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
Oct 12, 2018	2018_768693_0012	025586-18	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

MELISSA HAMILTON (693), JULIE KUORIKOSKI (621)

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): October 1 to 5, 2018.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (DOC), Long-Term Care(LTC) Lead, Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Activity Coordinator, residents and residents' family members.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **8 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. (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 has 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.

Inspector #621 reviewed resident #002's most current care plan as a result of a staff interview which identified this resident to have an identified nutritional condition with no plan. On review of the care plan, last revised on a certain date in September 2018, the Inspector noted in the plan, that resident #002 was to be provided a specific intervention at a specified number of times daily. However, on review of the physician's orders on resident #002's chart, the Inspector noted an order from a specific date in October 2017 to stop the intervention.

During an interview with PSW #106, they reported to their knowledge, resident #002 did not utilize the specified intervention.

During an interview with the LTC Lead, they reported to Inspector #621 that resident #002 had been ordered this specific intervention; however, the resident refused to use this intervention so it was discontinued. The LTC Lead identified that all staff had access to the resident's care plan on the electronic health record, and when there was a change to a resident's care needs, that registered staff were responsible for updating the care plan. Together with the Inspector, the LTC Lead reviewed resident#002's most current care plan, which identified that resident #002 continued to have this intervention a certain number of times a day, as part of their nutrition care needs. The LTC Lead confirmed to the Inspector that the plan of care, including resident #002's care plan had not been reviewed and revised to reflect their current care needs with respect to this intervention. [s. 6. (10) (b)]

2. Resident #004 was observed by Inspector #693 during stage one of the RQI to have an intervention in place on their bed. Follow up observations were made on three dates in October, 2018, and resident #004 was observed in bed with the intervention in use.

Inspector #693 reviewed resident #004's most current care plan. The care plan indicated that resident #004 utilized this intervention while in bed.

Interviews were conducted with PSW #104, RPN #105, and RPN # 101. PSW #104 and RPN #105 indicated that resident #004 utilized this intervention when in bed. RPN #101

indicated that resident #004 utilized this intervention but in a different manner while in bed, and that the care plan should have been updated to reflect resident #004's current care needs.

A review of the home's policy, entitled "Plan of Care" indicated that the plan of care was to be reviewed and revised according to the reassessment of the resident.

In an interview with the LTC lead, they acknowledged that resident #004's care plan indicated that they utilized an intervention in a certain manner while in bed and that resident #004 utilized this intervention differently than the care plan indicated, and therefore; the care plan should have been updated to reflect the current needs of resident #004.

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 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. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by residents, and those doors were kept closed and locked when they were not being supervised by staff.

During a tour of the home, Inspector #621 observed the doors to two soiled utility rooms to be unlocked and unsupervised. On entry to the soiled utility room across from resident room #202, the Inspector had identified an open cupboard which had three full bottles of Purell Advance Foam Hand Rub; one bottle of EcoLab Disinfectant Cleaner with a caution label which stated "Do Not Drink"; one bottle of Getinger Clean Foam Spray and one bottle of Scantax Oder Zone pellets. On entry to the second soiled utility room, located across from the unit shower room, the Inspector found an unlocked cupboard, containing two full bottles of Purell Advance Foam Hand Rub.

During an interview with the LTC Team Lead, they reported that the soiled utility rooms in the resident home areas were not locked, as all cleaning and disinfection agents were kept locked in the cupboards found in each of these rooms. Together with the Inspector, the LTC Team Lead observed both soiled utility rooms to be unlocked and unsupervised; that the cupboards in both rooms were unlocked; and all cleaning and disinfection agents were accessible. The LTC Team Lead confirmed to the Inspector that having industrial cleaning and disinfection agents accessible in an unlocked and unsupervised non-residential rooms within the home posed a safety hazard to residents. [s. 9. (1) 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 all doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the use of a PASD under subsection (3) to assist a resident with a routine activity of daily living that was included in the Resident's plan of care had been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.

Resident #004 was identified as having required further inspection related to the use of two Personal Assistive Service Devices (PASD). During observations on three days in October, 2018, resident #004 was observed to be utilizing the two identified PASDs.

Inspector #693 reviewed resident #004's most current care plan. The care plan indicated that resident #004 utilized the two identified PASDs.

Interviews were conducted with PSW #104 and RPN #105, they indicated that resident #004 utilized both identified PASDs as per the most recent care plan. RPN #105 stated that the home did not require consent for the use of a PASD and therefore there was no documented evidence to indicate a consent was obtained for resident #004's PASD use.

A review of the home's policy: " NUR 106 :Use of Personal Assistive Service Devices (PASDs)" last revised in June 2015, indicated that the use of a PASD must be approved by a clinician who is required to obtain informed consent for the treatment from the resident or substitute decision maker (SDM).

In an interview with the LTC lead, they indicated that resident #004 utilized the two identified PASDs. The LTC lead confirmed that there was no consent in place for the use of the PASDs for resident #004. [s. 33. (4) 4.]

2. Resident #002 was identified as having required further inspection related to the use of a PASD. During observations on three days in October, 2018, resident #002 was observed utilizing the identified PASD.

Inspector #693 reviewed resident #002's most current care plan. The care plan indicated that resident #002 utilized the identified PASD.

Interviews were conducted with PSW #104 and RPN #105, and they indicated that resident #002 utilized the PASD as per the most recent care plan. RPN #105 stated that the home did not require consent for the use of a PASD and therefore there was no documented evidence to indicate a consent was obtained for resident #002's PASD use.

In an interview with the LTC lead, they indicated that resident #002 utilized the identified PASD. The LTC lead confirmed that there was no consent in place for the use of the PASD for resident #002. [s. 33. (4) 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 the use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if the use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

Resident #005 was identified as having required further inspection related to altered skin integrity.

A review of resident #005's most recent medication review indicated that on a date in September, 2018, a physician ordered a medicated treatment to be applied a specific number of times daily. Review of resident #005's Electronic Medication Administration Record (eMAR) from a day in September, 2018, to a day in October, 2018, showed that the medicated treatment order had not been signed by a registered staff as administered on four days in September, 2018.

A review of the progress notes did not indicate that the medicated treatment had been applied to resident #005 on the four identified days in September, 2018.

In an interview with RPN #101, they stated that after administering or applying a medication to a resident they were responsible for signing the eMAR to identify that the medication or treatment was given as ordered by the prescriber.

A review of the home's policy: "Medication Administration: 5.1 Medication Administration Record" last revised in September 2018, identified that medication administration was to be documented on the resident's eMAR at the time the medication was given by the person administering the medication, the eMAR was to be initialed by the person administering the medication.

During an interview with the LTC lead they stated that resident #005's eMAR had not been signed by the nurse who administered the medication for the medicated treatment for altered skin integrity on four identified days in September, 2018. Upon review of resident #005's progress notes from these dates the LTC lead stated that the medicated treatment was not applied to resident #005 on the four identified dates in September, 2018, as directed by the prescriber. [s. 131. (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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident involving a resident was documented together with a record of the immediate actions taken to assess and maintain the resident's health.

Resident #005 was identified as having required further inspection related to altered skin integrity.

A review of resident #005's most recent medication review indicated that on September 12th, 2018, a physician ordered a medicated treatment to be applied a specific number of times in a day. Review of resident #005's Electronic Medication Administration Record (eMAR) from a specific day in September, 2018, to a specific day in October, 2018, showed that the order for the medicated treatment had not been signed by a registered staff as administered on four days in September, 2018.

Interviews were conducted separately with RPN #101 and RPN #105, and they stated that if they were to make a medication incident it was the home's process to complete a medication incident report and document what happened on the form as well as the resident's condition and the steps that were taken after the incident occurred.

A review of the home's policy: "Medication Administration: 5.10 Missing Signatures" last revised in September 2018, identified that a missing signature on an eMAR would be considered a medication incident, and that the procedure for reporting a medication incident was to be followed.

During an interview with the LTC lead they stated that resident #005's eMAR had not been signed by the nurse administering the medicated treatment for altered skin integrity on four days in September, 2018. The LTC lead confirmed that these missing signatures were considered a medication incident and that a medication incident report should have been completed, and was not. [s. 135. (1)]

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 medication incident involving a resident and every adverse drug reaction is documented, together with a record of the immediate actions taken to assess and maintain the resident's health, to be implemented voluntarily.

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 the licensee responded in writing within ten days of receiving Resident's Council advice related to concerns or recommendations.

Inspector #693 reviewed the Residents Council meeting minutes for July, August and September 2018, and the following concerns were brought by the Resident's Council to the home:

September 2018:
- Coffee for visitors: Residents would like to be able to offer coffee/tea to their visitors. The residents receive priority for beverages/snacks. Resident Council is willing to pay a fee for coffee if necessary.
- Residents have complained of another resident's excessive noise. It was explained that said resident is being monitored by staff and patience is requested from other residents.
- Air vent above table 4 & 5 is blowing straight on residents and is cold.

No written response was indicated with any of the above concerns from the licensee.

In an interview with the Resident's Council President: Resident # 007, they stated that the September meeting took place on September 25, 2018, and that the Resident's Council had not received any written response from the home to the concerns brought forward in the September meeting.

During an interview with the Activity Coordinator on October 5th, 2018, they stated that it was their responsibility to forward any concerns submitted by the Resident's Council to the administration and that the administration should respond within ten days. The Activity Coordinator showed the Inspector an email from October 2, 2018, in which they had sent the minutes and concerns to the administrator and all departmental managers and stated they had not received a written response back to provide to the Resident's Council within ten days. [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 if Family Council had advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee, within 10 days of receiving the advice, responded to the Family Council in writing.

During an interview with Family Council member, they reported to Inspector #621 that they had participated in a meeting of Family Council on September 20, 2018, and there had been concerns brought forward at that meeting. They identified that to their knowledge, they had not been provided a written response back to Family Council within 10 days, to address the Council members concerns.

Inspector #621 reviewed the September 20, 2018, minutes of Family Council, and noted under the section titled "Open Floor for Members Concerns/Suggestions", the following:
a) A member wanting to discuss with management the Keto diet for residents;
b) A suggestion made to send information about the home's activities to the local paper;
c) Members identifying they were not able to locate nursing staff around nursing desk;
d) Members requesting resident urine collection bags be covered for resident dignity;
e) A member suggesting that nursing staff write on resident boards the name of the nurse who is on for that day or evening; and
f) A member reporting that some residents are sitting under air vents and that it was too cold for them.

During an interview with Activity Coordinator, they identified to Inspector #621 that they had only completed typing of the September 20, 2018, meeting minutes of Family Council on October 2, 2018, and that a copy of the minutes of Family Council with the identified concerns had only been sent to the home's managers from nursing, maintenance, dietary and administration via email on October 2, 2018. The Activity Coordinator confirmed that as a consequence, the home had not provided a written response within 10 days to Family Council for the written concerns identified in the September 20, 2018, meeting. [s. 60. (2)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the contact information of the Director, or the contact information of a person designated by the Director to receive complaints; 2017, c. 25, Sched. 5, s. 21 (1)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(g.1) a copy of the service accountability agreement as defined in section 21 of the Commitment to the Future of Medicare Act, 2004 entered into between the licensee and a local health integration network;
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(l.1) a written plan for achieving compliance, prepared by the licensee, that the Director has ordered in accordance with clause 153 (1) (b) following a referral under paragraph 4 of subsection 152 (1); 2017, c. 25, Sched. 5, s. 21 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee failed to ensure that copies of the inspection reports from the past two years were posted in the home, in a conspicuous and easily accessible location.

During a tour of the home, Inspector #621 noted postings of public inspection reports on a bulletin board across from nursing station. On further inspection, the Inspector noted that there was no public inspection report posted for Complaint Inspection report #2017_633577_0013 with report date of August 14, 2017, as identified on the home's Compliance History Report.

During an interview with the LTC Lead, they identified to Inspector #621 that the public version of all the home's inspection reports from the past several years were posted on the bulletin board, across from the nursing. Together with the Inspector, the LTC Lead reviewed the posted inspection reports, along with the home's compliance history, and confirmed that the public version of Complaint Inspection report #2017_633577_0013, dated from August 14, 2017, was not posted in the home at the time of inspection, and should have been. [s. 79. (3) (k)]

2. The licensee has failed to ensure that the most recent minutes of the Resident meetings, with consent of the Resident Council was posted in the home, in a conspicuous and easily accessible location.

During an interview with the President of Residents' Council, they informed Inspector #621 that the Council had meetings most months, and the last meeting was held on September 25, 2018. The President of Residents' Council identified that the home had the Council's consent to post minutes of their meetings on the bulletin board across from the dining room, so they were accessible to all residents and visitors who wished to review them.

Inspector #621 identified a bulletin board across from the dining and activity room where information pertaining to Residents' Council was posted. However, on further review, the Inspector found no postings of minutes from any meetings of the Council.

During an interview with the Activity Coordinator, they confirmed to Inspector #621 that Residents' Councils last meeting was on September 25, 2018; however, they had not posted the most current minutes in the home.

During an interview with the Long-Term Care Lead, they confirmed that the most current minutes of Residents’ Council were not posted in the home at the time of inspections, and should have been. [s. 79. (3) (n)]

Issued on this 15th day of October, 2018

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

Original report signed by the inspector.