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

Division de la responsabilisation et de la performance du système de santé
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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
Oct 16, 2015	2015_246196_0013	015799-15	Resident Quality Inspection

Licensee/Titulaire de permis

NIPIGON DISTRICT MEMORIAL HOSPITAL
125 HOGAN ROAD NIPIGON ON P0T 2J0

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

NIPIGON DISTRICT MEMORIAL HOSPITAL
125 HOGAN ROAD P O BOX 37 NIPIGON ON P0T 2J0

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

LAUREN TENHUNEN (196), DEBBIE WARPULA (577)

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): September 14, 15, 16, 17, 18, 21, 22, 23, 2015

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (DOC), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Recreation Therapist, Registered Dietitian (RD), Physiotherapist (PT), Dietary Lead, Maintenance Lead, Dietary Aide, Housekeeping Aide, Laundry Aide, Residents and family members.

During the course of inspection, the inspectors conducted a walk through of all resident care areas, observed the provision of care and services to residents, observed the interactions between staff and residents, the interactions between residents, reviewed the health care records of several residents and reviewed various home policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Continence Care and Bowel Management
Critical Incident Response
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

5 WN(s)
3 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. 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 where bed rails are used, the resident was 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.

On a particular day during the inspection, Inspector #577 observed resident #002 to have bed rails elevated. Inspector further reviewed resident #002's care plan, which indicated under a nursing focus intervention that included which bed rails are up when the resident was in bed, and under another nursing focus, the interventions included bed rails up in bed.

Inspector #577 spoke with S#100 who reported that two top rails are used for all residents and resident #002 uses bed rails because they are a fall risk. They reported that there isn't a bed rail assessment documented and the home does not assess residents for bed rails. They further reported that if a resident has recurrent falls, bed rails are implemented.

In September 2015, Inspector spoke with S#106 who reported that their department does not perform any bed system inspections and that nursing staff will notify them if there are any concerns with a residents mattress.

In September 2015, Inspector spoke with S#108 who reported that they do not assess residents for bed rail use. Inspector received a bed inventory form from the Administrator/Director of Care which indicated that the hospital has 18 Hill Rom (2005) beds, one Hill Rom Care Assist (2008) bed, one Carroll (2011) bed and two Carroll (2014) beds. They further confirmed the type of bed that resident #002 is using. [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 that ensures 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, to be implemented voluntarily.

WN #2: 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 failed to ensure that, drugs were stored in an area or a medication cart, that complies with manufacturer's instructions for the storage of the drugs.

During the inspection, Inspector #577 inspected the home's medication cart and found several expired medications, as follows;
- one bottle of medication with expiration date of April 2015
- one tablet of medication for resident #015, with expiration date of July 30, 2015
- two blister packs (35 tablets) of medication for resident #011, with expiry date of July 2015

Inspector spoke with S#109 and S#100 who both reported that it was the responsibility of the night staff to check the medication cart for expired medications and to dispose of the medication.

In September 2015, Inspector #577 reviewed Janzen's, the pharmacy service providers Medication policy and procedure manual for long-term care, V. 2005. Page 44 indicated, "medications that are discontinued, expired or remain after the resident leaves the facility, are destroyed and disposed of by the facility in accordance with applicable federal and provincial laws and regulations. Medication awaiting disposal are documented on the record of drug destruction sheet and stored in a locked, secure area designated for that purpose until disposal."

The home failed to store and destroy several expired medications appropriately, and instead kept them stored in the medication cart with other prescribed medication. [s. 129. (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 that ensures drugs are stored in an area or a medication cart, that complies with manufacturer's instructions for the storage of the drugs, to be implemented voluntarily.

WN #3: 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. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that that no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident.

In the autumn of 2014, a Critical Incident System report was submitted to the Director regarding an incident in which medication was administered to the incorrect resident of the home.

During the inspection, Inspector #577 reviewed the licensee's medication incident report which indicated that resident #004 received nine different medications that had not been prescribed for them. The report also indicated that S#110 had pre-poured the medication and had not properly identified the resident.

Inspector reviewed the medication policy and procedure manual for long-term care by the pharmacy service provider. On page 55, specifically the "Administration of medication" section indicated that "residents are identified before medication is administered". The home's policy, "Medication Administration on LTC" #PAT-3-05, dated Feb. 2010, was reviewed by the inspector and indicated that the nurse was to correctly identify the resident prior to the administration of medication. [s. 131. (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 that ensures that that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

WN #4: 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of resident #011 and the needs and preferences of that resident, specifically in regards to their oral status.

The health care records for resident #011 were reviewed for information regarding oral hygiene. The current care plan, under a nursing focus included the intervention "has dentures and or removable bridge" and "some or all natural teeth lost - does not have or does not use dentures (or partial plates)". The most recent MDS assessment, included this same information of "has dentures and /or removable bridge" and "some or all natural teeth lost - does not have or does not use dentures (or partial plates) ".

Interviews were conducted with staff members #102, 103 and 104, and they all reported to the inspector that resident #011 did not have teeth nor dentures.

The care plan contained contradicting information regarding resident #011 having teeth or a denture and therefore was not based upon an assessment of the resident. [s. 6. (2)]

2. The licensee has failed to ensure that the care set out in the plan of care is provided to resident #013 as specified in the plan, specifically in regards to nutritional supplements.

The most recent weight recorded for resident #013, was documented and the subsequent BMI (Body Mass Index) and noted this resident as underweight. The resident was identified as a moderate nutritional risk and malnourished based upon the most recent RD's assessment.

Inspector #196 conducted an interview with the Registered Dietitian (RD) regarding resident #013's nutritional status, weight and BMI and they reported that the resident had a low BMI for a long time, they had refused supplements and recently a specialized drink was recommended and agreed upon by the resident.

Staff member #104 reported to the inspector on a particular day during the inspection, that a specialized drink had not been provided to resident #013 on that day. During a further discussion with the RD, it was determined that approximately two and a half weeks earlier, they had documented a recommendation for a specialized drink on the physician's orders sheet in the resident's chart. The RD then reported that the recommendation had been missed and it wasn't until the MD was contacted by the registered nursing staff on September 16, 2015, that the RD's recommendation of a specialized drink was ordered and initiated. [s. 6. (7)]

3. The licensee has failed to ensure that resident #013 was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan was no longer necessary, specifically in regards to nutritional supplements.

The health care record for resident #013 was reviewed for information regarding nutrition. The current care plan, identified the order of a nutritional supplement.

An interview was conducted with S#107 and they reported that no supplement was given to resident #013 and that it had been ordered in the past but the resident was refusing it all the time and refused to take it. S#113 reported to the inspector that resident #013 was not receiving the nutritional supplement and that the current care plan was not accurate. [s. 6. (10) (b)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #002 who was unable to toilet independently some or all of the time received assistance from staff to manage and maintain continence.

Inspector #577 reviewed resident #002's care plan which indicated their continence status and toileting routine interventions. Inspector reviewed the resident's most recent bladder/bowel continence assessment which indicated their continence status.

During the inspection, Inspector #577 observed resident #002 up in their wheelchair in the dining room from 1145hr to 1250hrs, before and after lunch service. Inspector observed S#111 escort the resident to their room at 1250hrs and provide continence care. Later that day, Inspector spoke with S#104 who reported that this resident was both continent and incontinent of urine. They further reported that this resident was to be toileted before and after breakfast, after lunch, 1400hrs and after dinner.

On another day during the inspection, Inspector #577 observed resident #002 up in their wheelchair from 1100hr to 1240hrs, before and after lunch service. At 1240hrs, Inspector observed a PSW offer and take resident to their bathroom to be toileted. Inspector spoke with S#111 concerning residents toileting routines and they reported that resident #002 was urinary incontinent and will sometimes request to be toileted. In addition, S#111 reported that resident was toileted in the morning when they get out of bed, after lunch, 1500hr, and after dinner. They further reported that they did not toilet resident before lunch yesterday and that staff do not routinely toilet residents before lunch as they are busy bathing residents.

Inspector spoke with S#103 who reported that resident #002 was toileted in the morning, after breakfast, after lunch, and in the afternoon after coffee. S#112 also reported that resident was toileted in the morning, after lunch before supper and prn (as needed). [s. 51. (2) (c)]

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Rapport d’inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Issued on this 23rd day of October, 2015

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

Original report signed by the inspector.