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 # / Registre no	Type of Inspection / Genre d'inspection
Sep 12, 2016	2016_381592_0020	013512-16	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

MELANIE SARRAZIN (592), GILLIAN CHAMBERLIN (593), MICHELLE JONES (655)

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 30, 31 and September 01, 02, 06 and 07, 2016

During the course of the inspection, the inspector(s) spoke with the Administrator, The Director of Care (DOC), RAI MDS Coordinator, Day Care Coordinator, Staff Educator, Environmental Service Supervisor, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), a member of Residents' Council, Family Members and Residents.

During the course of the inspection, the inspector(s) conducted a tour of the Resident care areas, reviewed Residents' health care records, home policies and procedures, staff work routines, observed Resident rooms, observed Resident common areas, reviewed the Admission process and Quality Improvement system, reviewed Residents' Council minutes, observed a medication pass and observed the delivery of Resident care and services.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Residents' Council
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **4 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 has failed to ensure that the resident-staff communication and response system allows calls to be cancelled only at the point of activation.

On August 30 and 31, 2016, 20 residents rooms were observed by Inspector #592 and #593. Upon activating the call bell system in residents' washrooms, Inspectors were unable to cancel calls at the point of activation. The activation board located in the residents' bedrooms were the only place that allowed calls to be cancelled. To cancel calls made from the residents' washrooms, Inspectors needed to access the activation board in the residents bedrooms.

During a walk through of the home with the maintenance supervisor, a call bell was activated in a resident's washroom. The maintenance supervisor told Inspector #592 the call would be then cancelled at the activation board located in the resident's bedroom. He further told Inspector #592 that each resident's washroom in the home was set up the same way. The maintenance supervisor further told Inspector #592 that he was not aware that the resident-staff communication and response system had to allow calls to be cancelled only at the point of activation. He further told Inspector #592 that he would contact the home's external company for guidance.

During an interview with the DOC, she told Inspector #592 that she was not aware that the resident-staff communication and response system had to allow calls to be cancelled only at the point of activation. [s. 17. (1) (c)]

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 and response system will allowed calls to be cancelled at the point of activation, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident has fallen, the resident was assessed and that where the condition or circumstances of the resident require, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

During a staff interview, RPN #100 indicated to Inspector #592, that resident #001 had sustained a fall on a specified date in August 2016.

Upon a review of resident #001's health record, it was determined that resident #001 had sustained three falls within 28 days. It was documented as follows:

On a specified date in August 2016 at a specific time, resident #001 was found by staff members lying on the floor alongside his/her bed when his/her seat alarm was ringing. The resident was aggressive and non-compliant with staff to get him/her up. The resident was calmed down and when asked how he/she fell, the resident was unable to provide explanation.

21 days later at a specific time, yelling was heard from a specific room, upon immediate investigation, resident #001 was seen sitting on the floor. The resident was assessed and assisted up and no apparent significant injury was noted at that time.

Then, five days later, at a specific time, the resident was found sitting on floor next to his/her bed. Assisted by two staff, the resident was put back to bed. No further injuries present, but the resident did say he/she hit his/her head.

On September 6, 2016, during an interview with RPN #107, she indicated to Inspector #592, that when a resident has fallen twice during the month or if a resident was identified as a frequent faller, the Registered Nursing staff were responsible to complete

a post fall assessment tool specifically designed for falls.

In a review of the home's Policy titled "Fall Prevention and Management Program" reviewed on June/August 2016, the Policy indicated under Team Responsibilities Nursing (RN and RPN-RAI-MDS team) the following:

-Completes re-assessment (post-fall investigation) following a change in health status, following multiple falls (weekly or more often), and following a fall resulting in a significant injury.

On September 6, 2016, during an interview with the Day Care Coordinator, she indicated to the Inspector that a post-fall investigation form was expected to be completed by the Registered Nursing staff when a resident had fallen twice during one week period or if the fall resulted in a significant injury. She further indicated to Inspector #592 that she was not able to find the post assessment fall for resident #001. The Day Care Coordinator further indicated that the post-fall investigation tool should have been completed for resident #001 as this fall was the second fall within a seven day period. [s. 49. (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 when a resident has fallen, a post fall assessment is conducted using a clinically appropriate instrument, to be implemented voluntarily.

WN #3: 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 drugs were stored in an area or a medication cart that is secure and locked.

On September 2, 2016, at 0752 hours, Inspector #592 observed on the secure unit a medication cart left unattended beside the dining room. Four female residents were present in the dining room and one female resident was wandering around the medication cart. Inspector #592 noted that upon trying to open the top drawer of the medication cart, the cart was not locked and medications were exposed in their packages. Inspector #592 further noticed at the bottom of the medication cart that upon lifting the top of the storage area titled "narcotic scheduled" that the compartment was not locked and several controlled substances were observed in their medication packages.

During an interview with PSW #103 who was passing by, she told Inspector #592 that she did not know where the registered staff was and was unable to locate any registered staff at the current time. A Housekeeping staff who was passing nearby told Inspector #592 that she would try to locate the registered staff on the unit.

At 0758 hours, six minutes later, RPN #104 met Inspector #592 at the medication cart and noted in the presence of the inspector that the medication cart was not locked and that the controlled substance storage area was not locked. RPN #104 told Inspector #592 that he left the medication cart to respond to a resident call bell and forgot to lock

the medication cart which, should be locked at all times. [s. 129. (1)]

2. The licensee has failed to ensure that controlled substances were stored in a separate, double locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

On September 2, 2016, at 0752 hours, Inspector #592 observed on the secure unit a medication cart left unattended beside the dining room. Four female residents were present in the dining room and one female resident was wandering around the medication cart. Inspector #592 noted that upon trying to open the top drawer of the medication cart, the cart was not locked and medications were exposed in their packages. Inspector #592 further noticed at the bottom of the medication cart that upon lifting the top of the storage area titled "narcotic scheduled" that the storage area was not locked and several controlled substances were observed in their medication packages.

On September 1, 2016 at 0845 hours, during a medication cart observation on unit F, Inspector #592 observed one orange tablet in a medication cup container belonging to a specific resident stored in the resident bin with non-controlled medications.

During an interview with RPN#101, she told Inspector #592 that the tablet was a controlled substance identified as a narcotic medication and was prepared ahead for the resident who was leaving the home around 1030. She further told Inspector #592 that she was aware that controlled substances were to be stored in a separate locked area within the locked medication cart but in that case she pre-poured the controlled substance ahead of time.

During an interview, the DOC indicated to Inspector #592 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. [s. 129. (1) (b)]

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 when drugs are stored in the medication cart, that the medication cart is secure and locked and that controlled substances are stored in a separate, double locked stationary cupboard in a separate area within the locked medication cart, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (2) The drug destruction and disposal policy must also provide for the following:
1. That drugs that are to be destroyed and disposed of shall be stored safely and securely within the home, separate from drugs that are available for administration to a resident, until the destruction and disposal occurs. O. Reg. 79/10, s. 136 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's drug destruction and disposal policy included any controlled substance that was to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that was available for administration to a resident, until the destruction and disposal occurred.

On September 1, 2016, during an observation of the secure unit medication cart, Inspector #592 observed in the bottom drawer in the lock controlled storage area titled "PRN", one brown bottle containing a liquid. The brown bottle was labeled "soapy solution for controlled substances."

During an interview with RPN #100, she told Inspector #592 that the bottle was containing soap and water; used for narcotic waste whereby drugs were disintegrated when mixed with the solution. She further showed to Inspector #592 the rubber stopper on top of the brown bottle lid, preventing the controlled drugs to not be withdrawn

manually by anyone. RPN #100 further told Inspector #592 that once the bottle was full, the pharmacist and the DOC were to remove the bottle and provide a new one. Therefore the discontinued narcotic drugs were kept with the active PRN controlled drugs until destruction.

On the same day, during an observation of the medication cart on unit F, Inspector #592 observed in the lock controlled storage area titled PRN the same brown bottle containing a liquid with the same label.

During an interview with RPN #101, she told Inspector #592 that the brown bottle was for the wasting of controlled drugs. She indicated that this practice prevented the Registered Nursing staff from wasting the control drug in the sharp container. She further told Inspector #592 that the bottle was kept with the active medication until the DOC and the pharmacist picked up the brown bottle for destruction.

Upon a review of the home's pharmacy policy and procedures provided by the DOC, Inspector #592 was unable to find a policy related to any controlled substance that are to be destroyed and disposed of, are to be kept separate from any controlled substance that are available for administration to a resident.

During an interview with the DOC, she told Inspector #592 that it was the home's practice to keep a bottle with soapy water for controlled drugs disposal with the active drugs. She further told Inspector #592 that the practice was put in place following a nursing staff meeting with the home's pharmacist in January 2016 for staff convenience. The DOC told Inspector #592 that the policy and procedures for the waste of narcotic using the brown bottle was not available. She further told Inspector #592, that the home's revised Drug Destruction and Disposal Policy did not include that any controlled substances that were to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that was available for administration to a resident, until the destruction and disposal occurred. [s. 136. (2) 1.]

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 home's drug destruction and disposal policy includes that controlled substance that is to be destroyed should not be stored with any controlled substance that is available for administration to a resident, to be implemented voluntarily.

WN #5: 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. The licensee has failed to ensure that semi-annual meetings were convened to advise such persons of the right to establish a Family Council.

During an interview with the Director of Staff Development on September 6, 2016, she indicated that there was no Family Council established in the home and was not able to recall since when. She further told Inspector #592 that the home did try to recruit family members by doing a meeting on April 15, 2015. The Director of Staff Development further told Inspector #592 that the home had sent a memo regarding the Resident/Family Survey distributed this year in order to try to recruit family members. She further told Inspector #592 that since April 15, 2015 semi-annual meetings to advise residents' families and persons of importance of their right to establish a Family Council were not held in the home. [s. 59. (7) (b)]

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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

Issued on this 13th day of September, 2016

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

Original report signed by the inspector.