Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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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
Nov 22, 2013	2013_211106_0031	373-13, 374-13	Complaint

Licensee/Titulaire de permis

BOARD OF MANAGEMENT OF THE DISTRICT OF KENORA
1220 Valley Drive, KENORA, ON, P9N-2W7

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

NORTHWOOD LODGE
51 Highway 105, P.O. Box 420, RED LAKE, ON, P0V-2M0

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

MARGOT BURNS-PROUTY (106)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): October 9, 2013

The following logs were reviewed as part of this inspection: Log # S-000373-13, S-000374-13

During the course of the inspection, the inspector(s) spoke with Administrator/Director of Care (DOC), Administrative Assistant (AA), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeeper, Residents

During the course of the inspection, the inspector(s) conducted a walk-through of resident home areas and various common areas, observed care provided to residents in the home and reviewed resident health care records

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping

Dignity, Choice and Privacy

Personal Support Services

Sufficient Staffing

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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. On October 9, 2013, inspector observed 2 PSWs change a resident's brief. Resident was laying in their bed covered by a blanket, when the PSWs removed the resident's blanket to provide care, the resident's pants were pulled up only to the resident's knees. Inspector asked one of the PSWs if all residents were left in bed by staff with their pants on and pulled half down. The PSW reported that it was a common practice, unless the resident has a history of "digging" in their briefs when their pants are down. The resident's right to be treated with courtesy and respect and in a way that fully recognized their individuality and respects their dignity was not fully respected and promoted. [s. 3. (1) 1.]

2. On October 9, 2013, inspector observed 2 PSWs transfer a resident from their bed into their wheelchair. The resident was laying in their bed covered by a blanket, when the PSWs removed the resident's blanket to provide care, the resident's pants were pulled only up to the resident's knees. The resident's right to be treated with courtesy and respect and in a way that fully recognized their individuality and respects their dignity was not fully respected and promoted. [s. 3. (1) 1.]

3. On October 9, 2013, inspector observed 2 PSWs change a resident's brief. The PSWs did not shut the door to the resident's room, instead opened the washroom door. The open washroom door provided some privacy but did not afford the resident complete privacy during this personal care. The PSWs also neglected to close the resident's window curtains. The resident's right to be afforded privacy in treatment and in caring for his or her personal needs was not fully respected and promoted. [s. 3. (1) 8.]

4. On October 9, 2013, inspector observed 2 PSWs change a resident's brief. The PSWs did not shut the door to the resident's room, instead they opened the washroom door. The open washroom door provided some privacy but did not afford the resident complete privacy during this personal care. During the resident's brief change a RN and another staff member entered the resident's room, neither of these staff members closed the door to the hallway. The resident's right to be afforded privacy in treatment and in caring for his or her personal needs was not fully respected and promoted. [s. 3. (1) 8.]

5. On October 9, 2013 at 15:05 hrs, inspector observed a PSW enter a resident's room to provide care. The PSW did not close the door to the room but opened the door to the washroom, the open washroom door provided some privacy but did not

afford the resident complete privacy. The resident's right to be afforded privacy in treatment and in caring for his or her personal needs was not fully respected and promoted. [s. 3. (1) 8.]

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 the residents' right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity and their right to be afforded privacy in treatment in caring for their personal needs are fully respected and promoted, 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 "Lifting and Transferring Assessment OHS 020" for resident #003 was reviewed by inspector and it indicated the resident is a "2 person pivot transfer". Two other transfer assessments completed at an earlier date for this resident, also indicated that resident #003 is a "2 person pivot transfer".

The written plan of care document for resident #003 was reviewed by the inspector and in regards to transferring it indicated the following:
-"TRANSFERRING: Requires extensive assistance-support of limb or weight-bearing support by staff during transfer"
-"Bed rails used for bed mobility or transfer"
-"lifted manually".
The plan of care does not give clear direction to staff in regards to the manner in which the resident is to be transferred or the number of staff required to complete the transfer.

On October 9, 2013, two PSWs were interviewed. One PSW reported that resident #003 was a 1 person transfer and the other PSW reported that the resident was a 2 person transfer. A CIS report that was submitted to the Ministry of Health and Long-Term Care , indicated that resident #003 had sustained injury during a transfer; this report indicated that the resident was a 1 person transfer at the time of the incident.

The Licensee failed to ensure that the plan of care for resident #003, sets out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. The plan of care for resident #001 was reviewed by inspector and it indicated that the resident is to be transferred with the assistance of 2 or more staff members via a "HOYER" lift. The "Lifting and Transferring Assessment OHS 020", for resident #001 was reviewed, it indicated that the resident is to be transferred via a ceiling lift by 2 staff members.

On October 9, 2013, the inspector observed 2 PSWs transfer resident #001 from their bed to their chair manually by a two person pivot transfer method, no mechanical lift was used during this transfer. The licensee failed to ensure that the care set out in the plan of care is provided to resident #001 as specified in their plan of care. [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 the plan of care for resident #003 sets out clear directions to staff and others who provide care to the resident, specifically in regards to how resident #003 is transferred and to ensure that the care set out in the plan of care for resident #001 is provided to that resident as specified in their plan of care, specifically in regards to transferring, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. On October 9, 2013 at approximately 11:15 hrs, during the initial tour of the home the inspector observed the following:
-the dining room, both large and small areas, had multiple food crumbs on floor
-the TV lounge by main doors has loose debris and crumbs on the floor and multiple dried dark liquid spill marks on floor
-an unidentified white thick debris was stuck to floor in middle of the TV lounge by the main doors
-2 cookies found in potted plant in the TV lounge on table near door
-2 used Kleenex and crumbs on table by screened in porch in the TV lounge
-an unopened small single serving of strawberry boost 1.5 found at end of hallway A in window sill
-7 dead large mosquito/knat type bugs found in window sill at the end of the hall way A
-a build up of loose debris on floor between window seat at end of hallway A and blue loveseat (dead flies, small straw, dirt)
-multiple small dried spill marks found though-out home and resident rooms. [s. 15. (2) (a)]

2. On October 9, 2013, at approximately 11:30 hrs, inspector observed the following:
-in a resident room, a light layer of dust on TV shelf unit. [s. 15. (2) (a)]

3. On October 9, 2013, at approximately 11:30 hrs, inspector observed the following:
-in a resdient room, a layer of dust on resident's shelf unit
- when a finger was brushed against the surface a visible streak was made and dust was left on the inspector's finger. [s. 15. (2) (a)]

4. On October 9, 2013, at approximately 12:00 hrs, inspector observed the following:
- in a resident room, small gum type candy on floor 1 piece and ½ piece under bed
-multiple greenish yellow dried spill/spit marks on floor, most noted by window but observed in other areas of room, under bulletin board, near night stand
-one spot of what appears to be wet mucus on floor approximately 2" x1". [s. 15. (2) (a)]

5. On October 9, 2013 at approximately 14:55 hrs, inspector observed the following:
-in dining room, both large and smaller areas, crumbs and food debris under all tables, some tables had more crumbs/debris than others, much of the same debris noted earlier in the day

-spilled water under one small table in the dining room
-2 cookies were still in plant in the common lounge area, same cookies noted from earlier in the day
-the same dried spills on the floor from earlier tour this day
-gum or other debris was stuck to the floor near nursing desk
-in a resident room, the wet and dried mucus spots still on floor and pieces of gum that were observed earlier were still on the floor. [s. 15. (2) (a)]

6. On October 9, 2013, at approximately 16:00 hrs, inspector observed the following:
-boost, napkin and same debris at the end of hall by window down hallway A, this same debris was noted earlier in the day
-toilet in the common washroom across from administration office had feces on the inside of the raised toilet seat

The licensee failed to ensure that the home, furnishings and equipment are kept clean and sanitary. [s. 15. (2) (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 the home, furnishings and equipment are kept clean and sanitary, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) 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. 31 (3).

Findings/Faits saillants :

1. On Oct 9, 2013, inspector requested that the Administrator/DOC provide the home's written nursing and personal care staffing plan and they provided the following documents:
-"Mission and Philosophy", policy # NUR 001, revised 02/10
-"Nursing Goals", policy #NUR 002, revised 02/10
-"Objectives", policy #003, revised 02/10
-"Nursing Services", policy # NUR 004, revised 02/10
-"Scheduling", policy # NUR 285, revised 02/10
-"Staff Illness/Replacement", policy # NUR 290, revised 02/10
-"Guidelines for RN / RPN Duties", policy # NUR 255, revised, 02/10
-"Job Description - Registered Practical Nurse", policy # ADM 165, revised April 2005
-"Job Description - Registered Nurse", policy # ADM 160, revised April 2005
Inspector reviewed the above policies.

The Administrator/DOC reported the home's staffing compliment is as follows:
-Days: 3 PSW, 1 RPN, 1 RN
-Evenings: 3 PSW, 1 RN
-Nights: 1 PSW, 1RN

The Administrator/DOC reported that in the last few months the home has been short staffed. A written back-up plan for nursing and personal care staffing, that addresses situations when staff, including the staff who must provide nursing coverage required, cannot come to work, could not be found. The "Staff Illness/Replacement" policy #NUR 290 contains procedures the home follows to call in staff when staff are unable to come into work, but it does not provide a plan to follow if staff are working short and unable to fully staff the shift. There is no information regarding what the staff do to ensure that care needs of residents are met when the staff are working short.

The licensee failed to ensure that the written staffing plan includes a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work. [s. 31. (3)]

Issued on this 22nd day of November, 2013

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