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 soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 20, 2017	2017_572627_0017	009439-17	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

SYLVIE BYRNES (627), TIFFANY BOUCHER (543)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): October 2-5, 2017.

The following additional intakes that were submitted to the Director were inspected during this Resident Quality Inspection:

- One Critical Incident (CI) related to plan of care, and
- One Complaint related to care concerns.

During the course of the inspection, the inspector(s) spoke with the Administrator (Admin.), Director of Care (DOC), Food/Housekeeping Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), family members and residents.

The Inspector(s) also conducted daily tours of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, numerous policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **7 WN(s)**
- **4 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. 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 ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

Resident #006 was identified as having a health concern from their past to most recent Minimum Data Set (MDS) assessment.

Inspector #543 reviewed the resident's care plan, which indicated the resident had a specific health concern.

Inspector #543 reviewed resident #006's heatlh care assessments and noted that these assessments had not identified the specific type of health concern.

On October 4, 2017, Inspector #543 interviewed RPN #101 regarding resident #006's health concern. RPN #101 indicated that resident #006 had an ongoing heath concern. They indicated that the health concern had changed.

On October 5, 2017, Inspector #543 spoke with the Administrator and the DOC, who indicated that resident #006 did not in fact have the documented health concern, as it had improved. They verified that the care plan had not been reviewed or revised to reflect the current status of the health concern. [s. 6. (10) (b)]

2. A complaint was submitted to the Director regarding care concerns for resident #008.

On September 29, 2017, during an interview with Inspector #627, the complainant stated that resident #008 often refused to take part in a certain activity, therefore, the staff had stopped asking the resident to attend. The complainant wished that staff encouraged the

resident to attend the activity. The complainant had asked for alternatives for the activity to be provided, however, they stated that only one staff member ensured the resident received the alternative. The complainant indicated that if the resident was asleep, the alternative was not provided to the resident.

Inspector #627 reviewed a specific health care record for a two month period, for resident #008. The health care record for a specific month, indicated that resident #008 had taken part in the activity daily. A review of the heath care record for the following month indicated that the resident had not taken part in the activity at all.

Inspector #627 reviewed the notes from the "Monthly Quality Assurance" meeting (monthly meetings when resident care concerns were discussed amongst a multidisciplinary team) for a specific month. There was no mention of resident #008 refusing to take part in the activity.

Inspector #627 reviewed resident #008's care plan in effect at the time of the Inspection and noted that none of the interventions addressed the resident's lack of participation in the activity.

On October 4, 2017, Inspector #627 interviewed PSW #104 who stated that resident #008 required assistance to attend the activity. They further stated that if a resident refused to take part in the activity, the registered staff were made aware, and staff provided the resident with an alternative. They stated that resident #008 required a lot of encouragement to attend the activity.

On October 4, 2017, Inspector #627 interviewed RN #103 who stated that they were aware that resident #008 was not taking part in the activity during a specific month. RN #103 stated that when a resident refused to take part in the activity, the registered staff was made aware. This was reported to the following shift and to the Physician. If the lack of participation persisted, it was addressed in the Monthly Quality Assurance meetings and the resident's care plan would be updated as needed. RN #103 confirmed that the care plan had not provided interventions to address #008's refusal to attend the activity.

On October 5, 2017, Inspector #627 interviewed the Director of Care who verified that resident #008 was not taking part in the activity, and that it had not been addressed in the Monthly Quality Assurance meeting. They further stated that resident #008's care plan had not been reviewed and revised when the resident's care needs had changed.

(10) (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 residents' care plans are reviewed and revised when the residents' care needs change or the care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home had their personal items, including personal aids, labelled within 48 hours.

On October 2, 2017, during the initial tour of the home, Inspector #627 observed the following items in the tub rooms: each of these items were used and unlabeled.

- Four combs,
- five Lady Speed deodorants,
- three Brut deodorants,
- two Speed Stick deodorants,
- four nail clippers,
- one Crest Toothpaste,
- one blue razor,
- one Secret deodorant,
- one bar of soap in unlabelled black dish,
- one bottle of Listerine mouthwash,
- one Fanciful styling mousse and
- one Nivea cream.

Inspector #627 reviewed the home's policy titled "Orientation - Competency Profiles - Health Care Aides" last revised April 2, 2010, which indicated to "label all residents' belongings".

On October 2, 2017, during separate interviews with Inspector #627, PSW #106 and #107 stated that all of the residents' products should be labelled. The products were brought to the tub room on bath days with the resident, and returned to the resident's room once the bath was completed.

During an interview with the Inspector, the DOC confirmed that it was the home's expectation that all of the resident's products be labelled and returned to the resident's room after the bath was completed. [s. 37. (1) (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 reach resident of the home have their personal items labelled, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure all staff who provided direct care to residents received as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or intervals provided for in the regulations: 2- Skin and Wound Care.

A resident was identified as having a wound from their past to most recent MDS assessment.

On October 4, 2017, Inspectors #543 and #627 interviewed the Administrator regarding the Skin and Wound program and requested the annual training records for the Skin and Wound Care program. The Administrator indicated that they would verify if there was training/education completed in 2016.

On October 5, 2017, the DOC informed Inspectors #543 and #627 that the home did not have documentation related to education for their Skin and Wound Care program for 2016. They verified that no education/training had been completed for skin and wound care for 2016 and 2017. [s. 76. (7) 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 all staff who provide direct care to residents are provided with annual training in Skin and Wound care, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 116 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that an interdisciplinary team, which included the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a Registered Dietitian who was a member of the staff of the home, met annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

On October 5, 2017, during an interview with the Administrator, Inspector #627 requested the documentation for meeting of the interdisciplinary team who evaluated the effectiveness of the medication management system.

On October 5, 2017, Inspector #627 interviewed the Administrator who stated that as part of their "Quality Assurance" program, the Pharmacist completed an audit of the medication inventory and storage, procedure and documentation, however the home had not had an annual meeting with an interdisciplinary team to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. [s. 116. (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 an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a Registered Dietitian who is a member of the staff of the home, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee has failed to ensure that copies of the inspection reports from the past two years for the long-term care home was posted in the home.

On October 2, 2017, during a tour of the home, Inspector #627 noted one Inspection report, #2016_282543_0027, for a Resident Quality Inspection (RQI), which was completed September 20-23 and 26-29, 2016, posted on the display board by the entrance.

Inspector #627 reviewed the home's inspection history and identified that an RQI, #2015_391603_0028, had also been conducted on August 31-September 4 and September 8-9, 2015, which was not posted.

During an interview with the Inspector #627, the Administrator verified that Inspection report #2015_391603_0028 should have been posted, and stated that they would re-post it. [s. 79. (3) (k)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of an incident that caused an injury to a resident for which the resident was transferred to a hospital and that resulted in a significant change in the resident's health condition, no later than one business day after the occurrence of the incident, followed by a report required under subsection four (4).

A critical incident (CI) report was submitted to the Director on a specific date. According to the CI report resident #007 had complained of pain.

Inspector #543 reviewed resident #007's progress notes, which indicated that the resident had confirmation of a specific type of injury.

Inspector #543 interviewed the Administrator regarding the CI report. They substantiated that the incident was reported late. [s. 107. (3) 4.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and reported to the resident or the resident's Substitute Decision Maker (SDM).

Inspector #627 reviewed three medication incident reports.

All three reports indicated a description of the incident, that the Physician had been notified, however there was no documentation identifying the immediate actions to assess and maintain the resident's health or if the resident or the resident's SDM was notified of the incident.

Inspector #627 interviewed the Administrator who verified that the report had not identified what immediate actions were taken to assess and maintain the resident's health and that there was no identifying if the resident or the resident's SDM had been notified of the incident. [s. 135. (1)]

2. The licensee has failed to ensure that for ever medication incident and adverse drug reaction, corrective actions were taken as necessary and a written record was kept of everything under clauses (a) and (b).

Inspector #627 reviewed three medication incident reports during the Inspection. During this review, the Inspector noted that there was no documentation of corrective actions taken.

Inspector #627 interviewed the Administrator who verified that the report had not identified the corrective actions taken, although every incident was analyzed and corrective actions had been implemented. [s. 135. (2)]

Issued on this 20th day of October, 2017

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

Original report signed by the inspector.