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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

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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
Dec 8, 2016	2016_326569_0027	029149-16	Resident Quality Inspection

Licensee/Titulaire de permis

PROVINCIAL NURSING HOME LIMITED PARTNERSHIP
1090 MORAND STREET WINDSOR ON N9G 1J6

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

SEAFORTH MANOR NURSING HOME, DIVISION OF PROVINCIAL NURSING HOME LIMITED PARTNERSHIP
100 JAMES STREET SEAFORTH ON N0K 1W0

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

DONNA TIERNEY (569), MELANIE NORTHEY (563)

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): October 31, November 1, 2, and 3, 2016.

An inquiry log #034177-15 related to the Critical System Intake #1135-000013-15 and #1135-000003-16, was also completed during this inspection.

During the course of the inspection, the inspector(s) spoke with the General Manager (GM), Director of Care (DOC), Program Services Manager (PSM), Food Services Manager (FSM), Resident Services Coordinator (RSC), Restorative Care Coordinator (RCC), Resident Assessment Instrument (RAI) Coordinator, Registered Dietitian (RD), Pharmacist, a Registered Nurse (RN) and a Registered Practical Nurse (RPN), Personal Support Workers (PSW), Health Care Aides (HCA), members of Residents' and Family Council, family members, and over 20 residents.

The Inspector(s) also conducted a tour of the home and made observations of residents, activities and care. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed. Inspector(s) observed medication administration and drug storage areas, resident/staff interactions, infection prevention and control practices, the posting of Ministry information and inspection reports, and the general maintenance, cleanliness and condition of the home.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Residents' Council

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

6 WN(s)
5 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 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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident and the goals the care was intended to achieve.

On a specified date during the home's Resident Quality Inspection (RQI), an identified resident was observed with a specific device in place.

There were multiple documented entries in the resident's clinical record which stated the resident was a medium or high risk for falls and used the specific device for mobility and did not use a restraint.

During an interview with Health Care Aide (HCA) #109, they shared that the specific device was used for positioning as a fall prevention strategy. The HCA shared that the interventions related to the use of the specific device would usually be documented in the kardex for Personal Support Workers (PSWs) under the mobility or safety focus and shared that the specific device for this resident was not documented as part of the kardex.

In an interview with a Registered Nurse (RN) #104, they shared that the specific device

would be charted as part of the resident's plan of care under restorative.

Record review of the identified resident's current care plan documented goals and interventions for mobility, safety and restorative care without an intervention related to the use of the specific device. All other areas of the care plan were reviewed with no documentation found for the use of the specific device. There were no goals, interventions, or directions in place related to the use of the specific device that set out the planned care for this resident.

Restorative Care Aide (RCA) #112 shared that the specific device did not act as a restraint for the resident because it did not limit their freedom of movement. The RCA also shared that the specific device should be identified in the care plan and kardex for staff who provided this direct care to the resident.

The licensee failed to ensure that the specific device used to assist the identified resident with positioning, comfort and safety was included in their plan of care. [s. 6. (1)]

2. The licensee failed to ensure that the outcome and effectiveness of the care set out in the plan of care was documented.

An identified resident triggered in stage one of the RQI where by the resident had unplanned weight loss at a rate in excess of regulatory limits according to the record review.

Record review of the resident's current care plan in the electronic clinical record documented to provide a specific nutritional intervention at a specified time. The goal was identified "to maintain ideal body weight/ goal weight range." The "Nutritional Risk Assessment V9" completed quarterly on a specified date identified the resident as high nutritional risk.

Director of Care (DOC) #102 shared that the specific nutritional intervention would be documented in Point of Care (POC) under a specific task. The DOC and Food Services Manager (FSM) #107 agreed that there would be no way of knowing the resident's consumption of the specific nutritional intervention. DOC #102 also shared that there were other residents in the home that had the specific nutritional intervention as part of their nutrition plan of care.

During a telephone interview, Registered Dietitian (RD) #106 acknowledged that there

was no way to assess whether the nutritional intervention was taken or not and shared that there was no way to determine if the nutritional intervention was consumed or refused by looking at the specific task in Point of Care. The RD also shared that it would be valuable to have the nutritional intervention separate from the current task.

The licensee failed to ensure that the outcome and effectiveness of the specific nutritional intervention set out in the plan of care for the identified resident was documented.

The severity of this issue was determined to be a level 1 which is minimum risk and the scope a level 2 which is a pattern. The home's compliance history for this area of legislation is a level 2 which is one or more unrelated non compliance in the last three years. [s. 6. (9)]

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 there is a written plan of care for each resident that sets out the planned care for the resident and the goals the care is intended to achieve, and that the outcome and effectiveness of the care set out in the plan of care was documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan, policy, protocol, procedure, strategy or system, in place was complied with.

Three identified residents triggered from Stage one of the RQI for significant weight loss exceeding limits.

Monthly weight records on the clinical records were reviewed for these residents and demonstrated that they experienced a weight loss of 2.5 kilograms (kg) or greater over several different months during a specified time frame. There was no documented evidence found that re-weighs were requested or completed.

The home's policy "Weight Monitoring" #RC-3.690 (date created or last revised not available) stated the PSW would "Immediately reweigh any resident with a weight variance (from the previous month) of 2.5 kg" and the RN/RPN would "Request the PSW reweigh the resident if there was a 2.5 kg difference in the resident's weight from the previous month."

Registered Dietitian (RD) #106 acknowledged the home's policy that any resident with a weight variance of 2.5 kg or more over one month should be re-weighed. RD #106 shared that if she noticed a weight variance of 2.5 kg or more over one month, she would request that staff re-weigh the resident.

In an interview with DOC #102 she shared that Resident Services Coordinator (RSC) #108 managed monthly weights. RCS #108 was interviewed and acknowledged that she oversaw the weight program. She stated that re-weighs are required for weight variances of 2.5 kg or more in one month or if the RD or registered staff requested a re-weigh. RSC

#108 indicated that re-weights should be recorded under Weight Summary in PointClickCare and it was the home's standard practise to re-weigh all residents with a weight variance of 2.5 kg or more over one month.

The licensee failed to ensure that the home's policy for Weight Monitoring was complied with. No re-weighing occurred for the three identified residents following weight variances of 2.5 kg or more over one month.

The severity of this issue was determined to be a level 1 which is minimum risk and the scope a level 3 which is widespread. The home's compliance history for this area of legislation is a level 2 which is one or more unrelated non compliance in the last three years. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan, policy, protocol, procedure, strategy or system, in place is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident who was incontinent received an

assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions.

Review of the clinical record for an identified resident showed the following:
-the Minimum Data Set (MDS) admission assessment section H indicated the resident was continent of bladder.
-the following MDS section H quarterly review assessment indicated the resident was occasionally incontinent of bladder.
-the next MDS section H quarterly review assessment indicated the resident was frequently incontinent of bladder.
The Interdisciplinary Care Conference Summary note stated that the identified resident had worsened urinary continence. A Bowel and Bladder Continence Assessment was completed for this resident on admission. There were no other completed continence assessments found for this resident in their clinical record.

The home's policy "Continence/Incontinence – Guidelines for Care" #RC-3.380 effective April 2005, stated "Registered Staff will: 1. Upon admission, at the time of the quarterly review, during the annual assessment and when there is any change in a resident's condition that affects a resident's bladder and bowel functioning: a. Obtain information about the resident's bowel and bladder routine. b. Identify contributing factors to incontinence. c. Reference Bladder and Bowel Assessment Criteria." Another one page document titled Ongoing Assessments and Tasks, indicated that registered staff were to do a bladder and bowel continence assessment in PCC when there was a change in the resident's condition related to continence.

During an interview with RN #104 and RPN #105, they shared that continence assessments were done for all residents on admission, however both were unsure as to when additional continence assessments were to be completed.

In an interview with DOC #102 she agreed that the identified resident had a progressive decline in their bladder continence from their admission assessment to the two following quarterly reviews She also acknowledged that the only continence assessment that was completed for this resident was at their admission.

A continence assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions was not completed for the identified resident when they were identified as incontinent.

The severity of this issue was determined to be a level 2 which is minimum risk and the scope a level 2 which is a pattern. The home's compliance history for this area of legislation is a level 2 which is one or more unrelated non compliance in the last three years. [s. 51. (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 a resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee failed to respond in writing to Residents' Council within 10 days of receiving Residents' Council concerns or recommendations.

In an interview with the licensee appointed assistant to Residents' Council, Program Services Manager (PSM) #103, she shared that the licensee has provided written responses to Residents' Council, but not within 10 days.

Record review of the 2016 Residents' Council minutes showed a written response to Residents' Council by General Manager (GM) #101 on October 2016 with no specified date. That response was related to an issue identified in the September 1, 2016 meeting minutes.

General Manager (GM) #101 shared that she had responded in writing to Residents' Council suggestions and concerns, but that occurred for the next meeting and acknowledged that concerns or recommendations were not responded to in writing to Residents' Council within 10 days.

The severity of this issue was determined to be a level 1 which is minimum risk and the scope a level 3 which is widespread. The home's compliance history for this area of legislation is a level 2 which is one or more unrelated non compliance in the last three years. [s. 57. (2)]

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 the licensee responds in writing to Residents' Council within 10 days of receiving Residents' Council concerns or recommendations, to be implemented voluntarily.

WN #5: 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 failed to ensure that the advice of the Residents' Council was sought in the development and carrying out of the satisfaction survey.

Record review of the 2016 Residents' Council minutes failed to demonstrate any documentation that the home's satisfaction survey was reviewed by Residents' Council and their advice sought in the development and carrying out of the survey prior to its distribution.

The Program Services Manager (PSM) #103, who was the licensee appointed assistant to Residents' Council, said in an interview that the satisfaction survey was sent out in June 2016. She also shared that the survey was not provided to Residents' Council for their input prior to it being distributed.

GM #101 acknowledged that Residents' Council's input was not sought in the development and carrying out of the satisfaction survey prior to it's distribution.

The severity of this issue was determined to be a level 1 which is minimum risk and the scope a level 3 which is widespread. The home's compliance history for this area of legislation is a level 2 which is one or more unrelated non compliance in the last three years. [s. 85. (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 that the advice of the Residents' Council is sought in the development and carrying out of the satisfaction survey, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Findings/Faits saillants :

1. The licensee failed to develop an interdisciplinary medication management system that provided safe medication management and optimized effective drug therapy outcomes for residents and also failed to ensure that written policies and protocols were developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

On a specific dated the medication cart was observed parked in the hall outside the chart room at 1130 hours. Director of Care (DOC) #102 unlocked the cart, and the top drawer of the medication cart was observed with an opened ampoule of injectable medication standing upright in the middle of a roll of tape. The ampoule neck was snapped and the ampoule was left open to the air. DOC #102 acknowledged the ampoule was stored in the top drawer of the medication cart and shared that it should be stored in the resident's labelled cubby.

The DOC then asked Registered Nurse (RN) #104 where the ampoule should be stored and who the ampoule belonged to, and RN #104 said that it was for an identified resident and shared that the ampoule used that morning was discarded after opening and was not sure how long the ampoule on the top shelf had been there.

DOC #102 said that the registered staff leave the opened ampoule open to the air and in the medication cart for the duration of their shift in case a second dose could be used. If the second dose was not used during the course of their shift the staff member would discard the medication and ampoule at the end of their shift. DOC #102 shared that as far as she knew there was no written policy and protocol developed related to the use and disposal of ampoule medications.

During an interview, Pharmacist #114 shared that leaving the opened ampoule exposed to the air posed a sterility issue, but that it did not affect the efficacy of the drug and the drug would not degrade in potency when left open to the air. The Pharmacist said that the recommendation was not to leave an opened ampoule of medication in the

medication cart for a second use, but rather to discard the remaining medication and use a new ampoule for the next prescribed dose.

The registered staff left an opened medication ampoule failing to provide safe medication management and optimized effective drug therapy outcomes for an identified resident, and the home failed to ensure that a written policy and protocol was developed related to the use and disposal of ampoule medications. [s. 114.]

Issued on this 22nd day of December, 2016

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

Original report signed by the inspector.