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 4, 2016	2016_463616_0019	022132-16	Resident Quality Inspection

Licensee/Titulaire de permis

NIPIGON DISTRICT MEMORIAL HOSPITAL
125 HOGAN ROAD NIPIGON ON P0T 2J0

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

NIPIGON DISTRICT MEMORIAL HOSPITAL
125 HOGAN ROAD P O BOX 37 NIPIGON ON P0T 2J0

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

JENNIFER KOSS (616), DEBBIE WARPULA (577)

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): August 22-26, 2016

Additional intakes completed during this inspection include: a Critical Incident (CI) related to alleged staff to resident abuse and a CI related to falls prevention.

During the course of the inspection, the inspector(s) spoke with the Acting Director of Patient Services/Chief Nursing Officer (DOPS/CNO), Nurse Manager, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Registered Dietitian (RD), Personal Support Workers (PSWs), Activity Coordinator, family members, and residents.

During the course of the inspection, the inspector(s) directly observed the delivery of care and services to residents, resident to resident interactions, conducted a tour of resident home areas, reviewed resident health care records, various home policies, procedures, and programs.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
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)
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 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 has failed to ensure that where bed rails were used the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident.

Inspector #577 observed residents #002, #003, and #004 lying in bed with bed rails in a specific position.

During a record review of resident #002's care plan, the Inspector noted the nursing intervention which indicated the previously observed bed rails were to be in a specific position when the resident was in bed, and used for bed mobility or transfer.

During a record review of resident #003's care plan, the Inspector noted the nursing intervention which indicated the previously observed bed rails were to be in a specific position when the resident was in bed.

During a record review of resident #004's care plan, the Inspector noted the nursing intervention which indicated the previously observed bed rails were to be in a specific position when the resident was in bed.

During an interview with RPN #100, they reported that residents #002, #003, and #004 used bed rails for bed mobility and further indicated that physiotherapy and nursing staff had decided on the use of bed rails.

During an interview with Physiotherapist #110, they reported to Inspector #577 that physiotherapy did not assess for bed rail use and had not documented a progress note for residents #002, #003, and #004 concerning bed rails.

On August 25, 2016, Inspector #577 conducted an interview with the Acting Director of Patient Services/Chief Nursing Officer (DOPS/CNO) and the Nurse Manager who reported that the home did not perform bed rail assessments and the bed rail assessment tool was currently in draft. On September 26, 2016, Inspector #577 spoke with the Nursing Manager who confirmed that the maintenance department conducted a bed system inspection on all 22 beds in June, 2016. They further reported that four beds failed in Zone 1 and they had been repaired and/or replaced. [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 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, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knew of, or that was reported was immediately investigated.

Inspector #616 reviewed a Critical Incident report (CI) which was submitted to the Director in September, 2015. The CI related to alleged staff to resident abuse. The CI indicated that resident #010 had reported that RPN #107 shook their finger at the resident and spoke to the resident in a tone that created fear.

Inspector #616 reviewed a progress note which documented the resident's report that RPN #107 had yelled at them the previous night. In the documentation, two registered staff were notified of the resident's report.

The Inspector determined the resident was no longer a resident in the home, and the registered staff identified in the reported incident was unavailable at the time of inspection.

On August 25, 2016, Inspector #616 interviewed the Nurse Manager and the DOPS/CNO who confirmed that there was no record of any investigation surrounding the allegations reported by resident #010 on that particular date. [s. 23. (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 every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of, or that is reported to the licensee, is immediately investigated, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home had his or her personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and of acquiring, in the case of new items.

On August 22, 2016, Inspector #577 observed residents' personal items in the tub rooms to be unlabelled and unclean. The Inspector found the following:

a) Tub room #1: three unlabelled, used stick deodorants, one unclean black brush covered in grey hair, one unclean pink comb covered in black hair, and one used pair of toe nail clippers in the cupboard.

b) Tub room #2: one unlabelled, used stick deodorant and one pair of used toe nail scissors.

3) Shower room #3: two disposable used razors with hair shavings and one unlabelled stick deodorant.

During an interview with RPN #104, Inspector #577 showed them the unclean, unlabelled personal items in the tub and shower rooms and they reported that all personal items should have been labelled. During an interview with RPN #105, Inspector #577 showed them the unclean, unlabelled personal items in the tub and shower rooms. RPN #105 reported that all personal items should have been labelled, used disposable razors were to be disposed of in sharp containers, and used nail scissors were to be placed in the utility room for autoclaving. RPN #105 placed the used razors in the sharp container and took the scissors and nail clippers to be autoclaved. RPN #105 further confirmed that used combs and brushes were to be returned to the resident's rooms.

A review of the home’s policy titled "Personal Hygiene Items" revised date of February, 2016, indicated that personal hygiene products were not to be shared amongst residents and each resident would have their own personal care items labelled and stored in the tub room cupboard.

On August 25, 2016, Inspector #577 interviewed the DOPS/CNO and the Nurse Manager who reported that all residents' personal belongings should have been labelled, combs/brushes should have been labelled and returned to the resident's rooms, and razors should have been discarded. [s. 37. (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 each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing, labelled within 48 hours of admission and of acquiring, in the case of new items, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident had fallen, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Inspector #577 reviewed a CI report submitted to the Director in October, 2015, related to resident #009's fall which occurred on the same day as the report was submitted.

Inspector #577 and the Nurse Manager reviewed resident #009's progress notes and found that the resident had 13 falls over approximately one year.

A review of the home's program titled "Falls Prevention and Management" revised June, 2016, indicated that post-fall, a Morse fall risk assessment is to be done and registered staff were to complete the post-fall assessment.

A review of the health records for resident #009 revealed that ten out of 13, or 77 per cent of the post-fall assessment forms were not completed. The resident did not have a post-fall assessment using a clinically appropriate assessment instrument that was specifically designed for the following falls:

-August, 2015
-September, 2015 (more than one fall on the same day)
-October, 2015 (two falls)
-February, 2016
-May, 2016
-July, 2016 (two falls)
-August, 2016

Inspector #577 interviewed the DOPS/CNO and the Nurse Manager on August 25, 2016. Both confirmed that the Morse Fall Scale was the home’s clinical tool in use for post-fall assessment since October 2015. They further reported that staff were required to complete the Morse Fall Scale assessment on admission, quarterly, with any change of condition, and after every resident fall.

During an interview with the Nurse Manager, they confirmed to the Inspector that the electronic post-fall assessment should have been completed after every fall, and was only completed for two falls in October, 2015. [s. 49. (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 when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #5: 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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

Inspector #616 reviewed resident #001's Quarterly Nutrition Assessment, completed by the Registered Dietitian (RD). In this assessment the resident's nutrition/hydration risk was determined to be moderate.

The Inspector noted in the resident's health care record that a physician prescribed weights to be obtained. The home's list of residents and their prescribed weights also indicated that resident #001 was to have their weight obtained as ordered. The weight book and the electronic weight record were each reviewed by the Inspector. Two of the eight ordered weights were not documented in either of the records.

RPN #100, RPN #109, and PSW #108 stated to the Inspector that residents' weights were obtained and documented by the PSWs on paper, in the weight book. They stated that registered staff or PSWs documented the weights in the electronic health record.

A review of the home's policy "Management of Weight Changes in LTC Residents", #PAT-5-73, last reviewed November, 2009, indicated that weights were to be recorded in the weight book and then written on the weight profile of the resident's nursing care plan.

During an interview with the Nurse Manager on August 25, 2016, they stated to the Inspector that weights were documented by staff in the weight book, but they were also expected to have documented in the resident's electronic health record. They verified the policy reference to the "weight profile of the resident's nursing care plan" was the electronic health record. They stated to the Inspector the weights should have been documented as ordered in the plan of care. [s. 6. (9) 1.]

2. Inspector #616 reviewed resident #002's Quarterly Nutrition Assessment completed by the RD. In this assessment the resident's nutrition/hydration risk was determined to be high. The RD had recommended that weights to be obtained with a specific frequency related to this risk factor.

The Inspector noted in the resident's health care record that a physician had prescribed weights to be obtained. The resident's current care plan identified that nursing was to obtain a weight as ordered related to the resident's risk factor. The home's list of residents and their prescribed weights also indicated that resident #002 was to have their weight obtained as ordered. The weight book and the electronic weight record were reviewed by the Inspector. Four of 10 ordered weights were not documented in either of the records.

RPN #100, RPN #109, and PSW #108 stated to the Inspector that residents' weights were obtained and documented by the PSWs on paper, in the weight book. They stated that registered staff or PSWs documented the weight in the electronic health record.

A review of the home's policy "Management of Weight Changes in LTC Residents", #PAT-5-73, last reviewed November, 2009, indicated that weights were to be recorded in the weight book and then written on the weight profile of the resident's nursing care plan.

During an interview with the Nurse Manager on August 25, 2016, they stated to the Inspector that weights were documented by staff in the weight book, but they were also expected to have documented in the resident's electronic health record. They verified the policy reference to the "weight profile of the resident's nursing care plan" was the electronic health record. They stated to the Inspector the weights should have been

documented as ordered in the plan of care. [s. 6. (9) 1.]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that within 10 days of receiving Residents' Council advice related to concerns or recommendations, a response was made by the licensee to the Residents' Council in writing.

Inspector #616 reviewed minutes from a Residents' Council meeting dated May 30, 2016, where a concern related to food temperature was raised. On June 1, 2016, the Council liaison (Activity Coordinator #106) had forwarded the concern by email to the kitchen department. On June 23, 2016, the Council liaison received an email response.

During an interview with the Council liaison on August 26, 2016, they stated to the Inspector that they brought the response to a member of the Council, as well as communicated the response at the next meeting. They confirmed to the Inspector that the response was made to the Council liaison 16 days later.

During an interview with the Nurse Manager on August 26, 2016, they confirmed the written response was not made to the Residents' Council within 10 days of receiving the advice, and should have been. [s. 57. (2)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee responded in writing within 10 days of receiving Family Council advice related to concerns or recommendations.

Inspector #577 reviewed the Family Council Meeting Minutes dated February 9, 2016, which identified numerous concerns, as follows:

-bedrails and restraints
-positioning of beds by housekeeping
-billing from Janzen's
-hand hygiene
-medication policy on administration
-location of the medication cart
-hospital tour for family members of new resident's
-prn medication not being administered
-resident aprons
-unattended snack cart
-lack of heat in the dining room
-dressing residents appropriately for the dining room
-covering catheter bags and
-advising family when a resident needs toiletries.

During an interview with the Activity Coordinator #106 on August 26, 2016, they reported that they were the assistant to the Council and had forwarded these concerns to the previous DOPS on February 12, 2016, and to the current Nurse Manager on March 9, 2016. They further confirmed that the Council had not received a written response within 10 days, or at all. [s. 60. (2)]

Issued on this 4th day of October, 2016

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

Original report signed by the inspector.