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

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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
Aug 20, 2014	2014_211106_0011	S-000246-14	Resident Quality Inspection

Licensee/Titulaire de permis

MANITOUWADGE GENERAL HOSPITAL
1 HEALTH CARE CRESCENT, MANITOUWADGE, ON, P0T-2C0

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

MANITOUWADGE GENERAL HOSPITAL
1 HEALTH CARE CRESCENT, MANITOUWADGE, ON, P0T-2C0

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

MARGOT BURNS-PROUTY (106)

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 17, 18, 19, 24, 25, 2014

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Ontario Teleheath Network (OTN)Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeeping Lead, Dietary Aides, Physiotherapist Assistant (PTA), Family Members, and Residents.

During the course of the inspection, the inspector(s) conducted a walk through of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed the health care records for several residents, and reviewed numerous licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
Residents' Council
Skin and Wound Care
Sufficient Staffing

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 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. On June 18, 2014, while conducting resident observations the inspector noted that a bed rail was in the up position on resident #585's bed. A recent RAI MDS assessment for resident #585, does not indicate that bed rails are used for this resident. On June 18, 2014, during a staff interview a RPN indicated that bed rails used for bed mobility for this resident. The care plan document for resident #585 indicates that staff are to encourage the use of bed rails to assist with turning.

On June 25, 2014 staff member #S-100 reported to inspector that there are no documented bed rail assessments completed for residents. The licensee failed to 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. [s. 15. (1) (a)]

2. On June 18, 2014, while conducting resident observations the inspector #597 noted that a bed rail was in the up position on resident #422's bed. A recent RAI MDS assessment for resident #422, indicates that bed rails are used for bed mobility. On June 18, 2014, during a staff interview staff member #S-100 indicated that bed rails are used for bed mobility and call bell access for this resident. The care plan document, effective May 27, 2014, for resident #422, does not indicate that bed rails are used for this resident.

On June 25, 2014 staff member # S-100 reported to inspector that there are no documented bed rail assessments completed for residents. The licensee failed to 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. [s. 15. (1) (a)]

3. On June 18, 2014, while conducting resident observations the inspector #106 noted that bed rails were in the up position on resident #418's bed. A recent RAI MDS assessment, for resident #418, indicates that bed rails are used for bed mobility. On June 18, 2014, during a staff interview staff member # S-100 indicated that bed rails are used for bed mobility and call bell access for this resident. The care plan document, for resident #419, indicates that bed rails are used to aid in bed mobility.

On June 25, 2014 staff member # S-100 reported to inspector that there are no

documented bed rail assessments completed for residents. The licensee failed to 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. [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 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, specifically regarding residents, # 585, #422, and #418, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. On June 18, 2014, inspector #597 interviewed resident #422's spouse, they reported that falls generally occur when the resident's medications have worn off and they forget their limitations. The resident will forget to ring for nurse and will attempt to transfer out of bed and go to the bathroom on their own. On June 24, 2014, inspector #106 and #597 interviewed a RPN who indicated that resident #422 will forget to ring for assistance and fall when in the washroom or ambulating to the washroom.

The Health Care Record (HCR) for resident #422 was reviewed by Inspector #597, for the last 6 months, which indicated, during this time the resident had six falls. Resident #422 was also assessed to be a high risk for falls, indicating High Risk Fall prevention intervention required. The Care Plan Document for resident #422 was reviewed and there were no fall risk prevention strategies indicated.

The licensee failed to ensure that the plan of care is based on, at a minimum, interdisciplinary assessment of the following with respect to the resident's health conditions, including allergies, pain, risk of falls and other special needs. [s. 26. (3) 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 the plan of care for resident #422 is based on, at a minimum, interdisciplinary assessment of the following with respect to the resident's health conditions, including allergies, pain, risk of falls and other special needs, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury. O. Reg. 79/10, s. 48 (1).
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions. O. Reg. 79/10, s. 48 (1).
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. O. Reg. 79/10, s. 48 (1).
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

1. The health care record (HCR) for resident #422 was reviewed and it indicated that the resident had multiple falls in the last 6 months, however, there were no fall prevention interventions found in the resident's care plan document.

When resident #422 most recently fell they sustained injury, resulting in altered skin integrity. On June 24, 2014, the DOC indicated that the home did have some parts of the falls prevention program in place, however, it was not fully developed and implemented as per the LTCHA and Regulations.

The licensee failed to ensure that the following interdisciplinary programs are developed and implemented in the home: 1. A falls prevention and management program to reduce the incidence of falls and the risk of injury. [s. 48. (1) 1.]

2. On June 18, 2014, during stage 1 interview inspector #579 noted that resident #422 had altered skin integrity.

The Health Care records for resident #422 were reviewed and they indicated that the resident had a recent fall and sustained injury, resulting in altered skin integrity. The "Manitouwadge General Hospital Weekly Skin Assessment" for resident #422 was reviewed and the following was found:
-June 12, 2014: no indicated alteration in skin integrity
-June 16, 2014: altered skin integrity
-June 19, 2014: no indicated alteration in skin integrity (this was one day after inspector 597 observed altered skin integrity to the resident)

On June 24, 2014, inspector #597, asked the Nursing Supervisor if the home developed and implemented a Skin and Wound Program and they indicated that they did not.

The licensee failed to ensure that a skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions is developed and implemented in the home. [s. 48. (1) 2.]

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 following interdisciplinary programs are developed and implemented in the home: A falls prevention and management program to reduce the incidence of falls and the risk of injury, and a skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions is developed and implemented in the home, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. On June 24, 25, 2014, inspectors #106 and #579 observed that the drywall under and near the sky-light at the nursing station was cracked, buckled and peeling. The licensee failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. [s. 15. (2) (c)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. On June 18, 2014, resident #417 told inspector #597 that they have dentures but do not wear them because they make their mouth sore. The resident also stated that the dentures have not been adjusted. On June 24, 2014, staff member # S-101 told inspectors #106 and #597 that resident #417 will only wear their dentures when they go out of the home with friends and family.

On June 25, 2014, during an interview with staff member #S-100, inspectors asked them if residents are offered annual dental assessments and other preventive dental services, subject to payment being authorized by the resident/SDM if payment is required. Staff member #S-100 told the inspectors that they do not offer the annual dental assessments to the residents. The licensee failed to ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes, an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. [s. 34. (1) (c)]

WN #6: 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. On June 24, 2014, during an interview with the DOC and the Nurse Manager, the DOC reported that currently the home has only conducted annual meetings to advise residents' families and persons of importance to resident of their right to establish a Family Council. The licensee failed to ensure that semi-annual meetings are convened to advice residents' families and persona importance to residents of their right to establish a Family Council. [s. 59. (7) (b)]

WN #7: 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. On June 19 and 25, 2014, inspector #106 observed personal items (not drugs or drug-related supplies) in the double locked drawer of the LTC medication cart.

On June 19, 2014, a RPN indicated that residents have requested that staff store these items for safe keeping. The licensee failed to ensure that drugs are stored in an area or a medication cart, that is used exclusively for drugs and drug-related supplies. [s. 129. (1) (a)]

Issued on this 21st day of August, 2014

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