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

Division des foyers de soins de longue durée
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
Jan 2, 2018	2017_671684_0012	022181-17	Resident Quality Inspection

Licensee/Titulaire de permis

The Board of Management for the District of Manitoulin
70 Robinson Street Postal Bag 460 LITTLE CURRENT ON P0P 1K0

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

MANITOULIN CENTENNIAL MANOR HOME FOR THE AGED
70 ROBINSON STREET POSTAL BAG 460 LITTLE CURRENT ON P0P 1K0

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

SHELLEY MURPHY (684), AMY GEAUVREAU (642), CHAD CAMPS (609)

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): December 4-8, and 11-15, 2017.

Additional logs inspected during this RQI included:

-One critical incident, submitted to the Director related to resident falls; and
-One follow up for CO #001 from inspection #2017_565612_0008, related to the home's failure to follow the Zero Tolerance of Abuse Policy.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Acting Director of Care (Acting DOC), Activity Director, Resident Assessment Instrument (RAI) Coordinator, Pharmacist, Dietitian, Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), family members and residents.

The inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, staff personnel files and reviewed numerous licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
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
Recreation and Social Activities
Residents' Council

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

- **8 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 20. (1)	CO #001	2017_565612_0008	642

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. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home had his or her personal items, including personal aids such as dentures, glasses and hearing aids labelled within 48 hours of admission and of acquiring, in the case of new items.

During the initial tour of the home on a specified day in December 2017, Inspector #609 observed:

-An unlabeled nail file and toe pick found beside the tub, in Tub Room-5; while

-Four pairs of unlabelled used nail clippers, two unlabelled used deodorants and two unlabelled used mouth wash bottles were found in Tub Room-1.

A review of the home's policy titled "Management of Resident belongings- RC-07-01-03" last updated April 2017, indicated that the nurse would ensure all personal belongings were labelled with the resident's name within 48 hours of admission.

During an interview with PSW #106 they verified that all residents' personal items were to be labelled.

During an interview with the Acting DOC, the Inspector relayed the observations of unlabelled items which they verified should have been labelled within 48 hours of admission. The Acting DOC further verified that PSW #107 had left resident #012's nail clippers and toe pick in Tub Room-5 and should have placed them back into the resident's labelled container after use. [s. 37. (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 ensuring that each resident of the home has his or her personal items, including personal aids such as dentures, glasses, and hearing aids labelled withing 48 hours of admission and of acquiring, in case of new items, to be implemented voluntarily.

WN #2: 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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

On a specified day in December 2017, Inspector #609 observed resident #005 to have altered skin integrity.

A review of the home's policy titled "Skin and Wound Program: Wound Care Management- (RC-23-01-02)" last updated February 2017, required registered staff to:
-Promptly assess a resident's altered skin (which included bruises and skin tears) on initial discovery;
-Assess the altered skin integrity weekly at a minimum; and
-Write a progress note if the altered skin had resolved.

A review of resident #005's health care records indicated that on a specified day in 2017, RPN #122 discovered and assessed the resident's altered skin integrity.

During an interview with PSW #123, they verified that resident #005 had ongoing impaired skin integrity since for at least two months in 2017, and that the impaired skin had significantly worsened.

A review of the "Skin and Wound Observation and Communication Form" used by PSWs to alert Registered staff of skin concerns found that resident #005 had altered skin integrity identified in three months in 2017.

A further review of resident #005's health care records found no indication that the resident's altered skin integrity had ever resolved.

A review of the altered skin assessments for resident #005 from the last quarter of 2017, found no weekly skin assessments were performed on the resident's altered skin integrity for 80 days. [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 ensuring that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated., to be implemented voluntarily.

WN #3: 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. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program.

While observing resident #011's medication administration, Inspector #609 observed RPN #106 perform the following:
-Check the resident's medication perscription with the computer Electronic Medication Administration Record (EMAR);
-Use a keypad to access the stairwell to go to another unit;
-Exit the stairwell via an exit button;
-Double check the order for the medication with another registered staff member;
-Return to their unit via the stairwell;
-Found resident #011; and
-Administered the medication.

Throughout the process of preparing, checking and administering the medication to resident #011, RPN #106 did not perform any hand hygiene.

A review of the home's policy titled "Hand Hygiene- (IC-02-01-07)" last updated

September 2017, required staff to perform hand hygiene after touching any high-touch surface such as keyboards, doorknobs and elevator buttons. The policy also indicated that hand hygiene was to be performed before initial resident contact and after environmental contact.

During an interview with RPN #106, they verified that throughout the checking, preparing and administration of resident #011's medication, they did not perform any hand hygiene.

During an interview with the Acting DOC, they verified that after touching many contact surfaces RPN #106 should have performed hand hygiene before they initially touched resident #011 to administer their medication. [s. 229. (4)]

2. During an interview with Inspector #684, resident #010 informed them that they had required interventions in place, to be performed by staff. In a further interview five days later with resident #010, the resident indicated that no staff performed the required interventions when providing care to them.

Inspector #684 reviewed resident #010 progress notes which indicated that on a specified day in May 2017, the facility received results confirming that the resident required specific interventions.

In a further interview with, PSW #120, Inspector #684 asked PSW #120 why resident #010 had the specified interventions; they stated they "had no idea". The Inspector asked if they applied any PPE; they stated they "put on gloves when they go into the room and a mask if the resident was coughing". The Inspector noted that the resident had different interventions specified than those described by the PSW.

Inspectors #684 and #609 observed PPE to be used for resident #010, as well as posted portions of the plan of care which had indicated the type of required interventions that were to be followed when providing the resident's care, or which resident the interventions were for in the semi-private room.

A review of the home's Infection- "(IC-05-01-03) policy states that "Care Plan- Use to indicate presence of infectious organism, tests required and when, status of testing, treatment needs as well as precautions required by care staff." The policy indicated that the resident's care plan should also indicate any changes to the normal care requirements"; as well as "Implement contact precautions and ensure the required PPE

is available for staff providing care."

The home's "Isolation" (IC-03-01-12) policy indicated that "Care staff must wear personal protective equipment and practice routine/standard precaution practices and, where required, additional precautions. The policy stated "Ensure that the care plan and progress notes are updated accordingly once it is determined that a resident requires isolation."

A review of the "Provincial Infectious Diseases Advisory Committee (PIDAC), Routine Practices and Additional Precautions, In All Health Care Settings, 3rd edition" a document that was developed by the Provincial Infectious Diseases Advisory Committee on Infection Prevention and Control (PIDAC-IPC). PIDAC-IPC is a multidisciplinary scientific advisory body that provides evidence-based advice to the Ontario Agency for Health Protection and Promotion (Public Health Ontario) regarding multiple aspects of infectious disease identification, prevention and control. PIDAC-IPC's work is guided by the best available evidence. On page 26/113 it indicates that signage specific to the type (s) of Additional Precautions should be posted:
-A sign that lists the required precautions should be posted at the entrance to the client/patient/resident's room or bed space.
-Signage should maintain privacy by indicating only the precautions that are required, not information regarding the patient's condition.

Inspector #684 interviewed the Director of Care(DOC) who confirmed that when a resident had specified interventions staff were to wear the appropriate PPE when providing personal care which may involve bodily fluids. Inspector #684 confirmed with the DOC that the posted portion of resident #010's plan of care was incorrect. [s. 229. (4)]

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 ensuring that staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #4: 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).

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 has failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

During an interview with PSW #114, Inspector #684 asked PSW #114 how they knew when a resident required a specified intervention. PSW #114 responded there would be signage outside of the resident's room, and that it would be noted in the resident's care plan.

Inspector #684 interviewed PSW #120 who was the primary care giver for resident #010 who indicated they had no idea why resident #010 required the specified interventions. The Inspector asked PSW #120 if they applied any PPE, they indicated they put on gloves when they went into the room and a mask if the resident was coughing.

Inspector #684 reviewed resident #010's care plan and was unable to identify any direction related to the specified interventions.

Inspector #684 reviewed the home's policy "Isolation" (IC-03-01-12) which indicated that "Care staff must wear personal protective equipment and practice routine/standard precaution practices and, where required, additional precautions". Procedures stated to ensure that the care plan and progress notes were updated accordingly once it was determined that a resident required the specified interventions.

During an interview with Acting DOC, Inspector #684 asked how a staff member would know a resident required the specified interventions. The Acting DOC stated it was indicated in their care plan. The Acting DOC verified that resident #010's care plan did not provide clear direction related to the required specified interventions. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the resident was 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 changed or care set out in the plan was no longer necessary.

On a specified day in December 2017, Inspector #609 observed resident #006 sitting in their wheel chair with leg rests applied. One of the resident's legs was unsupported and left against the edge of the leg rest. Some 32 minutes later the resident was observed in the same position.

During an interview with the Acting DOC on a specified day in December 2017, Inspector #609 verified that PSW #121 had notified them of resident #006's pressure concerns, and that same day PSW #121 changed the resident's care by adding an identified intervention.

A review of resident #006's health care records on a specified day in December 2017, found no documentation to support that the registered staff were made aware of the resident's pressure concerns nor what had been implemented.

A review of the home's policy titled "Care Planning- (RC-05-01-01)" last updated April 2017, indicated that the care plan was to be revised when appropriate to reflect the resident's current care needs.

A review of resident #006's plan of care found no mention of the identified intervention.

During the same interview with the Acting DOC they verified that they did not update resident #006's the plan of care.

During an interview with the Administrator they verified that staff were to comply with the home's care planning policy and that this had not occurred when resident #006's identified intervention was not updated within the plan of care. [s. 6. (10) (b)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas were kept closed and locked when they were not being supervised by staff.

During the initial tour of the home Inspector #609 observed:
-The home's storage room door down the Maple hall to be unlocked and unattended at 1048 hours. Inside the storage room was oxygen supplies, syringes and needles, iodine disinfectant, hydrogen peroxide, prescription creams such as conjugated estrogen as well as residents' health care records; and
-The chair scale storage room on the upper floor to be unlocked and unattended. Inside, a chair scale as well as access to five large electrical breakers boxes were noted.

A review of the home's policy titled "Harmful Substances- (SL-08-01-03)" last updated October 2015, outlined that staff were to keep locked housekeeping storage areas; dietary storage areas; maintenance storage areas; housekeeping closets and carts; medication and treatment rooms as well as any other location that could be dangerous if a resident were to gain access.

During an interview with PSW #105 they verified that the chair scale storage room door should have been locked when not attended.

During an interview with the Acting DOC they verified the storage room door should have been closed and locked. [s. 9. (1) 2.]

WN #6: 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 has failed to ensure that the home was equipped with a resident-staff communication and response system that could be easily seen, accessed and used by residents, staff and visitors at all times.

A) On a specified day in December 2017, Inspector #609 identified that the call bell for resident #006's bed would not function when activated. Electrical tape was noted around the call bell cord.

A review of the home's policy titled "Nurse Call System- (RC-08-01-01)" last updated April 2017, indicated that the call system would be available near the resident's bed and that care staff were to check the call bell system every shift to ensure that it was functional and to report any issues or concerns immediately to the Charge Nurse.

During an interview with PSW #107 they verified that resident #006's call bell was not functioning when activated and that the cord had electrical tape applied. The PSW denied checking the call system every shift and stated that approximately one week previously they noted that the call bell malfunctioned. They denied reporting the concern to the Charge Nurse.

During an interview with the Acting DOC they indicated that they were unaware that staff were to check the call system every shift to ensure it was functioning. The Acting DOC then outlined how maintenance concerns were also to be documented by staff in the maintenance log books located on the upper and lower unit nursing stations.

A review of the upper unit maintenance log books for the past quarter, found no documentation reporting resident #006's malfunctioning call bell.

B) During an interview resident #010, they informed Inspector #609 that they lacked the strength to press the call bell when they needed assistance.

During an interview with PSW #110, they were made aware that resident #010 did not have the strength to use the call bell to call for assistance. They indicated that they would immediately mitigate the concern by trialling another type of call bell.

The following day, the same call bell that resident #010 could not use remained unchanged.

During another interview with PSW #110, they denied reporting the call bell concern to the Charge Nurse, trialling any change of call bell, or identifying the concern in the maintenance log book.

A review of the upper unit maintenance log books for the last quarter of 2017, found no documentation reporting resident #010's unusable call bell.

During an interview with the Administrator they indicated that PSW #110 should have reported resident #010's call bell concern to the Charge Nurse, and that this had not occurred. [s. 17. (1) (a)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

On a specified day in December 2017, prior to resident #011's specified medication administration, RPN #106 informed Inspector #609 that the resident required a specified amount of the medication.

The amount of medication resident #011 required was recorded on a double check sheet by RPN #106. The medication and the double check sheet were then reviewed by the Acting DOC who signed off that the amount of medication was correct on the sheet. RPN #106 then proceeded to administer the medication to resident #011.

A review of the home's policy titled "Medication Management- (RC-16-01-07)" last updated February 2017, outlined how the nurse was to ensure that medications were administered following the eight "Rights of Administration" which included the right dose.

A review of resident #011's EMAR indicated that the resident was to receive a regular dose of medication.

During an interview with RPN #106 they did not correctly check the EMAR prior to administering the medication to resident #011.

RPN #106 also described to Inspector #609 the process for double checking dosages by:
-Writing the resident's name, room number, date, time, type of medication, resident condition and dosage on the double check sheet and sign off; then
-Bring the medication and the double check sheet to another registered staff member to review and sign off, prior to administering the medication.

A review of resident #011's double check sheet found no parameters to indicate what amount of medication the resident actually required.

During an interview with the Acting DOC they acknowledged that they signed off on the incorrect dosage of medication for resident #011, because without the parameters on the double check sheet, the second registered staff member to sign would not know what the actual dose should have been. [s. 131. (2)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written record was kept of the quarterly review of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions as well as any changes and improvements identified in the review.

A review of the May and September 2017, Professional Advisory Committee (PAC) meeting minutes Inspector #609 found no documentation in the PAC meeting minutes, of the review of the medication incidents nor documentation of any changes and improvements identified in the review.

Inspector #609 interviewed the Acting DOC who indicated that medication incidents and adverse drug reactions were reviewed quarterly during the PAC meetings.

A review of the home's policy titled "Medication Incident and Reporting- (RC-16-01-09)" last updated February 2017, outlined how all medication incident and adverse drug events as well as corrective action plans were to be reviewed at the PAC meetings.

During an interview with Pharmacist #119, they verified that they attended the PAC meetings, whereupon an analysis of the medication incidents and adverse drug reactions would take place as well as discussions of any changes or improvements identified. The DOC, also verified that medication incidents and adverse drug reactions were reviewed at the PAC meetings, and they discussed any changes and improvements identified.

The DOC acknowledged that the analysis of the medication incidents as well as any changes and improvements identified were not documented. [s. 135. (3)]

Issued on this 4th day of January, 2018

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

Original report signed by the inspector.