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
Oct 26, 2017	2017_655679_0011	022204-17	Resident Quality Inspection

Licensee/Titulaire de permis

1895357 Ontario Inc.
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

MICHELLE BERARDI (679), LOVIRIZA CALUZA (687), TIFFANY BOUCHER (543)

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 16-20, 2017.

Additional logs inspected during this RQI included:

-Five critical incidents submitted to the Director related to resident falls.

During the course of the inspection, the inspector(s) spoke with the Director of Care, Registered Nurse (RN) Manager, Life Enrichment Manager, Administrative Assistants, Registered Dietitian (RD), RNs, Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), family members and residents.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records and, reviewed numerous licensee policies, procedures and programs.

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

During the course of this inspection, Non-Compliances were issued.
- **4 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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).

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 :

A Critical Incident (CI) report was submitted to the Director on a particular date, which indicated that resident #004 sustained a fall. According to the CI report, the resident was ambulating in an area of the home and fell. The fall resulted in an injury.

Inspector #543 reviewed this resident's care plan, which identified that resident #004 was at a specific level of risk for falls, and required a certain level of assistance after their fall. Specific interventions were outlined in the residents plan of care.

On October 18, 2017, the following observation were made:

At a particular time, Inspector #679 observed the resident without the specified interventions in place.

Subsequently, Inspector #543 observed the resident. The Inspector observed that the interventions to prevent falls were not in place.

Inspector #543 and RPN #107 observed resident #004, and verified that the specified fall intervention was not in place.

Inspector #543 interviewed PSW #109 who verified that resident #004 sustained an injury after their fall, and that specific interventions were to be implemented.

Inspector #543 interviewed RPN #107 who verified that since the resident sustained an injury after their fall, interventions were put in place. RPN #107 indicated that it was the responsibility of whoever assisted the resident to ensure the interventions were in place.

3. A CI report was submitted to the Director on a particular date. The CI report outlined that resident #002 sustained a fall, resulting in an injury.

A review of resident #002's care plan in place at the time of the fall indicated that the resident was at a specific risk level for falls, and that a specified intervention (an item) was to be implemented.

A review of the electronic progress notes, indicated that the staff had received the intervention (the item) on a particular date.

A review of the Fall incident report identified that when resident #002 fell, the intervention was not in place as stated in the care plan.

In an interview with Inspector #687 on October 19, 2017, PSW #118 indicated that resident #002 required a specific level of assistance. PSW #118 stated that due to resident #002's specific level of fall risk, interventions were in place to minimize resident's fall incidents.

In an interview with Inspector #687 on October 20, 2017, at 0905 hours, the DOC informed the Inspector that staff need to follow the interventions in place for the resident as outlined in the care plan.

4. 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.

On October 17, 2017, Inspector #679 observed resident #005 with their mobility aid and a specific device in place.

A review of the electronic care plan, outlined an intervention that directed staff to ensure the device was in place at specific times.

During subsequent observations on October 17, 18 and 19, 2017, Inspector #679 observed resident #005 with the device in place, outside of the times outlined in the plan of care.

In an interview with Inspector #679 on October 19, 2017, RN #120 confirmed that the plan of care did indicate that the device was to be used at specific times. Following the interview, RN #120 approached Inspector #679 to outline that they had contacted Occupational Therapist #121, who identified that the device was to be applied at a different time then outlined in the plan of care. RN #120 indicated that the care plan was to be updated.

In an interview with the DOC on October 19, 2017, they identified that care plans were to be updated with any change in resident status.

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 the care set out in the plan of care is provided to resident #004 as outlined in the plan, to be implemented voluntarily.

WN #2: 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 :

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 October 16, 2017, during the initial tour of the home, Inspector #687 made the following observations:

- In a specific tub room, two deodorants, and one bottle of after shave were observed used and unlabelled.
- In a specific tub room, one bottle of shampoo, one bottle of body lotion, four hair brushes and one shower sponge was observed used and unlabelled.
- In a specific tub room, one stick of deodorant and one bottle of body lotion were observed used and unlabelled.
- In a specific tub room, one bottle of body lotion and two tubes of toothpaste were observed used and unlabelled.

A review of the policy entitled "Residents Belongings and Missing Residents Belongings", last revised January 2017, outlined that all resident personal items were to be labelled at the time of admission and when new items were given to the resident.

In an interview with the DOC on October 19, 2017, they confirmed that all residents personal belongings were to be labelled upon admission and upon acquiring new items.

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 each resident of the home has 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, 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 :

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

On October 17, 2017, resident #006 was observed by Inspector #543 with a particular device in place.

Subsequently, on October 17, 18 and 19, 2017, Inspector #679 observed resident #006 with a particular device in place.

Inspector #679 reviewed the current electronic care plan which did not outline that the resident required the use of the specific device.

A review of the progress notes outlined that on a particular date, resident #006's device was discontinued.

On October 19, 2017, Inspector #679 and RN #103 reviewed the resident's paper chart, care plan, and the resident's electronic progress notes and were unable to identify that consent was received from the resident or their SDM for the use of the device after it was discontinued a number of months prior.

A review of the homes policy titled "Restraint Policy" last revised in January 2017, outlined that "Where the PASD restricts the movement of the resident and the PASD will be required on an ongoing basis the following is required: Consent form completed by resident, Power of Attorney for Personal Care or SDM".

In an interview with Inspector #679 on October 19, 2017, RN #103 indicated that the use of the device is outlined in the residents care plan, and that the device wouldn't be initiated without consent from the family or resident and a physicians order.

In an interview with Inspector #679 on October 19, 2017, the DOC confirmed that it was the expectation of the home that consent was obtained for the use of any PASD.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

The licensee has failed to ensure that drugs were stored in an area or a medication cart, that was used exclusively for drugs and drug-related supplies and that was secure and locked.

During an observation conducted on October 16, 2017, Inspector #687 noted a number of topical prescription creams in a tub room.

On October 19, 2017, Inspector #543 interviewed RN #103 who verified that all prescription medications, including topical creams were to be stored in the medication cart, and not to be left in the tub rooms.

In an interview with Inspector #679 on October 19, 2017, the DOC verified that all prescription medications were to be returned to registered staff to be stored in the medication room.

Issued on this 26th day of October, 2017

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

Original report signed by the inspector.