Ontario

Inspection Report under the *Long-Term Care Homes Act, 2007*

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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Dates of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'inspection**
April 27-29, 2011	2011_188_2667_26Apr131018	Complaint, S-00701

Licensee/Titulaire
584482 Ontario Inc., 689 Yonge Street, Midland, ON, L4R 2E1, FAX: 705-528-0023

Long-Term Care Home/Foyer de soins de longue durée
Manitoulin Lodge, 3 Main Street, PO Box 648, Gore Bay, ON, P0P 1H0, FAX: 705-282-3422

Name of Inspector/Nom de l'inspecteur
Melissa Chisholm (#188)

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a complaint inspection.

During the course of the inspection, the inspector spoke with: the Administrator, the Director of Care (DOC), the registered nursing staff, personal support workers (PSW) and residents

During the course of the inspection, the inspector: conducted a walk through of the home, reviewed the health care record of the residents, observed staff practices, reviewed policies and procedures, observed staff interactions with residents and the care of residents.

The following Inspection Protocols were used during this inspection:
Skin and Wound Care
Personal Support Services
Accommodation Services – Laundry

Findings of Non-Compliance were found during this inspection. The following action was taken:

4 WN

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.6(1)c Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out, (c) clear direction to staff and others who provide direct care to the resident.

Findings:

1. Inspector reviewed the plan of care for a resident. The care plan for this resident identifies an intervention related to urinary continence. Inspector noted a physician's order to discontinue this intervention. The licensee failed to ensure the plan of care provides clear direction to staff and others who provide direct care to the resident.
2. Inspector reviewed the plan of care for a resident. The care plan identifies a staged wound. The same document also identifies the same wound at a different stage. Conflicting information regarding the stage of this residents wound is provided in the care plan. The licensee failed to ensure the plan of care provides clear direction to staff and others who provide direct care to the resident.

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WN #2: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.6(8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

Findings:

1. Inspector reviewed the health care record of two residents. These residents were ordered oxygen therapy via nasal prongs. This was written on the Medication Administration Record (MAR) of these two residents. Inspector noted that the requirement of oxygen is not included anywhere else in both the resident's plans of care. Personal Support Workers (PSW) do not have access to the MARs. The licensee failed to ensure staff who provide direct care to these residents are given convenient and immediate access the plan of care.

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WN #3: The Licensee has failed to comply with O. Reg. 79/10 s.130(2) Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following: #2. Access to these areas shall be restricted to, i) persons who may dispense, prescribe or administer drugs in the home, and ii) the Administrator.

Findings:

1. Inspector observed on April 27, 2011 at 14:05h in the "TUB ROOM 2" two grey baskets containing prescription creams. There were approximately 23 containers of creams in one basket and 11 containers of creams in the second basket. This storage room is accessible to all staff members. The

licensee failed to ensure drugs are stored in an area that is restricted to persons who may dispense, prescribe or administer drugs in the home.

2. Inspector observed on April 28, 2011 at 09:47h in the "TUB ROOM 2" one grey basket containing prescription creams. Inspector informed the Registered Practical Nurse who indicated the basket of prescription creams must be kept in the treatment room and proceeded to remove the basket and place in the locked treatment room. The licensee failed to ensure drugs are stored in an area that is restricted to persons who may dispense, prescribe or administer drugs in the home.
3. Inspector observed on April 29, 2011 at 08:52h in the "TUB ROOM 2" one grey basket containing four resident prescription creams. This storage room is accessible to all staff members. The licensee failed to ensure drugs are stored in an area that is restricted to persons who may dispense, prescribe or administer drugs in the home.

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WN #4: The Licensee has failed to comply with O.Reg. 79/10 s.50(2)(b)(iv) 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, (iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Findings:

1. Inspector reviewed the health care record of a resident related to skin assessment. This resident has a documented wound with a regularly scheduled dressing change. Inspector reviewed the "Stage II: Care-Plan, Assessment and Treatment Sheet" found in the treatment binder for this resident. Over a two month time period the sheet was only completed once. No other wound re-assessment was located by the inspector for the reviewed two month time period. The licensee failed to ensure a resident exhibiting altered skin integrity was reassessed at least weekly by a member of the registered nursing staff.

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Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.**
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection). June 9, 2011