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

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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
Aug 20, 2015	2015_285126_0030	O-002370-15	Resident Quality Inspection

Licensee/Titulaire de permis

HILLTOP MANOR NURSING HOME LIMITED
82 Colonel By Crescent Smiths Falls ON K7A 5B6

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

HILLTOP MANOR NURSING HOME LIMITED
1005 ST LAWRENCE STREET P.O. BOX 430 MERRICKVILLE ON K0G 1N0

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

LINDA HARKINS (126), MEGAN MACPHAIL (551), MELANIE SARRAZIN (592)

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): August 4, 5, 6, 7, 10, 11,12,and 13, 2015

Complaint Log #O-001407-14 was inspected during this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Acting Director of Care, the Assistant Director of Care, several Registered Nurses, several Registered Practical Nurses, several Personal Support Workers, the Director of Food Services, the Registered Dietitian, the Activity Director, the Director of Environmental Service, several housekeeping staff, one Physiotherapist Assistant, the President of the Resident Council, several residents and several family members.

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

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

- **5 WN(s)**
- **3 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care for Resident #23 sets out clear direction to staff and others who provide direct care to the resident with regards to the resident's seating when in the Broda chair

Commencing on August 4, 2015 and on multiple occasions throughout the course of the inspection, Resident #23 was observed sitting in a Broda chair with his/her legs dangling off the edge of the seat and not supported.

Resident #23's health care record indicates that on a specific date in February 2015, Resident #23 was assessed (by ADP Authorizer), and the Broda chair was deemed to be appropriate.

The Assistant Director of Care indicated that Resident #23 was using a Broda chair belonging to the home and had been assessed by an Occupational Therapist. The ADOC indicated that when seated in the Broda chair, Resident #23's legs should be supported.

PSW, S #115 indicated that Resident #23 likes to be in a fetal position and has been using the Broda chair for at least six months. The PSW indicated that the resident's feet should be resting on the leg rest.

Resident #23's written plan of care in effect at the time of the inspection indicates that he/she uses a wheel chair for all mobility and requires total assistance to propel the wheel chair.

On August 14, 2015, Resident #23 was observed to be sitting in a reclined position in the Broda chair with the vinyl strap leg rests extended and supporting his/her legs and feet.
[s. 6. (1) (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 that the written plan of care for Resident #23 sets out clear direction with regards to the resident’s seating when in the Broda chair., 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 comply with O.reg 79/10 s. 15 (1) (a) in that the licensee did not ensure that where bed rails are used, 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;

On August 5, 2015, Inspector #592 and #551 observed in several rooms, quarter rails not well secured to the bed frames causing potential entrapment zones and safety risks for residents.

On August 10, 2015, during an interview with PSW S#107 and RPN S#106, they told Inspector #592 that it is everyone's responsibilities to write any disrepair or concerns in the communication binder located at the nurse's desk in order for the maintenance department to do a follow-up.

On August 10, 2015, during an interview with the Director of Environmental Services, he told Inspector #592 that staff were responsible to report any disrepair or concern in the communication binder located at the nurse's desk. He further indicated that monthly health and safety audits were done throughout the home but no side rails/bed system were on that monthly audits or any other maintenance schedule. He indicated that the housekeeping staffs were disinfecting 10 beds a day and that they were responsible to report any rails in disrepair but was not notify of any disrepair. Side rails in those specific rooms were shown to the Environmental Manager who indicated that these rails were not well secured and would be fixed immediately.

On August 11, 2015, during an interview with PSW S #108, she told Inspector #592 that a specific resident in one of those room was independent and was going in and out of bed on his/her own. She indicated that another resident in one of those room was also independent and using the quarter rails to assist for transferring in and out of bed and using the quarter rails for self-repositioning and to assist him/her to sit up in bed. During the course of the interview with PSW S# 108, one specific Resident stated to Inspector #592 that the bed rail was fixed yesterday and was feeling safer now.

On August 11, 2015, during an interview with the Administrator, he told Inspector #592 that no bed system evaluation was done at the home since 2012. He further indicated that several bed systems were changed and fixed following the evaluation in 2012, but no other follow-up was done since. [s. 15. (1) (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 all bedrails in the home are installed securely to the bed frames, to be implemented voluntarily.

WN #3: 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:
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

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 Resident #42 was provided with the personal assistance and encouragement required to eat.

On August 11, 2015, Resident #42 was observed during the lunch meal. Resident sits at table #5 which has four seats, and during this lunch meal there were two staff members assisting other residents at the table.

At 12:06, the resident was noted to be sitting in the chair, slouched forward with his/her forehead resting on the table. Resident #42 received the entrée at 12:24. At 12:25, the resident remained slouched forward with his/her forehead on the table and remained this way until 12:31 when he/she briefly lifted his/her head but did not have anything to eat or drink. At 12:35, Resident #42 lifted his/her head and took one drink of orange juice then

put his/her head back on the table.

Resident #42 was not provided with personal assistance and encouraged to eat from the time he/she received the entrée at 12:24 until twenty three minutes later at 12:47 when a PSW who had been assisting residents at table #3 roused Resident #42 , picked up the sandwich and asked him/her if he/she wanted to try it. The resident accepted two bites, then refused all other offers for more, to drink and for dessert. Resident # 42 was escorted from the dining room at 12:52 having eaten two bites of a sandwich and sips of orange juice.

A review of Resident #42's health care record indicates that he/she was assessed as being at high nutritional risk and has lost 10.2% (3.9kg) of body weight in the past three months. Resident #42 is on a diabetic diet and is ordered an oral supplement.

On August 12, 2015, the ADOC was interviewed and stated that it was her expectation that, if Resident #42 was slouched forward at the table and not eating or drinking, that staff would provide him/her with the necessary encouragement and assistance to eat and drink. The ADOC stated that Resident #42 does not eat well at lunch or supper. [s. 73. (1) 9.]

2. The licensee has failed to ensure that proper technique was used to assist Resident #23 with eating.

Resident #23 has resided in the home since 2009. Resident #42 consumes a pureed texture, nectar thick liquids diet and is reliant for feeding.

On August 4 and 10, 2015, lunch meal service in the main dining room was observed, and it was noted that Resident #23 sits in a Broda chair for meals but not in a fully upright position. Interviews with PSW, S #115 and the Assistant Director of Care indicate that due to rigidity, Resident#23 is unable to sit in a fully upright position.

On August 10, 2015, it was noted that Resident #23 was fed with his/her neck in a hyperflexed position so that the head and neck were tilted back. A pillow was supporting the resident's midsection on the right side. At 12:25, PSW, S #103 was noted to bring the resident's head forward to an upright position to give him/her sips of a beverage. Otherwise the resident was fed with the neck hyperflexed while being fed soup, entrée, dessert and beverage.

On August 13, 2015, the Registered Dietitian was interviewed and indicated that feeding a resident with the neck hyperflexed was not a safe feeding practice. [s. 73. (1) 10.]

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 resident requiring assistance to eat are provided with personal assistance and encouragement and resident are fed with proper technique if required feeding., to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 13. Every licensee of a long-term care home shall ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy. O. Reg. 79/10, s. 13.

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident bedroom occupied by more than one resident have sufficient privacy curtains to provide privacy.

On August 4th and 5th, 2015 the following was observed:

In room 27-1, a four bed residents room, resident #41 does not have a curtain at the front of his bed to provide privacy, therefore all three residents sharing that bedroom could see resident #41 when care is provided. The privacy curtain was prevented from fully closing, leaving an opening related to the placement of the ceiling lift track.

In room 20, a semi private room, a resident does not have a privacy curtain that completely close around the bed.

In room 22, a semi private room, two residents does not have a privacy curtain that completely close around their beds , therefore exposing them when care is provided if someone else walk in the room.

In room 29-1, a semi private, a resident does not have a privacy curtain that completely close around the bed. The privacy curtain was prevented from fully closing , leaving an opening related to the placement of the ceiling lift track.

Discussion held with Director of Environmental Services who indicated that he was not aware that some of the privacy curtains did not provide privacy as they were not closing completely around the residents area. He indicated that audits are completed on a monthly basis and Housekeeping staff are checking the privacy curtain and the bedroom drapes on a daily basis.

Discussion held with Housekeeping S #105 who indicated that she checked the privacy curtains on a daily basis to ensure there is no stain or odors on the curtain. She specifically indicated that she does not open the curtain to ensure they provide privacy. [s. 13.]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 59. Family Council

Specifically failed to comply with the following:

s. 59. (7) If there is no Family Council, the licensee shall,
(a) on an ongoing basis advise residents' families and persons of importance to residents of the right to establish a Family Council; and 2007, c. 8, s. 59. (7).
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council. 2007, c. 8, s. 59. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that when there is no Family Council the licensee shall convene semi-annual meetings to advise such persons of the right to establish a Family Council.

Interview held with the Director of Activity on August 10, 2015, and he indicated that there is no Family Council in the Home.

Interview held with the Administrator on August 11, 2015, indicated that they have not done semi-annual meeting to advise such person to the right to establish a Family Council. [s. 59. (7) (b)]

Issued on this 13th day of November, 2015

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

Original report signed by the inspector.