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
Oct 17, 2016	2016_188168_0023	029676-16	Resident Quality Inspection

Licensee/Titulaire de permis

Corporation of the City of Brantford and the Corporation of the County of Brant
97 Mount Pleasant Street BRANTFORD ON N3T 1T5

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

JOHN NOBLE HOME
97 MOUNT PLEASANT STREET BRANTFORD ON N3T 1T5

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

LISA VINK (168), CAROL POLCZ (156), LESLEY EDWARDS (506)

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): October 11, 12, 13 and 14, 2016.

During the course of this inspection the following other intakes were inspected concurrently.
Complaint 028826-16 - related to prevention of abuse and neglect
Critical Incident 0006137-16 - related to falls prevention and plan of care
Critical Incident 013764-16 - related to falls prevention.

During the course of the inspection, the inspector(s) spoke with the Administrator, Acting Director of Care (ADOC), Risk Management/Quality Improvement Nurse, Nutrition Services Manager/Registered Dietitian (RD), Restorative Care Nurse, registered nursing staff, personal support workers, former management staff of the home, family members and residents.

During the course of this inspection, the inspectors: toured the home, observed the provision of care and services, reviewed documents including but not limited to: meeting minutes, policies and procedures, internal investigative notes and clinical records.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

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

7 WN(s)
5 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. (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).

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

Resident #013 was identified to have bed rails in the raised position on their bed. Interview with the resident and registered staff #114, #105 and #113 verified that the resident used the rails, in the raised position, when in bed. A review of the Minimum Data Set (MDS) assessment completed May 11, 2016, identified that the resident used bed rails for mobility and transfers. The MDS assessment completed August 10, 2016, did not include that the resident used rails for bed mobility or transfers. Interview with registered staff #114, #105 and #113 verified that the two assessments were not consistent with each other. [s. 6. (4) (a)]

2. The licensee 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.

A. The plan of care for resident #010 indicated that they required encouragement or cueing for eating. The MDS assessment dated September 14, 2016, indicated that they required one person physical assist for eating on three of seven observation days. The plan of care was not updated to reflect current needs, when the resident's care needs had changed, related to the level of assistance required for eating as confirmed with registered staff #105.

B. The plan of care for resident #011 indicated that they required assistance with toileting. Interview with registered staff #105 on October 13, 2016, identified that the resident was incontinent. Interview with staff #112 and #110 on October 13, 2016, confirmed that the resident was incontinent and was not toileted. It was reported that the resident very rarely used the toilet and had a brief for containment. A review of the Resident Flowsheets indicated that the resident was incontinent of bladder on 37 of 39 occasions and incontinent of bowel on nine of nine occasions in October 2016. The plan of care was not updated when the resident's needs changed or care set out in the plan was no longer necessary. [s. 6. (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 staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other and that the resident is 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 change or 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. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where bed rails were used the bed system was evaluated in accordance with evidenced based practices and if there were none, in accordance with prevailing practices, to minimize the risk to the resident.

Health Canada approved two documents identified as "Guidance Documents" and directed that the recommendations in these documents were to be used to assist health care facilities in the assessment of the resident and the resident's bed system when bed rails were used.
These two documents are identified as: "Clinical Guidance For the Assessment and Implementation of Bed Rails In Hospitals, Long Term Care Facilities, and Home Care Settings", developed by the Hospital Bed Safety Workgroup, dated April 2003, and "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards", based on the US FDA Guidance Document entitled "Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment", which was developed by the Hospital Bed Safety Workgroup and adopted by Health Canada in 2006.

Resident #013 was identified to have three bed rails in the raised position on their bed. Two of the rails were standard commercial rails used on a number of beds in the home and the third was a small domestic rail attached to the bed by a belt or strap around the frame. Interview with the resident identified that all three rails were used when they were in bed and that this was their preference. A review of the Facility Entrapment Inspection Sheet completed September 18, 2016, identified that the resident's bed passed all zones of entrapment when tested; however, only identified the testing of two bed rails on the bed. Interview held with registered staff #113, who completed the assessment, verified that the third rail was on the bed at the time of the testing; however, was not tested. At the request of the inspector the bed system was tested again on October 13, 2016, at which time the third rail failed zone 1, which was identified by registered staff #113.
The resident's bed system was not evaluated to minimize risk to the resident. [s. 15. (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 where bed rails are used the bed system is evaluated in accordance with evidenced based practices and, if there are none, in accordance with prevailing practices, to minimize the risk to the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
19. Safety risks. O. Reg. 79/10, s. 26 (3).

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care was based on an interdisciplinary assessment of safety risks.

Residents #011 and #014 were observed with a device in use. Nursing staff #102 identified that the devices were used as a fall prevention strategy to prevent residents from falling out of bed. Interview with staff #110 and #112 reported that resident #011 flailed their arms and legs and was able to move in bed.
The plans of care for residents #011 and #014 identified that the devices were used as a fall intervention to prevent them from falling out of bed.
A review of the manufacturer's guidelines, from Posey Company, regarding the use of the device indicated that homes should always follow their procedures and policies regarding resident assessments, monitoring and rehabilitation when they use the device.
The ADOC confirmed that there was no formalized procedures or policies in place to direct staff in the safe use of the device. Interview with the ADOC confirmed that the devices were used for fall prevention and that the home had not implemented a formalized risk assessment for use and that these residents were not assessed for safety risks associated with the use of the device. [s. 26. (3) 19.]

2. The licensee failed to ensure that the Registered Dietitian (RD), who was a member of the staff of the home, completed a nutritional assessment for the resident on admission and whenever there was a significant change in the resident's health condition.

Resident #010 was identified in the clinical record to have been hospitalized in April 2016. The resident returned from hospital in April 2016, with a new diagnosis and change in health status. The resident was not assessed by the RD until the next scheduled quarterly assessment on June 27, 2016, during which time, the resident had another admission to hospital. Interview with the RD on October 13, 2016, confirmed that the resident was not assessed for the significant change in condition upon return from hospital. [s. 26. (4) (a),s. 26. (4) (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 plan of care is based on, at a minimum, an interdisciplinary assessment of the following with respect to the residents safety risks and to ensure that the registered dietitian complete a nutritional assessment for the resident on admission and whenever there is a significant change in health condition, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Resident #017 had fragile skin and multiple areas of skin breakdown. On October 11, 2016, the resident was identified to have a skin tear with a treatment in place. A review of the clinical record did not include an assessment of the area of altered skin integrity using a clinically appropriate assessment instrument when it was first identified. The Treatment Administration Records (TAR) for October 2016, identified the area and the treatment in place at the beginning of the month. The first assessment of the area, in the progress notes, was not an initial assessment and was completed on October 2, 2016, by registered staff #107. Interview with registered staff #107 verified that there was no initial assessment of the area of altered skin integrity by a member of the registered nursing staff using a clinically appropriate assessment instrument as required. [s. 50. (2) (b) (i)]

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 resident who exhibits altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee failed to ensure that residents with the following weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated when there was a change of 5 per cent of body weight, or more, over one month, or a change of 7.5 per cent of body weight, or more, over three months, or a change of 10 per cent of body weight, or more, over 6 months or any other weight change that compromised their health status.

Resident #011's weights were reviewed from May until October 2016, as recorded in the clinical record. This review identified that there was a significant weight change on July 1, 2016, which represented a change of 19.6% when compared to the previous month's weight. Then again there was a significant weight change on September 6, 2016, which represented a weight change of 47.5% when compared to the August weight, and finally there was a significant weight change on October 3, 2016, which represented a weight change of 11.8% when compared to the September 6, 2016 weight. Interview with the RD on October 13, 2016, confirmed that the weight changes noted above were not assessed nor actions taken. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

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 with the weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

Resident #040 reported to registered staff #109 that registered staff #108 insulted them when she spoke with them. The resident also identified that they were "finally being brave" in discussing the incident. Staff member #109 reported the allegation to the charge nurse and sent electronic documentation to the current ADOC to inform them of the concern. The allegation was initially communicated to staff on the evening shift and the following day was investigated, which included interviews of the resident and staff, by management staff #120. The home did not report the incident to the Director until five days after it was first communicated by resident #040, as confirmed by staff #120. The home did not immediately report the allegation of abuse as required in the legislation.

A review home's "Prevention of Resident Abuse and Neglect" policy 3-A-60, dated February 2014, included the expectation that alleged, actual or suspected abuse was to be reported to the Director; however, identified that the home was to make a report within 10 days and a final report on the request of the Ministry. Interview with the Administrator and ADOC verified that the home's "Prevention of Resident Abuse and Neglect" policy was not clear and should direct staff that alleged, actual or suspected abuse was to be reported to the Director immediately with a follow up report to be made within 10 days, if needed. [s. 20. (1)]

WN #7: 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 failed to ensure that staff participated in the implementation of the infection prevention and control program.

On October 11, 2016, a used night catheter drainage bag, without a cap in place, was found on the back of the toilet, in a basket, which also contained a collection container and slipper bed pan, in a resident's shared washroom. The catheter bag was still present on October 13, 2016. The catheter bag contained a small amount of clear liquid which had leaked out of the bag onto the back of the toilet as there was no cap in place. Registered staff #114 observed the bag on October 13, 2016 and identified that the bag should had been labelled and a cap in place for infection control reasons. Not all staff participated in the infection prevention and control program. [s. 229. (4)]

Issued on this 21st day of October, 2016

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

Original report signed by the inspector.