
The resident-staff communication and response system was not properly calibrated so that the level of sound is audible to staff.
On November 6, 2013 at 1240 hours the call bell was ringing for a resident's room. The call bell light in the hallway was activated and a sound was audible in the location of room, however was not audible to the staff that were in the dining room or to the staff that was feeding another resident in their room.
This was confirmed by the Administrator who stated that the call bell usually is audible at the desk and in the dining room. [s. 17. (1) (g)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):

1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):

2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,

i. a breakdown or failure of the security system,

ii. a breakdown of major equipment or a system in the home,

iii. a loss of essential services, or

iv. flooding.

O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to inform the Director immediately, in as much detail as possible of an outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.
The Inspectors arrived at the home to do a Service Area Office Initiated Inspection and was notified that the home was declared to be in respiratory outbreak since October 31, 2013. As of November 5, 2013 the licensee had not notified the Director of the outbreak. [s. 107. (1)]

2. The licensee did not inform the Director no later than one business day after the occurrence of the incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital.
An identified resident was taken to hospital with a subsequent significant change in status.
The Director of Care and Administrator confirmed that there was no critical incident report submitted for this incident. [s. 107. (3)]

WN #9: 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 failed to ensure that drugs are stored in an area or a medication cart that is secure and locked.
On November 5, 2013 it was noted that the treatment cart containing prescription topicals was in the clean utility room by the nursing station. The treatment cart was not locked and two prescription topicals were noted to be on the top of the cart.
The registered staff confirmed that all staff had access to the room and that the cart was not locked. [s. 129. (1) (a)]

Issued on this 28th day of November, 2013

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

SHARON PERRY