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
Nov 19, 2015	2015_263524_0037	008696-15	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

SEAFORTH MANOR NURSING HOME, DIVISION OF PROVINCIAL NURSING HOME LIMITED PARTNERSHIP
100 JAMES STREET SEAFORTH ON N0K 1W0

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

INA REYNOLDS (524), CHRISTINE MCCARTHY (588), MELANIE NORTHEY (563)

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 2, 3, 4, 5, 6, 9, 2015.

During the course of the inspection, the inspector(s) spoke with the General Manager, the Director of Care, the Activity Director, the Social Worker, the Resident Service Coordinator, the Resident Assessment Instrument Coordinator, the Food Service Manager, the Nurse Manager, the Physiotherapy Assistant, two Registered Practical Nurses, one Registered Nurse, seven Personal Support Workers, one Cook, one student, forty Residents and three Family Members.

The inspector(s) also conducted a tour of the home, observed care and activities provided to residents, meal service, medication administration, medication storage area, resident/staff interactions, infection prevention and control practices, reviewed clinical records and plans of care for identified residents, postings of required information, and minutes of meetings related to the inspection, reviewed relevant policies and procedures of the home, and observed the general maintenance, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Skin and Wound Care

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

8 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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A) Observation of the Emergency Drug Box on November 5, 2015, revealed identified discrepancies with the contents, the list of contents and that it was last updated August 20, 2015.

Record review of the home's "Emergency Pharmacy Services – Emergency Box" policy Index Number 02-02-10 dated October 1, 2012, revealed that, "The consultant pharmacist or Quality Improvement Nurse Representative (QINR) will check the Emergency Drug Box monthly to ensure that the drug supply is complete and up-to-date."

Interview with the Director of Care on November 5, 2015, confirmed the discrepancies between the contents of the Emergency Drug Box and the current Emergency Drug Box listing, and that the list of contents was dated August 20, 2015. The DOC confirmed that the Emergency Drug Box contents and list of contents should be both accurate and up-to-date. [s. 8. (1) (b)]

2. B) Review of the home's "Refrigeration Temperatures Recording" policy dated January 2006 states that the "temperature chart shall be completed a minimum of two times each day" to ensure that foods requiring refrigeration are kept within the acceptable safe temperature range.

Record review of the temperature recording chart posted on the resident's refrigerator in the Activity common room for the period October 1 – November 4, 2015, revealed the refrigerator temperatures were not recorded on 69 occasions or 99% of the time.

The Activity Director confirmed that the temperatures in the resident's refrigerator was not documented and the home's expectation that it should be.

C) Review of the home's "Food Service Temperature" policy #NM-3.110 dated June 2013, directed dietary staff to take food temperatures prior to serving and record all temperatures on the Food Temperature Chart form.

A review of the Food Temperature Records for September 7 – November 4, 2015, revealed food temperatures were not always recorded prior to serving for the following dates:
- September 25, 29 and October 1, 2015 for the noon meal
- September 7, 15, 17, October 1, 5, November 2, 4, 2015 for the evening meal and for the second evening meal sitting on September 14, 20 and October 8, 2015.

During the course of the inspection, random residents were interviewed and shared the following comments regarding food temperatures:
- meat, potatoes and vegetables were not always served hot
- 90% of the food that should be hot was cold and included porridge, meat, veggies and soup
- the food was cold a lot of times.

Interview with the Food Service Manager on November 6, 2015, confirmed the expectation that policies and procedures that were put in place were to be complied with and that food temperatures were to be recorded prior to each meal service and sitting.

D) Review of the home's "Food Brought to Residents from Outside Sources" policy #NM-3.260 dated June 2013, stated that "food brought to residents from outside the facility will be monitored by staff" on an ongoing basis to ensure the food is safe for consumption and that "perishable foods should be labeled and refrigerated as soon as possible".

Observation of the resident refrigerator in the Activity common room area on November 4, 2015, at 1145 hours revealed the following:

-a half unpeeled orange with green and white fuzzy mold like substances
-an unlabeled and undated bowl of red dessert
-undated bowl of diced peaches
-tapioca pudding that had an expiry date of October 2015
-yogurt that had an expiry date of November 1, 2015
-Asian Sesame dressing that had an expiry date of August 28, 2015
-almond milk that had an expiry date of October 19, 2015.

This was confirmed by the General Manager and the Activity Director. The Activity Manager acknowledged that unlabeled and expired food and drinks should not be kept in the resident's Activity room refrigerator. [s. 8. (1) (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 that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee had failed to ensure that the home, furnishings and equipment was kept clean and sanitary.

Observation of the resident refrigerator in the Activity common room area on November 4, 2015, at 1145 hours revealed the following:
-the shelves and base inside the refrigerator had a heavy build-up of numerous black and brown encrusted stains.

This was confirmed by the General Manager and the Activity Director. Interview with the General Manager confirmed the expectation that the home's equipment was to be kept clean and sanitary. [s. 15. (2) (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 home, furnishings and equipment is kept clean and sanitary, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee had failed to ensure that staff participated in the implementation of the infection prevention and control program.

Dining observation of the meal service revealed a Personal Support Worker did not follow hand hygiene and safe food handling practices. The Personal Support Worker collected dirty dishes from the soup service and without washing hands sought out a piece of plastic cracker wrapper with their fingers from an identified resident's soup. The same Personal Support Worker then retrieved a clean spoon for another resident without washing hands.

Staff interview with the Director of Care on November 2, 2015, confirmed all staff were to participate in the implementation of the infection prevention and control program that included hand hygiene when switching between dirty and clean tasks in the dining room.

Observation of a Tub Room on November 2, 2015, during the initial tour of the home revealed used clothing, wet towels and soiled linens placed on top of an oxygen dispensing tank. Staff interview with a Personal Support Worker confirmed the clothing and linens were dirty and wet and should not be stored on the oxygen dispensing tank. [s. 229. (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 that staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that the following rights of residents were fully respected and promoted: 8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.

During the medication administration observation, a registered staff administered a medical treatment to a resident who was sitting with one resident at the dining room table. There were six other residents sitting at other tables, within visual and listening distance.

Record review of the resident's current plan of care revealed an absence of information related to the administration of the medical treatment in the dining room.

Review of the home's "Medications Practices - Privacy Medication Pass" policy # RC-5.120 dated 2010, stated that "During the medication pass, maintain the Personal Health Information (PHI) of all residents in confidence at all times. This includes and is not limited to: a) Locking out the eMar screen when nurse is not viewing data b) Maintaining used strip packaging on the medication cart and disposing following established procedure at the end of the medication pass."

Interview with the Director of Care confirmed that the home did not seek the approval of residents receiving the medical treatment, or those sitting at other tables, for the administration of the medical treatment in public. The Director of Care confirmed that the current process did affect residents' privacy. [s. 3. (1) 8.]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee had failed to respond in writing within 10 days of receiving Family Council advice related to concerns or recommendations.

Record review of the "Seaforth Manor Nursing Home Family Council" meeting minutes dated January 27, 2015, revealed concerns related to a better location for scooters for easier access and storage, tiles on the front steps were slippery, drive way pot holes to be graded in the spring and a request for an anti-slip mat at the bottom of the entrance stairs to the basement. Under "New Business", concerns were documented related to mouth care, nail care and use of community nail polish. The General Manager was present during this meeting, but there was no documented evidence of a written response within 10 days of receiving the concerns on January 27, 2015.

Record review of the "Seaforth Manor Nursing Home Family Council" meeting minutes dated May 5, 2015, revealed an ongoing concern related to an anti-slip mat at the bottom of the entrance stairs to the basement. The General Manager was present during this meeting, but there was no documented evidence of a written response within 10 days of receiving the concern on May 5, 2015.

Record review of the "Seaforth Manor Nursing Home Family Council" meeting minutes dated September 15, 2015, revealed an ongoing concern related to an anti-slip mat at the bottom of the entrance stairs to the basement. Under "New Business", concerns were documented related to pot holes in the drive way and confusion related to the leave of absence (LOA) books. The General Manager was present during this meeting, but there was no documented evidence of a written response within 10 days of receiving the concerns on September 15, 2015.

Staff interview with the General Manager and Director of Care on November 9, 2015, revealed there was no formal process in place to respond in writing within 10 days if the General Manager did not speak to the concerns directly at the meeting with documented follow up in writing in the minutes and posted within 10 days. [s. 60. (2)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

**s. 72. (2) The food production system must, at a minimum, provide for,
(c) standardized recipes and production sheets for all menus; O. Reg. 79/10, s. 72 (2).**

Findings/Faits saillants :

1. The licensee had failed to ensure that the food production system, at a minimum provided for, standardized recipes and productions sheets for all menu items.

Review of the Monday, Week 4 Production sheets for November 9, 2015, for the breakfast, lunch and dinner menus revealed serving quantities were not available for all menu items to assist staff in food production. This was confirmed by the cook. The cook also confirmed that there were no production sheets available to guide snack production. Some of the missing recipes not available to the cook included: Pureed eggs, pureed stewed prunes and pureed sweet toast.

Interview with the Food Service Manager on November 9, 2015, confirmed the expectation that there were standardized recipes and production sheets for all menus to guide staff in the production of the menu items for residents. [s. 72. (2) (c)]

WN #7: 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. (1) Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations. 2007, c. 8, s. 79. (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that the required information was posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations: copies of the inspection reports from the past two years for the long-term care home, the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council and an explanation of the protections afforded under section 26 related to whistle-blowing protection.

Observations made during the initial tour of the home on November 2, 2015, at 0945 hours revealed the following:

Observation of the bulletin board revealed copies of the inspection reports from the past two years for the long-term care home were not posted as required. The Resident Quality Inspection Report from September 2014 and a Complaint Inspection Report from June 2014 was absent from the bulletin board and was not posted in any other area of the home. Interview with the Director of Care confirmed that not all public inspection reports were posted from the past two years for the long-term care home.

Observation of the Resident/Family bulletin board revealed the most recent minutes of the Family Council meetings were not posted. Interview with the Social Worker, who also acts as the appointed assistant, and the Activity Director confirmed the home had approval for posting the Family Council minutes, the last Family Council meeting was September 15, 2015, and the minutes should have been posted.

Observation of the bulletin board revealed information was not posted in the home related to whistle blowing protection. The Director of Care confirmed the whistle blowing policy was not posted in the information binder or on the bulletin board. [s. 79. (1)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Findings/Faits saillants :

1. The licensee had failed to seek the advice of the Family Council in developing and carrying out the survey, and in acting on its results and document and make available to the Family Council the results of the satisfaction survey in order to seek the advice of the Council about the survey.

Record review of the "Seaforth Manor Nursing Home Family Council" meeting minutes dated January 27, May 5, and September 15, 2015, revealed the home did not seek the advice of the Family Council in developing and carrying out the survey and did not discuss the results of the satisfaction survey with Family Council.

The Social Worker confirmed she was the appointed assistant approved by Family Council to assist the Council and confirmed there was no documented evidence of the home seeking the advice of Family Council prior to carrying out the satisfaction survey or the results of the survey. [s. 85.]

Issued on this 20th day of November, 2015

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

Original report signed by the inspector.