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

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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
Dec 10, 2014	2014_211106_0018	S-000482-14	Resident Quality Inspection

Licensee/Titulaire de permis

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

Algoma Manor Nursing Home
145 Dawson Street THESSALON ON P0R 1L0

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

MARGOT BURNS-PROUTY (106), JENNIFER LAURICELLA (542), JESSICA LAPENSEE (133)

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 17, 18, 19, 20, 21, 24, 25, 26, 27, and 28, 2014

The following logs were reviewed as part of this inspection: S-000482-14, S-000126-14

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Clinical Care Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), RAI Coordinator, Maintenance Staff, Housekeepers, Personal Support Workers (PSW), Recreation Assistants, Dietary Aides, Family Members and Residents.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **4 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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

1. On November 27th, 2014, inspector #542 completed a health care record review for resident # 001. The care plan located on Point Click Care (PCC) indicated that there were several different interventions that could be utilized in order for the direct care team to complete the resident's daily mouth care, however the kardex located in the resident's room did not list any interventions.

Inspector #542, interviewed the RAI Coordinator who stated that most of the staff have access to the care plans on PCC however, some may not as they have yet to receive an account. The RAI coordinator stated that they have several updated kardexs that need to be replaced in the resident's rooms that are no longer current. Inspector #542 then asked 4 different Personal Support Workers (PSWs) if they could show this inspector how they access the care plans of the residents, only 1 PSW was able to access a care plan and the other 3 did not know how to access a resident's care plan.

The licensee has failed to ensure that staff and others who provide direct care to a resident are kept aware of the contents of the plan of care and given convenient and immediate access to it. [s. 6. (8)]

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 staff and others who provide direct care to a resident are kept aware of the contents of the plan of care and given convenient and immediate access to it, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. During stage one it was observed by inspector #106, that resident #023's top bed rails were in the up position. On November 26, 2014, during an interview with staff member #S-100, they reported that the 2 top bed rails are placed up and the bed is placed in the lowest position when the resident is in bed. Registered staff member #S-101 reported that resident #023 uses the 2 top rails for bed mobility.

On November 26, 2014, the inspector asked a RN and the ADOC to provide the documentation of the completed assessment for the resident and his or her bed system to ensure that the bed rails are appropriate for this resident. The ADOC and RN were unable to provide any documentation and indicated that residents are asked what bed rails they would like up or if they request bed rails up, along with staff opinion to determine which bed rails are used for each resident. [s. 15. (1) (a)]

2. Over the course of the inspection, inspector observed resident #002 to have two full bed rails in the up position while the resident was in bed. A health care record review was completed for resident #002 by inspector #542 which indicated that the resident uses the rails to assist with bed mobility.

On November 27th, 2014, inspector #542 interviewed a registered staff member who stated that the home does not assess the resident when bed rails are used. [s. 15. (1) (a)]

3. Inspector #542 completed a health record review for resident # 004. The care plan indicates that the resident has two bed rails raised while in bed. On November 27th, 2014, inspector #542 interviewed a registered staff and was informed that the home does not assess the resident where bed rails are used.

The licensee has failed to ensure that where bed rails are used, the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident. [s. 15. (1) (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 that the resident is assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 21. Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. O. Reg. 79/10, s. 21.

Findings/Faits saillants :

1. On November 27, 2014, resident #027, reported to inspector #106, that it felt cold down the hallway near their room. The inspector walked down the hall towards the resident's room and the air temperature did feel cooler than the temperature in the dining area. [s. 21.]

2. On November 27th, 2014, inspector #133 monitored bedroom and common area temperatures in identified areas throughout the home. This occurred between 10:15am and 12:30am. Inspector #133 left their thermometer for 5 minutes in each identified area before recording the temperature. The following details areas that were found to be below 22 C.

A particular Resident Care Unit:

Resident room - at bedside table of bed #1 - 20.7 C. It is noted the resident had an "atomic clock" on top of their free standing closet, across from the bed, that included a temperature indicator. This temperature indicator reflected a temperature of 20.8C.

Resident Room - at bedside table of bed #1 - 20.3 C.

Resident Room - on the wall ledge next to bed #1 - 21.1C

Resident Room - at the bedside table of bed #1 - 21.3 C

Resident Room - at the bedside table - 21.5C.

Resident Room - at the bedside table for bed #1 - 20.7 C. It is noted that the temperature of the air coming out of the wall vent next to the bed was measured at 19 C.

Resident Room - at the bedside table for bed #1 - 20.8C

Resident Room - at the bedside table - 21.5C.

Hallway, outside of clean utility room and across from a bedroom - 21.1C. It is noted that the temperature of the air coming out of the ceiling vent in this immediate area was measured at 17.3C.

Resident Room - at the bedside table of bed #1 - 21C.

A particular Resident Care Unit:

Resident Room - at the bedside table - 21.3 C

Dining room - at table #4 - 21C. It is noted that a thermostat on the wall in the immediate area reflected a temperature of 70.5 F (21.3 C)

A particular Resident Care Unit:

Dining room - at table #5 - 21.2 C. It is noted that a thermostat on the wall in the area reflected a temperature of 71 F (21.6 C)

On November 27th, 2014, at 2pm, inspector #133 met with a maintenance worker, staff member #S-102. They explained that the heating system is fully automated, and due to its complexity, it is controlled remotely by an outside service provider. They explained that the system is continuously heating and cooling, based on established set points. They acknowledged that it can get cold for residents, when the system is in a cooling cycle, particularly if they are in the area of a return air vent. These vents are throughout the hallways and common areas such as dining rooms, and also in every bedroom. It

was noted that in shared bedrooms, bed space #1 is directly impacted by cool air from these vents as they are on the upper wall next to the bed, whereas in bed space #2, along the window wall, radiant heating panels are situated. As well, it was discussed that when privacy curtains, which extend to the ceiling, are drawn, the cycling of warm and cool air within a shared bedroom is impacted.

They indicated to the Inspector that a nursing staff member had informed them earlier that the inspector had been monitoring temperatures within a unit. In response, they explained that they had checked the computerized system and noted the temperature of the air from the return air vents in the hallway, in the area of a bedroom, was showing at 68 F (20 C). They looked at this area again in the inspector's presence and it was showing at 68.5 F (20.2 C). They acknowledged that the home does not monitor temperatures in resident bedrooms or common areas, rather, they assume the system is set correctly and is working as it should. They acknowledged that they were not aware that, as per O. Reg 79/10, the temperature is never to be below 22 C. They indicated they would call the service provider that controls the heating system remotely to discuss adjusting set points and that a system to ensure the home is always maintained at a minimum temperature of 22 C would be implemented.

The licensee has failed to comply with O. Reg. 79/10, s. 21. in that the licensee has failed to ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. [s. 21.]

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 home is maintained at a minimum temperature of 22 degrees Celsius, to be implemented voluntarily.

WN #4: 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 :

1. On November 27th, 2014, the following observations were made:

Resident Room - On the left side of the sink counter, in the shared washroom, Inspector #133 observed a blue electric razor with no name or other such identifying information on it.
Resident Room - On the right side of the sink counter, in the shared washroom, Inspector #133 observed a black electric razor with no name or other such identifying information on it.

Resident Room - On the left side of the sink counter, in the shared washroom, Inspector #133 observed a blue electric razor with no name or other such identifying information on it.

Resident Room - On the left side of the sink counter, in the shared washroom, Inspector #133 observed a black electric razor with no name or other such identifying information on it.

On November 27th, 2014, Inspector #133 spoke with the Clinical Care Coordinator (CCC) and asked if there is a process in place for labelling electric razors. The CCC explained that there is a labelling machine in the nurse office that staff are supposed to use to label resident's personal items, such as electric razors.

The licensee has failed to comply with O. Reg. 79/10, s. 37 (1) a. in that the licensee has failed to ensure 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. This is specifically with regards to electric razors. [s. 37. (1)]

Issued on this 10th day of December, 2014

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

Original report signed by the inspector.