Ontario

**Ministry of Health and Long-Term Care**

**Inspection Report under the Long-Term Care Homes Act, 2007**

**Ministére de la Santé et des Soins de longue durée**

**Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue**


**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**

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| Date(s) of inspection/Date(s) de l'inspection | Inspection No/ No de l'inspection | Type of Inspection/Genre d'inspection |
|---|---|---|
| Apr 18, 19, 20, May 1, 2, 2012 | 2012_138151_0009 | Complaint |

**Licensee/Titulaire de permis**

LADY ISABELLE NURSING HOME LTD
102 CORKERY STREET, P.O. BOX 10, TROUT CREEK, ON, P0H-2L0

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

LADY ISABELLE NURSING HOME
102 CORKERY STREET, P.O. BOX 10, TROUT CREEK, ON, P0H-2L0

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

MONIQUE BERGER (151)

## Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Complaint inspection.**

**During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Registered Staff, Personal Support Workers (PSW),Recreation Program Manager, Activity Aides, residents and visitors**

**During the course of the inspection, the inspector(s)**
**- directly observed the delivery of care and services to residents**
**- directly observed the recreation and rehabilitation programs as they occurred,**
**- did daily walk-through of the home**
**- directly observed night shift staff routines**
**- reviewed resident health care records**
**- reviewed policy and procedure manuals,**
**- reviewed job descriptions and routines for Registered Staff and PSW: night shift duties,**
**- reviewed current staffing schedules,**
**- audited staff documentation regarding the provision of baths**
**- reviewed recreation calendars**

**The following Inspection Protocols were used during this inspection:**

**Personal Support Services**

**Recreation and Social Activities**

**Findings of Non-Compliance were found during this inspection.**

| NON-COMPLIANCE / NON-RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.<br><br>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. 114. Medication management system**

**Specifically failed to comply with the following subsections:**

**s. 114. (3) The written policies and protocols must be,**
**(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and**
**(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).**

**Findings/Faits saillants :**

1. **********
Inspector observed a resident walking by nursing station with a medication cup in hand. Resident proceeded to put the medication cup on the desk and to take pills one by one. No registered staff was at the nursing station or in the near vicinity.

Review of the resident's plan of care does not identify that the resident is to self-administer medications.

The home has not ensured the home's medication management system has policies and protocols developed, implemented, evaluated and updated in accordance with evidence-based practices and,if there are none, in accordance with prevailing practices[O.Reg.79/10, s.114(3)(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 that ensures the home's medication management has policies and protocols developed, implemented, evaluated and updated in accordance with evidence-based practices and , if there are none of these, in accordance with prevailing best-practices, to be implemented voluntarily.***

**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply**
**Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:**
**1. All areas where drugs are stored shall be kept locked at all times, when not in use.**
**2. Access to these areas shall be restricted to,**
**i. persons who may dispense, prescribe or administer drugs in the home, and**
**ii. the Administrator.**
**3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.**

**Findings/Faits saillants :**

1. **********
The Inspector noted in medication cart left unlocked and unattended in the hallway. No Registered Staff was found in direct view of the cart. Inspector was able to open medication drawers containing resident medications. Shortly after Inspector ascertained the cart was unlocked, a member of the Registered Nursing staff came out from a resident's room, returned to the cart and continued with the morning medication pass.

The licensee has not ensured that steps are taken to ensure the security of the drug supply, including, ensuring that all areas where drugs are stored are kept locked at all times when not in use.
[O.Reg.79/10, s.130 (1)]

***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 that ensures steps are taken to ensure the security of the drug supply, including ensuring that all areas where drugs are stored are kept locked at all times when not in use, to be implemented voluntarily.***

**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.**

**Findings/Faits saillants :**

1. **********
Inspector noted 5 of 13 men were not shaven.
The licensee did not ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. [O. Reg. 79/10, s. 32.]

***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 that ensures each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis, to be implemented voluntarily.***

**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 41. Every licensee of a long-term care home shall ensure that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep. O. Reg. 79/10, s. 41.**

**Findings/Faits saillants :**

1. **********

Inspector observed night shift routines and noted the following:
A.) residents are awakened at 2400 and 0400 h for continence rounds. Residents are checked to see if they are wet or soiled and, if this is the case, are changed.

B.) the PSW Night Assignment roster identifies 8 residents that are to be awakened and gotten up between 0600 h-0700 h. Staff interviewed stated that this is to assist day shift with AM care. In response to direct questions asked by the Inspector, staff provided the following information:
- they must wake the residents to do this care.
- the residents chosen for this list are pre-chosen,
- the list of residents does not change day to day,
- to the best of their recollection, the residents/family were not consulted regarding this routine.

C.) the home has several 4-bed rooms. On night shift Inspector observed that at the 0400 h continence round, a resident was awaken to change her incontinent product. In this process, staff put the lights above the bed on. This woke the roommate who got up from bed and sat in a chair at the bedside.

The licensee has not ensured that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep.
[O. Reg. 79/10, s. 41.]

***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 that ensures each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep, to be implemented voluntarily.***

**WN #5: 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 subsections:**

**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 Inspector observed at the sink, at nursing station, a basket containing 3 electric shavers. Two of the three shavers were found to be unclean with heavy facial hair shavings in the head of the razor. Staff interviewed confirmed that these electric razors are "used on those residents who do not have their own"
The licensee has not ensured that all staff participate in the implementation of the infection control program.
[O.Reg.79/10, s.229 (4)]

2. **********

Inspector observed night shift routines in the care delivery to residents. Inspector observed that staff changing a resident threw the used incontinent product and soiled resident clothing on the floor during the process.

The licensee has not ensured that all staff participate in the implementation of the infection control program.
[O.Reg.79/10, 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 that ensures all staff participate in the implementation of the infection control program, to be implemented voluntarily.***

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**WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.**

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**Findings/Faits saillants :**

1. On a night shift, at 0315 h., the Inspector entered the home through the home's main entrance doors. The doors were locked to prevent exit by a key pad exit door system on the inside of the doors. From the outside of the building and by the door, a red button, when pushed, by-passes this system and allows entering the home. Inspector entered the home unbeknown to staff attending to residents down the hallways. Once noticed by staff, Inspector introduced self giving name and title and advised staff of the purpose of the inspection. No staff on shift asked to see the Inspector's credentials.

A staff member interviewed confirmed that the door " always used to be locked about 9 in the evening".

Administrator confirmed that it has been past practice to lock the doors during the latter part of evening shift and during night shift.

The licensee did not ensure that the home is a safe and secure environment for its residents. [LTCA,2007 S.O.2007,c.8, s. 5.]

**Issued on this 3rd day of May, 2012**

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

Monique G. Berger