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

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Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 9, 2014	2014_295556_0031	O-001015-14	Resident Quality Inspection

Licensee/Titulaire de permis

NORTH RENFREW LONG-TERM CARE SERVICES INC.
47 Ridge Rd, DEEP RIVER, ON, K0J-1P0

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

NORTH RENFREW LONG-TERM CARE SERVICES INC.
47 RIDGE ROAD, P.O. BOX 1988, DEEP RIVER, ON, K0J-1P0

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

WENDY PATTERSON (556), MEGAN MACPHAIL (551), RUZICA SUBOTIC-HOWELL (548)

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 29, 30, October 1, 2, 3, 6, 7, 8, 2014.

During the course of the inspection, the inspector(s) spoke with the Administrator, Manager of Resident Services (MRS), Dietary/Environmental Services Supervisor, Building Maintenance Personnel, Registered Nurse (RN), Registered Practical Nurses (RPN), Registered Dietitian (RD), Personal Support Workers (PSW), Housekeepers (HSKP), Infection Control Lead, Recreation Supervisor, Dietary Aides, Physiotherapy Assistant, Representative of the Resident's Council, Residents, and Family Members.

During the course of the inspection, the inspector(s) reviewed resident health care records, toured resident care areas, reviewed the Zero Tolerance of Abuse and Neglect policy, reviewed internal investigation documentation, environmental services records, reviewed menus, restraint policy and procedure, resident council minutes, documentation of family information meetings, observed residents meal and nourishment services, observed medication administration, reviewed the planned menu cycle including both meals and snacks, diet list and associated information, activity calendar, multi month recreation participation report, activity details reports, activity plans, observed resident to resident interaction, and staff to resident interaction.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #017 as specified in the plan.

Resident #017 is a resident who does not participate in recreational activities outside of his/her room. A review of the health care record indicated that staff are to bring 1:1 activities to #017 in his/her room and provide encouragement to participate in 1:1

activities of interest such as Touch and Texture, and that #017 enjoys 1:1 book reading in his/her room.

In an interview Recreation Worker #S113 stated that every Thursday there is an activity called Touch and Texture and the recreation staff are to go to #017's room and stay 30 minutes to an hour. #S113 further stated that in addition to Touch and Texture they are to read stories to #017 on a 1:1 basis. #S113 stated there is a list known as the Activity Plan that states that #017 is one of the priorities for Room to Room Visits and the Touch and Texture activity, and stated that #017 should get both of these activities on a 1:1 basis every week.

In an interview Recreation Worker #S114 stated that every Thursday there is 1:1 time for residents who spend most of their time in their room and each of these residents get at least 30 minutes of 1:1 time. #S114 stated that #017 is one of the residents who is to receive 1:1 time.

A review of the activities calendar for July/14, Aug/14, and Sept/14 was conducted and it was noted that Touch and Texture was on the calendar weekly for a total of 11 times over the 3 months. A review of the Activity Plan for July/14, Aug/14, and Sept/14 for Touch and Texture was conducted and stated that when the activity of Touch and Texture was provided #017 was to receive the activity. A review of the Activity Details Report for July/14, Aug/14, and Sept/14 indicated that #017 received the activity of Touch and Texture 3 out of a possible 11 times.

A review of the Activity Plan for the activity of Room to Room Visits for Sept/14 was reviewed and stated that when the activity of Room to Room Visits was provided #017 was to receive the activity.

The Recreation Supervisor stated there was no Activity Plan for July/14 or August/14 for the activity of Room to Room Visits however the recreation staff are aware that when they have a few minutes they are to go to a resident and spend 1:1 time with that resident and then document the activity on Point of Care (POC) which then tabulates to the Activity Details Report. The Recreation Supervisor further stated that what was showing on the Activity Details Report provided to Inspector #556 included all of the Room to Room Visits, and Touch and Texture that was provided to #017 for July/14, Aug/14, and Sept/14.

A review of the Activity Details Report and the Progress notes for July/14, Aug/14, and

Sept/14 indicated that #017 received the activity of 1:1 (Room to Room Visits) 4 times over the 3 month period. [s. 6. (7)]

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 all residents who do not participate in recreational activities outside of their room are provided the recreational activities set out in their plan of care, to be implemented voluntarily.

WN #2: 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 can be easily seen, accessed and used by residents, staff and visitors at all times.

On Sept 29, 2014 Resident #015 was observed sitting in a wheelchair in his/her room. The resident-staff communication and response system (call bell) cord was attached

to the side rail of the bed and at least 4 feet away from where the resident was sitting. The resident stated to Inspector #556 that if he/she needed a nurse he/she would have no ability to access and use the call bell.

On Sept 29, 2014 Resident #011 was observed sitting in an easy chair in his/her room with the remains of his/her lunch on a tray in front of him/her. The call bell cord was approximately 4 feet away from where the resident was sitting and hanging straight down from the call bell unit that was fixed to the wall behind the bed. The resident stated to Inspector #556 that he/she normally has the door closed when in his/her room and that if he/she needed a nurse he/she would have no ability to access and use the call bell.

On Sept 30, 2014 Inspector #548 observed the call bell unit to be fixed to the wall beside Resident #005's bed at the bottom end of the bed. When the call bell cord was stretched out the cord did not reach to the middle of the bed. PSW #S102 was in the room at the time and stated that should the resident need assistance he/she would have to get out of bed and go to the foot of the bed to pull the call bell cord. Later the same day Inspector #548 observed Resident #005 lying in bed, the call bell cord was hanging straight down from the call bell unit parallel to the resident's feet and was not accessible to the resident while lying in bed.

Resident #006 lives in a shared room and is capable of using the call bell. It was observed by Inspector #548 that there is only one call bell in the room which is located on the opposite wall from the resident's bed. Staff member #S102 who was in the room on Sept 30, 2014 at the time of the observation stated to Inspector #548 that the resident would have to get out of bed and walk across the room to access the call bell.

On Sept 30, 2014 Inspector #556 observed Resident #001 lying in bed. PSW #S102 was in the room at the time and stated that the Resident had not gotten up yet because he/she was not feeling well. The call bell cord was observed by Inspector #556 to be hanging straight down from the wall unit that was fixed to the wall approximately 3 feet from the head of the bed and not within reach of the resident.

On October 2, 2014 Inspector #556 observed Resident #016 sitting in the recliner chair in his/her room and the call bell cord was hanging straight down from the call bell unit that was fixed to the wall behind the bed across the room, approximately 6 feet away, from the resident. In an interview PSW #S103 stated that the resident is not able to get out of the chair on his/her own to access the call bell.

In an interview the MRS stated that the expectation is that every resident will have a call bell within reach when they are in their room whether in bed or in their easy chair. MRS further stated that education will be done immediately to ensure that all staff comply with the home's expectation of making call bells accessible to residents at all times when they are in their rooms. [s. 17. (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 ongoing monitoring of the placement of resident-staff communication and response system (call bells) so that they are easily seen, accessed, and used by resident, staff, and visitors at all times, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing.

On September 29, 2014 Resident #009 stated that a shirt and a pair of underwear went missing 2-3 months ago and that he/she reported it to the staff but they have not been able to locate the missing clothing.

On September 29, 2014 Resident #015 stated that a sweater that he/she got for his/her birthday went missing and that he/she reported it to the staff and they are looking for it but they haven't found it yet.

In an interview PSW #S112 stated that resident laundry is done twice a week on their bath day. The clothing to be laundered is in a labelled laundry basket in the resident's bathroom. The load of laundry is started by the evening shift, and then the night shift usually finish it. The clothing items are not labelled. Only one resident's laundry is done at a time, and the labelled basket is in front of the washer so everyone knows whose laundry is in the machine. The staff on night shift fold the clothing and put it in a basket outside the resident's room door and then the day shift staff put it away. #112 further stated that if a piece of clothing got left in the washer or dryer by mistake and then mixed with the next load, because the clothing isn't individually labelled, there would be no way of knowing who the clothing item belonged to.

In an interview the MRS stated that she was the designated lead for laundry in the home. She further stated that the Resident's personal clothing items are not labelled because it is not the practice of the home to label resident clothing. The MRS stated that they are such a small facility that a large percentage of the time the staff know whose clothes are whose. The MRS stated that sometimes missing socks are not able to be located, and the odd item has gotten mixed up in the linen that is laundered at the Deep River and District Hospital, but that doesn't happen very frequently. [s. 89. (1) (a) (ii)]

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 all residents' clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The Licensee has failed to ensure the implementation of the infection prevention and control program during the administration of medications to residents.

This home has implemented, as part of their Infection Prevention and Control Program, the Just Clean Your Hands program which indicates that hand hygiene is to be performed before and after resident contact.

During an interview with Inspector #548 the Manager of Resident Services (MRS) indicated that her expectation was that all registered nursing staff wash or disinfect their hands prior to the preparation of medications and after administration of medications.

On September 29, 2014 two medication administrations were observed by Inspector #548 at approximately 1pm. It was observed that #S100 prepared an oral medication for administration to Resident #001. The Inspector observed that #S100 did not wash

or disinfect her hands prior to the preparation of the medication. #S100 placed the medication in Ensure pudding prior to administration to #001. #001 dribbled the pudding onto his/her chin several times while taking the prepared medication. Each time #S100 wiped the resident’s chin causing the tissue to become wet. Inspector #548 observed that #S100 did not wash or disinfect her hands after the administration of the medication. Subsequently, it was observed that #S100 began preparing medications for another resident without washing or disinfecting her hands. #S100 then administered a topical medication patch to Resident #011's right leg and a different topical medication patch to #011's left chest area. #S100 did not wash or sanitize her hands after the administration of these medications to #011. [s. 229. (4)]

2. The licensee has failed to ensure that immunizations against pneumococcus, tetanus and diphtheria are offered to all residents in accordance with the publicly funded immunization schedules posted on the Ministry website.

During the resident quality inspection, on the Infection Prevention and Control Program Confirmation Checklist for question #3: are residents offered immunization against pneumococcus (once in a lifetime), tetanus and diphtheria (Td vaccine boosters every 10 years for continued protection) in accordance with the publicly funded immunization schedules posted on the Ministry website, the Administrator answered “no”.

In an Interview the Administrator stated that residents are not consistently offered immunization against pneumococcus, tetanus and diphtheria.

In an interview the Manager of Resident Services (MRS) stated that resident immunizations are recorded under the immunization tab in point click care (PCC) and that if an immunization was offered to a resident and refused it would be recorded there as well.

An audit was conducted of the residents in the home and 4 residents had no record of being offered a pneumococcus vaccination, and 9 residents had no record of being offered a tetanus and diphtheria vaccination. [s. 229. (10) 3.]

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 all residents are offered immunizations against pneumococcus, tetanus and diphtheria, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a care conference of the interdisciplinary team providing resident #014's care was held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his/her substitute decision maker.

On September 30, 2014 during a family interview the substitute decision maker for Resident #014 stated that he/she couldn't remember being invited to attend an annual care conference for #014. The family members of two other residents who were also interviewed stated that they were invited by the home to attend an annual care conference.

A review of the Resident's health care record indicated that #014 was admitted to the home on a specific date, and seven weeks later an interdisciplinary care conference was held, however there is no further documentation in the health care record to indicate that an annual care conference occurred after that.

In an interview the Manager of Resident Services (MRS) stated that the annual care conferences aren't always completed, and it's possible that the annual care conference for #014 did not take place. The MRS further stated that the only place the care conference would be documented is in the progress notes in point click care (PCC) and the task of documenting for all care conferences is completed by the MRS therefore if the care conference had been held it would be documented in PCC. She further stated that she doesn't remember attending an annual care conference for #014. [s. 27. (1)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a physician, or registered nurse in the extended

class, ordered or approved the restraining of Resident #012.

On September 30, and October 2, 2014 Resident #012 was observed in bed with both side rails up in the horizontal position.

In an interview RPN #S101 stated that side rails were used for Resident #012, that the resident is physically capable of getting out of bed on his/her own when the rails are down, and that when the side rails are raised they prevent the resident from voluntarily getting out of bed.

In an interview PSW #S103 stated that the side rails are what are keeping Resident #012 in the bed.

The resident’s care plan under the focus of safety stated that bed side rails are to be in full position while in bed to prevent the resident from falling out of bed, and that the POA consents to the use of bed side rails.

A review of the Resident’s health care record was conducted and Inspector #556 was not able to locate a physician's order for the bed side rails. [s. 31. (2) 4.]

2. On September 30, and October 1, 2014 Resident #014 was observed in bed with both side rails up in the horizontal position.

In an interview PSW #S103 stated that Resident #014 could roll out of bed if the side rails were not up. She further stated that #014 requires 1 staff member to assist him/her to move in bed but the resident does a lot of the work, he/she pretty much rolls on his/her own. She further stated that if #014 wanted to exit the bed the bed rails would prevent him/her because he/she would not be able to lift his/her legs over the rails.

A review of the #014’s plan of care indicated, under the focus of safety, that both bed rails are to be in the full position and the bed at the lowest level when #014 is in bed.

A review of #014’s health care record was conducted and Inspector #556 was not able to locate a physician's order for the bed side rails dated prior to October 3, 2014.

In an interview RPN #S101 stated that there was no physician's order for #014's bed side rails prior to October 3, 2014 as they did not think they needed to have a

Physician's order.

In an interview PSW #S111 stated that neither Resident #012 nor Resident #014 would be able to put their bed rail down on their own.

Between September 30th and October 3rd, 2014 Inspector #556 noted that the only type of restraint observed to be in use in the home was bed rails, and while resident #012, and #014 were in bed staff were monitoring the residents at least every hour.

A review of the homes policy entitled "Minimizing of Restraining" dated November 30, 2010, reviewed November 2013 states that a physical restraint is defined as any manual method, or physical or mechanical device, material, or equipment, that is attached or adjacent to the person's body, that the person cannot physically or cognitively remove easily, and that does, or has the potential to restrict the resident's freedom of movement or normal access to his or her body. If the device is used to restrain and not assist in a routine activity of daily living it is then a physical restraint. The policy further states that the Physician on-call will be notified and must give a verbal or written order to apply or administer and remove or discontinue the physical or chemical restraint.

In an interview the Manager of Resident Services (MRS) stated that there would not be a physician's order on the Resident's health care record because it has not been the practice in the home to obtain a physician's order for any type of restraint. The MRS further stated that the Physician had been to the home on October 3, 2014 and an order had been obtained for the bed rails for #012 and #014. [s. 31. (2) 4.]

WN #7: 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 are convened to advise residents' families and persons of importance to residents of their right to establish a Family Council.

A review was conducted of the documentation provided by the Administrator pertaining to family meetings convened by the home. The documentation indicated that family meetings have taken place on November 22, 2011, May 23, 2013, and May 15, 2014.

In an interview the Administrator stated that the home had intended to have a second meeting in 2013 but other operational priorities prevented the meeting from taking place. [s. 59. (7) (b)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
4. Monitoring of all residents during meals. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that all residents are monitored during meals.

PSW S#113 was interviewed and stated that Resident #017 eats all meals in his/her room. RN S#115 was interviewed and stated that staff on the unit are expected to monitor residents who are eating in their rooms, and stated that the expected frequency of monitoring is every ten to fifteen minutes.

Resident #017 was assessed as being at high nutritional risk, and consumes a regular texture diet.

On October 7, 2014, Resident #017 received his/her lunch tray at 12:16pm.

At 12:32pm, it was observed that Resident #017 had completed the meal and no staff member had monitored him/her while he/she was eating. [s. 73. (1) 4.]

Issued on this 9th day of October, 2014

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