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 # / Registre no	Type of Inspection / Genre d'inspection
Jul 26, 2016	2016_505103_0025	020627-16	Complaint

Licensee/Titulaire de permis

MANORCARE PARTNERS II
6257 Main Street Stouffville ON L4A 4J3

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

FRIENDLY MANOR NURSING HOME
9756 County Road, #2 P.O. Box 305 DESERONTO ON K0K 1X0

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

DARLENE MURPHY (103)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): July 19-22, 25, 2016

The following log was inspected, Log 020627-16 (complaints related to resident care needs).

During the course of the inspection, the inspector(s) spoke with Personal support workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), the Dietitian (RD), Food Service Supervisor, Activation Supervisor, the Director of Care (DOC) and the Administrator.

During the course of the inspection, the inspector reviewed the resident health care record, observed resident dining and resident care.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Medication
Nutrition and Hydration
Personal Support Services
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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. (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 has failed to ensure resident #001's plan of care had clear directions in regards to oral care.

Resident #001's health care record was reviewed. The family of resident #001 raised concerns to staff related to the oral care being provided to this resident. The family indicated they observed tooth decay and the resident, upon admission to the home, had all of their own teeth except for a partial plate. The family raised further concerns that resident #001's recent loss of appetite may be related to pain associated with the tooth decay.

The family inquired if an identified treatment could be used prior to meals and as required to alleviate mouth pain and to encourage increased intake at meal times. RN #106 was interviewed and indicated the physician approved the use of the identified treatment before meals on an identified date and stated the family could supply it.

The resident's medication administration record and treatment records were reviewed but did not indicate the use of or directions for the identified treatment. The identified treatment was found in the resident medication slot. Twelve days after the physician's approval of the identified treatment, RPN #105 was asked if she had given the treatment to resident #001 today. The RPN indicated she was not aware the resident was to receive it and later acknowledged it was in the resident medication slot.

RN #106 was interviewed and indicated the direction to use the identified treatment was in the registered staff communication book. The entry did state the physician had approved the use of the identified treatment before meals, but there was no indication which resident it was for. RN #106 did state the approval should have been included on the medication administration record to ensure all staff were aware of the use and directions.

The resident health care record was reviewed and resident #001's current care plan under "Mouth Care" indicated:
-ensure dentures are in mouth and cleaned after meals; remove and soak dentures at night; has a partial denture.

PSW staff were interviewed and indicated the resident does not wear dentures and no longer wears the partial plate. The staff members stated resident #001 was no longer

capable of performing their own mouth care and the resident often refused the care. The PSW staff indicated refusals of mouth care are not always reported to the registered staff.

The resident's current care plan in regards to mouth care and the use of the identified treatment failed to provide clear directions to staff. [s. 6. (1) (c)]

2. The licensee has failed to ensure resident #001's plan of care gives clear directions in regards to the level of assistance required during meals.

On July 20, 2016, resident #001 was observed during the lunch meal. The resident was seated at a table with four additional residents, three of which required full assistance for feeding. Resident #001 was provided the lunch meal, was given initial set up assistance and was then left to manage the meal on their own. Eighteen minutes after receiving the meal, a PSW seated across from resident #001 and assisting another resident was observed to lean across the table and assisted the resident to take one bite of food and then returned to feeding the other resident. Thirty minutes after resident #001 received the meal, a staff member sat beside the resident and tried to encourage the resident to eat and drink . This staff member left resident #001 after five minutes. Another staff member briefly sat with resident #001 and told the resident they should eat. One hour after the meal was served, the resident was noted to have 90% of the meal untouched.Throughout the meal, resident #001 was observed to be agitated and was intermittently asking for help.

Staff #102 was interviewed and stated the dietitian had recently sat with resident #001 throughout two meals and the resident had eaten well. The staff member indicated resident #001 was sitting at a table for residents that require assistance with meals, but that the resident was still able to feed themself. It was staff #102's opinion that the resident required encouragement and intermittent assistance only during meals. The set up of the table was reviewed with this staff member and she acknowledged resident #001 was placed such that a staff member was not seated beside the resident during meals.

The Registered Dietitian was interviewed and confirmed resident #001 did eat well when she provided assistance. She stated the resident responded well to having a staff member beside him/her throughout the meal and it appeared to alleviate his/her anxiety. The Dietitian indicated resident #001 was moved to a feeding assistance table with the intention of giving the resident dedicated assistance throughout the meals. She stated

the resident should have a staff member seated directly beside them throughout meals to reduce the resident's anxiety and to occasionally feed or support the resident throughout the meal.

Resident #001's current care plan was reviewed and under "Eating" indicated:
-provide intermittent encouragement and physical assist; resident will feed self entire meal with set up prompting and assistance.

The current care plan does not provide clear directions to ensure resident #001 is seated beside a staff member throughout the meal to provide the resident with the needed assistance. [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 resident #001's plan of care is updated to reflect the use and directions for the identified medication, to provide clear directions for resident #001's mouth care needs and to accurately reflect resident #001's level of assistance required during meals, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001 received regular oral care in the morning and evening.

On July 19 and 20, 2016, this inspector observed resident #001 and found his/her teeth were soiled with food debris. The resident's room was inspected on July 19 and 20, 2016 and there was no evidence of available mouth care supplies or of used mouth care equipment in the resident garbage in the room. The inspector did find an unopened toothbrush and toothpaste in resident #001's top drawer.

On July 20, 2016, PSW staff were interviewed in regards to resident #001's mouth care needs and was advised the resident required staff to perform mouth care as the resident was no longer able to manage on their own. Staff indicated toothettes and mouthwash are used and that the resident does refuse mouth care sometimes. At a time following the interviews with PSW staff, an opened package containing two toothettes were found on the resident bedside table alongside a bottle of mouthwash, and the resident garbage had evidence of one used toothette. The following day, this inspector found the same opened package of two toothettes and mouthwash on the resident bedside table and there was no evidence of used toothettes found. The resident's documentation did not reflect any refusals by resident #001.

The Director of Care was interviewed and indicated she had also noted resident #001 to have food debris in the teeth and indicated the staff required education on the importance of mouth care. [s. 34. (1) (a)]

2. The licensee has failed to ensure resident #001 was offered an annual dental assessment and other preventative dental services.

The Administrator was interviewed in regards to how residents are offered annual dental assessments. She stated dental service forms are included in the admission package and on display outside the main office. The Administrator stated to her knowledge, the home does not discuss the dental options directly with residents or family members.

RN #106 indicated a mobile dental company has not been in the home for an extended period of time. She stated dental options are not discussed during care conferences and to her knowledge there is no formalized means of offering annual dental assessments to residents at this time. [s. 34. (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 resident #001 receives the physical assistance required with mouth care in the morning and the evening and to ensure residents are offered an annual dental assessment and other preventative services, to be implemented voluntarily.

WN #3: 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. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug was administered to a resident unless the drug had been prescribed for the resident.

On an identified date, RPN #104 administered an identified analgesic to resident #001. The resident's physician orders were reviewed and indicated resident #001 was ordered a different identified analgesic and did not have an order for the analgesic resident #001 received.

The home completed a medication incident report and informed the physician, the pharmacist and the substitute decision maker of the error. There were no negative outcomes identified for resident #001 as a result of the error. [s. 131. (1)]

2. The licensee has failed to ensure that drugs were administered to resident #001 in accordance with the directions for use specified by the prescriber.

Resident #001 had a physician order to receive an identified analgesic and another identified medication. On an identified date, RPN #104 failed to administer these medications. The error was discovered the same day at approximately 1400 hour. A medication incident report was completed and there was no identified negative outcomes to resident #001.

The Administrator was interviewed and indicated all medication errors are reviewed on a quarterly basis during the Professional Advisory Committee. [s. 131. (2)]

Issued on this 27th day of July, 2016

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

Original report signed by the inspector.