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

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

London Service Area Office
291 King Street, 4th Floor
LONDON, ON, N6B-1R8
Telephone: (519) 675-7680
Facsimile: (519) 675-7685

Bureau régional de services de London
291, rue King, 4iém étage
LONDON, ON, N6B-1R8
Téléphone: (519) 675-7680
Télécopieur: (519) 675-7685

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 20, 2014	2014_229213_0002	L-000002-14	Resident Quality Inspection

Licensee/Titulaire de permis

THE CORPORATION OF THE COUNTY OF ELGIN MUNICIPAL HOMES
39262 Fingal Line, RR #1, ST. THOMAS, ON, N5P-3S5

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

ELGIN MANOR
39262 FINGAL LINE, R. R. #1, ST. THOMAS, ON, N5P-3S5

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

RHONDA KUKOLY (213), INA REYNOLDS (524), JUNE OSBORN (105), SHANNON WATT (525)

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): January 6, 7, 8, 9, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Resident Care Coordinator, the Manager of Program and Therapy Services, the Manager of Support Services, 8 Personal Support Workers, 2 Health Care Aides, 3 Activation Aides, 1 Dietary Aide, 1 Cook, 1 Maintenance Staff, 27 Residents and 4 Family Members.

During the course of the inspection, the inspector(s) toured the home; observed meal service, medication passes, medication storage areas and care provided to residents; reviewed health records and plans of care for identified residents; reviewed policies and procedures of the home and the home's internal investigation records; and observed general maintenance, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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. (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).

Findings/Faits saillants :

1. The licensee failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff regarding programs as evidenced by:
a) A record review revealed the MDS assessment for a Resident identified specific interests. These assessed interests were not included in the plan of care for this Resident.
b) The Activation Aide and the Manager of Program and Therapy Services both confirmed that the above assessed interests were not included in the plan of care for this Resident. [s. 6. (1) (c)]

2. The licensee failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff regarding bowel care as evidenced by:
a) A record review revealed that a Resident was assessed as being incontinent of bowel using briefs and pads. The plan of care for this Resident did not indicate interventions related to bowel care.
b) The Director of Care confirmed that it is an expectation that interventions related to bowel care are on care plans when appropriate. [s. 6. (1) (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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that foods and fluids were served at a temperature that was both safe and palatable to the residents as evidenced by the following:
a) On January 9, 2014, in Garden Grove dining room, the following menu item was noted as not being held at palatable temperatures when probed at 08:40 hr during the breakfast meal service:
Poached Eggs - 137.1F
The acceptable minimum for hot food temperature is 140F.
During interview with the Manager of Support Services on January 9, 2014, she confirmed that food temperatures at breakfast are not monitored.

b) On January 9, 2014, in Garden Grove dining room, the following menu items were noted as not being held at palatable temperatures when probed at 12:15 hr during the lunch meal service:
Minced Peas - 119F
Minced Brussel Sprouts - 107F
Brussel Sprouts - 134.7F
The acceptable minimum for hot food temperatures is 140F.
Service pans were noted to be double stacked and one steam well was not in use.
One Resident commented that the peas were not hot because "the butter did not melt".
During interview with the Manager of Support Services on January 9, 2014, she confirmed the expectation that staff maintain acceptable food temperatures of all menu items during the lunch meal service.

c) On January 9, 2014, in Orchard Grove dining room, the following items were noted as not being held at palatable temperatures when probed at 12:16 hr during the lunch meal service:
Minced Peas - 119F
Minced Brussel Sprouts - 107F
The acceptable minimum for hot food temperatures is 140F.
Menu items were placed in a steamwell that was not turned on.
During interview with the Manager of Support Services on January 9, 2014, she confirmed the expectation that staff turn on the steamwell when in use to maintain acceptable food temperatures of all menu items during the lunch meal service. [s. 73. (1) 6.]

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 food and fluids are served at a temperature that is both safe and palatable to the residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. Staff failed to participate in the implementation of the infection prevention and control program as evidenced by:
a) Call bell cords in Resident washrooms were fabric and the cords in three rooms were found to be soiled.
b) An interview with the Administrator revealed that there should not be fabric call bell cords in Resident washrooms and she will be replacing these cords with vinyl cords.
[s. 229. (4)]

2. Staff failed to participate in the implementation of the infection prevention and control program as evidenced by:
a) A record review revealed that a Resident had a diagnosis which required specific interventions. There were no directions in place related to these interventions. A Health Care Aide confirmed that directions should be posted regarding these interventions for staff and/or visitors. There were no interventions regarding this diagnosis included in this Resident's care plan. An interview with the Director of Care

confirmed that directions should be posted regarding these interventions for staff and/or visitor and these interventions should be included in the care plan.

b) A record review revealed that a second Resident had a diagnosis which required specific interventions. There were no directions in place related to these interventions. A Personal Support Worker confirmed that directions should be posted regarding these interventions for staff and/or visitors.

c) A cart with equipment was outside of and between 2 Resident rooms, there were no directions indicating what equipment was to be used or for whom. Two Personal Support workers confirmed they were not sure who the equipment was to be used for and that there should be directions in place for staff and visitors.

d) The Infection Control Policy #1.1 indicates directions are to be in place for staff and visitors related to specific interventions. [s. 229. (4)]

3. Staff failed to participate in the implementation of the infection prevention and control program as evidenced by:
a) Five used, unlabeled hair brushes were observed in 3 different spa rooms.
b) Staff confirmed that these brushes should not be there and are now unusable. [s. 229. (4)]

4. The licensee failed to ensure that each resident admitted to the home is screened for tuberculosis within 14 days of admission, unless the resident has already been screened at some time in the 90 days prior to admission as evidenced by:
a) A record review revealed that there was no documentation of a TB skin test or a chest x-ray completed after admission or within 90 days of admission to the home for a particular Resident.
b) Two Registered Practical Nurses confirmed that there was was no documentation of a TB skin test or a chest x-ray completed after admission or within 90 days of admission to the home for this Resident. [s. 229. (10) 1.]

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 all staff participate in the implementation of the infection control program, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the provisions and outcomes of the care set out in the care plan are documented as evidenced by:
a) A record review revealed the care plan for a Resident indicated this Resident was to have music therapy visits. These music therapist visits were not documented.
b) The Manager of Program and Therapy Services confirmed that music therapy visits are not documented. [s. 30. (2)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident exhibiting altered skin integrity is assessed at least weekly by a member of the registered nursing staff as evidenced by:
a) A record review revealed that a Resident had an alteration in skin integrity. This Resident did not have a a weekly wound assessment documented for a 9 week interval.
b) The Director of Care confirmed that it is an expectation that weekly wound assessments are documented in the progress notes. [s. 50. (2) (b) (iv)]

Issued on this 20th day of January, 2014

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

Rhonda Kukoly