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
Sep 28, 2017	2017_418615_0023	017764-17	Resident Quality Inspection

Licensee/Titulaire de permis

KINGSWAY NURSING HOMES LIMITED
310 Queen Street East R.R. #6 ST. MARYS ON N4X 1C8

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

KINGSWAY LODGE NURSING HOME
310 QUEEN STREET EAST R.R. #6 ST. MARYS ON N4X 1C8

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

HELENE DESABRAIS (615), CAROLEE MILLINER (144)

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): August 14, 15, 16 and 17, 2017.

The following concurrent inspection was conducted during the Resident Quality Inspection:

Complaint #001507-17/IL-48918-LO related to maintenance services.

During the course of the inspection, the inspector(s) spoke with the Administrator, four Registered Nurses (RNs), the Registered Practical Nurse-Resident Assessment Instrument Coordinator (RPN-RAI Coordinator), one Registered Practical Nurse (RPN), the Director of Dietary (DD), one Registered Dietician (RD), seven Personal Support Workers (PSWs), the Family and Residents' Council representatives, over 20 residents and three family members.

Inspector(s) also toured the resident home areas and common areas, medication rooms, observed resident care provision, resident/staff interaction, medication administration, medication storage areas, reviewed relevant resident clinical records, posting of required information, relevant policies and procedures and observed general maintenance and cleanliness of the home.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Residents' Council

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

4 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A review of a resident's clinical record stated the resident was identified as being at high nutritional risk and the resident has had a weight loss since a specific date. The clinical record also stated the resident was bathed on two different days. The physician's last medication and treatment review, included the directive to weigh the resident weekly on the bath days.

A review of the resident's bath and weight records were reviewed and baths and weights were not documented in the resident's clinical record as completed on five different days while the resident was in the home. The clinical record did not include documentation that the resident had refused their baths on the identified days.

During an interview, an RPN said that PSW's were required to document bath refusals on the resident's bath record located in the Point Of Care (POC) program and to report the refusal to the registered staff on duty on their nursing unit. The RPN stated that the resident's baths and weights were not completed on five different days as outlined in the residents' plan of care.

During an interview, the Administrator acknowledged that the resident's baths and weights were not completed as outlined in their plan of care and that the home's expectation was that the care set out in the plan of care was provided to the resident as specified in the plan.

The licensee failed to ensure that the resident's baths and weights were provided as specified in the plan of care.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was determined to be isolated during the course of this inspection. There was no compliance history of this legislation being issued in the home. [s. 6. (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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident who was incontinent received an assessment that: included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident required.

A review of three residents' Minimum Data Set (MDS) Annual assessments, on different specific dates, indicated a change in the residents' incontinence.

A review of the residents' current care plan indicated that the residents were incontinent of bladder and bowel, with interventions identified for scheduled toileting and type and size of the supplies used.

A review of the residents' clinical records found no documented evidence of incontinence

assessments including identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions.

During interviews, a RN, a RPN and a PSW stated that the residents were incontinent of bladder and bowel and had a toileting program in place. When asked where to find the residents' continent assessment, the RN responded "I don't know". A RPN stated that they did not know how to locate continence assessments for residents and had never seen a completed continence assessment.

During an interview, a RN stated that the PSWs fill out a “Comfort Dry Audit" to know what supplies were needed for the residents but this was not an assessment of the residents' incontinence. The RN also said that in the home’s PCC there was an incontinence assessment tab named “Admission/Quarterly Bowel and Bladder Continence Evaluation” but this was not completed for residents.

During interviews, the RPN-RAI Coordinator said that residents' incontinence was documented with the MDS quarterly assessment and acknowledge that this assessment was not specifically designed for assessment of incontinence. The Administrator and the RPN-RAI Coordinator stated that the home's expectation was that residents with incontinence should be assessed with a clinically appropriate instrument designed for assessment of incontinence to develop specific interventions.

The licensee failed to ensure that residents who were incontinent received a continence assessment that: included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident was required.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was determined to be widespread during the course of this inspection. There was no compliance history of this legislation being issued in the home. [s. 51. (2) (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 a resident who is incontinent receive an assessment that: includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were developed and implemented to ensure that all equipment, devices, assistive aids and positioning aids in the home were kept in good repair.

A review of the home's maintenance log book indicated that on a specific date, a resident's device was not functioning, with the initials of Maintenance staff written below that note. During an interview, the Administrator said that when the maintenance staff initials a note in the book it was because the repair was completed, however could not say when it was completed. The next note was stating that the resident's device was missing a piece to make it function.

A review of the resident's progress notes, on a specific date, stated in part that the resident was using the device that needed the missing piece stated above and was

eating their meal in an unsafe position. The resident was found by staff with a harsh cough and red faced. The DOC was notified about the device in disrepair who requested the Maintenance staff to replace it. The resident's device was replaced and the resident was monitored for signs of aspiration.

During an interview, the Administrator, stated that the home documented general maintenance like painting, repairs and devices and said that if a device was broken, that they would replace it immediately.

A review of the home's "Schedule for Preventative Maintenance" policy #M03 stated, " A Maintenance Log Book is located on each floor. Specific schedules for maintenance of all equipment are located on a clipboard in the maintenance room. Repairs to equipment are done as required. DOE also does walk through to determine areas in need of repair".

Review of the home's maintenance program's "equipment use checklist" and "audits" did not include the maintenance of residents' devices mentioned above.

During an interview, the Administrator acknowledged that for six days the resident was using a device that was not in good repair and that procedures were not developed and implemented to ensure that these specific devices were in good repair.

The licensee failed to ensure that procedures were developed and implemented to ensure that all equipment, devices, assistive aids and positioning aids in the home were kept in good repair.

The severity was determined to be a level three as there was actual harm. The scope of this issue was determined to be isolated during the course of this inspection. There was no compliance history of this legislation being issued in the home. [s. 90. (2) (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 procedures are developed and implemented to ensure that all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, to be implemented voluntarily.

WN #4: 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. (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:
2. What alternatives were considered and why those alternatives were inappropriate. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act was documented and that the documentation included what alternatives were considered and why those alternatives were inappropriate.

Observations of two residents on three different days, showed the residents using a device with a restraint.

A review of the residents' MDS Quarterly review assessments, on a specific date, there was no mention of the use of that device with a restraint.

A review of the residents' care plan indicated the "Use/ Application of an external device, Nurse assess restraint and continuation of restraint is needed".

A review of the physician's order for the residents included an order for a the use of the

device with a restraint for safety or for prevention of injury to self or to others .

A review of residents' clinical records had no documented evidence of an assessment including what alternatives were considered and why those alternatives were inappropriate.

During interviews, the RPN-RAI Coordinator, a RN and a PSW, stated that the use of the device and the restraint were used to prevent the residents from falling. The RPN-RAI Coordinator said that there were no assessments completed for possible alternatives interventions for the resident and any other resident in the home using a restraint. [s. 110. (7) 2.]

A review of the home's policy #09-01-01 (no date) stated, "The philosophy of least restraint is encouraged in the LTC facility. Least restraint means all possible alternative interventions are exhausted before deciding to use a restraint. Restraints shall be viewed as last resorts. Restraints are to be used only in circumstances where there exist an imminent risk of harm to the resident or others, only after careful assessment by a regulated health professional, and only after determining that available alternatives would prove inadequate".

During interviews, the Administrator and the RPN-RAI Coordinator stated that the home's expectation was that each resident using a restraint should be assessed for consideration of alternatives to the use of a restraint and why those alternatives were inappropriate.

The licensee failed to ensure that documentation concerning the use of a physical device to restrain the residents under section 31 of the Act included what alternatives to the use of a restraint were considered and why those alternatives were inappropriate.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was determined to be isolated during the course of this inspection. There was a compliance history of this legislation being issued in the home. [s. 110. (7) 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 to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and that the documentation include what alternatives were considered and why those alternatives were inappropriate, to be implemented voluntarily.

Issued on this 28th day of September, 2017

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

Original report signed by the inspector.