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

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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
Aug 9, 2017	2017_624196_0009	009424-17	Resident Quality Inspection

Licensee/Titulaire de permis

GERALDTON DISTRICT HOSPITAL
500 HOGARTH AVENUE WEST GERALDTON ON P0T 1M0

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

GERALDTON DISTRICT HOSPITAL
500 HOGARTH AVENUE WEST GERALDTON ON P0T 1M0

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

LAUREN TENHUNEN (196), DEBBIE WARPULA (577)

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): June 12-16 and 19-23, 2017

The following intakes were inspected during this inspection:

Critical Incident System (CIS) intakes:
- one intake related to a resident's fall; and
- one intake related to an incident of alleged staff to resident neglect.

During the course of the inspection, the inspector(s) spoke with the Administrator, Long-Term Care (LTC) Manager, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Registered Dietitian (RD), Dietary Aids (DA), Resident Assessment Instrument (RAI) Coordinator, Recreation Aid, Ward Clerk, residents and their family members.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, reviewed relevant staff personnel files, licensee policies, procedures, programs, relevant training and resident health care records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

- **5 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 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, where the Long-Term Care Homes Act, 2007 or Ontario Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, that the plan, policy, protocol, procedure, strategy or system, was complied with.

Ontario Regulation 79/10, s. 48. (1) indicates that the falls prevention and management program to reduce the incidence of falls and the risk of injury is developed and implemented in the home.

A Critical Incident System (CIS) report was received by the Director in 2017, related to resident #016's fall which resulted in a change to their health status.

Inspector #577 conducted a record review of resident #016's progress notes which indicated that the resident fell on four different dates in the winter and the spring of 2017.

During the inspection, Inspector #577 reviewed the home's program titled "Fall Prevention and Management program - 2016", which indicated that when a resident falls, the registered staff were required to document the following in a progress note:
-date and time of the incident, location of the incident, whether the fall was witnessed or unwitnessed, status of the resident
-which assessments were completed (i.e Morse fall) and outcome of the assessment
-who was notified of the fall, probable cause of the fall, resident outcome and interventions taken to prevent further falls or related injury.

A record review of resident #016's progress notes related to the most recent three falls did not reveal which assessments were completed, the outcome of the assessments or interventions taken to prevent further falls or related injury.

Inspector #577 conducted an interview on a particular date, with RPN #104 who reported that when a resident falls, they documented the following in a progress note:
-time and location of fall
-contributing factors of fall
-assessment of injuries and vital signs
-transfer status
-individuals notified of fall
-analgesics given post fall for pain.

During an interview with the Resident Assessment Instrument (RAI) Coordinator on a particular date, they reported to the Inspector that staff were required to document the fall assessment and head to toe assessment in the progress notes.

During an interview with the Long-Term Care (LTC) Nurse Manager on a particular date, Inspector #577 reviewed the progress notes related to the three most recent falls. The LTC Nurse Manager confirmed that the progress notes should have included a fall assessment and the outcome of the assessment and interventions taken to prevent further falls. [s. 8. (1) (a),s. 8. (1) (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 that ensures where the Long-Term Care Homes Act, 2007 or Ontario Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, that the plan, policy, protocol, procedure, strategy or system, was complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to ensure the security of the drug supply, including the following: Access to these areas shall be restricted to, persons who may dispense, prescribe or administer drugs in the home, and the Administrator.

During the observation of medication administration, RPN #101 reported to Inspector #196, that some specific staff members have access with their swipe cards to the locked medication room.

On a particular day, staff member #110 demonstrated to Inspector #196 their use of a swipe card to enter the locked medication room in order to complete a task.

On June 21, 2017, the LTC Nurse Manager reported to the Inspector that only registered staff members on the long-term care side had access to the locked medication rooms. When told by the Inspector that staff member #110 was observed to use their swipe card to gain entry to the rooms, they stated they had forgotten that they had access, unsupervised, in order to complete a task. [s. 130. 2.]

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 that ensures that steps are taken to ensure the security of the drug supply, including the following: Access to these areas shall be restricted to, persons who may dispense, prescribe or administer drugs in the home, and the Administrator, to be implemented voluntarily.

WN #3: 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

During a record review by Inspector #196, resident #014 was identified as having an area of altered skin integrity.

Inspector #196 reviewed resident #014's health care records and identified that the resident had an assessment done by the Registered Dietitian (RD) on a specific date in the spring of 2017. The RD had written on the "Order Sheet and Progress Notes" the suggestion to discontinue a particular type of medication and start a different type of medication. The physician's written initials were beside the RD assessment.

On June 20, 2017, the Inspector reviewed the current medication list and the Medication Administration Record (MAR) and neither identified the suggested particular type of medication and instead listed the original type as being currently administered.

On June 21, 2017, the Inspector interviewed the RD who reported that they were unclear why the recommendation dated on a specific date in the spring of 2017, was not ordered by the MD although it had been initialed by them. They went on to write a new progress note this same date asking the MD to cosign prior to the implementation of this particular type of medication as a result of the Inspector bringing it forward to them.

On June 22, 2017, the Inspector interviewed the LTC Nurse Manager and they reported that the MD had initialed that they had acknowledged the RD's suggestion, but would have had to write an order for this medication and this had not been done. [s. 6. (4) (a)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 59. Family Council

Specifically failed to comply with the following:

s. 59. (7) If there is no Family Council, the licensee shall,
(a) on an ongoing basis advise residents' families and persons of importance to residents of the right to establish a Family Council; and 2007, c. 8, s. 59. (7).
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council. 2007, c. 8, s. 59. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that they convene semi-annual meetings to advise family members and persons of importance to residents of their right to establish a Family Council.

On June 15, 2017, Inspector #577 spoke with the LTC Nurse Manager who reported that the home did not have a Family Council. They reported that every six months they sent out a letter to the residents' families advising them of their right to form a Family Council and to contact the Manager for any questions or interest. They further reported that they had a meeting with residents and their families in May 2017.

On June 26, 2017, Inspector #577 spoke with the LTC Nurse Manager who confirmed that the meeting in May 2017, was the only organized meeting with residents and their families and they have not organized semi-annual meetings with residents' families. [s. 59. (7) (b)]

WN #5: 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:
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home has a dining and snack service that includes, at a minimum, a review of meal and snack times by the Residents' Council.

During an interview with the Residents' Council President #017, during the inspection, they revealed to Inspector #577 that meal and snack times had not been discussed with the Residents' Council.

On June 22, 2017, the Inspector conducted an interview with the assistant to the Residents Council #107. They reported that the Residents' Council had not reviewed meal and snack times. [s. 73. (1) 2.]

Issued on this 9th day of August, 2017

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

Original report signed by the inspector.