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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 21, 2019	2019_781729_0006	015653-18, 016957-18, 024921-18	Complaint

Licensee/Titulaire de permis

Bay Haven Nursing Home Incorporated
499 Hume Street COLLINGWOOD ON L9Y 4H8

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

Bay Haven Nursing Home
499 Hume Street COLLINGWOOD ON L9Y 4H8

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

KIM BYBERG (729)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 1, 2, 3, 6, 7, 8, 9, 10, 2019.

**Log #024921-18 related to nutrition and hydration and alleged abuse,
Log #015653-18 related to transferring and positioning,
Log #016957-18 related to improper or incompetent treatment of a resident that resulted in harm or risk to a resident.**

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Clinical Nurse Manager, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Health Care Aids (HCA), Food Service Supervisor (FSS), Dietitian, Ward Clerk, Residents and Family Members.

A Critical Incident inspection #2019_781729_0007 was completed in conjunction with this inspection.

The inspector also observed resident rooms and common areas, meal and snack service, medication administration practices, residents and the care provided to them; reviewed health care records and plans of care for identified residents, and relevent policies and procedures of the home.

**The following Inspection Protocols were used during this inspection:
Falls Prevention
Nutrition and Hydration
Personal Support Services
Skin and Wound Care**

During the course of this inspection, Non-Compliances were issued.
- **3 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	Légende 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 has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put any strategy in place, the strategy was complied with.

In accordance with O. Reg. 79/10, s. 49 (1), the licensee was required to ensure that the falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids.

Specifically, staff did not comply with the licensee's Falls Prevention and Management Program, that was last revised January 2019, that included completing head injury routine (HIR), which was part of the licensee's Falls Prevention and Management Program.

A review of the home's policy titled "Falls Prevention and Management Program", last reviewed and revised January 2019, stated registered nursing staff were to initiate HIR for all unwitnessed falls where a head injury was not ruled out, as well as witnessed falls that had resulted in a possible head injury, or if the resident was on anticoagulant therapy. The procedure on the home's neurological flow sheet (NFS) stated to monitor blood pressure, pulse, respirations, pupil reaction, and level of consciousness every fifteen minutes for one hour, every thirty minutes for one hour, every hour for four hours, then every four hours for twenty-four hours.

A) A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) on a specified date, that reported resident#001 fell and hit

their head on the floor.

A review of resident #001's NFS indicated that they were to have an assessment on a specified date at 2345 hours and four hours later at 0345 hours. The column for the time of 2345 hours was blank, and there was no assessment completed at 0345 hours.

RPN #104, the home's clinical nurse manager, shared that HIR is initiated if there are any lesions or bleeding on the head or if a fall was unwitnessed.

RPN #104 and DOC #100 shared that they would have expected the NFS to be completed in full.

B) The home completed a risk management report located on point click care (PCC) for resident #010 on a specified date. Resident #010 was on the floor face down. At the time of the incident, resident #010 pointed to an area of their head when asked if they hit their head.

A review of resident #010's NFS indicated that they were to have an assessment completed on a specified date at 0400 hours. It was documented on the NFS at 0400 hours that resident #010 was sleeping. There was no documentation completed of their movement, hand grasps, pupil size, pupil reaction, speech, blood pressure, pulse, respiration or temperature.

RPN #104 and DOC #100 shared that they would have expected the NFS would be completed in full, even if the resident was asleep.

The licensee failed to ensure that the strategy to reduce or mitigate injury within the home's falls prevention and management policy, specifically completion of the head injury routine, for resident #001 and #010 was complied with. [s. 8. (1) (a),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 the home's fall prevention policy, specifically, monitoring a resident with a head injury or suspected head injury is followed, 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. (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 ensure that the planned menu items were offered and available at each meal and snack.

During lunch service it was observed that PSW #103 was serving soup to residents sitting at eleven of the fifteen tables. Six residents sitting at two other tables were not being offered or served the soup course.

A) Resident #007 was observed being served the pancake entrée. A PSW cut up their pancakes and continued to serve co-residents. It was observed that resident #007 was not offered or served the soup that had been served to the other residents.

Resident #007 was assessed by registered dietitian (RD) #109, and a progress note was completed which stated that resident #007's fluid intake continued to fluctuate and usually did not meet their calculated daily requirements.

B) A review of the seating chart revealed that resident #008 was to sit at a specified table, however during observations, they were seated at a different table. A PSW served resident #008 their pancake entrée but they were not offered or served soup.

Resident #008 was assessed by RD #109, and their quarterly review assessment that

was documented in PCC, stated that resident #008's documented fluid intake fluctuated and did not always meet their daily calculated fluid needs.

PSW #116 shared that they did not offer soup to the identified tables, as the residents sitting at those tables did not have the ability to answer and make their meal choice.

PSW #105, and PSW #106 shared that every resident was to be offered both soup and an entrée, and if a resident was not able to choose, they would look on the resident kardex for their meal preferences. They shared that even though a resident was not able to speak and communicate, they should be offered soup. PSW #105 and PSW #106 stated that they documented soup as a fluid on Point Of Care (POC).

RD #109 shared that soup was recorded as a fluid in POC and that resident #007 and resident #008 should have received soup, and if consumed, it would have improved their daily fluid intake.

The FSS #119 shared that residents that sit at four of the fifteen tables required the assistance of staff to eat. They were not served soup at the same time as residents whom are independent, as they required a staff member to be present at the table to assist them. FSS #119 stated that all residents were to be offered soup and if they were not able to answer, staff were to provide them with the soup that was being served.

The licensee failed to ensure that the planned menu items were offered to residents at table twelve and thirteen, specifically resident #007 and resident #008. [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 that every resident is offered the home's planned menu items that are available at each meal and snack, specifically, residents that are unable to communicate their choices, to be implemented voluntarily.

WN #3: 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 ensure that drugs stored in an area or a medication cart were kept secure and locked.

A) Inspector #729 observed the medication cart located outside of a resident room. The medication cart was left unlocked and unattended by staff in the home. Resident rooms and hallway located in the vicinity of the medication cart did not reveal any staff members present.

RPN #115, who was not administering medications from that cart, stated that they were alone on the unit, and promptly went and locked the cart after inspector #729 identified the concern.

RPN #121 shared that they were working on the specified date, and were responsible for the medication cart. RPN #121 was not aware that the cart was left unlocked and thought that since they were using both the medication cart and the treatment cart at the same time, they may have forgotten to lock the medication cart. They stated that their nursing practice was to ensure that the computer screen and cart was locked, when they were not in attendance.

B) A second occurrence was observed when the medication cart was left unattended at the entrance to the dining room. Upon further observation, the medication cart was not locked and RPN #117 was located across the dining room with their back to the cart, administering medications to a resident.

RPN #117, stated that their cart should be kept locked, but they were able to see the cart. RPN #117 did not look up nor acknowledge inspector #729 standing beside their unlocked cart. RPN #117 shared that their practice was to always ensure that the cart was safe, and that the screen and cart were locked.

DOC #100 shared, that it was an expectation of the nursing staff that when they left the cart, it was locked, and they had their keys with them.

The licensee failed to ensure that drugs were stored in an area or a medication cart, that was kept secure and locked. [s. 129. (1) (a) (ii)]

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 all medications are stored in an area or a medication cart that is secure and locked, specifically, when the registered staff members are not at their medication carts, to be implemented voluntarily.

Issued on this 3rd day of June, 2019

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

Original report signed by the inspector.