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

Sudbury Service Area Office
159 Cedar Street, Suite 403
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 403
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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
Oct 10, 2014	2014_395151_0002	S-000352-14	Resident Quality Inspection

Licensee/Titulaire de permis

FOYER HEARST - MATTICE - SOINS DE SANTE
67-15th Street, P.O. Box 1538, HEARST, ON, P0L-1N0

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

FOYER DES PIONNIERS
67 15TH STREET, P.O. BOX 1538, HEARST, ON, P0L-1N0

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

MONIQUE BERGER (151), TIFFANY BOUCHER (543)

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): Sept. 22,23,24,25,26,29,30, Oct. 1,2,3, 2014

RQI relates to log number S-000352-14

During the course of the inspection, the inspector(s) spoke with
- Administrator
- Director of Care
- Food Service Supervisor
- Recreation and Activation Co-ordinator
- Maintenance Manager
- Registered Staff
- Personal Support Workers (PSW)
- Dietary Aides
- Family Council Chair
- Resident Council President
- Residents
- Family members and visitors

During the course of the inspection, the inspector(s)
- toured the home daily
- conducted audits as required by the Resident Quality Inspection protocols
- reviewed resident health care records
- reviewed policies, procedures, protocols and programs concerning the management of responsive behaviours
- reviewed policies, procedures, protocols and programs concerning infection control program
- reviewed policies, procedures, protocols concerning medication administration
- conducted audit of dining services
- reviewed policies, procedures, protocols in regards to annual review of required programs

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Pain
Personal Support Services
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home

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 O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. Inspector conducted a dining observation in Dining Rooms A and B. Inspector noticed that an RN entered the dining room with a tray of medications and placed several medication cups of medications in front of varied residents and left the dining room without ensuring that the residents had taken the medication given to them

In the immediate ensuing interview with the Inspector, RN confirmed that this was the usual practice and that the medications are signed off in the Medication Administration Record as having been taken. The RN stated these residents were very lucid, had verbalized that they wished their pills to be given this way, that the registered staff did not have time to come back over time to ascertain if the residents had taken the medication but they felt confident that these residents, being as lucid as they were, would have consumed the medication by meals end.

The Inspector interviewed the Administrator who confirmed that there were no orders for medication self-administration for the residents referenced.

As such, the licensee has failed to ensure that that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. [s. 131. (5)]

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 that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident, to be implemented voluntarily.

WN #2: 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. (2) The licensee shall ensure,
(e) that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 229 (2).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. In an interview with Inspector 151 on September 30, 2014, Administrator confirmed that there is no formal process to evaluate the annual Infection Control Program that would satisfy the requirements of r.229.(2) (e)

As such, the licensee has failed to ensure that there is a written record of the annual Infection Prevention and Control program evaluation that includes the following:
* the date of the evaluation
* the names of the persons who participated
* a summary of the changes made, and
* the date those changes were implemented [s. 229. (2) (e)]

2. Inspector reviewed the home's policies and procedures in regards to resident and staff immunization. Inspector was unable to locate any policy referencing the offer of tetanus and diphtheria immunizations to residents. In an interview with Inspector 151, Administrator confirmed that the home did not as yet offer immunization for tetanus and diptheria and has not updated it's policies in reference to r 229 (10) 3.

As such the licensee has failed to ensure that residents are offered immunizations against tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. [s. 229. (10) 3.]

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 record of the annual Infection Prevention and Control Program evaluation that meets the requirements of r.229.(2)(e) and that the home develops and implements policies and procedures that includes offering residents immunization against tetanus and diphteria, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. Inspector interviewed a family member during stage one of the Resident Quality Inspection being conducted in the home. The family member stated that staff conveyed information regarding the resident who is a family member in the corridor of the home, where the conversation could be overheard. Inspector interviewed two registered staff who confirmed that, on occasion, both have had discussions with family about their related family resident in the corridors of the home.

As such, the licensee has failed to ensure that the licensee fully respected and promoted the resident's right to have his or her personal health information (within the meaning of the Personal Health Information Protection Act, 2004) kept confidential, [s. 3. (1) 11. iv.]

WN #4: 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).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. Inspector reviewed resident #168's most recent MDS assessment that identified the resident had moderate daily pain. The Inspector also reviewed the resident's care plan and found no focus of care planning addressing pain management.

The Inspector reviewed the home's policy titled: Pain Assessment and Management. The procedures for this policy stated the home would initiate a written plan of care within 24 hours of admission and update as necessary.

As such, this resident's care plan does not set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. Inspector reviewed resident #158's most recent MDS assessment which identified this resident had moderate daily pain. The Inspector also reviewed this resident's care plan, this care plan did not address pain or pain management.

The Inspector reviewed the home's policy titled:Pain Assessment and Management. The procedure of this policy stated that the home will initiate a written plan of care within 24 hours of admission and update as necessary.

As such, this resident's care plan does not set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

3.Inspector conducted a family interview with resident #186's family member. The family member told the Inspector that the home had moved the resident to another room without notifying the family. As well, the family stated that the resident's medications were changed, and the family was not contacted to discuss the change.

Inspector spoke with two staff members on the unit regarding notifying resident's family designate of any changes in care, services, medication,and, new physician orders. One of the two staff interviewed, stated that families are not always notified of all changes.

As such, the licensee failed to ensure that the designate of the resident / SDM had been provided the opportunity to participate fully in the development and implementation of the plan of care. [s. 6. (5)]

4. Inspector reviewed resident #200 health care records and noted that an incident of verbal and physical aggression occurred. Inspector reviewed the resident's care plan for responsive behaviours and noted in the section addressing physical aggression that staff were to do hourly observation for 72 hours to try to identify the cause of the behaviour. Inspector could find no record of hourly observations. In an interview, both the Administrator and the Director of Care confirmed that for this resident and for

this incident, that directive was not followed.

As such, the licensee has failed to ensure that the care set out in the plan of care provided to the resident as specified in the plan. [s. 6. (7)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. Inspector reviewed the home's supper meal processes. Inspector noted that on Unit C, residents were being served food in plastic scoop plates that were heavily scored by fork and knife action, that were heavily stained by food stuff and were scaling with layers peeling away. Inspector noted that the majority of the plates were in this condition.

As such the licensee has failed to ensure that the home, its furnishings and equipment are kept clean and sanitary [s. 15. (2) (a)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).

Findings/Faits saillants :

1. Inspector reviewed the home's responsive behaviour program. Inspector was unable to locate any reference that identified the process to refer residents to specialized resources. In addition, the Inspector could not locate any reference that identified available specialized resources for this home. In an interview with the Inspector, Administrator and Director of Care confirmed that the program did not provide a written protocol for the referral of residents to specialized resources and did not identify the resources available.

As such the licensee has failed to ensure that there are written protocols for the referral of residents to specialized resources where required. [s. 53. (1) 4.]

2. In an interview with Inspector, Administrator confirmed that there is no record of annual evaluation of the Responsive Behaviour program that meets the requirements of this regulation.

As such the licensee has failed to ensure that there a written record relating to each evaluation that includes:

* date of the evaluation
* names of the persons who participated
* summary of the changes made, and
* date that those changes were implemented [s. 53. (3) (c)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. Inspector spoke with the Resident Council President, who stated the licensee responds verbally to concerns and will do so in a timely manner, however, no written response follows.
The Inspector spoke with the home's Administrator who confirmed that there is no response in writing within 10 days of receiving advice related to concerns or recommendations. Administrator also confirmed the home's usual practice to address concerns is to do so in person or verbally with the Council.

As such, the licensee has failed to ensure that response is in writing within 10 days of receiving Resident Council advice related to concerns or recommendations. [s. 57. (2)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. Inspector spoke with the Family Council President, who stated the licensee responds verbally to concerns and will do so in a timely manner, however, no written response follows.
The Inspector spoke with the home's Administrator who confirmed that there is no written response within 10 days of receiving advice related to concerns or recommendations. Administrator also confirmed the home's usual practice to address concerns is to do so in person or verbally with the Council.

As such, the licensee has failed to ensure that response is in writing within 10 days of receiving Family Council advice related to concerns or recommendations. [s. 60. (2)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 65. Recreational and social activities program

Specifically failed to comply with the following:

s. 65. (2) Every licensee of a long-term care home shall ensure that the program includes,
(a) the provision of supplies and appropriate equipment for the program; O. Reg. 79/10, s. 65 (2).
(b) the development, implementation and communication to all residents and families of a schedule of recreation and social activities that are offered during days, evenings and weekends; O. Reg. 79/10, s. 65 (2).
(c) recreation and social activities that include a range of indoor and outdoor recreation, leisure and outings that are of a frequency and type to benefit all residents of the home and reflect their interests; O. Reg. 79/10, s. 65 (2).
(d) opportunities for resident and family input into the development and scheduling of recreation and social activities; O. Reg. 79/10, s. 65 (2).
(e) the provision of information to residents about community activities that may be of interest to them; and O. Reg. 79/10, s. 65 (2).
(f) assistance and support to permit residents to participate in activities that may be of interest to them if they are not able to do so independently. O. Reg. 79/10, s. 65 (2).

Findings/Faits saillants :

1. In interviews during stage one of The Resident Quality Inspection, residents # 135, 164,and,168 informed the inspector that there were no weekend/evening activities or that they had no knowledge of weekend/evening activities. Inspector reviewed the home's activities record for the last 3 months, interviewed staff, reviewed residents' health care records relating to care plan of the individual residents recreational and social programming and reviewed records of attendance to these activities. Inspector noted that the schedule included and that residents attended week-end activities. However, Inspector also noted that in a 3 month span, only 1 activity was scheduled for a time after the supper meal. In an interview, staff # 0021 confirmed that historically, there have been very few activities scheduled for the evenings.

As such, the licensee has failed to ensure that the program includes the development and implementation of a schedule of recreation and social activities that are offered during days, evenings and weekend. [s. 65. (2) (b)]

WN #10: 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:
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences. O. Reg. 79/10, s. 73 (1).

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:
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. Inspector observed the supper meal service and noted that the only resident nutritional profile available for staff to reference when serving resident food or drink was found in the kitchen on the bulletin board. Residents were served food directly from either the servery or from a movable "Susie Q" cart that went table to table. At no time did the Inspector observe any staff to reference the dietary profiles when plating food for the residents. Inspector noted that there was no dietary profile for staff to reference on the 'Susie Q" cart.

Inspector observed the morning and afternoon snack and fluid pass down corridor B. Inspector noted that no dietary profile resource for staff to reference was on on the carts on either of these passes.

In an interview with Inspector, staff #020 confirmed that there are no dietary profiles attached to dietary and snack carts for staff to reference, that this was tried and that staff remove them. Staff #020 confirmed that the the profiles contained resident specific consideration for special dietary needs, altered texture type, specific food allergies, adequate hydration needs and "likes and dislikes".

As such, the licensee has failed to ensure that there a process to ensure that food service workers and other staff assisting residents are aware of the residents' diets,

special needs and preferences. [s. 73. (1) 5.]

2. Inspector 151 observed the evening meal for residents in dining rooms A and B. Inspector observed the menu for the day was posted in large font on an inside wall of the dining room near the servery. Inspector noted the dessert was posted as blueberry yogurt cake and pineapple tid-bits. Inspector confirmed that these choices were available for all texture modified diets including pureed diets. Inspector observed that 2 residents asked what the dessert choices were and staff told them the pureed blueberry yogurt cake was chocolate pudding. These two residents chose the "chocolate pudding". Staff did not reference the large print menu posted within the room before answering the residents.

As such, the licensee has failed to ensure that there a process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences. [s. 73. (1) 5.]

3. Inspector observed the supper resident meal. Inspector noted that residents were being rushed through the meal. As soon as the final entree was served to the residents, dessert was put out to each resident in the dining room next to their entree plate. Inspector spoke to staff #020 who stated that through audits for resident dining, it was found that there was a pattern for the evening meal to be rushed in this fashion.

As such the licensee has failed to ensure that meals served course by course unless otherwise indicated by the resident or the resident's assessed needs. [s. 73. (1) 8.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 114 (3).
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Findings/Faits saillants :

1. Inspector reviewed the home's policies and procedures regarding medication administration and identified that all policies were last reviewed in February 2012, with the exception of one (Drug/Treatment Administration by Resident) reviewed on September 24, 2014. Inspector also noted that some of the policies had dated and inaccurate references; i.e. reference to the "Nursing Home Act" no longer in effect since July 2010.

In an interview with the Inspector, the Director of Care confirmed that the medication policy and procedure binder provided to the Inspector was the one with the most recent and updated policies.

As such, the licensee has failed to ensure that the written policies and protocols developed, implemented, evaluated and updated are in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. [s. 114. (3) (a)]

Issued on this 10th day of October, 2014

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