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
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 9, 2016	2016_450138_0006	001845-16	Resident Quality Inspection

Licensee/Titulaire de permis

Kemptville District Hospital
2675 Concession Road P.O. Bag 2007 KEMPTVILLE ON K0G 1J0

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

KEMPTVILLE DISTRICT HOSPITAL
2675 CONCESSION ROAD P. O. BAG 2007 KEMPTVILLE ON K0G 1J0

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

PAULA MACDONALD (138)

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): January 25, 26, 27, 28, 29, and February 1, and 2, 2016.

During the course of the inspection, the inspector(s) spoke with residents, the Activity Coordinator, the acting Team Leader, the Dietitian, a dietetic intern, registered practical nurses (RPNs), personal care assistants (PCAs), food service workers (FSWs), volunteers, and the Vice President of Nursing and Clinical Services.

The Inspector also conducted a review of resident health care records, toured residential and non residential areas, observed meal services, observed snack services, observed a medication administration, reviewed Residents' Council Meeting minutes, reviewed the home's menu, reviewed an employee's partial training record, reviewed the policy "Self-Administration of Medications" with a revision date of July 1999, and reviewed the policy "General Hospital Security" with a revision date of August 2012.

The following Inspection Protocols were used during this inspection:
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Snack Observation

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

5 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee failed to comply with section 6.(4)(a) of the Act in that the licensee failed to ensure that the staff and others involved in different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.

On February 1, 2016, the Inspector reviewed resident #001's health care record and noted that there was an External Consult Record from a physician recommending specific nutritional interventions for both food and fluid. The Inspector continued to review the resident's health care record and noted that these recommendations would be a change to resident #001's existing nutritional plan of care. It was noted that the nursing plan of care had been updated with the recommendations the same day the External Consult Record was dated. It was also noted there was no documentation to support that the nutritional plan of care had been reassessed and updated.

The Inspector spoke with Food Service Worker (FSW) #106 and Personal Care Assistant (PCA) #102 on January 28, 2016, and Volunteer #107 on February 1, 2016, regarding the nutritional care needs of the residents on the unit as all were observed to provide residents food and/or fluid items. All stated to the Inspector that there were no residents in the unit on diets other than regular or diabetic diets nor were there any specific nutritional considerations for both food and fluid for the residents.

The Inspector spoke with the Dietitian on February 1, 2016, regarding the recommendations on the External Consult Record. The Dietitian stated that the she was unaware of these recommendations and acknowledged that this would be a change to the resident's nutritional plan of care. She stated that she would be required to reassess resident #001's nutritional plan of care. [s. 6. (4) (a)]

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 the assessments related resident #001 are integrated and are consistent with each other, 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,
(b) includes menus for regular, therapeutic and texture modified diets for both meals and snacks; O. Reg. 79/10, s. 71 (1).

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee failed to comply with section 71.(1)(b) of the regulations in that the licensee failed to ensure that the home's menu cycle included menus for textured modified diets for both meals and snacks.

On January 25, 2016, the Inspector observed the lunch meal service and noted that the meal choice sheet indicated resident #002 was to receive a minced texture modified diet. The Inspector asked an unnamed FSW about the meal choice sheet and the FSW stated that the sheet was used to communicate resident dietary needs to serving staff. The FSW also confirmed that resident #002 was to receive a minced texture modified diet (the Inspector later reviewed the resident's health care record which confirmed that the resident was to receive a minced texture modified diet). It was observed by the Inspector that a regular meal of chicken pasta primavera and green beans was portioned for resident #002 and the entire meal including the green beans and pasta was finely cut up by a PCA until it was a suitable minced texture. The dessert options for the lunch meal were peaches or brownies. The FSW stated that the peaches were suitable for the minced texture modified diet but that the brownie would be required to be moistened with milk in order to be suitable.

The Inspector observed another lunch meal on January 29, 2016. Resident #002, who still required a minced texture modified diet, was provided a meal that consisted of an omelette, potato cubes, and pepper strips. It was noted by the Inspector that the omelette was the only portion of the meal cut up for resident #002. The potato cubes and pepper strips remained in large pieces. The Inspector observed that resident #002 struggled to chew and swallow this meal appropriately demonstrated by pocketing of food in the mouth and a difficulty clearing the mouth between bites of food. For dessert, resident #002 selected iced banana cake which was presented to the resident without

being moisten. The Inspector spoke with a different FSW, FSW #106, regarding the desserts for the minced texture modified diet and she stated that the banana iced cake was suitable for the minced texture modified diet. The iced banana cake was not moistened as the brownie was on January 25, 2016.

On February 1, 2016, the Inspector again observed a third lunch meal. The Inspector observed that resident #002 received chicken parmigiana and peas. It was noted that the chicken had been cut up to a minced texture but that the peas and penne pasta in the meal was untouched and remained whole. The resident was observed to eat less that 25 per cent of the meal.

On February 2, 2016, the Inspector spoke to FSW #106 regarding the minced texture modified diet. FSW #106 stated that she did not have a specific minced texture modified menu but would receive guidance from the Dietitian on appropriate food items. FSW #106 provided the example that if resident #002 selected penne pasta for supper the following evening that the penne pasta would need to be minced for the resident. The Inspector asked why the penne pasta for supper would be minced if the penne pasta served to the resident as noted on February 1, 2016, at lunch was served whole. FSW #106 was unable to explain the difference nor was she able to explain why cakes and brownies served for desserts were sometimes moistened with milk and other times not.

Later that same day, the Inspector spoke with the Dietitian and requested a copy of the menu to support the minced texture modified diet. The Dietitian stated that there was no specific menu for the minced texture modified diet. [s. 71. (1) (b)]

2. The license failed to comply with section 71.(4) of the regulation in that the licensee failed to ensure that the planned menu items were offered at each snack.

On January 26, 2016, resident #006, resident #008, and resident #012 reported to the Inspector that they were not offered a beverage mid-morning. On January 27, 2016, the Inspector observed PCA #102 distribute glasses of water to residents on the unit at approximately 1000 hours. The inspector observed the same routine the following day on January 28, 2016, and spoke with PCA #102 regarding this observed routine of distributing of water. PCA #102 stated that she was completing the morning fluid pass which occurs every morning between 0900 and 1000 hours. She confirmed to the Inspector that this was the only fluid pass in the morning and that only water was offered to the residents.

The Inspector obtained the home's snack menu which outlined a mid-morning snack of resident choice of juice, water, coffee and tea. The Inspector spoke with the Dietitian on February 1, 2016, and she stated that the snack menu referred to by the Inspector was correct and is to be provided to the residents. She stated that the unit is stocked with the supplies according to the snack menu. [s. 71. (4)]

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 the home has a menu to support the minced texture modified diet, to be implemented voluntarily.

WN #3: 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. (2) The licensee shall ensure there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents. O. Reg. 363/11, s. 1 (3).

Findings/Faits saillants :

1. The licensee failed to comply with section 9.(2) of the regulations in that the licensee failed to ensure that there was a written policy that deals with when the doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents.

Mid-morning on January 25, 2016, the Inspector observed the door leading to the outside secure balcony at the end of the unit to be unlocked so that the outside secure balcony was accessible. It was also noted by the Inspector that the outside balcony was in disarray as there were several pieces of patio furniture tipped over. No staff were observed in the area at the time of this observation.

On January 29, 2016, the Inspector spoke with the Vice President of Nursing and Clinical Services, who has the responsibility of the Administrator position for the home, and she stated that the door to the secure outside balcony is to be kept locked during the winter

as residents do not access the balcony during this time of the year. The Inspector requested the home's policy on doors to secure outside areas.

Later that day, on January 29, 2016, the Inspector proceeded to the door to the secure balcony and again noted that it was unlocked. The balcony was still in disarray. No staff were noted in the area.

On February 1, 2016, the Vice President of Nursing and Clinical Services met with the Inspector and provided the Inspector with the policy, "General Hospital Security" which she stated related to doors. The Vice President of Nursing and Clinical Services further stated that the policy did not specifically refer to the door leading to the outside secure balcony and also that there was no other policy relating to that specific door. The Inspector reviewed the policy provided and noted that it did not address the door leading to the secure outside balcony as had been stated by the Vice President of Nursing and Clinical Services.

On February 2, 2016, the Inspector spoke with PCA #105 regarding the door to the outside secure balcony. PCA #105 stated that the door is usually locked but that it is sometimes opened to allow fresh air in. The Inspector asked how unwanted resident access was monitored when the door to the balcony was unlocked. PCA #105 was unable to describe anything specific other than to say that staff are aware of the residents' whereabouts on the unit.

The Inspector proceeded to the door to the secure outside balcony again of February 2, 2016, before concluding the inspection and observed that the door was closed and locked. [s. 9. (2)]

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 :

1. The licensee failed to comply with section 129.(1)(a)(ii) of the regulations in that the licensee failed to ensure drugs are stored in an area or a medication cart that is secure and locked.

On January 29, 2016, the Inspector observed that resident #012 had two medical devices on the resident's over bed table in his/her room: each labelled as a specific drug. The inspector spoke with resident #012 regarding these two drugs and the resident stated that the drugs stay on his/her over bed table in his/her room, that s/he positions them specifically in a way so that s/he knows s/he has taken the drug.

Later that day, the Inspector spoke with the acting Team Leader, who fulfills the Director of Nursing role in the home, regarding the two drugs in resident #012's room. The acting Team Leader stated that all drugs including resident #012's drugs are to be kept secure in a locked area for resident safety and that she would rectify the situation immediately by securing resident #012's drugs. [s. 129. (1) (a) (ii)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. The licensee has failed to comply with section 131.(5) of the regulations in that the licensee failed to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident.

On January 29, 2016, resident #012 was observed to have two medical devices on the resident's over bed table in his/her room: each labelled as a specific drug. The Inspector spoke with Registered Practical Nurse (RPN) #103 regarding these drugs for resident #012. RPN #103 stated that resident #012 self administers both drugs and that this is permissible as long as there is written physician's direction to do so, usually as a physician's order. The Inspector reviewed resident #012's health care record including the physician's orders and physician's notes and was unable to find any written direction for the resident to self administer these drugs. The Inspector also spoke with resident #012 about self administering these drugs. Resident #012 stated that s/he was unaware as to why s/he was to self administer these two drugs and stated that s/he did not have any consultation with the physician regarding the self administering of these drugs.

Later that day on January 29, 2016, the Inspector spoke with the acting Team Leader regarding the self administration of drugs for residents. The acting Team Leader stated that the self administration of drugs may only occur if there is a written physician's order. The Inspector discussed resident #012's self administration of two specific drugs. The Inspector and the acting Team Leader reviewed the physician's orders and were unable to find a physician's order for the self administration of the specific drugs. After reviewing the physician's orders for resident #012, the acting Team Leader stated to the Inspector that the resident should not be self administering these specific drugs and that she would rectify the situation immediately. [s. 131. (5)]

Issued on this 9th day of February, 2016

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

Original report signed by the inspector.