Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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
Aug 22, 2019	2019_793743_0011	004949-18, 005198-18, 030639-18, 031062-18, 010997-19	Critical Incident System

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

KIYOMI KORNETSKY (743)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): July 25-26, July 29-August 2, and August 6-8, 2019.

The following intakes were completed in this Critical Incident inspection:
Log# 010997-19 related to a medication error.
Log# 030639-19 related to responsive behaviours.
Log# 005198-18 related to an unexpected death.
Log# 031062-18 related to a fall.
Log# 004949-18 related to infection prevention and control.

The inspector reviewed clinical records and plans of care for relevant residents, pertinent policies and procedures and the home's documentation related to relevant investigations.

During the course of the inspection, the inspector(s) spoke with the Director Nursing (DON), the Clinical Nurse Manager (CNM), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Food Services Manager, Dietician, Housekeeping, MediSystem Pharmacist, residents and Pharmacy Assistant and Office Manager.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Medication
Nutrition and Hydration
Responsive Behaviours

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

i) A Critical Incident (CI) was submitted to the Ministry of Long-Term Care (MLTC) related to the unwitnessed fall of resident #003 that resulted in an injury.

Resident #003's plan of care stated they required extensive assistance from two staff for toileting and assistance from three staff for transfers.

The resident's plan of care also listed the resident as occasionally incontinent, however, their most recent Minimum Data Set assessment indicated the resident was continent.

Resident #003 was observed self-propelling while in their wheelchair with both legs, standing up from their wheelchair independently and self-transferring while in the washroom. Personal Support Worker (PSW) #115 assisted resident #003 after they attempted to toilet independently, however, they did not call for additional staff support.

PSW #116 said resident #003 was continent and able to toilet independently, but staff should be supervising the resident, while RN #114 said resident #003 was able to self-transfer.

The Clinical Nurse Manager (CNM) #111 said the current plan of care was outdated.

ii) Over a seven month period, resident #003 had 15 unwitnessed falls, of which seven

occurred in the resident's washroom.

A multidisciplinary progress note identified resident #003 as high risk for falls. It was noted that the resident attempted to self-transfer and walk short distances when they needed to use the washroom. The resident's plan of care indicated that the resident was to use a specific device, and staff were made aware that the resident may remove it.

Resident #003 was observed in their wheelchair without the specific device. The following day, their plan of care was updated indicating it was no longer required.

The CNM #111 was asked what new intervention was put in place. Resident #003 still remained at high risk for falls and was observed on two separate days going into their room and closing the door. The CNM #111 replied that staff were to check on the resident if the resident's door was closed, however, they acknowledged that this intervention was not on the resident's plan of care.

The licensee failed to ensure that the written plan of care for resident #003 provided clear direction to staff and others, when they failed to update the resident's plan of care to reflect the residents current transfer needs, continence status and interventions to replace the specific device. [s. 6. (1) (c)]

2. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A) A CI was submitted to the MLTC related to the unwitnessed fall of resident#003 that resulted in an injury.

Over a seven month period, resident #003 had 15 unwitnessed falls, of which seven occurred in the resident's washroom.

The resident was identified as a high risk for falls and attempted to self-transfer and walk short distances when they needed to use the washroom.

Fall prevention interventions listed on resident #003's plan of care included the use of a specific device, toileting before and after meals when required, two person assist with toileting and comfort rounds every two hours.

According to the CNM #111, Director of Nursing (DON) #108 and Registered Nurse (RN)

#112, comfort rounds included assessing a resident's pain, need for toileting, position, and possessions. As per the CNM #11, comfort rounds were not scheduled, and were completed by any staff member who had contact with the resident.

During the inspection, resident #003 was observed in their wheelchair without the specific device.

On a particular day Registered Nurse #113 did not complete comfort rounds for resident #003, nor did staff ask the resident if they needed assistance with toileting after lunch. Twelve minutes later, inspector #743 observed resident #003 attempting to self toilet.

On another day, PSW #115 was also observed entering resident #003's room to take the resident to lunch. PSW #115 did not complete comfort rounds, nor ask the resident if they needed assistance with toileting. After lunch, the resident returned to their room and two minutes later, PSW #110 entered the room, but did not speak to the resident, conduct comfort rounds, or ask if the resident needed assistance with toileting.

The DON #108 and the CNM #111 acknowledged that staff did not follow the resident's plan of care when resident #003 did not receive comfort rounds and was not toileted before and after meals.

The licensee failed to ensure that the care set out in the plan of care was provided to resident #003, when they failed to follow the resident's fall interventions, assisting with toileting before and after meals, and completing comfort rounds.

B) A CI was submitted to the MLTC related to an altercation that occurred between resident #001 and resident #002.

Documentation indicated that the Home's video surveillance captured an altercation that occurred between resident #001 and resident #002. Resident #001 and resident #002 were seated beside each other when resident #002 started yelling and hitting resident #001. Resident #001 responded by hitting resident #002; after which resident #002 hit resident #001 with an item they were holding. Resident #001 sustained a minor injury as a result of the altercation.

Resident #002's transitional plan of care documented that the resident may exhibit aggressive behaviors towards co-residents who invaded their personal space. Multiple interventions were recommended including re-directing intrusive co-residents away from

resident #002.

Resident #002 was assessed by a Geriatric unit. Recommended strategies included ensuring the resident was not seated in high congested or noisy areas, and to redirect others from resident #002's personal space.

Resident #002's plan of care had multiple interventions to address their responsive behaviors, and also included instructions that staff were to immediately remove residents who were in resident #002's personal space.

During the inspection, resident #002 was observed sitting within arm's reach of resident #010. After forty minutes, PSW #104 removed resident #010, however, they proceeded to wheel resident #011 to sit within arm's reach of resident #002.

Registered staff #106 said resident #002's behaviors were unpredictable and the resident should not be placed within arms reach of any resident at any time.

The DON #108 said that on the date of the altercation between resident #001 and resident #002, resident #001 and resident #002 should not have been seated next to each other. They also acknowledged that it was not ideal for resident #002 to be placed near other residents when seated in front of the nursing station.

The licensee failed to ensure that the care set out in the plan of care was provided to resident #002, when resident #001 was not removed from resident #002's personal space; and when residents #010 and #011 were placed within reach of resident #002.

C) Resident #007 was identified as being at high risk for falls.

The plan of care had numerous fall interventions in place, including supervising the resident and keeping them within view of staff, ensuring the breaks were engaged when the resident was in their wheelchair and a specific device was to be used when they were in bed or in their wheelchair.

Documentation in PCC risk management indicated that resident #007 had an unwitnessed fall.

RPN #112 noted that resident #007 was found sitting on the floor in front of their wheelchair. The device was activated, however, staff were receiving report and were

unaware. In addition, the breaks were not engaged on the resident's wheelchair.

When asked if staff followed the resident's plan of care on the date of the unwitnessed fall, the CNM #111 said that resident #007 should have been at the nursing station where there was more supervision and the breaks on the wheelchair should have been engaged.

The licensee failed to ensure that the care set out in the plan of care was provided to resident #007, when the resident fell after not being within direct supervision of staff and their wheelchair was found without the breaks engaged. [s. 6. (7)]

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 plan of care for each resident sets out clear directions to staff and others who provide direct care, and that the care set out in the plan of care is provided to residents as specified in the plan, to be implemented voluntarily.

WN #2: 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 failed to ensure that where the Act or Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any system, the system

was complied with.

In accordance with O.Reg.79/10, s.49 (2), the licensee was required to ensure that after a resident fell, the resident was assessed, and that a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Specifically, the licensee failed to comply with the home's "Falls Prevention and Management Program" last reviewed in April 2018; that required Registered staff to complete a Head Injury Routine (HIR) for all unwitnessed falls, if the resident was on anticoagulant therapy, as well as witnessed falls that resulted in a possible head injury.

The licensee also failed to comply with the Home's Head Injury Routine, that directed staff to monitor a resident's blood pressure, pulse, respirations, pupil reaction and level of consciousness every 15 minutes for 1 hour, every 30 minutes for 1 hour, every 1 hour for 4 hours and every 4 hours for 24 hours.

A) A CI was submitted to the MLTC related to the unwitnessed fall of resident #003 on a specific date. Staff initiated a HIR at 1420 hours, however, did not complete the subsequent HIR assessments as per the HIR routine. The resident was not assessed every 15 minutes for one hour, nor were they assessed every four hours until 24 hours after the fall.

Resident #003 then sustained another unwitnessed fall. The risk assessment completed in PCC indicated that staff heard a bump from resident #003's room and determined the resident had slipped in the washroom. The resident's paper and electronic records were reviewed, however, a HIR could not be located.

As per the resident's paper medication administration record (MAR), the resident was prescribed an anticoagulant. The CNM #111 acknowledged that a HIR should have been completed.

B) A record review was completed in PCC for resident #007 and documentation in risk management indicated that the resident was found sitting in front of their wheelchair on the floor. The fall was unwitnessed.

The CNM #111 said the Home's policy directed staff to complete a HIR for unwitnessed falls. A HIR could not be located for resident #007 after their unwitnessed fall, and the

CNM #111 acknowledged that a HIR should have been completed.

The licensee failed to ensure the Home's "Fall Prevention and Management Program" policy, last revised April, 2018, was complied with; when they failed to complete a HIR for resident #007 and resident #003, after the residents' unwitnessed falls. [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 the home's Falls Prevention and Management Program, specifically when monitoring residents after unwitnessed falls, is complied with, to be implemented voluntarily.

WN #3: 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 failed to ensure that drugs were administered to residents in accordance with the directions for use as specified by the prescriber.

A CI was submitted regarding a medication error involving resident #005.

Resident #005 was prescribed a medication that was to be administered once a day. Review of the resident's MAR found that the medication had been documented as administered once a day over a thirteen day period.

Registered Practical Nurse (RPN) #120 said they found three extra doses of the medication in the resident's medication card.

Delivery schedules for the medication were reviewed with MediSystem's Pharmacy Assistant #121. It was possible, due to the overlap in delivery days, that there could have been one extra dose, however, not three extra doses.

According to the DON #108, staff should not sign that a medication was administered to a resident prior to administering the medication. The DON #108 said that resident #005 missed three doses of the medication, because staff did not follow the home's medication process. Staff were found to have signed on the electronic medication record (eMAR) that the medication had been administered to resident #005 without double checking that the resident had in fact received the medication.

The licensee failed to ensure the medication was administered as prescribed, when they failed to administer the medication to resident #005 on three separate days. [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 that drugs are administered in accordance with the directions for use as specified by the prescriber, to be implemented voluntarily.

Issued on this 4th day of September, 2019

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

Original report signed by the inspector.