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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 12, 2018	2018_633577_0011	019591-18	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

DEBBIE WARPULA (577), LISA MOORE (613), MELISSA HAMILTON (693)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): August 7-10 and August 13-16, 2018.

Additional intakes completed during this inspection were:

- One Critical Incident System (CIS) report related to a resident fall with injury;

- One CIS report related to a disease outbreak; and

- One Complaint report related to heat temperatures in the home.

A Follow-Up Inspection was conducted concurrently, please refer to Inspection #2018_633577_0015.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Physiotherapist (PT), Registered Dietitian (RD), Nutrition Manager, the Resident Assessment Instrument (RAI) Coordinator, Physiotherapist Assistant (PTA), Personal Support Workers (PSWs), Unit Clerk, Cook, residents and family members.

The inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident, and resident to resident interactions, reviewed relevant health records, as well as licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Residents' Council
Responsive Behaviours
Safe and Secure Home
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **1 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. 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 medication cart that was used exclusively for drugs and drug related supplies and that was secured and locked.

On August 8, 2018, Inspector #613 observed the first floor medication room door propped open while registered staff were in the room. While Inspector #613 was in the medication room the Nutrition Manager entered between 1510 hours (hrs) and 1515 hrs to obtain a document from a filing cabinet; the Activity Manager entered the room twice to review papers on the desk during this time. At 1535 hrs Inspector #693 observed the Nutrition Manager enter the medication room while the registered staff were present to use the label machine; at 1558 hrs to use a hole punch; and at 1600 hrs to remove a document from a binder located in the medication room.

On August 14, 2018, at 1125 hrs, Inspector #693 observed the medication room door to be propped open. The Unit Clerk had entered the medication room and placed a form in a binder, while an RN was present.

During an interview with the Unit Clerk they stated they have entered the medication room when a registered staff was present for a number of reasons. They stated that inside the medication room there was a shelf with binders for all nursing related books, orientation checklists and doctors' orders. They stated that they have needed to enter the medication room as part of their role in the home to acquire the call in book, appointment

book, lab book to complete the requisitions, month end books, shredding, Medication Administration Record (MAR) and health cards.

During an interview with RPN #116 they stated that the following items were stored in the medication room: medication carts, stock medications on the shelves, double locked narcotics in the cupboards, discontinued medications in a locked cupboard, dressing supplies, paperwork which included requisitions and a list of staff that may need to be called for the next shift.

During an interview with RN #117 they stated that the following items were stored in the medication room: medication carts, all treatment supplies, additional medication stock, paper cups, medication cups, narcotics stored in the locked boxes in the medication carts and in the double locked cupboard, extra personal support flow sheets, infection control items, nursing forms and referrals and a list of staff to call if someone called in sick.

During an interview with the Nutrition Manager they stated that they have entered the medication room when a registered staff was present to retrieve items such as alcohol wipes, dietary requisition forms as well as to check the home's supply of apple sauce,nutritional supplements, pudding, and to check the conference schedule that was posted in the medication room.

In an interview with the DOC they stated that the following items were stored in the medication room: medication carts, government stock drugs, narcotics that were double locked, dressing supplies, and policy books for nursing and dietary requisitions. They further confirmed that the medication room was not used exclusively to store drugs and drug related supplies. [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 to ensure that drugs are stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies that is secure and locked, to be implemented voluntarily.

WN #2: 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. (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 provided to the resident as specified in the plan.

Resident #002 was identified as having a change in their continence through their most recent Minimum Data Set (MDS) assessment.

A review of resident #002's care plan interventions indicated that resident #002 required a certain type of assistance, with a specific number of staff related to a specific continence care activity.

During observations throughout the inspection, Inspector #577 did not observe the certain type of assistance to be provided to resident #002.

During an interview with PSW #122, they reported to Inspector #577 that staff have had to assist the resident when they ask for assistance; otherwise they were independent with their specific care activity.

PSW #123 and PSW #109, together with Inspector #577, reviewed resident #002's care plan interventions. Both reported to the Inspector that the resident was independent and staff were not providing any specific type of assistance. PSW #123 further reported that resident #002 would ask the staff for assistance when they needed help.

During an interview with RN #110, they reported to Inspector #577 that the staff should have been following the specific continence care activity as identified in the care plan.

The DOC, together with Inspector #577, reviewed resident #002's care plan interventions and they confirmed that staff were not providing care as per care plan interventions related to resident #002's specific care needs. [s. 6. (7)]

2. 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 #613 reviewed a Critical Incident (CI) report that identified resident #009 had a fall, for which the resident was transferred to the hospital, which resulted in a negative health outcome.

During observations by Inspector #613, resident #009 was observed in the lounge area on one of the units, to be sitting in a special wheelchair in a specific position with a device.

A review of resident #009's care plan did not identify that the resident required the use of a device or special wheelchair.

A review of the home's policy titled, "The Care Plan" last revised January 2017, identified that the care plan was a description of the care needed for the resident and the care plan must be regularly reviewed and revised by the registered staff.

RPN #012 and RPN #103, with the Inspector reviewed the care plan and confirmed that neither the device or special wheelchair was identified in the resident's care plan. Further, they stated that the care plan had not been updated to reflect use of the device or special wheelchair. RPN #102 stated they were put in place after the resident's fall.

During an interview with the DOC, they stated that resident care plans were to be updated right away by the registered staff. The DOC further stated that for resident #009, registered staff should have updated the care plan to include the use of the device and special wheelchair right away but this had been an oversight on their part. [s. 6. (10) (b)]

WN #3: 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. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD 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. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the use of a PASD under subsection (3) to assist a resident with a routine activity of living may be include in a resident's plan of care only if all of the following are satisfied: the use of the PASD had been consented to by the resident or, if the resident was incapable, a substitute decision-maker of the resident with authority to give that consent.

Inspector #613 reviewed a Critical Incident (CI) report that identified resident #009 had a fall, for which the resident was transferred to the hospital which resulted in a negative health outcome.

During observations by Inspector #613, resident #009 was observed in the lounge area on one of the units, to be sitting in a special wheelchair in a specific position with a device.

A review of the home's policy titled, "Restraint Policy" last revised January 2017, identified that informed consent was required from the resident or their Power of Attorney for Personal Care or Substitute decision-maker (POA/SDM). The completed form would be filed in the residents' record.

A review of resident #009's electronic health care record on Point Click Care (PCC) and paper chart did not identify consent for the use of the device or special wheelchair as a Personal Assistive Service Device (PASD).

During an interview with RPN #102 and RPN #103, they stated that resident #009 was unable to provide their own consent for the use of the devices and that consent should be obtained from the Substitute Decision Maker (SDM) prior to its use. RPN #102 reviewed the resident's paper chart and confirmed there was no documentation to identify that resident #009's SDM had provided consent for the use of the devices. RPN #103 reviewed the resident's electronic progress notes on PCC and confirmed there was no documentation in the progress notes to identify resident #009's SDM had provided consent.

During an interview with the DOC, they stated that staff were expected to receive consent from the resident's SDM prior to the use of a PASD. [s. 33. (4) 4.]

WN #4: 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.

During a review of the home's most recent medication incident from the last quarter, Inspector #693 found that resident #012 was given a specific medication for their health condition, and the medication had been previously discontinued two years prior.

Inspector #693 reviewed the current medication orders for resident #012 which failed to have a valid order for the specific medication given. Inspector #693 reviewed medication orders from two years prior, and found that the specific medication had been discontinued by the physician on that date.

During an interview with RPN #105, they stated that on a specific day, resident #012 had a change in condition and they had looked into the resident's pill porter, noticed the specific medication and administered one tablet to resident #012 to assist their condition. RPN #105 stated that when they went back to sign the MAR they had realized that the specific medication was no longer listed on resident #012's MAR. RPN #105 stated that they reviewed all previous orders for resident #012 and found that the specific medication had been discontinued by the physician two years prior. They reported that they should have checked the MAR before administering the medication and that resident #012 had received a medication that was not prescribed to them.

A review of the home's policy titled "Administration of Medication - #0215", identified that the MAR must accompany the medication being administered and be consulted prior to administering medication.

During an interview with the DOC they confirmed that the order for the specific medication for resident #012 had been discontinued by the prescriber two years prior, and resident #012 had received the specific medication and it was not prescribed. [s. 131. (1)]

Issued on this 15th day of October, 2018

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

Original report signed by the inspector.