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
Sep 15, 2015	2015_200148_0028	O-002383-15	Resident Quality Inspection

Licensee/Titulaire de permis

MAXVILLE MANOR
80 Mechanic Street MAXVILLE ON K0C 1T0

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

MAXVILLE MANOR
80 MECHANIC STREET WEST MAXVILLE ON K0C 1T0

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

AMANDA NIXON (148), JOANNE HENRIE (550), LINDA HARKINS (126)

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 31 - September 3 and September 8-11, 2015, on site.

This inspection also included a Critical Incident Report.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care (DOC), Director of Environmental Services, Director of Food Services, Nursing Administrative Assistant, Activity Director, Physiotherapy Assistants, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Food Service Workers, family and residents.

In addition, the inspectors reviewed resident health care records, policies related to the medication management system, staffing schedules, snack menus and resident council minutes. Inspectors observed resident care and services, staff and resident interaction, access to the communication system and several meal services.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

6 WN(s)
2 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 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 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.

It was established that the home's resident-staff communication system includes a wall panel with push button and pull cord activation.

The Inspection Report of April 29, 2014 (2014_200148_0012), provided evidence under O.Regulation 79/10, s.17(1), indicating that the resident-staff communication system (i.e. wall panel) was located in the corner, behind the bed in four resident rooms within the secure unit. Due to furniture placement and the length of pull cord attached to the wall panel, the resident-staff communication system was not easily accessible to residents, staff and visitors at the time.

During the current inspection, within the secure unit of the home, eight resident rooms were identified whereby the communication system was not easily accessible to residents, staff and visitors. The identified resident rooms were observed to have the wall panel located near the corner of the room whereby due to the location of furniture, a person in need of access to the panel would need to climb over the bed. Inspectors noted that in other resident rooms in the home the length of the pull cord is extended and made accessible when the location of furniture inhibits the ease of accessibility to the wall panel. Such an extension did not exist in the rooms identified.

Inspector #148 observed that the communication system was not easily accessible in the Chapel and Town square. Both of these areas were observed by the inspection team to be used regularly by residents. The wall panel in the Town square is located to the right of the double doors leading to the boardroom/library. In front of the panel is a large Canadian flag on a portable flag pole; the panel was not easily seen by the inspector at the time of the initial tour. On a later date during an observation with the home's Director of Environmental Services, the flag pole was moved to an adjacent location, allowing the panel to be easily seen. The wall panel in the Chapel is located to the left of the entrance doors. The doors were observed to be propped open using a chair, whereby the wall panel was behind the door. The wall panel was not easily seen by the inspector, in addition, for a resident, staff or visitor to access the wall panel the chair would need to be moved and the door would need to be closed. [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 to ensure that the resident-staff communication system is easily seen and accessed by residents, staff and visitors at all times,, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
1. There is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained. 2007, c. 8, s. 31 (2).
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).
3. The method of restraining is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable methods that would be effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 31 (2).
6. The plan of care provides for everything required under subsection (3). 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
1. There is a significant risk that the resident or another person would suffer serious

bodily harm if the resident were not restrained.
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1.
3. The method of restraining is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable methods that would be effective to address the risk referred to in paragraph 1.
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining.
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.
6. The plan of care provides for everything required under subsection (3).

On September 2 and 11, 2015, Inspector #148 and #550 observed Resident #9 seated in a wheelchair with a lap belt applied, while propelling self in the hallway. Resident #35 was also observed by Inspector #148 and #550 seated in a tilted wheelchair with a lap belt and a padded table top applied. In addition, Resident #35 was observed on September 10, 2015, by Inspector #550 in bed with two full bed rails in use.

Through staff interviews, it was established by Inspector #550 that the lap belt for both Residents #9 and #35 were used as a physical restraint to prevent the residents from falling out of the chair and injuring themselves. The bed rails for Resident #35 were also established as a physical restraint, as the rails prevented the resident from falling out of the bed and causing injury to self. Both residents were unable to remove the devices and their movements were inhibited.

Inspector #550 reviewed the health care records for both residents. The plan of care for both residents included the use of the physical devices as they related to positioning. The health care record did not include that the resident would suffer harm if not restrained, what alternatives had been considered, that the method of restraining was the least restrictive, or that a physician order for the devices to be used as restraints was obtained.

During an interview, the Care Coordinator RN #S110, who was identified by the DOC as responsible for monitoring restraints in the home, indicated to Inspector #148 and #550 that the lap belts for Residents #9 and #35 and the bed rails for Resident #35, were not assessed as restraints but as positioning aids. Further to this, she confirmed that the

requirements of section 31 of the Act were not met for the identified devices. In discussion with RN #S110, related to the requirements of Personal Assistive Service Devices, she was not aware of the requirements under s.33 of the Act. [s. 31. (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 when the restraining of a resident by a physical device is to be included in a resident's plan of care, that all requirements of this section are satisfied, to be implemented voluntarily.

WN #3: 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 their medication administration policy is complied with.

In accordance with O.Regulation 79/10, s.114 (1) and (2), the home shall develop a medication management system and ensure that there are written policies and protocols developed to ensure accurate acquisition, dispensing, receipt, storage, administration and destruction and disposal of all drugs used in the home.

During the medication administration observation on September 9, 2015, at 11:45a.m., Inspector #550 observed RN #S108 giving a packet of medication containing three different pills and a medication cup containing another pill to Resident #38 for the resident to take at a later time, during and after the meal. Resident #38 took the medication pack and the medication cup to the dining room; RN #S108 did not remain with the resident until the medication was taken. RN #S108 indicated to Inspector #550 that Resident #38 is capable of taking the medication on his/her own and this is the reason she gave the resident the medication to take. RN #S108 signed the medication in the computer system as "self administered".

Inspector #550 reviewed the home's Medication Administration policy dated February 2010 and observed the following documented under "procedure":
6. Check the identity of the resident using two client identifiers before giving the medication and remain with the resident until the medication is taken.

During an interview, the DOC indicated to Inspector #550 it is her expectation that the registered staff follow their policy when administering medication to a resident and that no resident should be given medication to take on their own. [s. 8. (1) (b)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the PASD described in subsection (1) that is used to assist a resident with a routine activity of living is included in the residents' plan of care.

Resident #30 was observed by Inspector #550 wearing a lap belt while seated in a wheelchair on September 2 and 11, 2015. The resident was also observed on September 8 and 10, 2015, while seated in a wheelchair with no lap belt applied.

PSW #S105 indicated to Inspector #550, that the lap belt for Resident #30 is used at times, for positioning because the resident slides in the chair.

During an interview, RN #S110 indicated to Inspector #550 that Resident #30 does not require a lap belt when in the wheelchair. She indicated the lap belt should be removed from the chair as it is not needed. The lap belt is currently used by staff as a PASD, but has not been assessed as such.

Inspector #550 reviewed the resident's health records and observed there was no documentation for the use of the PASD in the resident's plan of care. [s. 33. (3)]

WN #5: 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. The licensee has failed to ensure that 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.

During the medication observation, Inspector #550 observed 16 vials of Lorazepam 4mg/ml stored in a blue nylon pouch that is locked with a key lock. The nylon pouch is stored in an unlocked medication refrigerator within the locked medication room.

During an interview, the DOC indicated to Inspector #550 that she was not aware that controlled substances have to be stored in a separate, double-locked stationary cupboard in a locked area or stored in a separate locked area within the locked medication cart. The DOC agreed that the nylon pouch is not secure as it can easily be removed from the refrigerator and cut open with a pair of scissors. [s. 129. (1) (b)]

WN #6: 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. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident.

During an interview, RN #S108 indicated to Inspector #550 that Resident #34 and #53 self administer a medication and the medication is kept at bedside. This was also confirmed by Resident #34 and #53.

A review of Resident #34 and #53's health care records by Inspector #550 revealed documentation of a physician order for the medicadtion but no order was found for the self administration.

During an interview, the Director of Care indicated that for a resident to be able to self administer medication, an evaluation of the resident's ability to self administer has to be completed and it has to be approved by the prescriber. She indicated Resident #34 and #53 would be competent to self administer medication but that no evaluation was done and a physician's order had not been obtained as per the home's policy. [s. 131. (5)]

Issued on this 15th day of September, 2015

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

Original report signed by the inspector.