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 8, 2015	2015_396103_0056	O-032491-15	Resident Quality Inspection

Licensee/Titulaire de permis

County of Lennox and Addington
97 Thomas Street East NAPANEE ON K7R 4B9

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

Lennox and Addington County General Hospital
8 Richmond Park Drive NAPANEE ON K7R 2Z4

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

DARLENE MURPHY (103)

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 26-27, 30, December 1-3, 2015.

The following intakes were included in this inspection: Log O-002058-15 and O-002059-15.

During the course of the inspection, the inspector(s) spoke with residents, Registered Nurses (RN), Registered Practical Nurses (RPN), the Director of Care (DOC) and the Administrator.

During the course of this inspection, the inspector conducted a full walking tour of the unit, observed dining room service, medication administration and infection control practices, reviewed medication storage, resident health care records and applicable policies.

The following Inspection Protocols were used during this inspection:
Dining Observation
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **4 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 following finding relates to Log O-002059-15:

The licensee failed to ensure staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and consistent with each other.

On an identified date, resident #041 asked PSW #104 to assist him/her to the washroom. The resident advised the PSW they would need someone else to assist as he/she had been unsteady on their feet and that staff over the past couple of days had been using two staff to assist them. PSW #104 indicated to the resident that she could manage on her own. During the transfer the resident sustained a skin tear and later reported to a family member that he/she had been manhandled during the transfer.

The progress notes for two identified dates were reviewed. On the first identified date, the physiotherapist indicated the resident was unsteady on their feet and to begin ambulating the resident with the assist of two and a two wheeled walker. Later that day, resident #041 sustained a fall while attempting to self transfer to the washroom. The physiotherapist reassessed the resident on the following date and indicated the resident had physically declined and again documented to ambulate with the assist of two and a two wheeled walker.

Two separate entries were made on the evening shift of the second identified date by nursing staff which indicated the resident was shakey, unable to use the walker and was a heavy two person transfer.

The resident care plan in effect at the time of this incident indicated the following: Under "Toileting"-resident can mobilize with the assist of one into the bathroom using a 2 wheeled walker.

The mobility assessments of the physiotherapist made on the two identified dates were not reflected in the resident plan of care. Resident #041 was no longer residing on the convalescent care unit at the time of this inspection. [s. 6. (4) (b)]

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 changes in the resident plan of care are updated and accurately reflect the resident care needs, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure resident #041 was assessed by a registered dietitian (RD) and changes made to the resident's care plan relating to nutrition and hydration were implemented.

Resident #041 was admitted to the convalescent care unit on an identified date. The resident health care record was reviewed and indicated the resident had a past history of a specified wound care condition. On a specified date, the RD indicated in a progress note that the wound care nurse had made her aware resident #041 had an open wound. The note further indicated the RD had a discussion with the resident who was agreeable to starting a supplement to increase protein at breakfast. The RD indicated the supplement was ordered.

The resident care plan in effect at this time was reviewed and indicated under "Nutrition", increase protein at breakfast by providing Ensure High protein supplement (wound healing support).

This inspector was unable to find any documentation to support the implementation of a supplement. RN #100 was interviewed and stated it was the usual practice of the unit to notify the dietitian when residents develop skin impairment. RN #100 further indicated the dietitian would be notified by phone and written referrals are not used. The RD who ordered this supplement was currently on a leave of absence and could not be interviewed.

RN #100 stated at the time of this order, supplements were being managed by the PSW's and they were responsible for the documentation. RN #100 reviewed the resident health care record and was unable to find any entries to support the resident had received the supplement. According to this RN, the unit changed the process in June 2015 as problems had been identified in ensuring residents were receiving the prescribed supplements. She stated all supplements are now ordered through the physician orders, documented on the eMAR's and it is the responsibility of the registered staff to ensure the supplements are taken and to provide ongoing education to the residents who require them. [s. 50. (2) (b) (iii)]

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 supplements ordered for the purpose of wound support are given as prescribed, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 69 in that significant weight changes for resident #041 were not assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated.

Resident #041 was assessed on admission as high nutritional priority related to a specified diagnosis, an open wound and a recent weight loss. The resident's plan indicated to monitor the resident's intake and weight.

Resident #041 was noted to have weight changes on five consecutive, identified weeks.

There were no documented dietitian assessments found except for the initial admission assessment with a specified date. The RD was unable to be interviewed as she is on a leave of absence. RN #100 stated the unit takes weekly weights due to the short stay nature of the unit and that the dietitian generally assesses the resident weights weekly. The RN confirmed the absence of any subsequent assessments by the RD. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 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 dietitian assesses weight changes and that actions are taken and outcomes are evaluated, to be implemented voluntarily.

WN #4: 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. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure drugs are administered to the resident in accordance with the directions for use specified by the prescriber.

Resident #041 required regular dressing changes and the resident had indicated to the physician the dressing changes were painful. The resident health care record was reviewed and on a specified date, the physician ordered an analgesic to be used as needed and 30 minutes before dressing changes.

The resident's Medication Administration Record (MAR) was reviewed and indicated dressing changes were completed on eight identified dates without being administered the prescribed analgesic thirty minutes prior to the dressing changes.

On four of the identified dates, the progress notes indicated the resident experienced pain during the dressing changes.

RN #100 reviewed the MAR and confirmed the analgesic was not administered as prescribed. The RN stated she believed the order was missed as it had been listed with the as required medications. [s. 131. (2)]

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 drugs are administered in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The following finding relates to Log O-002059-15:

The licensee has failed to ensure the written policy of zero tolerance of abuse was complied with.

On an identified date, resident #041 advised a family member that he/she had been "manhandled" by a staff member earlier in the day. The family member informed RPN #103 and this allegation was reported to the DOC. The home immediately began a thorough investigation into the allegation and informed the MOHLTC.

During a review of the investigation, it was noted that the police were not notified of the allegation. The DOC was interviewed and stated the family did not want the police notified. The DOC did state at the time she was made aware of the allegation, she felt there were sufficient facts to support a physical abuse may have occurred.

The home's Abuse Policy, ADM-VI-06 with an effective date of February 3, 2014 was reviewed and indicated under "Procedures", notify the police if the alleged, suspected or witnessed incident of abuse of a resident may constitute a criminal offence. [s. 20. (1)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when resident #041's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment specifically designed for that purpose.

Upon admission, resident #041 had a documented pain assessment completed which indicated the resident was experiencing pain in an identified location and the current analgesic orders were effective 75% of the time. The resident was referred to OT and PT at that time and an analgesic was ordered on an as needed basis.

During one identified month, the resident took eleven doses of the as required analgesic; eight of these doses were administered during a six day period of time and on three occasions the doses were documented as ineffective. The following identified month, nine doses of the as required analgesic were taken throughout the month and on three occasions the doses were documented as ineffective. The resident progress notes were reviewed during this two month period of time and indicated the resident was now experiencing pain in another identified area which had not been previously identified in the admission assessment.

On an identified date, the physician ordered an analgesic to be used as needed and 30 minutes before dressing changes. Five days later, the physician ordered an additional analgesic for one week for the identified area of pain. Two days later, the physician further ordered an increase in the analgesic.

There were no documented pain assessments related to the resident's identified area of pain completed until sixteen days after the physician initially ordered analgesic specific to the identified area of pain. [s. 52. (2)]

Issued on this 8th day of December, 2015

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

Original report signed by the inspector.