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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 20, 2015	2015_380593_0017	011134-15	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

GILLIAN CHAMBERLIN (593)

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 16 - 19, 22 - 25, 2015.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nursing Staff, Dietary Staff, Activation Staff, Maintenance Staff, residents and family members.

The inspector also observed the provision of care and services to residents, observed staff to resident interactions, observed resident to resident interactions, observed residents' environment, tested the resident-staff communication and response system, reviewed resident health care records and reviewed home policies.

The following Inspection Protocols were used during this inspection:
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
Recreation and Social Activities
Resident Charges
Residents' Council
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **6 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
O.Reg 79/10 s. 253.	CO #001	2014_332575_0013	593

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).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for each resident that sets out the planned care for that resident.

During an interview with Inspector #593 June 24, 2015, #S-100 reported that resident #004 was hospitalized during a month in 2014 due to a specific type of infection. They further added that the resident is prescribed certain medications related to this and gets the occasional infection which they described as very bad- on average two per year.

A review of resident #004's Medication Administration Record (MAR) found three pro re nata (PRN) or as required medications ordered related to this type of infection.

A review of resident #004's plan of care found no goals or interventions relating to the residents symptoms, reoccurring infections or use of the previously mentioned PRN medications. [s. 6. (1) (a)]

2. The licensee has failed to ensure that there is a written plan of care for each resident that sets out, clear direction to staff and others who provide direct care to the resident.

A review of resident #005's health care record found that the resident is at high nutritional risk and has interventions in place to manage this including the provision of an oral nutrition supplement. There was no flow sheet located for the provision of this

supplement nor was it recorded on the MAR.

Inspector #593 observed during the PM nourishment passes June 18 and 24, 2015 and the AM nourishment pass June 24, 2015, resident #005 was not provided with the oral nutrition supplement either by dietary staff or by nursing staff.

During an interview with Inspector #593 June 24, 2015, the home's Registered Dietitian confirmed that resident #005 is required to receive an oral nutrition supplement between meals at the AM and PM nourishment times. They further added that nursing staff are responsible for the administration of the supplement to the resident.

During an interview with Inspector #593, #S-100 reported that resident #005 is to receive oral nutrition supplements however they cannot remember exactly when the resident is to receive this as it is the responsibility of the dietary staff to administer the oral nutrition supplements.

A review of the home's policy: Nutrition Care and Hydration- Meal and Snack times B-150 dated June 15, 2010, found that residents with special diet needs will be sent nourishments in accordance to his/her prescribed diet. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

A review of resident #005's health care record found that the resident was a high nutrition risk and had interventions in place to manage this including the addition of a nutrition supplement to meals and certain foods.

During the dinner meal service on June 23, 2015, Inspector #593 observed the provision of a meal to resident #005 consisting of turkey, green beans and mashed potato. The posted menu included mashed potato as an option and #S-106 confirmed that all residents were served the same mashed potato including resident #005. Inspector #593 observed all residents including resident #005 to be served from the same pot of mashed potatoes.

During the dinner meal service on June 23, 2015, Inspector #593 observed the provision of a pudding for dessert to resident #005. The posted menu included pudding as one of the dessert options and #S-106 confirmed that all residents were served the same pudding for dessert including resident #005.

During an interview with Inspector #593 June 24, 2015, the home's Registered Dietitian confirmed that resident #005 is supposed to receive a nutrition supplement added to their food especially certain foods. They further reported that along with the Food Service Manager, they are trying to get dietary staff to be more consistent with resident dietary requirements.

A review of the home's policy: Nutrition Care and Hydration- Meal and Snack times B-150 dated June 15, 2010, found that residents with special diet needs will be sent nourishments in accordance to his/her prescribed diet. [s. 6. (7)]

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 the plan of care for each resident is kept current with all resident care needs, sets out clear direction to staff and others who provide direct care and that care is provided to the resident as per the plan of care specifically to residents #004 and #005, 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 ensure that 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 the risk to the resident.

During an interview with Inspector #593 June 24, 2015, the Maintenance Manager #S-102 reported that the home does undertake annual checks of the beds however this covers basic maintenance only. #S-102 confirmed that the beds are removed from the home and taken to the maintenance department where basic preventative maintenance is undertaken.

During an interview with Inspector #593 June 24, 2015, #S-100 reported that along with #S-101, an assessment checklist was developed to use for the assessment of residents and their safety when they have bed rails in place. They further added that they completed this checklist nearly one year previously however, they were still waiting on approval to implement the document into the home.

During an interview with Inspector #593 June 25, 2015, the DOC confirmed that the annual maintenance checks undertaken of the beds does not include assessment of the resident and their bed system when bed rails are used. They further reported that nursing staff are responsible for these checks and that an assessment checklist was developed by registered staff for bed rail assessment and they are currently waiting on approval from the medical advisory therefore this checklist has not been used for any residents currently in the home with bed rails in use. The DOC confirmed that each resident with bed rails has not been assessed or their bed system evaluated.

A review of the home's policy: Bedside Rails B-50 dated June 20, 2010, found that each resident will be assessed individually for the use of side rails. [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 ensuring that each resident is assessed and their bed system evaluated in accordance with evidence-based practices to minimize the risk to the resident and ensuring that all steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment, to be implemented voluntarily.

WN #3: 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 is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times.

During the inspection, Inspector #593 observed on numerous occasions, three residents with no bedside access to the resident-staff communication and response system. The remaining residents in the home were observed to have a cord with a call button which could be attached to the bed and easily accessed. The three residents had call buttons located on their bed rails however these were only accessible when the bed rails were in the up position.

During an interview with Inspector #593 June 18, 2015, #S-103 reported that the three residents had access to a bedside call button but only when the bed rails were in the up position. The only call button was located on the bed rail which was not accessible when the bed rails were down.

During an interview with Inspector #593 June 24, 2015, the DOC reported that they were not aware that these three residents did not have the cord style call system in place by their bed. They further added that this was an easy fix for the home to put the call bells back in place.

A review of the home's policy: Call System B-63 dated July 14, 2010 found that all residents are to have access to the call system in their room, and shown how to use it. [s. 17. (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 has bedside access at all times to the resident-staff communication and response system and that it can be easily seen, accessed and used at all times, to be implemented voluntarily.

WN #4: 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. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a required policy in place is complied with.

A review of the home's policy: Falls prevention Strategy B-138 dated July 2010 found that the Fall Prevention Assessment is to be reviewed within 24 hours of a fall.

During an interview with Inspector #593 June 24, 2015, #S-100 reported that the tool that is used in the home post falls is the Morse Fall Scale Assessment and this is required to be completed for every fall in the home.

A review of resident #003's health care record found that the resident had sustained six falls over the past two months. The Morse Fall Scale assessment was completed for four of the six falls however for two falls occurring in June, there was no Morse Fall Scale Assessment completed. [s. 8. (1) (a),s. 8. (1) (b)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 65. Recreational and social activities program

Specifically failed to comply with the following:

s. 65. (2) Every licensee of a long-term care home shall ensure that the program includes,
(a) the provision of supplies and appropriate equipment for the program; O. Reg. 79/10, s. 65 (2).
(b) the development, implementation and communication to all residents and families of a schedule of recreation and social activities that are offered during days, evenings and weekends; O. Reg. 79/10, s. 65 (2).
(c) recreation and social activities that include a range of indoor and outdoor recreation, leisure and outings that are of a frequency and type to benefit all residents of the home and reflect their interests; O. Reg. 79/10, s. 65 (2).
(d) opportunities for resident and family input into the development and scheduling of recreation and social activities; O. Reg. 79/10, s. 65 (2).
(e) the provision of information to residents about community activities that may be of interest to them; and O. Reg. 79/10, s. 65 (2).
(f) assistance and support to permit residents to participate in activities that may be of interest to them if they are not able to do so independently. O. Reg. 79/10, s. 65 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Recreational and social activities program includes a schedule of recreation and social activities that are offered on weekends.

During Stage 1 of the Resident Quality Inspection (RQI), several residents reported that there were no scheduled activities available on weekends and they would like activities scheduled on the weekends, as sometimes they are bored during this time.

A review of the home's activity schedule for April, May and June 2015 found one activity scheduled on the weekend during this three month period.

During an interview with Inspector #593 June 19, 2015, #S-104 reported that there may be additional activities that are offered on the weekends that are not on the schedule they reviewed the three month period April, May and June 2015, they found that only one activity had taken place on the weekend during this period.

A review of the home's policy: Recreation and Social Activities B-252 dated July 2012, found that activities will be provided on some evenings and weekends as well as daytime and will include some indoor and outdoor activities. [s. 65. (2) (b)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(f) is reviewed by the Residents' Council for the home; and O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home’s menu cycle is reviewed by the Residents’ Council for the home.

During an interview with Inspector #593 June 23, 2015, #S-104 reported that the home’s menu cycle has not been reviewed by the Residents’ Council during any of the monthly meetings.

During an interview with Inspector #593 June 24, 2015, the home’s Registered Dietitian #S-105 reported that the home’s menu cycle is reviewed twice per year and #S-105 is involved in the review. They confirmed that they do not attend the Resident Council meetings to review the menu cycle with the council and they did not even know that this was required. Furthermore, they confirmed that there is no formal review of the menu with any residents in the home that they are aware of. [s. 71. (1) (f)]

Issued on this 21st day of July, 2015

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

Original report signed by the inspector.