Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

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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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Oct 24, 25, 26, 29, 30, 31, 2012	2012_051106_0026	Complaint

Licensee/Titulaire de permis

KENORA DISTRICT HOME FOR THE AGED BOARD OF MANAGEMENT
35 Van Horne Avenue, Box 725, DRYDEN, ON, P8N-2Z4

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

PRINCESS COURT
PRINCESS STREET, BOX 725, DRYDEN, ON, P8N-2Z4

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

MARGOT BURNS-PROUTY (106)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Registered Dietitian (RD), Personal Support Workers (PSW), Family Members and Residents.

During the course of the inspection, the inspector(s) conducted a walk-through of resident home areas and various common areas, observed care provided to residents in the home and reviewed resident health care records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance

Continence Care and Bowel Management

Critical Incident Response

Family Council

Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Responsive Behaviours

Sufficient Staffing

Training and Orientation

Findings of Non-Compliance were found during this inspection.

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. 15. Accommodation services

Specifically failed to comply with the following subsections:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. On October 24, 2012, during a tour of the home inspector 106 noted the following:

-many door jams to resident rooms throughout the home, with scratches where the paint scraped off and metal was visible
-1st floor the heater in the hallway near the tub room has multiple scuff marks
-lower wall near the public elevator on 1st floor has scuff marks
-multiple scuff marks on the lower wall near the public elevator on 2nd floor
-gouges on the wall near the door in two resident rooms on the 2nd floor
-the vent on the tub room door was bent on the lower right corner and was not flush with the door on the 2nd floor
-the corner near the electrical room on 2nd floor had a moderate sized gouge to the mid corner and a gouge to the lower corner
-gouges on the lower walls in the hallway near four resident rooms on the 2nd floor
-the 3rd floor wall across from the dining room, near the nursing station has multiple scuff marks from the lower wall to approximately eye level
-the wall in the hallway near a hand sanitizer dispenser has been patched with a drywall compound but has not been painted
-the base board in the hallway on the 3rd had been repaired with duct tape
-gouges on the wall near a resident washroom on 3rd, the door jam to this washroom was also noted to have a gouge.

The licensee failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. [LTCHA, 2007, S. O. 2007, c. 8, s. 15 (c)] (106)

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following subsections:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention.
2. Mental health issues, including caring for persons with dementia.
3. Behaviour management.
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations.
5. Palliative care.
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. On October 26, 2012, staff member # S-103, reported that staff who provide direct care to residents have not received annual training in the area of palliative care. The licensee failed to ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with resident, training in the areas set out in the following paragraphs, at time or at intervals provided for in the regulations: 5. Palliative care. [LTCHA, 2007, S. O. 2007, c. 8, s. 76 (7) 5] (106)

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following subsections:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation;
(b) set out the organization and scheduling of staff shifts;
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident;
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. On October 25, 2012, inspector 106 requested a copy of the home's written staffing plan for nursing services and personal support services. On Oct 26, 2012, at approximately, 1000h, staff member #S-100 provided inspector 106, the Princess Court, "Staffing Profile - 2012". The inspector reviewed the staffing profile and this document did not include a written back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work. The licensee failed to ensure the staffing plan includes a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work. [O. Reg. 79/10, s. 31 (3) (d)] (106)

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following subsections:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;
(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time;
(e) continence care products are not used as an alternative to providing assistance to a person to toilet;
(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes;
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and
(h) residents are provided with a range of continence care products that,
(i) are based on their individual assessed needs,
(ii) properly fit the residents,
(iii) promote resident comfort, ease of use, dignity and good skin integrity,
(iv) promote continued independence wherever possible, and
(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The RAI MDS assessment of a resident indicates, the resident is on a scheduled toileting plan. The Plan of care for the resident was reviewed and no scheduled toileting plan was found. The licensee failed to ensure that the resident had an individualized plan of care to promote and manage bowel continence. [O. Reg.79/10, s. 51 (2) (b)] (106)

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following subsections:

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices;
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. On October 26, 2012, staff member # S-102, reported to inspector 106, that the home does not currently have a written responsive behaviours program. The licensee failed to ensure that a responsive behaviours program, as referred to in O. Reg. 79/10, s. 53 (1), was developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. [O. Reg. 79/10, s. 53 (3) (a)] (106)
2. On October 26, 2012, inspector 106 reviewed a resident's, health care record, it indicates that the resident has a history of responsive behaviours. The plan of care for this resident was reviewed by inspector 106 and no specific interventions were found that direct staff how to manage the resident's behaviours. [O. Reg. 79/10, s. 53 (4) (b)] (106)

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 for each resident demonstrating responsive behaviours, strategies are developed and implemented to respond to those behaviours., to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following subsections:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. Documentation of a meeting between staff member #S-100 and the family of a resident were provided to inspector 106 and reviewed. The home's documentation regarding the concerns brought forward by the family of the resident do not indicate the type of action that was taken to resolve the family's concerns or any final resolution if any to address the family's concerns. The licensee failed to ensure that a documented record is kept in the home that includes, (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant. [O. Reg. 79/10, s. 101 (2)] (106)

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following subsections:

s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.

3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.

4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

1. On October 29, 2012, staff member # S-101 reported to inspector 106, that the home has not currently implemented their pain management program. The licensee failed to ensure that an interdisciplinary program for pain was developed and implemented in the home to identify pain in residents and manage pain . [O. Reg. 79/10, s. 48 (1) 4] (106)
2. On October 29, 2012, staff member # S-101 reported to inspector 106, that the home has not currently implemented their continence care and bowel management program. The licensee failed to ensure that an interdisciplinary program for continence care and bowel management program was developed and implemented to promote continence and to ensure that residents are clean, dry and comfortable. [O. Reg. 79/10, s. 48 (1) 3] (106)

Issued on this 31st day of October, 2012

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