Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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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 31, 2014	2014_380593_0011	S-000347-14	Resident Quality Inspection

Licensee/Titulaire de permis

913096 ONTARIO LIMITED
1202 Highway 94 R.R. #1 Corbeil ON P0H 1K0

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

NIPISSING MANOR NURSING CARE CENTER
1202 Highway 94 Box 40 Corbeil ON P0H 1K0

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

GILLIAN CHAMBERLIN (593), MONIKA GRAY (594), TIFFANY BOUCHER (543)

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): September 8th - 19th, 2014

Five additional logs were incorporated into the RQI including three reported critical incidents and two complaints.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Nutrition Manager, Registered Nursing Staff, Registered Dietitian, Dietary Staff, Activation Staff, Maintenance Staff, Personal Support Workers (PSW), Residents and Residents' family members.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home

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

- **9 WN(s)**
- **2 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. 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:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9. (1).
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).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. Critical incident was submitted to the Ministry of Health and Long-Term Care by the licensee involving the elopement of Resident #013 on May 22nd, 2014. It is unsure how the Resident was able to exit the home however it is believed that they may have followed visitors leaving out of the front door.

Observations by Inspector #593 September 11, 2014 found that the front door of the home, which leads to the outside grounds and carpark, has no audible or visual alarm. This was confirmed when Inspector #593 held the door open for 3 minutes during which time there was no audible or visual alarm associated with this door.

During an interview with Inspector #593, the Director of Care (DOC) advised that the door should have an audible alarm when held open and believes this is activated after 15 seconds. At this time, the door was retested and no audible alarm was heard after the door was held open for 2.5 minutes. The DOC and the Administrator advised that the wander guard system has recently been installed on this front door and this may have caused the alarm to be deactivated.

As such, the licensee has failed to ensure that all doors leading to the outside of the home are equipped with an audible door alarm that allows calls to be canceled only at the point of activation. [s. 9. (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 ensuring that all doors exiting the home are equipped with a door access control system with an audible door alarm that is on at all times, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(c) includes alternative choices of entrees, vegetables and desserts at lunch and dinner; O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. Inspector #593 observed September 08, 2014, during the lunch service in the main floor dining room a tray puree meal served to Residents on pureed diets. There was no alternative pureed main meal option available to Residents requiring a pureed diet as observed by Inspector #593 and this was confirmed by dietary staff member #104.

Inspector #593 observed September 09, 2014, during the lunch service in the main floor dining room a sandwich puree meal served to Residents on pureed diets. There was no alternative pureed main meal option available to Residents requiring a pureed diet and there was no alternative choice of pureed vegetable sides served during this meal period. This was confirmed by dietary staff member #104.

Inspector #593 observed September 15, 2014, during the lunch service in the main floor dining room a sandwich puree meal served to Residents on pureed diets. There was no alternative pureed main meal option available to Residents requiring a pureed diet and there was no alternative choice of pureed vegetable sides served during this meal period. This was confirmed by dietary staff member #105.

Inspector #593 observed September 17, 2014, during the lunch service in the main floor dining room a tray puree meal served to Residents on pureed diets. There was no alternative pureed main meal option available to Residents requiring a pureed diet as observed by Inspector #593 and this was confirmed by dietary staff member #106.

Inspector #593 observed September 18, 2014, during the lunch service in the main floor dining room a tray puree meal served to Residents on pureed diets. There was no alternative pureed main meal option available to Residents requiring a pureed diet as observed by Inspector #593 and this was confirmed by dietary staff member #104. In addition, Residents requiring minced diets were served sandwiches with minced salad however there was no alternative main meal option available for Residents requiring a minced textured diet.

During an interview with Inspector #593 September 18, 2014 at 11:30, the homes Registered Dietitian advised that the expectation is that two main meal options will be available for Residents requiring texture modified diets including both minced and pureed diets.

During an interview with Inspector #593 September 18, 2014 at 15:00, the home's Nutrition Manager advised that there should be two main meal options for Residents requiring both minced and pureed diets and that a vegetable side should be provided with every meal.

As such, the licensee has failed to provide alternative choices of entrees and vegetables at lunch to Residents requiring a texture modified diet as required in the regulations. [s. 71. (1) (c)]

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 ensuring that all Residents receiving pureed, minced and regular textured diets are offered alternative choices of entrees and vegetables at every lunch and dinner service in the home., to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. A review of the home's policy titled Nutrition Assessment and Risk Identification, review date December 2013 found that a review of each Resident's Nutrition Care Plan shall be completed at least quarterly by the Registered Dietitian or delegate.

A review of Resident #012's health care record found that the most recent quarterly nutrition assessment completed for this Resident was in March 2014, based on the home's policy the next quarterly nutrition assessment was due in June 2014, however as of September 18th, 2014 this had yet to be completed.

During an interview with Inspector #593 September 18, 2014 the home's Registered Dietitian advised that the quarterly nutrition assessment was not completed due to an oversight on their part. As such, the licensee has failed to comply with the Nutrition Assessment and Risk Identification Policy ensuring that every resident will be reviewed at least quarterly by the Registered Dietitian or delegate. [s. 8. (1) (a),s. 8. (1) (b)]

WN #4: 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. It was reported to the home's Administration that on June 27th, 2014 two staff members witnessed another staff member slap a Resident's hand. It was reported by PSW staff members #116 and #117 that the Resident and another staff member were coming out of the bathroom and the Resident attempted to grab the sheet and pull it over the mattress. At which point, the staff member leaned over and slapped the Resident on the hand.

Inspector #543 reviewed the home's Policy-Zero Tolerance Policy on Abuse and Neglect. This policy stated that it is the policy of Nipissing Manor that any form of abuse by any person interacting with Residents and employees, whether verbal, physical, mental, through neglect or any other type of abuse, is forbidden and is subject to discipline up to and including termination.

As such, the licensee has failed to ensure that staff complied with their policy on Zero Tolerance of Abuse and Neglect. [s. 20. (1)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. It was reported to the home's Administration that on June 27th, 2014 a staff member witnessed another staff member slap a Resident's hand. Documentation stated that the Resident and another staff member were coming out of the bathroom and the Resident attempted to grab the sheet and pull it over the mattress. At which point, the staff member leaned over and slapped the Resident on the hand.

Inspector #543 reviewed the home's Policy-Zero Tolerance Policy on Abuse and Neglect. This policy stated that all staff are expected to fulfill their moral and legal obligation to report any incident or suspected incident of Resident abuse. According to the policy, the Nurse Manager must initiate the critical incident system (CIS) form using the mandatory report section immediately upon becoming aware of the incident.

Inspector #543 reviewed the critical incident and identified that the incident occurred on June 27th, 2013 but was not reported to the Ministry of Health and Long-Term Care until July 3rd, 2013.

As such, the licensee has failed to immediately report the information relating to abuse of a resident by anyone to the Director. [s. 24. (1)]

WN #6: 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. A review of Resident #012's health care record indicated that Resident #012 had lost 5% of their body weight over a one month period. This was highlighted in the Resident's on-line weight chart. Further review of Resident #012's progress notes found no action by the home's Registered Dietitian or other staff members within the home as a result of this weight loss.

During an interview with Inspector #593 September 18th, 2014 the home's Registered Dietitian confirmed that they had not assessed Resident #012 as a result of the weight loss occurring. The Registered Dietitian advised that that home's expectation is that Resident's weights are reviewed each month and those Residents with a significant weight loss of 5 per cent or more are reviewed by the home's Registered Dietitian.

A review of the home's policy titled Weight Change Management, review date December 2013 found that the Registered Dietitian conducts an assessment of Residents referred due to significant weight change and investigates possible nutrition factors responsible. Significant weight change is defined in the policy as 5% or more over one month. As such, the licensee has failed to ensure that Residents with a change in body weight of 5 per cent or more over one month are assessed and that actions are taken and outcomes are evaluated. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. Inspector #593 observed September 08, 2014, during the lunch service in the main floor dining room, staff serving both the soup and the main meal to Residents concurrently. In addition, it was observed that the desserts were served to Residents while they were still finishing their soup and main meals during this meal service.

Observations by Inspector #593 found that September 16, 2014 during the breakfast service in the main dining room, dining staff served both the cereal choice and hot meal option to Residents concurrently. A review of dietary records for Residents #005, #006, #007, #008, #009, #010, and #011 found there was no requirement for these Residents to be served all courses concurrently however, it was observed that these seven Residents were served both courses concurrently during this meal.

Observations by Inspector #593 found that September 17, 2014 during the first sitting of the lunch service in the main dining room, 18 Residents from tables 1, 3, 4, 5, 7, 10 and 11 were served the soup and the main meal concurrently. In addition, it was observed during the second sitting of lunch in the main dining room, 9 Residents from tables 4, 7, 9 and 10 were served the soup and the main course concurrently.

Observations by Inspector #593 found that September 18, 2014 during the second sitting of the lunch service in the main dining room, 6 Residents from tables 4, 5 and 6 were served the soup and the main course concurrently.

During an interview with Inspector #593 September 17, 2014 at 12:49, PSW staff member #115 advised that having the two meal services back to back with 45 minutes allocated for each sitting is busy, they further advised that often Residents are late coming to the dining room for the first seating and that this can hold them up. They advised that most Residents are fairly fast at finishing their meals however there are a few Residents who take their time and delay leaving the dining room even though they have finished their meals.

During an interview with Inspector #593 September 18, 2014 at 15:00, the home's Nutrition Manager acknowledged that staff not following course by course service is a known issue in the home and is something that they have been trying to address. In addition, they stated that the Residents have come to expect the soup and the main course being served together as the Residents in the first sitting believe they have to be quick to finish their meals before the Residents in the second sitting are seated.

As such, the licensee has failed to provide course by course service of meals for each resident in the home. [s. 73. (1) 8.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure procedures are developed for addressing incidents of lingering offensive odours given Inspectors #543, #593 and #594 noted lingering offensive odours in the area leading into 1st floor North Wing over the course of the inspection; September 08, 09, 10, 11, 15, 16, 17, 18 and 19th 2014. Inspector #594 interviewed Housekeeping Staff member #102 and PSW staff member #103 who both confirmed lingering offensive odours are present upon entrance to the North Wing. Inspector #594 reviewed the home's Environmental Services Binder and was unable to identify a procedure developed specifically to address incidents of lingering offensive odours. Inspector #594 interviewed the Administrator who verified there are no procedures developed specifically to address incidents of lingering offensive odours. [s. 87. (2) (d)]

WN #9: 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. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that each Resident admitted to the home is screened for tuberculosis within 14 days of admission given that Inspector #594 reviewed three random Resident immunization records and identified one Resident who was not screened within 14 days of admission. Inspector #594 increased the random Resident sample to 13 Residents and found three Residents, in total, not screened for tuberculosis within 14 days of admission. Resident #895 was admitted in 2012 and was not screened for tuberculosis until 21 days after admission. Resident #003 was admitted in 2013 and not screened for tuberculosis until 37 days after admission. Resident #004 was admitted in 2012 and not screened for tuberculosis until 56 days after admission.

Inspector #594 reviewed the homes policy for Tuberculosis screening titled Mantoux Screening – Residents, review date December 2013 which states all Residents will undergo Mantoux screening within 14 days of admission to the home. An interview with the DOC validated Residents #895, #003 and #004 were not screened for tuberculosis within 14 days of admission.

As such, the licensee has failed to ensure that all Residents are screened for Tuberculosis as provided for in the regulations. [s. 229. (10) 1.]

Issued on this 11th day of December, 2014

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

Original report signed by the inspector.