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
Jan 13, 2017	2016_435621_0018	028553-16	Resident Quality Inspection

Licensee/Titulaire de permis

SIOUX LOOKOUT MENO-YA-WIN HEALTH CENTRE
Fifth Avenue South PO Box 909 SIOUX LOOKOUT ON P8T 1B4

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

William A. 'Bill' George Extended Care Facility
75 FIFTH AVENUE SIOUX LOOKOUT ON P8T 1K9

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

JULIE KUORIKOSKI (621), SHEILA CLARK (617)

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): November 7 - 10, and 14 - 17, 2016.

One intake related to a critical incident the home submitted regarding a resident fall was inspected.

During the course of the inspection, the inspector(s) spoke with the Administrator, Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeeping staff, the Maintenance Supervisor, Maintenance Worker, Activity Coordinator(s), family members and residents.

During the course of the inspection, the Inspector(s) completed observations of the resident home area, observed staff to resident and resident to resident interactions, observed medication administration, reviewed infection, prevention and control practices, reviewed the home's health care records for several residents, along with relevant policies, procedures and programs of the home.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

5 WN(s)
3 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).

Findings/Faits saillants :

The licensee has failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provide direct care to the resident.

A Critical Incident System (CIS) report was submitted to the Director on a specific day in October 2016, related to an incident resulting in injury involving resident #007, which occurred on a specific day in September 2016.

On a day in November 2016, Inspector #621 observed resident #007 in their bed with a specific number of safety devices in position and engaged. The Inspector also observed written documentation in this resident's room which identified that a particular safety device was to be positioned in a certain location within the room.

Inspector #621reviewed resident #007's written care plan, last revised in November 2016, which identified that the bed was to be in a certain position with a specified number of safety devices also in certain positions, but different than what was posted in the resident's room to be required.

During an interview with RPN #101 on a particular day in November 2016, they reported to the Inspector that resident #007 required a specific number of safety devices in place for safety, mobility and repositioning, and the bed in a certain position. When Inspector #621 inquired where staff would locate information pertaining to this resident's plan of care, RPN #101 identified that documentation would be found in the resident's written care plan.

On a specific day in November 2016, the Administrator and RPN #101 reviewed information posted in resident #007's room and the care plan which was last revised in November 2016, and identified to the Inspector that the written plan of care provided unclear direction relating to bed positioning and use of particular safety devices when the resident was in bed. [s. 6. (1) (c)] (621)

2. A review by Inspector #617 of resident #006's Resident Assessment Instrument Minimal Data Set (RAI MDS) from September 2016, which indicated resident #006 had a medical condition which required use of certain care interventions and routines. A review of resident #006's care plan dated from November 2016, identified interventions for the medical condition which required staff assistance to complete the care required at certain intervals throughout the day, and that they required a certain care item to be used for their medical condition.

On a day in November 2016, Inspector #617 interviewed PSW #106 who reported that resident #006 required staff assistance with the identified care routine and required the use of a certain care item for their medical condition. PSW #106 further confirmed that resident #006's care plan did not give clear directions to staff on managing their medical condition. [s. 6. (1) (c)] (617)

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 for resident #006 and #007 that set out clear directions to 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. 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 has failed to ensure that the required information established by the regulations 2007, c. 8. s. 79, for the purposes of subsection (1) and (2) was posted in the home at the time of inspection.

On three days in November 2016, Inspector #617 toured the home and observed that the following required information under regulation 2007, c. 8. s. 79 (3) was not posted in the home at the time of inspection:

- the home's policy to promote zero tolerance of abuse and neglect of residents;
- notification of the home's policy to minimize the restraining of residents, and how a copy of the policy could be obtained;
- a copy of the service accountability agreement as defined in section 21 of the Commitment to Future of Medicare Act, 2004 entered into between the licensee and a local health integration network;
- an explanation of the measures to be taken in case of fire;
- an explanation of evacuation procedures; and
- posting of a copy of the Resident Quality Inspection (RQI) report #2014_211106_0010 from the previous two years of inspections.

During an interview on a specific day in November 2016, the Administrator confirmed to the Inspector that the above outlined and required information was not posted in the home at the time of inspection. [s.79.(3)] (617)

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 required information established by regulations 2007, c.8. s.79, for the purposes of subsection (1) and (2) is posted in the home at the time of inspection, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident was taking any drug or combination of drugs, including psychotropic drugs, there was monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

Inspector #617 completed a review of resident #004's Resident Assessment Instrument Minimal Data Set (RAI MDS) dated from September 2016, which indicated that this resident exhibited responsive behaviours. A review of resident #004's care plan dated from October 2016 identified this resident’s responsive behaviours and the care interventions required to manage these behaviours.

On a specific day in November 2016, Inspector #617 interviewed RPN #103, who identified that a prescribed medication was administered for resident #004 to manage their behaviours. RPN #103 further stated that they would document the administration of the prescribed medication on resident #004's Medication Administration Record (MAR) and include the reason for the administration and the resident's response on the back of their MAR or in their progress notes as a shift summary.

A review of resident #004's MAR and progress notes dated from October and November 2016, indicated that a specific medication was documented at a specific dose over a specified time frame for responsive behaviours. Out of 63 occurrences, the resident's response to the medication was not documented on 30 occurrences, or 48 per cent of the time.

A review of the home's policy titled "Administration of Medications - PH.3.10", last revised on September 18, 2013, indicated that all administered medication doses shall be recorded in the patient's health record, according to established procedure.

On a specific day in November 2016, the Administrator reviewed resident #004's MAR dated from October 2016, and reported to Inspector #617 that there were occurrences in the documentation where the resident's response the prescribed medication was missing. The Administrator further stated that the registered nursing staff were expected to document resident #004's response to the prescribed medication in the progress notes for the prescribed time intervals for each shift, or on the MAR. [s. 134. (a)] (617)

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 when resident #004 is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs, to be implemented voluntarily.

WN #4: 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 if Residents' Council advised the licensee of concerns or recommendations that the licensee within 10 days of receiving the advice, responded to the Residents' Council in writing.

Inspector #621 reviewed copies of the Residents' Council meeting minutes from two months in 2016, and identified the following concerns by residents:

- On a specific date in the winter of 2016, a resident was reported to be concerned about a co-resident taking certain items from a specified room;
- On a specific date in the winter of 2016, a resident was reported to be concerned about a specific item in disrepair and inquiring about a time line for maintenance to be done; and
- On two specific dates in summer of 2016, a specified number of residents reported concern about co-residents entering their room uninvited.

Inspector #621 also identified from the Residents' Council meeting minutes from two specific months in 2016 that the former Director of Care (DOC) was recorded to be in attendance.

Inspector #621 reviewed the Residents' Council binder provided where correspondence from the Administrator to Residents' Council relating to resident's concerns was reported by the Administrator to be located. On review of the binder, the Inspector found no record of written follow up within 10 days by the former Director of Care (DOC) or the Administrator to Residents' Council in response to the resident concerns identified at the meetings from two specific months.

During an interview with the Administrator on a specific date in November 2016, they reported to Inspector #621 that they and/or the former DOC attended Residents' Council meetings and provided a verbal response to any concerns expressed by residents at that time. The Administrator confirmed that there was no written record of a response from either themselves or the former DOC to resident concerns brought forward at the two specific Residents' Council meetings from 2016. [s. 57. (2)] (621)

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the names of all residents involved in the incident were reported to the Director under subsection 23 (2) of the Act, with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report.

Inspector #621 reviewed a Critical Incident System (CIS) report which was submitted to the Director on a specific date in October 2016. The report identified an unnamed resident was found with an injury by RPN #108 at a specific time during a particular day in September 2016.

During an interview on a day in November 2016, the Administrator confirmed that the unidentified resident's name was not included on the CI report and reported to the Director due to their unfamiliarity with adding information into the computer system at that time. [s. 107. (4) 2. i.] (621)

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Issued on this 13th day of January, 2017

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

Original report signed by the inspector.