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

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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
Aug 11, 2015	2015_384161_0014	O-002542-15	Resident Quality Inspection

Licensee/Titulaire de permis

ARNPRIOR (THE) AND DISTRICT MEMORIAL HOSP.
350 John Street North ARNPRIOR ON K7S 2P6

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

THE GROVE, ARNPRIOR AND DISTRICT NURSING HOME
275 IDA STREET NORTH ARNPRIOR ON K7S 3M7

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

KATHLEEN SMID (161), JESSICA LAPENSEE (133), LISA KLUKE (547), WENDY PATTERSON (556)

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): July 27 - 31, 2015, August 4 - 7, 2015.

During the course of the inspection, the inspector(s) spoke with Residents, Family Members, President of Residents' Council, President of Family Council, Personal Support Workers (PSW), Housekeeping Aides, Food Service Workers, Registered Practical Nurses, Registered Nurses, Business Office Coordinator, Maintenance Supervisor, Environmental Service Manager, Infection Prevention and Control Practitioner, Assistant Director of Care (ADOC) and the Vice President of Patient/Resident Services.

During the course of the inspection, the inspector(s) also conducted two Critical Incident Inspections log #'s O-001782-15 and O-002212-15.

During the course of the inspection, the inspector(s) conducted a tour of the Resident care areas, reviewed the Admission Process, Infection Prevention and Control, Quality Improvement & Required Programs checklists, Residents' health care records, home policies and procedures, staff work routines, posted menus, Resident and Family Council minutes. The inspector(s) observed Resident rooms, Resident common areas, the administration of medication, two meal services and the delivery of Resident care and services.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Admission and Discharge
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
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

- **3 WN(s)**
- **1 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. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
1. The circumstances precipitating the application of the physical device. O. Reg. 79/10, s. 110 (7).
2. What alternatives were considered and why those alternatives were inappropriate. O. Reg. 79/10, s. 110 (7).
3. The person who made the order, what device was ordered, and any instructions relating to the order. O. Reg. 79/10, s. 110 (7).
4. Consent. O. Reg. 79/10, s. 110 (7).
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that Resident #039 and Resident #042 had their seatbelt restraints applied in accordance with the manufacturer's instructions.

On a date in August 2015 Resident #039 was observed by Inspector #547 wearing a seatbelt while sitting in their wheelchair. The Resident was not physically or cognitively able to release the seatbelt. Inspector #547 noted that Resident #039 was agitated, holding onto the seatbelt with both hands, foot propelling their wheelchair while also trying to pull themself out of the wheelchair. On this same date in August 2015 Inspector #547 interviewed PSW #S111 who was caring for Resident #039. The PSW indicated

that he tightened the Resident's seatbelt to its maximum capacity and was aware that the seatbelt was too loose. PSW #S111 further indicated that registered staff were aware of this problem. On this same date in August 2015 Inspector #547 interviewed the Charge Nurse RN #S115 who indicated that she had not been made aware of any improperly fitted seatbelts in the home. Resident #039's front closure seatbelt was observed by Inspector #547 with RN #S115 to be very loose and required adjustment from the back of the resident's wheelchair.

On a date in August 2015 Resident #042 was observed by Inspector #547 wearing a four point seatbelt while sitting in her/his wheelchair. The Resident was not physically or cognitively able to release the seatbelt. On this same date in August 2015 Inspector #547 observed that Resident #042's seatbelt had a 4 finger space between the belt and the Resident, and also observed that there was a broken metal clip on one of the thigh straps on the four point seatbelt. Inspector #547 asked RPN #S103 to observe this, after which, RPN #S103 indicated she would make a notation in the maintenance log for an urgent repair.

On this same date in August 2015 PSW's #S111 and #S112 both indicated to Inspector #547 that they were not aware of how to tighten the seatbelts of Resident #039 and Resident #042 from the back of the chair. They assumed that registered nursing staff was aware of these Resident's loose belts. When directed by Inspector #547 to observe the seatbelts of Resident #039 and #042, both PSW's indicated that the seatbelts had not been properly applied.

Inspector #547 interviewed the ADOC and RN #S115 who indicated that the home's expectation for PSW's is to properly secure Resident's seatbelts and if the seatbelts are too loose, that they are to be tightened. [s. 110. (1) 1.]

2. The licensee has failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented including (a) he person who applied the device and the time of application, (b) monitoring (c) every release of the device and all repositioning.

From a date in July 2015 until 8 days later, Resident #039 and Resident #042 were observed by Inspector #547 wearing seatbelts while sitting in their wheelchairs. Both Residents were not physically or cognitively able to release their seatbelts. Their Point of Care records from these dates were provided by the ADOC and were reviewed by Inspector # 547. It was noted that the PSW staff were not consistently documenting the

person who applied the seatbelt, the time of application, the ongoing monitoring of the Residents while restrained nor the release of the seatbelt and repositioning of the Residents.

On August 7, 2015 the Vice President of Patient and Resident Services and the ADOC indicated to Inspector #547 that the PSW staff are to document hourly that Resident #039 and Resident #042's seatbelt restraints were monitored and that the Residents were released and repositioned every 2 hours as per the home's policy. [s. 110. (7)]

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 the seatbelts for Resident #039 and Resident #042 are applied in accordance with the manufacturer's instructions, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area or a medication cart that is secure and locked.

On July 27, 2015 at 12:40, July 28, 2015 at 09:20, July 29, 2015 at 09:10, August 5, 2015 at 12:45 and August 6, 2015 at 12:46, Inspector #161 observed that a medication cart was in the hallway outside the main dining room and it was unlocked and unattended while a Registered Practical Nurse was in the main dining room administering medications to Residents. It was also observed throughout this Resident Quality Inspection by Inspectors #161 and #547 that there were prescribed topical medications in 2 unlocked wire baskets attached to linen carts kept in the Resident hallways.

On August 7, 2015 at 09:35 Inspector #161 asked the ADOC and the VP of Patient and Resident Services to accompany the Inspector to the east hallway of the home. It was observed that a medication cart was outside a resident's room unlocked and unattended and that prescribed topical medications were in an unlocked wire basket attached to the linen cart in the hallway.

Discussion held with the ADOC and the Vice President of Patient and Resident Services who indicated that this was not acceptable practice and that they would immediately rectify this issue. [s. 129. (1) (a)]

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program.

On July 27, 2015 Inspector #547 noted during the initial tour of the home for the Resident Quality Inspection, that the home was currently on enteric outbreak precautions. Inside the East side tub room, an unlabelled used deodorant stick was located on the sink, three used disposable navy blue razors with stubble in the blades were located inside a clear plastic storage bin next to the tub as well as a small tub of Petroleum jelly was on the back of the toilet unlabelled and used. The West side tub room also had used blue disposable razors inside the clear plastic storage bin next to the tub as well as an unlabelled used deodorant stick and a black comb with grey hair in it.

On July 27, 2015 Inspector #556 observed an unlabelled toothbrush, black comb and nail clippers next to the sink inside Resident #017's room which is shared with another Resident.

On July 28, 2015 Inspector #547 observed two unlabelled urine specimen collection containers in the bathroom of Resident #031 which is shared by four Residents.

On August 6, 2015 Inspector #547 interviewed PSW #S117 and #S118 regarding these unlabelled items. PSW's #S117 and #S118 indicated that all items are to be labelled with the Resident's name and that no items are to be shared. Upon review of the linen cart in the West tub room, it was noted that one container of petroleum jelly was unlabelled and PSW# S118 told Inspector #547 that staff should be labelling the container. PSW # S118 indicated that used disposable razors are contaminated and should be thrown out in the sharps containers located in the tub rooms.

Inspector #547 interviewed the ADOC, who indicated that Resident items for personal use including urine specimen containers should always be labelled with the Resident's name. [s. 229. (4)]

Issued on this 11th day of August, 2015

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

Original report signed by the inspector.