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
Nov 14, 2016	2016_303563_0037	029146-16	Resident Quality Inspection

Licensee/Titulaire de permis

PROVINCIAL NURSING HOME LIMITED PARTNERSHIP
1090 MORAND STREET WINDSOR ON N9G 1J6

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

QUEENSWAY NURSING HOME, DIVISION OF PROVINCIAL NURSING HOME LIMITED PARTNERSHIP
100 QUEEN STREET EAST HENSALL ON N0M 1X0

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

MELANIE NORTHEY (563), DONNA TIERNEY (569), SHERRI COOK (633)

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): October 24-28, 2016

The following intakes were completed within the RQI:
031377-15 - 0933-000003-15 - Critical Incident related to incident that caused an injury to a resident
024555-16 - 0933-000003-16 - Critical Incident related to staff to resident abuse
027455-16 - 0933-000004-16 - Critical Incident related to a resident fall
030840-16 - IL-47530-LO - Complaint related to lack of recreational activities

During the course of the inspection, the inspector(s) spoke with the General Manager, the Director of Care, the Assistant Director of Care, the Resident Services Coordinator, the Nurse Manager, the Registered Dietitian, the Restorative Care Coordinator, on Restorative Care Aide, the Food Services Manager, the Cook, the Program Service Manager, Behavioural Supports Ontario Lead, two Registered Nurses, six Personal Support Workers, one Ward Clerk, three family members, and 40 plus residents.

The inspector(s) also conducted a tour of the home and made observations of residents, activities and care. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed. Inspector(s) observed medication administration and drug storage areas, resident/staff interactions, infection prevention and control practices, the posting of Ministry information and inspection reports and the general maintenance, cleaning and condition of the home.

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
Residents' Council
Responsive Behaviours

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

3 WN(s)
1 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 failed to ensure that there was a written plan of care for resident #008 that set out the planned care and the goals the care was intended to achieve for staff and others who provide direct care to the resident.

Record review of the "Consent to the Use of Personal Assistance Services Device (PASD)" dated May 29, 2015 documented the use of a "sitter select while in bed."

On October 25, 2016, resident #008's room was observed with a sitter alarm hooked to the headboard of the resident's bed.

On October 26, 2016 at 0940 hours, the Restorative Care Coordinator (RCC) #108 shared that the care plan did not have an intervention related to the use of the sitter select alarm and shared that the resident used this alarm when in bed as a strategy to prevent falls.

Record review of the current care plan in PointClickCare (PCC) for resident #008 did not include the sitter select alarm used while the resident was in bed. There were no goals or interventions in place related to the use of the sitter alarm that sets out the planned care for this resident.

The licensee failed to ensure that the sitter select alarm for resident #008 was part of the written plan of care that set out the goals the care was intended to achieve to staff and others who applied the alarm at rest periods in bed for this resident. [s. 6. (1)]

2. The licensee has failed to ensure that the outcome and effectiveness of the care set out in the plan of care was documented.

a) Resident #007 triggered in stage one of the Resident Quality Inspection where by staff reported that the resident was underweight with a low Body Mass Index (BMI) and not receiving nutrition interventions to gain weight.

Record review of the current care plan in PointClickCare (PCC) documented, “Provide 'High Energy High Protein' intervention: Provide 125ml of White HEHP milk at lunch, supper and PM snack. Does not like chocolate.” The goal was identified “to maintain within goal weight range.” The Nutritional Risk Assessment dated September 28, 2016 documented resident #007 at a high nutritional risk with a low BMI. (563)

b) A low BMI for resident #001 was triggered in stage one of the Resident Quality Inspection (RQI).

A Record review of the plan of care in PCC indicated that resident #001 had a low BMI and was at a medium nutrition risk. Resident #001 was to receive 200 mls of chocolate high energy high protein (HEHP) fluid intervention at lunch and supper with encouragement from staff to maintain adequate nutrition and hydration to promote weight gain within goal weight range. (633)

c) During stage one of the Resident Quality Inspection (RQI), resident #005 triggered for low body mass index.

Record review of the resident’s "Nutritional Risk Assessment V9" in PointClickCare (PCC) dated September 28, 2016, identified the resident as high nutritional risk. Review of the resident’s weight history from February to October, 2016, showed that the resident had progressive weight loss totaling 7.5 Kilo grams. The current care plan intervention for resident #005 stated “Provide 'High Energy High Protein' intervention : 200ml of Chocolate HEHP milk at breakfast, lunch and supper.”

Review of the tasks “Additional Hydration (Med Pass Fluids/Supplements, Other Fluids)”

question two "Amount of nutrition supplement consumed (in mls)" from the time period of September 27 to October 25, 2016, showed documentation as either zero or not applicable. (569)

Record review of the "Additional Hydration (Med Pass fluids/Supplements, Other Fluids)" task in Point Of Care (POC) for amount of nutrition supplement consumed (in mLs) for resident #001, #005 and #007 was documented as "0" within the last 30 days.

On October 25 and 26, 2016, PSW's #113 and #114, Nurse's Aide #112, Health Care Aide #115 and RN's #105 and #116 indicated that HEHP was documented in POC under the task "meals: daily fluid requirements" and was included in the total daily fluid intake for each day.

On October 26, 2016, RN #116, Resident Services Coordinator #103 and Director of Care #117 agreed that there was no way to know how much of the required nutritional supplement the resident was consuming, if any. DOC #117 explained that the High Energy High Protein (HEHP) intervention was incorrectly documented in POC under the "Meals; Daily Fluid Requirements" task for resident #001, #005 and #007. The DOC also shared that staff require education as to where to correctly document the HEHP intake in order to monitor the outcome and effectiveness of this intervention.

On October 27, 2016, during a telephone interview, the Registered Dietitian #106 shared there was no way to determine if the supplement was consumed or refused by looking at the total fluid intake task and shared there was a flaw in monitoring the HEHP supplement effectiveness.

The licensee has failed to ensure that the outcome and effectiveness of the HEHP intervention set out in the plan of care for resident #001, #005 and #007 was documented. [s. 6. (9)]

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 there is a written plan of care for resident #008 that set out the planned care and the goals the care is intended to achieve for staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: 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. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the Personal Assistance Services Device (PASD) used to assist a resident with a routine activity of living was included in the residents' plan of care.

On October 25, 2016 at 1355 hours, resident #007 was observed sitting in tilt manual wheelchair with a Velcro seat belt closed and under the resident's shirt out of sight. The resident was rocking back and forth in the chair and foot propelling very slowly.

Record review of the current care plan demonstrated there was no documented goal or interventions related to the use of the tilt manual wheelchair. There was no monitoring documented as part of the Point of Care tasks for Personal Support Workers (PSWs).

Record review of a progress note in PointClickCare (PCC) dated July 28, 2011 stated, "Shoppers Home Health delivered resident's tilt wheelchair today."

Record review of the Physician's Orders in PCC documented "PASD: VELCRO BELT to

be worn while up in wheelchair to prevent falls.” There was no approval for the use of the tilt manual wheelchair.

Record review of the "Consent to the Use of Personal Assistance Services Device (PASD)" dated December 2, 2014 documented the use of a Velcro seat belt. There was no consent for the use of the tilted manual wheelchair.

Record review of the “Assessments” tab in PCC demonstrated that the “PASD Assessment” was never completed before the use of the tilt manual wheelchair or the Velcro seat belt.

Record review of the "PASD Process" provided to inspector by Restorative Care Coordinator #108, stated, "Complete the PASD Assessment located on Point Click Care."

On October 25, 2016, the Restorative Care Aide (RCA) #107 and the Restorative Care Coordinator (RCC) #108 shared that the assessment for the use of the tilt manual wheelchair was not completed prior to implementation of this PASD. The RCA shared that resident #007 used a tilt manual wheelchair and staff tilt this resident at times and acknowledged that the plan of care did not include the use of a tilt manual wheelchair and there was no approval or consent for its use. The RCC shared that resident #007 was unable to incline herself from a tilted position and the tilt mechanism on the manual wheelchair did limit her freedom of movement.

On October 28, 2016 at 1200 hours, the Ward Clerk #122 shared that resident #007 would attempt to rise from her manual chair if the Velcro seat belt was not applied. The ward clerk also shared that the tilt mechanism on the resident's manual wheelchair has been used when the resident attempts to get out of bed, that the resident has the physical capability to get out of bed and staff would transfer the resident to the wheelchair and tilt it for safety and comfort.

On October 28, 2016 at 1200 hours, Health Care Aide #121 shared that the resident would try to get out of the wheelchair if the belt was not applied and shared that the resident has the ability to get out of bed on her own.

The licensee failed to ensure that the tilt manual wheelchair used to assist a resident with positioning, comfort and safety was included in the residents' plan of care. [s. 33. (3)]

WN #3: 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 name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(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)
(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)
(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 the most recent Residents' Council minutes were posted in the home.

During the initial tour and throughout the duration of the home's 2016 Resident Quality Inspection (RQI), the most recent minutes of Residents' Council were not observed to be posted in the home.

On October 27, 2016, Program Manager #120 and the accepted licensee appointed assistant to Residents' Council shared that they wrote the minutes of Residents' Council meetings which were filed in the Residents' Council binder located in the Program Manager #120's office. They further shared that they did not know where the Residents' Council board was and also had not posted the most recent minutes of the last meeting in the home.

In an interview with General Manager #101, they agreed that the most recent Residents' Council minutes should have been posted in a conspicuous and easily accessible location in the home. [s. 79. (3) (n)]

Issued on this 14th day of November, 2016

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

Original report signed by the inspector.