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

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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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
Mar 27, 2014	2014_347197_0005	O-000193-14	Resident Quality Inspection

Licensee/Titulaire de permis

Lennox and Addington County General Hospital
97 Thomas Street East, NAPANEE, ON, K7R-4B9

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

THE JOHN M. PARROTT CENTRE
309 BRIDGE STREET WEST, NAPANEE, ON, K7R-2G4

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

JESSICA PATTISON (197), COLETTE ASSELIN (134), SUSAN DONNAN (531)

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): March 18-21 and 24-26, 2014

The following concurrent inspections were conducted with the Resident Quality Inspection:
Log O-001031-13 - critical incident
Log O-001069-13 - critical incident
Log O-001172-13 - complaint

During the course of the inspection, the inspector(s) spoke with the Administrator, the Manager of Nursing, the Assistant Manager of Nursing, the Administrative Supervisor, the Environmental Services Supervisor, the Dietary Services Manager/Registered Dietitian, the Resident Services Coordinator/Manager of Activation, the Manager of Finance, the Family Council and Resident Council presidents, Registered Nurses, Registered Practical Nurses, Personal Support Workers, residents and resident family members.

During the course of the inspection, the inspector(s) reviewed resident health care records, policies (related to medication, abuse, falls prevention, infection control, laundry and maintenance), residents and family council minutes, the staffing plan, a record of falls for 2013, a call bell report, a dietary report, the current menu cycle, a hospital discharge list and observed dining service, laundry and maintenance services, medication pass, resident activities and care.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care
Sufficient Staffing
Trust Accounts

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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to comply with the LTCHA, 2007 S.O. 2007, Chapter 8 s. 6 (10) (c), in that Resident #410's plan of care was not reviewed and revised when the care set out in the plan of care as it relates to hydration was not effective.

On March 21, 2014, Inspector #197 interviewed Resident #410's Substitute Decision Maker. He/she indicated concern about the resident not getting enough fluid and feeling that staff did not have enough time to push fluids.

On March 26, 2014, Inspector #134 observed Resident #410 at 0930 hours, who was sleeping at the breakfast table. The resident's four drinks were untouched and there was half of a slice of toast left to eat. The resident's coffee was cold, but the resident did take a sip when prompted by the inspector. Once a new cup of hot coffee was served, the resident drank it without hesitation.

Staff member S100, who was assigned to assist Resident #410 at breakfast, was interviewed by the inspector and indicated assisting the resident with cereal earlier. Staff member S101 was also interviewed and indicated that staff try to give Resident #410 fluids but they are not always successful.

Staff member S102 indicated that the resident has difficulty staying in a fixed position and that it is important that staff ensure he/she is focused on the task of eating or drinking. This information was not found in the written care plan.

Staff member S101 was then observed sitting with the resident at 0940 hours and assisting with fluids, which the resident drank very well.

Resident #410's plan of care was reviewed and it indicates the resident requires additional fluids and specified the exact amount required. The intervention identified is for staff to encourage fluids throughout the day and evening.

The dietary report flow sheets for January to March 2014 were reviewed. There were forty days noted where the resident did not consume enough fluids to meet the need identified in the care plan.

The Registered Dietitian was interviewed by Inspector #134 and reported that she had not received any indication from staff that Resident #410 consumed insufficient fluids. [s. 6. (10) (c)]

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 resident #410's written plan of care, as it relates to hydration, is reviewed and revised when the care set out in the plan of care is not effective, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The following evidence is related to log O-001031-13.

The licensee has failed to comply with LTCHA, 2007 S.O. 2007, Chapter 8 s. 23.(2) in that the licensee did not report the results of an alleged abuse investigation undertaken under clause (1)(a).

On a specified date, the home submitted a Critical Incident Report to the Director upon being made aware of an alleged case of resident abuse. The report was then amended at a later date stating that the investigation was ongoing. No further updates or amendments were made to the Critical Incident Report.

On March 26th, 2014, Inspector #531 interviewed the Manager of Nursing and the Administrator who confirmed that the investigation into the alleged resident abuse had been completed and that the Director was not notified at that time of the results of the investigation. [s. 23. (2)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The following evidence is related to log O-001031-13.

The licensee has failed to comply with LTCHA, 2007 S.O. 2007, Chapter 8 s. 24.(1) in that a person who had reasonable grounds to suspect that abuse of a resident had occurred did not immediately report the suspicion and the information upon which it was based to the Director.

On March 25th, 2014, Inspector #531 interviewed staff member S103 who had previously observed an incident of alleged resident abuse. Staff member S103 confirmed that the alleged incident occurred during a specified time period and that it was not reported to the Manager of Nursing until a few weeks later.

On March 25th, 2014 during an interview with the Manager of Nursing and Assistant Manager of Nursing it was confirmed that the alleged resident abuse was not reported until a few weeks after it had occurred. Therefore the alleged abuse of a resident was not reported immediately to the Director. [s. 24. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 117. Medical directives and orders — drugs
Every licensee of a long-term care home shall ensure that,
(a) all medical directives or orders for the administration of a drug to a resident are reviewed at any time when the resident's condition is assessed or reassessed in developing or revising the resident's plan of care as required under section 6 of the Act; and
(b) no medical directive or order for the administration of a drug to a resident is used unless it is individualized to the resident's condition and needs. O. Reg. 79/10, s. 117.

Findings/Faits saillants :

1. The licensee has failed to comply with the O. Reg. 79/10 s. 117 (a) and (b), in that the Medical Directives for the administration of a drug to a resident is not reviewed when the resident's condition is assessed or reassessed in developing or revising the resident's plan of care.

The Licensee's Medical Directives Policy # 07-01-01 was reviewed. The list of medication was approved and signed by the Medical Director September 2013.

A list of medication with specific direction is provided. These medical directives are not reassessed when revising the resident's plan of care.

Residents #392, #396 and #352's "Physician Three Month Review" dated March 25, 2014 were reviewed by Inspector #134. There is no indication that the Medical Directives were renewed with the other medication orders. [s. 117. (a)]

2. The Medical Directives are not individualized to the resident's condition and needs.

Staff member S104 was interviewed by Inspector #134 on March 26, 2014 and indicated that medical directives are not used very often on that resident home area. Staff member S104 stated that he/she would use Ventolin with residents with shortness of breath who may not have a diagnosis of respiratory illness. The staff member will only use it once and would then call the physician to notify him or her that it was administered for further instruction. [s. 117. (b)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10 s. 129 (1) (b), in that eleven (11) injectable controlled substances were not stored in a separate, double locked stationary cupboard in the locked area or was not stored in a separate locked area within the locked medication cart.

On March 21, 2014 at 1100 hours, Inspector #134 observed eleven (11) injectable benzodiazepine (Ativan) vials stored in the Maple Lane medication room's small fridge. These vials were found with other food items. The vials were labeled with a sticker indicating they were required to be refrigerated.

The fridge was not locked and as such the controlled substances were not double locked as per legislative requirements. [s. 129. (1) (b)]

Issued on this 28th day of March, 2014

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs
Jessica Pattison, RD