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 # / No de registre	Type of Inspection / Genre d'inspection
Oct 23, 2017	2017_669642_0016	006965-17	Resident Quality Inspection

Licensee/Titulaire de permis

ANSON GENERAL HOSPITAL
58 Anson Dr. IROQUOIS FALLS ON P0K 1E0

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

SOUTH CENTENNIAL MANOR
240 FYFE STREET IROQUOIS FALLS ON P0K 1E0

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

AMY GEAUVREAU (642), LISA MOORE (613), LOVIRIZA CALUZA (687)

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): September 11-15, 2017.

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

Three Critical Incidents (CI) submitted to the Director related to falls resulting in a significant change in the resident's health status.

During the course of the inspection, the Inspector(s) directly observed the provision of care and services to residents, observed staff to resident interactions, resident to resident interactions, conducted a daily tour of the residents' home areas, reviewed relevant health care records, various home policies, procedures, and programs, observed medication administration.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Maintenance Manager, Rehab Co-ordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), housekeeping staff, residents and residents' family members.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **0 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a personal assistance service device (PASD) was used to assist a resident with a routine activity of living, that it was included in the resident's plan of care.

On three days during the inspection, Inspector #613 observed resident #001's bed to have two devices applied. A review of the resident's Minimum Data Set (MDS) quarterly assessment, revealed that resident #001 used the devices for bed mobility or transfers.

The Inspector reviewed the resident's most recent care plan which did not identify any information regarding the use of these devices used for the bed.

A review of the home's policy titled, "Restraints and Personal Assistive Safety Devices (PASD)" last revised on February 16, 2017, identified that the residents care plan should have indicated how, when, and why the device was used to support and promote independence and quality of life. In addition the care plan should have indicated the removal of the device as soon as it was no longer needed to promote independence.

During an interview with RN #107, they stated that resident #001 used the devices on their bed as a PASD for bed mobility and self-transfers. The RN stated the use of the devices should have been identified in the care plan under the focus PASD. RN #107 reviewed resident #001's most recent care plan and confirmed that the use of resident #001's devices as a PASD was not identified in their care plan.

During an interview with the Director of Care (DOC), they stated that the devices used as a PASD were to be documented in the resident's care plan. The DOC also confirmed that this information was missing from the resident's plan of care. [s. 6. (1) (a)]

2. The licensee has failed to ensure that there is a written plan of care for each resident that sets out clear direction to staff and others who provided direct care to the resident.

Resident #001 was identified as having worsening incontinence from their previous to most recent Minimum Data Set (MDS). Inspector #613 reviewed the MDS quarterly assessment and the Resident Assessment Protocols (RAPS), which identified that the resident was incontinent of urine daily and required the use of a continent product.

A review of the resident's care plan identified an intervention under the focus bladder-continent, stated that resident #001, "did not wear any incontinent products at this time and would let staff know if they needed one." The next intervention stated that the resident, "wore an incontinent product at all times now."

During interviews, with PSW #105 and RN #107, they stated that resident #001 was incontinent of urine and wore an incontinence product at all times. PSW #105 reviewed the care plan and confirmed the interventions for continence care were unclear.

During an interview with the DOC, they stated that resident #001's care plan interventions should have provided clear direction to staff to ensure that resident #001's care needs were met. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

On three days during the inspection, Inspector #613 observed resident #001's bed to have two devices applied. A review of resident's MDS quarterly assessment, revealed that resident #001 used the devices for bed mobility or transfers.

A review of the home's policy titled, "Restraints and Personal Assistive Safety Devices (PASD)" last revised in February 16, 2017, identified that the prescribing clinician was required to obtain and record the informed consent for the treatment from the resident

and or the SDM.

During an interview with RN #107, they stated that resident #001 used two devices on their bed as a PASD for bed mobility and self-transfers. The RN showed the Inspector a binder which was intended to contain all documented consents for PASDs. The binder contained forms titled, "Personal Assistive Service Devices", however, it did not contain a consent for the use of resident #001's devices. RN #107 confirmed there was no documented verbal or written consent by the resident or the resident's SDM for the use of the devices.

During an interview with the DOC, they confirmed that the form titled, "Personal Assistive Service Devices", should have been signed by resident #001's SDM to obtain consent of the devices prior to their implementation. [s. 6. (5)]

4. The licensee has failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Inspector #642 observed two devices in the assist position on resident #002's bed on a specific date during the inspection. The next day Inspector #613 observed the resident lying in their bed with the devices in the guard position and then the following day, resident #002 was observed lying in their bed with one of the devices in the guard position and the other device in the assist position.

A review of resident's MDS quarterly assessment, revealed that resident #002 used the devices for bed mobility or transfers.

A review of the home's policy titled, "Restraints and Personal Assistive Safety Devices (PASD)" last revised on February 16, 2017, identified that the prescribing clinician was required to obtain and record the informed consent for the treatment from the resident and or the SDM.

During an interview with RN #107, they stated that resident #002 used the devices on their bed as a PASD for bed mobility and self-transfers. The RN showed the Inspector a binder which was intended to contain all documented consents for PASDs. The binder contained forms titled, "Personal Assistive Service Devices", however, it did not contain a consent for the use of resident #002's devices. RN #107 confirmed there was no

documented verbal or written consent by the resident or the resident's SDM for the use of the devices.

During an interview with the DOC, they confirmed that the form titled, "Personal Assistive Service Devices", should have been signed by resident #002's SDM to obtain consent of the devices prior to their implementation. [s. 6. (5)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home had his or her personal items, labelled when acquiring new personal items.

Inspector #642 observed the residents' home areas during the inspection, and observed the residents' personal items, such as toothbrushes, combs, mouthwash, shaving cream, petroleum jelly, body spray, liquid soap, Tena cleansing and body lotions did not have the resident's personal names labelled on them. All items were identified in shared washrooms. Eight out of twenty residents or 40% did not have their personal items labelled.

The Inspector interviewed PSW #111 and PSW #112 who stated that it was a requirement that the residents' personal items were labelled at admission and when they acquired something new.

The Inspector interviewed RPN #113 and RN #103, who stated that it was a requirement that all staff should place the residents' names on the residents' personal items such as combs, toothbrushes', mouthwash, petroleum jelly, and Tena cleansing lotion and Tena body lotion.

The home's policy titled "Management of Resident Belongings" last revised November 22, 2016, stated that, "MICs Long Term Care (LTC) Homes will ensure that each resident of the home has his/her personal items, including personal aids labelled within 48 hours of admission and of acquiring, in the case of new items and cleaned as required. This is required under Section 37 of the Regulation in the Long Term care Homes Act, 2007."

The DOC was interviewed and they stated that "Yes" it was a requirement that the residents' personal items which were identified during the observations by the Inspector, should have been labelled by the nursing home staff with the residents' names when they acquired the new personal items. [s. 37. (1)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident had fallen, the resident was assessed using a clinically appropriate assessment instrument that was specifically designed for falls.

Inspector #687 reviewed a Critical Incident (CI) report, which the home had submitted to the Director. The CI report outlined that resident #006 had sustained a fall which had resulted in an fracture. A review of resident #006's two previous falls, noted that the first fall incident that had occurred, did not have a post fall assessment.

A record review conducted for resident #006 by Inspector #687, identified that the resident did not have a Post Fall Assessment for the first fall.

Inspector #687 interviewed RPN #103, who stated that for fall incidents, the registered staff (RN or RPN) responding to the fall incident would evaluate any injury or extent of injury and follow the Fall Prevention and Management Policy as outlined and complete the Post Fall Assessment.

The Inspector interviewed RN #107, who stated that staff were expected to follow the Falls Prevention and Management Policy as outlined which included Post Fall assessment, Head to Toe assessment and Morse Fall Risk assessment.

The Inspector reviewed the home's policy titled, "Fall Prevention and Management Program" last revised February 16, 2017, and under Procedure, Section-B. Post Fall Management, under RN/RPN, it states "Complete Post Fall Assessment Checklist."

During an interview with DOC, they stated that if there was a fall incident, the expectation was for the staff to follow the Falls Prevention and Management Program Policy which included the Post Fall Assessment, the Head to toe assessment, and the Morse Fall Risk Assessment. [s. 49. (2)]

Issued on this 25th day of October, 2017

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

Original report signed by the inspector.