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 sions de longue durée

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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
Apr 28, 2016	2016_288549_0009	000205-16	Complaint

Licensee/Titulaire de permis

The Corporation of the County of Renfrew
9 INTERNATIONAL DRIVE PEMBROKE ON K8A 6W5

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

MIRAMICHI LODGE
725 Pembroke Street West PEMBROKE ON K8A 8S6

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

RENA BOWEN (549)

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): April 19, 20, 21, 22, 25, 26, 2016

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses(RN),two Resident Care Coordinators (RCC), Food Services Manager (FSM), Registered Dietitian (RD), Director of Care (DOC) and the Administrator.

The inspector reviewed the resident's health care file, medication administration sheet, fluid intake, nutritional intake and bowel records, the home's Hydration policy FS_023 last reviewed April 30, 2015, Bowel Care Regime policy N-375 last reviewed September 25, 2015 and Continence Care-Bowel Constipation policy N-350.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Nutrition and Hydration
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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. 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 has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

1. In accordance with O. Reg. 79/10 s.48 (1) (3), every long-term care home shall ensure that a continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable is developed and implemented in the home.

Resident #001 was admitted to the home on a specific date in December 2015.

Resident #001's admission history completed by RN #126 on a specific date in December 2015 indicated that the resident's bowel routine was regular once a day.

On April 25, 2016 during an interview RPN #127 indicated that PSWs are responsible to document in Point Click Care (PCC) each shift indicating whether the resident had a bowel movement or not . RPN #127 indicated that on day two of no bowel movement PCC will automatically initiate an "Alert". The night RPN will then check the Medication Administration Record (MARS) to check if the resident in question has an order for a laxative. RPN #127 indicated that the night RPN will give suppositories and fleet in the morning as required if ordered. RPN #127 also indicated that all bowel interventions are documented in the progress notes and on the MARS.

Inspector #549 reviewed resident #001's bowel documentation from PCC for a specific time period in December 2015. The bowel documentation indicates that resident #001 did not have a bowel movement for a period of five days.

The home's policy titled Bowel Care Regime, N-375 last review date September 25, 2015, indicates on page one in the section titled Purpose: no more than 2-3 days should be allowed to go between bowel movements. Under the section titled Procedure, bullet number six indicates: PSW staff will document all bowel movements on the flow-sheet on Point of Care (POC). The number of days without a bowel movement is auto-populated by POC. Bullet number seven indicates: The RPN on night will log into PCC and click on the dashboard tab located in the left upper hand corner. Bullet number eight indicates: The RPN on night will the scroll down to the ALERT'S listed then click on the ALERT LISTING REPORT tab which is located on the right hand side. The ALERT list will identify which day the resident is without a bowel movement. Bullet number nine

indicates: the RPN will then right click on the screen with the mouse and scroll down to print out the ALTER"S list. Bullet number 10 indicates: The RPN on nights will then highlight residents with bowel ALERT'S and then will review the Medication Administration Record (MARS) for the resident and will write beside the ALERT what is due for the resident Day 2. Bullet number eleven indicates: The RPN on Days will ensure the resident is given the bowel intervention and will ensure to record any results in PCC/POC and on the printed ALERT list. The RN will seek an order for a laxative or further bowel interventions if there is not one already. Bullet number thirteen indicates: If the intervention is not effective the RPN will note this on the Alert list for the RPN on evenings to follow-up and will follow the same process if intervention is effective, (document on PCC/POC and remove from Alert List) so nights can assure there is intervention in the morning.

Inspector #549 reviewed resident #001's progress notes, treatment sheets and MARS for a specific time period in December 2015. The inspector was unable to locate any documentation indicating that there were any bowel interventions for the noted five day time period.

During an interview on April 21, 2016, RN #114 indicated to Inspector #549 that she was not aware that the resident did not have a bowel movement for five days until she was completing resident #001's hospital transfer form on a specific date in December 2015. RN#114 indicated that she is not aware of any bowel interventions for resident #001.

On April 26, 2016 during an interview RN #128 indicated that the PCC ALERT'S lists related to resident bowel movements are not kept by the home. A new ALERT"S list is printed when a changes occur with one resident the old list is shredded.

During an interview with RCC#2 it was indicated to Inspector #549 that the home's expectation is that the home's policy and procedures for Bowel Regimen be complied with.

During the same interview RCC#2 confirmed that the home's Bowel Regime policy was not complied with related to resident #001 bowel care.

2. In Accordance with LTCHA, S.O. 2007, Chapter 8, s. 11(1) (b) Every licensee of a long-term care home shall ensure that there is, an organized program of hydration for the home to meet the hydration needs of residents.

The home's policy titled Hydration, FS-023 last reviewed on April 30, 2015 indicates under Procedure: Interdisciplinary Team: Provides resident with a minimum of 1, 500 ml (6cups) of fluids per day unless otherwise on the residents care plan, either on the menu via meals and snacks or in combination with other activities (e.g. Recreation events, medication administration, etc.). Monitor resident's fluid intake using the Fluids-Intake tab in the Look Back Report of PCC and reports poor intake to the Registered Nurse. Under the Nursing staff section of the Hydration policy it indicates to monitor residents' hydration status, using the POC- fluids tab as part of their daily assessment. Report any of the following signs and symptoms of dehydration to the RPN: constipation, fatigue, nausea, weakness and loss of appetite.

The policy also indicates that the Registered Nurse/RPN plans appropriate oral re-hydration for residents whose intake is less than 1200ml/24hr or less than 75% of their calculated fluid needs x 14 consecutive days. Consult to RD is initiated.

Resident #001's written plan of care dated a specific date in December 2015 indicates that the resident is a nutritional risk and a hydration risk.

Inspector # 549 reviewed resident #001's fluid intake report for a specific time period in December 2015. On a specific date in December resident #001's fluid intake was 900ml, on a specific date in December, 900ml on a specific date in December, 900ml and a specific date in December, 300ml.

Inspector #549 reviewed resident #001's nutritional intake for specific time period in December 2015. On a specific date in December, resident #001 did not eat breakfast or lunch and took one bite of a hamburger at supper. On a specific date in December, the resident did not eat breakfast, 50% of lunch and supper, on a specific date in December the resident did not eat breakfast or supper, 10% at lunch, on a specific date in December , the resident ate 10% at breakfast, 85 % at lunch and 10% at supper, on a specific date in December the resident ate 5% at breakfast and lunch.

Review of resident #001's progress notes on a specific date in December 2015 indicated that the resident is not eating or drinking well.

During an interview on April 21, 2015 the Food Services Manager and the Registered Dietitian both indicated that they did not receive a referral for resident #001 related to the resident drinking less than 1200ml/24 periods, that the resident was not eating well and that the resident was not having bowel movements.

On April 21, 2015 the Food Services Manager confirmed with Inspector #549 that the home's hydration policy was not complied with related to resident #001's fluid intake. [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 home's Hydration and Bowel Care Regime policies are complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (9) The licensee shall ensure that the resident is reassessed and the care plan is reviewed and revised when,
(a) the resident's care needs change; O. Reg. 79/10, s. 24 (9).
(b) the care set out in the plan is no longer necessary; or O. Reg. 79/10, s. 24 (9).
(c) the care set out in the plan has not been effective. O. Reg. 79/10, s. 24 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident is reassessed and the care plan is reviewed and revised when the resident's care needs change.

Resident #001 was admitted to the home on a specific date in December 2015 for respite care.

The plan of care was developed for resident #001 on a specific date in December 2015 with the resident's spouse and daughter/son at the time of admission.

The plan of care dated a specific date in December 2015 and still in effect a time of discharge in December 2015 indicates that the resident eats independently, walks in room and corridor independently with a wheeled walker, requires limited assistance of

one staff for locomotion off unit and requires limited assistance of one staff for all aspects of personal care.

Inspector #549 reviewed resident #001's progress notes for a specified time period in December 2015.

The following was noted in the resident's progress notes: a specific date in December, 2015 Increased difficulty to assist resident to standing. The resident was unable to stand and walk with walker to come out to dining room for supper. Resident transferred to a wheelchair. On a specific date in December 2015 the resident was noted to be walking to the left and assistance needed to walk. Resident unable to take sips from a straw and difficulty taking medications. On a specific date in December 2015 resident assisted with breakfast. Resident is not able to feed self. On a specific date in December 2015 the resident was not weight bearing well, needing assistance of 2 staff to transfer into wheelchair.

On April 19, 2016 Inspector #549 interviewed RPN #101 who indicated that she recalls the resident was declining one day and then well the next. RPN #101 indicated to Inspector #549 that the resident required more assistance with dressing, transfers, walking and sometimes would be in a wheelchair and that the resident at times could not feed him/herself.

During an interview on April 20, 2016, RPN #106 indicated to Inspector #549 that resident #001 did not walk and was in a wheelchair for mobility.

PSW #105 indicated during an interview on April 20, 2016 that the resident was not well on admission. PSW #105 indicated that the resident was able to assist staff with care some days and other days he/she was not able to walk or feed him/herself.

On April 20, 2016 during an interview with the home's Registered Dietitian and Food Services Manager it was indicated to Inspector #549 that the resident's plan of care related to eating and fluid intake was not revised as they were not aware of the resident's change in condition.

During an interview on April 20, 2016, RCC #2 confirmed with Inspector #549 that resident #001's plan of care was not reviewed and revised to reflect the resident's change in care needs following his/her admission on a specific date in December 2015.

In summary the plan of care for resident #001 care needs changed following admission to the home however; the plan of care was not reviewed or revised to reflect the change in care needs. [s. 24. (9) (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 respite residents' plans of care are reviewed and revised when the resident's care needs change, to be implemented voluntarily.

Issued on this 29th day of April, 2016

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

Original report signed by the inspector.