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
Jan 10, 2017	2016_557575_0024	033019-16	Resident Quality Inspection

Licensee/Titulaire de permis

1895357 Ontario Inc.
1202 Highway 94 R.R. #1 Corbeil ON P0H 1K0

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

NIPISSING MANOR NURSING CARE CENTER
1202 Highway 94 Box 40 Corbeil ON P0H 1K0

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

LINDSAY DYRDA (575), RYAN GOODMURPHY (638)

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): December 12-16 and 19-20, 2016.

The following additional intakes were inspected during this Resident Quality Inspection:

-Three Critical Incidents (CIs) the home submitted to the Director regarding resident falls;

-One CI the home submitted to the Director regarding a medication incident; and

-Two complaints submitted to the Director regarding the care of two resident`s.

During the course of the inspection, the inspector(s) spoke with the Administrator, Acting Director of Care (ADOC), Physiotherapy staff, Life Enrichment Manager, Maintenance staff, Unit Clerks, Housekeeping and Laundry staff, Administrative Assistants, Registered Practical Nurses (RPNs), Registered Nurses (RNs), Personal Support Workers (PSWs), family members, and residents.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care
Sufficient Staffing

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

8 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 were used, the resident was assessed and their bed system evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident.

During stage one of the inspection, Inspector #638 observed resident #001 with one full bed rail engaged in the guard position on their bed. Inspector #575 observed resident #002 and #003's beds with two quarter bed rails engaged in the guard position.

a.) Inspector #638 conducted a review of resident #001's care plan which indicated that the resident was to have their left full bed rail engaged in the guard position while the resident was in bed. The care plan also indicated that the rail could be used as a repositioning aid, however, staff assistance was required for cuing and repositioning. In a concurrent review of the assessment records for resident #001, the Inspector was unable to identify any resident specific bed rail assessments.

b.) Inspector #575 reviewed resident #002's care plan which indicated that the resident required the use of two quarter bed rails when in bed. The resident's quarterly Minimum Data Set (MDS) assessment indicated that the resident used bed rails for mobility or transfer.

During an interview with PSW #113, they stated to the Inspector that the resident used the rails to pull themselves into sitting position.

c.) Inspector #575 reviewed resident #003's care plan which indicated that the resident required two partial bed rails to be in use when in bed. The resident's MDS assessment dated indicated that bed rails were used for mobility or transfer.

During an interview with PSW #111, they stated to the Inspector that resident #003's bed rails were used for safety to prevent the resident from falling out of bed.

In an interview with Inspector #638, RN #101 stated that it was common practice of the home that all residents would have one full bed rail engaged on their bed. RN #101 stated that the home did not complete any resident specific assessments to determine resident needs regarding bed rails.

A memo from the Ministry of Health and Long-Term Care (MOHLTC) dated August 21, 2012 was sent to all Long-Term Care (LTC) Home Administrators indicating that all LTC homes should use the Health Canada guidance document 'Adult Hospital beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards' as a best practice document in their homes. This document references the 'Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities, and Home Care Settings' (CGA), as a prevailing practice for the assessing the use of bed rails.

The CGA document indicated that automatic use of bed rails may pose unwarranted hazards to resident safety and evaluation is needed to assess the relative risk of using the bed rail compared with not using it for an individual patient. The use of bed rails should be based on a residents' assessed needs, documented clearly and approved by the interdisciplinary team. Policy considerations included but not limited to a risk- benefit assessment that identified why other care interventions were not appropriate or not effective if they were previously attempted and determined not to be the treatment of choice for the resident should be included in the residents plan of care. Additionally, a comprehensive assessment and identification of the residents' needs which include comparing the potential for injury or death associated with use or non-use of bed rails to the benefits for an individual resident should be included.

The CGA identified procedures including individualized resident assessments, sleeping environment assessments, and care planning guidelines. As well, Health Canada recommended that residents be re-assessed for risk of entrapment whenever there is a change in the patient's medication or physical condition.

Inspector #638 and #575 interviewed the Acting Director of Care (ADOC) who indicated that the home did not conduct any resident specific bed rail assessments and were unaware of the best practice guideline document regarding bed rail systems provided to all LTC homes in 2012.

During an interview with the Inspector #638 and #575, Maintenance staff #103 stated that the home completed a monthly audit of the entrapment zones of the bed systems using a tape measure. The Maintenance staff #103 further indicated that they did not utilize the entrapment tool in their bed rail audits and that there was no documentation of each assessed bed system identifying if the bed system had passed or failed the monthly bed system audit. [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 where bed rails are used, the resident is assessed and their bed system is evaluated in accordance with evidence-based practices and, if there are non, in accordance with prevailing practices, to minimize the risk to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that all areas where drugs were stored were kept locked at all times, when not in use.

Inspector #638 observed a medication pass on December 14, 2016. During the course of the medication pass, RPN #102 did not lock the medication cart during the medication pass for approximately 50 minutes. During this period, the RPN left the medication cart unlocked and unattended in the hallway with residents and staff in the vicinity, while administering medications to residents in their bedrooms on seven different occasions.

In an interview with Inspector #638, RPN #102 stated that they believed the cart could be left unlocked, as long as it was within eye sight of the staff member. The Inspector reviewed the legislative requirements within Ontario Regulation 79/10 with RPN #102, which stated that the medication cart must be kept locked at all times, when not in use.

Observations made on December 15, 2016, by Inspector #638 indicated that the medication cart was left unlocked and unattended for approximately five minutes, while RPN #110 administered medications and assisted residents.

Inspector #638 interviewed RPN #110, who stated that it was the home's expectation that the medication carts were kept locked when not in use. The RPN stated that this was necessary to prevent anyone from accessing items within the cart who were not supposed to.

In an interview with Inspector #638, the ADOC stated that it was the home's expectation that the medication cart was locked whenever the cart was left unattended. They went on to state that staff should only have had the cart unlocked when they are immediately present in front of the medication cart and having the cart within eye sight was not an acceptable practice. [s. 130. 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 ensuring that all areas where drugs are stored are kept locked at all times, when not in use, 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 no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident.

Inspector #638 reviewed a Critical Incident (CI) report submitted to the Director by the home related to a medication incident in which resident #011 was administered another resident's medications. Resident #011 had experienced side effects that affected their health post administration of another resident's medications.

Inspector #638 reviewed resident #011's progress notes which indicated that the resident had received another resident's medications during a medication pass in June 2016.

In an interview with Inspector #638, RPN #122 stated that only medications that were ordered for the resident would be administered to that resident. The home's process to ensure that the resident received the right medications included comparing the resident to their file photo and double checking with staff if still unsure. RPN #122 stated that this was an important step to avoid a medication error.

The home's policy titled "Medication Management – Policy #0215" last revised September 2016, indicated that the home's standard was that staff administered the correct medication to the correct resident at the specified administration time.

In an interview with Inspector #638 regarding the medication incident which occurred in June 2016, the ADOC stated that RPN #119 had administered another resident's medications to resident #011. The ADOC stated that there were certain checks required to ensure that staff administer medications to the right resident and that this step was missed. The ADOC confirmed that no drug should be administered to a resident unless the drug had been prescribed for the resident. [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 ensuring that no drugs are 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. (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 resident 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 changed or care set out in the plan was no longer necessary.

Inspector #575 reviewed a complaint submitted to the Director regarding the care of resident #008.

The Inspector reviewed resident #008's health care record. The resident's care plan indicated that the staff were to implement specific interventions related to eye care. The care plan also indicated that staff were to arrange consultation with an eye care practitioner annually, and the last assessment was on a specific date. The Resident Assessment Protocol (RAP) indicated certain interventions related to eye care. The most recent optometry note in the resident's chart was dated approximately one year after the specific date as indicated in the care plan.

The Inspector interviewed the resident's Substitute Decision Maker (SDM), who indicated different interventions than the care plan related to eye care.

During an interview with the ADOC, they stated that staff should have updated the care plan in regards to the most recent optometry note. The ADOC indicated that the care plan should have been updated to reflect the SDM's care directions. [s. 6. (10) (b)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written description of the Falls Prevention and Management program that included relevant policies, procedures, and protocols.

Inspector #575 reviewed two CI reports submitted to the Director in May and June 2016 respectively, regarding falls for resident #006 and #007.

The Inspector requested the Falls Prevention program policy from the ADOC and was provided with the home's policy titled "Nipissing Manor Falls Team" last reviewed March 2015. Part of the procedure after a resident had a fall was that the "falls team meets weekly to review all falls and identify further action and implement additional interventions".

The Inspector reviewed the falls team meeting minutes from May to November 2016, and noted that the meetings occurred monthly.

During an interview with the Administrator and the ADOC, they stated that the falls team did not meet weekly, and confirmed that the falls team met monthly. They were not sure when the team stopped meeting weekly. [s. 30. (1) 1.]

2. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

During stage one of the inspection, it was identified during a staff interview and census review, that resident #003 had an area of altered skin integrity.

On December 15, 2016, Inspector #575 observed the resident with a specific device in use.

The Inspector reviewed the resident's plan of care and did not locate any mention of the application of the device.

The Inspector interviewed PSW #111 regarding the device. The PSW stated that the resident had the device in use for approximately one month.

During an interview, RN #114 stated to the Inspector that they were not sure when the device was implemented.

During an interview with the ADOC, they stated to the Inspector that the device should have been added to the care plan and noted in the progress notes when it was initially implemented. The ADOC reviewed the progress notes and was not able to determine when the device was implemented, however, stated that it had been implemented for approximately one month. [s. 30. (2)]

3. During stage one of the inspection, it was identified through Minimum Data Set (MDS) that resident #004 had developed an area of altered skin integrity.

Inspector #638 conducted a review of resident #004's MDS assessments which indicated that the resident had developed an area of altered skin integrity. Further review verified that the resident had no previous history of altered skin integrirty since their admission approximately four months previous.

The Inspector reviewed the wound assessment records for resident #004 which indicated that there was no documented wound assessment completed over a nine day period. The resident had a period of nine days with no documented wound assessments indicating the progress of the altered skin integrity.

In an interview with Inspector #575, RN #114 stated that the orders regarding dressing changes were kept in the medication room and that each dressing change was documented in Point Click Care (PCC). The RN stated that a wound assessment would have been completed after every dressing change.

Inspector #638 reviewed the physician ordered wound care protocol, which stated that the staff were to change resident #004's dressing every five days.

The home's policy titled "Nipissing Manor Skin and Wound Care for RNs and RPNs" indicated that all wounds were required to be assessed at each dressing change and appropriate treatments implemented.

During an interview with Inspector #638, the ADOC indicated that it was the home's expectation that a wound assessment was completed after each dressing change. The documented assessments were kept within the assessments tab in PCC. Upon review of the assessments completed for resident #004, the ADOC stated that the staff completed the care, however, did not complete the required documentation of the wound as per the home's policy. [s. 30. (2)]

WN #6: 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. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee has failed to ensure that copies of the inspection reports from the past two years for the long-term care home were posted in the home.

On December 12, 2016, during the initial tour of the home, Inspector #575 observed the past inspection reports located in a binder on the main floor. The Inspector noted that the most recent inspection report (#2013_139163_0038) in the binder was dated December 4, 2013. The following inspection reports were missing from the binder:
2014_380593_0011
2015_269627_0008
2016_273638_0005
2016_273638_0004

During an interview with Administrative Assistant #107 on December 15, 2016, they stated that the Administrator had updated the binder in the afternoon on December 12, 2016.

During an interview with the Administrator on December 15, 2016, they confirmed that the inspection reports for the past two years were not posted in the binder during the morning of December 12, 2016. [s. 79. (3) (k)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that they seek the advice of the Family Council in developing and carrying out the satisfaction survey.

Inspector #575 interviewed the assistant to the Family Council. The Inspector asked if the home sought out the advice of the Family Council in the development and carrying out of the satisfaction survey. The assistant to the Family Council stated that the Family Council had not been consulted regarding the development and carrying out the satisfaction survey within the last year. [s. 85. (3)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of an incident that caused an injury to a resident for which the resident was taken to hospital and that resulted in a significant change in the resident's health condition no later than one business day after the occurrence of the incident, followed by the report required under subsection (4).

Inspector #575 reviewed Critical Incident (CI) report submitted to the Director in May 2016, regarding an incident that occurred involving resident #007 four days previous. The CI report described that resident #007 had an unwitnessed fall, was taken to hospital, and returned to the home the same day approximately 11 hours later, with a significant change in their health condition.

The Inspector noted that the incident occurred on a weekday, and it was not reported more than one business day after the incident occurred.

During an interview on December 20, 2016, with the Administrator and ADOC, they indicated that they were aware of the reporting timelines, and were not sure why the incident was reported late. [s. 107. (3) 4.]

Issued on this 11th day of January, 2017

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

Original report signed by the inspector.