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 # / Registre no	Type of Inspection / Genre d'inspection
Dec 30, 2016	2016_429642_0015	031090-16	Resident Quality Inspection

Licensee/Titulaire de permis

THE WOMEN'S CHRISTIAN ASSOCIATION OF LONDON
2022 Kains Road LONDON ON N6A 0A8

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

McCORMICK HOME
2022 Kains Road LONDON ON N6K 0A8

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

AMY GEAUVREAU (642), HEATHER PRESTON (640)

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): November 28-30 and December 1-2, 2016.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Environmental Services Supervisor, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Resident Assessment Instrument Coordinator (RAI Coordinator), Personal Support Workers (PSWs), housekeepers, family members, residents and Substitute Decision Maker (SDM).

During the course of the Resident Quality Inspection, the inspectors conducted a daily walk through of the resident home areas and various common areas, made direct observation of the delivery of care and services provided to the residents, interviewed staff and residents, observed staff to resident interactions, reviewed relevant health care records and various policies, procedures and programs of the home.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Residents' Council
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
4 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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe and secure environment for its residents.

During stage one of the inspection an initial tour of the home was conducted. Inspector #640 observed a cleaning closet was unlocked. In the cleaning closet, there were ten bottles of cleaning supplies such as AF79 concentrated disinfectant cleaner, pH7 ultra daily floor cleaner, and Kling - thickened acid toilet and urinal cleaner.

An interview with RPN #103 and housekeeper #104, revealed that it was the home’s expectation that the door to the cleaning closet was to be locked at all times when not supervised.

Inspector #640 interviewed the Environmental Services Supervisor and the Administrator who stated that the doors to the cleaning closets were to be kept locked at all times when not attended. [s. 5.]

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 has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Inspector #640 observed that resident #006 had a device on while they were in their wheelchair.

After review of the home's policy titled, "Restraints/Personal Assistance Service Devices (PASD) #NPC-1800-10", revised May 2016, it directed staff to complete the online "Restraint/PASD Assessment Form", and to consider and try alternatives prior to implementation of a device, obtain a physician order, a consent, and documentation of the release and repositioning of the device.

During interviews with the RPN #103 and RN #108, they both stated that there were no assessments, no documentation on the written plan of care, no alternatives, no physician order, no consent, and no two hourly checks or repositioning being documented for resident #006.

During an interview with the DOC, they stated that prior to the implementation of the device, staff were expected to assess the resident, consider alternatives, obtain a physician order, obtain a consent, document in the plan of care and comply with the policy "Restraints/Personal Assistance Service Device #NPC-1800-10." [s. 8. (1) (b)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails were used, the resident had been assessed and their bed system evaluated in accordance with evidence-based practices to minimize risk to the resident.

Inspector #640 observed two half bed rails to be in use for resident #006. A review of the health care records revealed no resident assessment and no bed system evaluation was completed.

A memo from the Ministry of Health and Long-Term Care (MOHLTC) dated August 21, 2012 was sent to all Long-Term Care (LTC) Home Administrators indicating that all LTC homes should use the Health Canada guidance document 'Adult Hospital beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards' as a best practice document in their homes. This document references the 'Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities, and Home Care Settings' (CGA), as a prevailing practice for the assessing the use of bed rails. The CGA document indicated that automatic use of bed rails may pose unwarranted hazards to resident safety and evaluation is needed to assess the relative risk of using the bed rail compared with not using it for an individual patient. The use of bed rails should be based on a residents' assessed needs.

During interviews with RPN #103 and RN #108, they both stated there were no assessments regarding the use of the bed rails for resident #006.

During an interview with the DOC, they told the Inspector that the expectation of the home was that staff were to complete an assessment and a bed system evaluation prior to the use of the bed rails. [s. 15. (1) (a)]

WN #4: 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 ensure that drugs were stored in an area or a medication cart, that was secured and locked.

a) During stage one of the RQI, Inspector #642 observed one prescribed cream on resident #002’s bed side table.

During an interview with PSW #109, they stated that the prescribed cream should not be on the residents side table, it should be locked in the medication cart.

During Interviews with RN #105 and the DOC, they both stated that the prescription cream should not have been left on the resident’s bed side table. The DOC stated, "No prescription creams should be at the bedside, they should have been stored and in the locked medication or treatment cart." [s. 129. (1) (a)]

2. b) Inspector #640 observed a jar of prescription ointment, which was found on an open shelf in resident #004’s room.

During an interview with RPN #100, they stated the prescribed medication for this resident should have been stored and locked in the medication room.

During an interview with the DOC, they stated that prescription creams should be stored in the locked medication room and not in the residents rooms. [s. 129. (1) (a) (ii)]

Issued on this 5th day of January, 2017

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

Original report signed by the inspector.