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
Jul 28, 2017	2017_652625_0011	009420-17	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

KATHERINE BARCA (625), JENNIFER KOSS (616)

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 5 to 9, 2017.

During the course of the inspection, the inspector(s) spoke with the Chief Nursing Officer (CNO)/Director of Patient Services, the Nurse Manager, the Administrative Assistant to Senior Management, Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and residents' friends and family members.

The Inspectors also reviewed resident health care records, various home's policies and procedures, council meeting minutes and incident reports. Inspectors conducted observations of residents, observed the provision of care and services to residents, observed resident and staff interactions and made observations of resident home areas.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Admission and Discharge
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

3 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. 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, where the Long-Term Care Homes Act, 2007 or Ontario Regulation 79/10 required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, that the plan, policy, protocol, procedure, strategy or system was complied with.

Ontario Regulation 79/10, s. 49. (1) indicates that the falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls.

The most recent Resident Assessment Instrument (RAI) – Minimum Data Set (MDS) identified that resident #003 fell within the past 30 days.

Inspector #625 reviewed resident #003's health care record including:
- electronic progress notes related to the resident's falls history between a specific date in the winter of 2016 and the spring of 2017 which identified resident #003 fell on seven specific dates during that time period; and
- "Morse Falls Risk Assessments" completed after the resident's falls on four of the dates.

Inspector #625 reviewed the home's policy/procedure titled "Falls Prevention and Management – NUR 101" last reviewed/revised June 2016. The policy identified that the "Morse Falls Risk Assessment" was to be completed when a change in a resident's health status put them at increased risk for falling such as two falls in 72 hours, more than three falls in three months and more than five falls in six months. The Inspector

noted that resident #003's fall on a specific date in the spring of 2017 was the fifth fall the resident had in less than three months.

During an interview with Inspector #625 on a specific date in the spring of 2017, RPN #102 stated that "Morse Falls Risk Assessments" were to be completed after each fall and quarterly. The RPN reviewed resident #003's progress notes and completed "Morse Falls Risk Assessments" and stated that a "Morse Falls Risk Assessment" had not been completed for each of resident #003's falls that had occurred, including one fall that occurred on a specific date in the spring of 2017, but should have been.

During a phone interview with Inspector #625 on June 13, 2017, the Nurse Manager stated that a "Morse Falls Risk Assessment" should have been completed after every resident fall but that one had not been completed after resident #003 fell on a specific date in the spring of 2017. [s. 8. (1) (a),s. 8. (1) (b)]

2. Ontario Regulation 79/10, s. 68 (2) (e) (ii) requires the home to have nutrition care and hydration programs and was required to ensure that the programs included a weight monitoring system to measure and record with respect to each resident, body mass index and height upon admission and annually thereafter.

The licensee failed to ensure that the nutrition and hydration program's weight monitoring system to measure and record each, with respect to resident, height upon admission and annually thereafter, was complied with.

During staff interviews, residents #008 and #009 were identified to Inspector #616 as not having had their height measured and recorded annually.

Inspector #616 reviewed the electronic care plans for both residents and found that for resident #008, their last recorded height was documented in 2012, after their admission the previous month. Resident #009 was admitted to the home in 2015 and their height had been documented the month following their admission. Heights for both residents had not been measured or recorded since their admission.

The Inspector interviewed PSW #103 and RPN #108 on a specific date in the spring of 2017. They each separately stated the heights of residents were obtained and recorded in MED e-care on admission to the home and not anytime after. RPN #108 stated that on admission, they would ask the resident how tall they were and document their response, or staff used a soft tape measure to measure those residents in wheelchairs. The RPN

also stated that they were aware heights were to be measured and recorded annually but that the home's weigh scale did not have the height ruler. [s. 8. (1) (b)]

3. During staff interviews, residents #003 and #010 were identified to Inspector #625 as not having had their heights measured and recorded on admission, and resident #007 was identified as not having had their height measured and recorded annually.

During staff interviews with RPN #107 on a specific date in the spring of 2017, they stated to the Inspector that residents #002 and #003 had not had admission heights completed and neither resident’s height was recorded in their health care record. The RPN also stated that resident #007’s last recorded height was documented in 2013.

On June 8, 2017, Inspector #625 reviewed the health care records for residents #002 and #003 and found that the residents had been admitted in 2016. The Inspector identified that there was no measured height recorded for either resident. The Inspector also reviewed the health care record for resident #007 and found that the resident's height had been measured and recorded last in 2013.

During an interview with Inspector #625 on a specific day in the spring of 2017, RPN #108 stated that residents’ heights were only measured on admission and that residents #002 and #003 had not had their heights measured since they were admitted. The RPN stated that heights were not measured and recorded annually.

During an interview with Inspector #625 on June 8, 2017, the Registered Dietitian (RD) #109 acknowledged that admission heights had not been measured and recorded for residents #002 and #003, and they had used height values obtained prior to the residents’ admissions into long-term care to complete their admission assessment of the residents. The RD stated that residents’ heights should be taken on admission.

During an interview with Inspector #625 on June 8, 2017, the Nurse Manager stated that residents’ height measurements were to be taken on admission and annually, and that it was not the expected practice to use heights obtained prior to residents’ admissions to long-term care.

A review of the home's policy/procedure titled "Management of Weight Changes in LTC Residents - NUR 125" last reviewed/revised January 2017, identified that, for all residents on the long-term care (LTC) unit, height was to be obtained on admission and yearly. [s. 8. (1) (b)]

4. During staff interviews, residents #001, #004 and #006 were identified to Inspectors #616 and #625 as having a low body mass index (BMI).

Inspector #616 reviewed the residents' electronic plans of care and found that resident #001's last recorded height corresponded with their admission date in 2010; resident #004's last recorded height corresponded with their admission date in 2013; and resident #006's last recorded height corresponded with their admission date in 2014. None of the residents had their heights measured or recorded since their admission dates. [s. 8. (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 that ensures that, where the Long-Term Care Homes Act, 2007 or Regulation 79/10 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, that the plan, policy, protocol, procedure, strategy or system was complied with, specifically with respect to:
- the falls prevention and management program providing for strategies to reduce or mitigate falls; and
- the nutrition and hydration programs including a weight monitoring system to measure and record with respect to each resident, body mass index and height upon admission and annually thereafter, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy to minimize the restraining of residents and to ensure that any restraining that was necessary was done in accordance with the Long-Term Care Homes Act, 2007 and Ontario Regulation 79/10 was complied with.

During observations by Inspector #625 of resident #003, they were identified as using a specific device, functioning as a potential restraint.

On four specific dates in June of 2017, Inspector #625 observed resident #003 with the specific device in use. On three of the dates, the Inspector asked and prompted the resident to release the device. The resident was not able to release the device during any observation made by the Inspector.

On a specific date in June of 2017, PSW #103 stated to the Inspector that resident #003 always used the specific device and they had not seen the resident release the device.

On a specific date in June of 2017, RPN #102 stated to the Inspector that they did not think that resident #003 could release the specific device.

Inspector #625 reviewed resident #003's current care plan last updated in the winter of 2017. The care plan did not detail the resident's use of the device.

On June 9, 2017, Inspector #625 reviewed the home's policy titled "Minimizing of Restraining of Residents: Use of Restraints – NUR 105" last reviewed/revised June 2015, which identified the following:
- A physician or Nurse Practitioner in collaboration with the interdisciplinary team was to prescribe a physical restraint;
- The prescribing clinician was to ensure that informed consent was obtained from the resident and/or substitute decision-maker;
- The care plan was to outline specific steps for applying and reapplying the device according to instructions given in the order and to manufacturer's instructions and specifications, specifying specific instructions in the care plan;
- The care plan was to outline specific steps for the monitoring of the resident a minimum of hourly by registered nursing staff or a person who was authorized by registered nursing staff;
- The care plan was to outline steps for releasing and repositioning the resident at least

every two hours; and
- The Physician, RN(EC) or registered nursing staff were to reassess the resident’s condition, effectiveness of the restraint, need for ongoing restraint use, and potential to employ a less restrictive restraint at a minimum of every eight hours and more frequently as determined by the circumstances or resident’s condition.

On a specific date in the spring of 2017, RPN #104 attempted to have resident #003 release the device. The RPN repeatedly demonstrated to the resident how to release it. The resident was not able to release the device. The RPN stated that, if a resident used a restraint, a doctor's order was required, the substitute decision-maker (SDM) would be required to consent to the use of the restraint, and the home's hourly “Restraint Use Record” and “Considerations When Contemplating the Use of Physical Restraints" (which included a quarterly review) would need to be completed. The RPN identified that these items were not completed for resident #003's use of the device.

On June 13, 2017, during a phone interview with Nurse Manager #101, they acknowledged that resident #003 was not able to release the device and stated it was functioning as a restraint. The Nurse Manager also acknowledged, with respect to the use of the device, that the home had not obtained an order for its use, had not obtained the consent for its use from the resident’s SDM, had not removed and reapplied the restraint every two hours and that the resident’s condition had not been reassessed and the effectiveness of the restraining evaluated at least every eight hours. [s. 29. (1) (b)]

2. During observations by Inspector #625 of resident #005, they were identified as using a specific device, functioning as a potential restraint.

On four specific dates in June of 2017, Inspector #625 observed resident #005 with a specific device applied. On three of the dates, the Inspector asked and prompted the resident to release the device. The resident was not able to release the device during any observation made by the Inspector.

On June 7, 2017, Inspector #625 reviewed resident #005’s current care plan. The care plan did not identify that the device was used as a restraint.

On a specific date in June of 2017, RPN #105 stated to the Inspector that they had not observed the resident release the device and did not think that the resident was able to release the device.

On a specific date in June of 2017, RPN #102 stated to the Inspector that they did not think that resident #005 could release the device.

On a specific date in June of 2017, RPN #104 attempted to have resident #005 release the device. The RPN prompted the resident to release the device, the resident was not able to release the device.

On a specific date in June of 2017, during a phone interview with resident #005's SDM #106, they stated that the resident had not been able to release the device for months. The SDM stated that they had not been approached to sign a consent or to consent to the use of the device.

On June 13, 2017, during a phone interview with Nurse Manager #101, they acknowledged that resident #005 was not able to undo the device and stated it was functioning as a restraint. The Nurse Manager also acknowledged, with respect to the use of the device, that the home had not obtained an order for its use, had not obtained the consent for its use from the resident's SDM, had not removed and reapplied the restraint every two hours and that the resident's condition had not been reassessed and the effectiveness of the restraining evaluated at least every eight hours. [s. 29. (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 that ensures that the written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations is complied with, with respect to residents #003 and #005 and all residents in the home, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (1) Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations. 2007, c. 8, s. 79. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the required information was posted in the home, in a conspicuous and easily accessible location in a manner that complied with the requirements, if any, established by the regulations.

The Long-Term Care Homes Act, 2007 s. 79 (3) (g.1) identifies that the required information for the purposes of subsections (1) and (2) includes a copy of the service accountability agreement as defined in section 21 of the Commitment to the Future of Medicare Act, 2004 entered into between the licensee and a local health integration network.

Inspector #625 reviewed the "LTCH Licensee Confirmation Checklist Admission Process" completed by the Nurse Manager of the home on June 5, 2017. The home had responded that they did not have a copy of the home's service accountability agreement posted in the home in a conspicuous and easily accessible location.

During an interview with RPN #108 on a specific date in June of 2017, they were unable to locate the a copy of the home's service accountability agreement posted on any of the bulletin boards where other required posted information was located. The RPN stated that they were not aware that the agreement was posted anywhere in the home.

During an interview with the Nurse Manager on June 8, 2017, they acknowledged that the home's service accountability agreement was not posted in the home. [s. 79. (1)]

Issued on this 28th day of July, 2017

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

Original report signed by the inspector.