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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## Public Copy/Copie du public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Sep 25, 2019 | 2019_549107_0010 | 026278-18, 031218-18 | Complaint |

### Licensee/Titulaire de permis

Blackadar Continuing Care Centre Inc.
101 Creighton Road DUNDAS ON L9H 3B7

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

Blackadar Continuing Care Centre
101 Creighton Road DUNDAS ON L9H 3B7

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

MICHELLE WARRENER (107), PHYLLIS HILTZ-BONTJE (129)

### 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): August 22, 23, 26, 27, 28, 29, September 3, 4, 5, 6, 10, 11, 2019.**

**The following inspections were conducted concurrently with this inspection:**
**Follow Up 2019_549107_0012 / 010184-19, 010185-19,**
**Critical Incident System 2019_549107_0011 / 014961-19, 015464-19.**

**The following complaints were included in this Complaint Inspection:**
**Log #026278-18 related to alleged staff to resident abuse**
**Log #031218-18 related to alleged staff to resident abuse, improper transferring, continence care, and medication management.**

**During the course of the inspection, the inspector(s) spoke with residents, the Administrator, Director of Care, Registered Nursing Staff (RN, RPN), Personal Support Workers, RAI-Co-ordinator, and Dietary and Environmental Manager.**

**The following Inspection Protocols were used during this inspection:**
**Continence Care and Bowel Management**
**Falls Prevention**
**Medication**
**Prevention of Abuse, Neglect and Retaliation**
**Reporting and Complaints**

**During the course of this inspection, Non-Compliances were issued.**
- **6 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| 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 | Légende<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 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 licensee failed to ensure that the written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

The licensee's policy titled, "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting RC-02-01-02", last revised April 2017, directed all employees to immediately report any alleged, suspected or witnessed resident incident of abuse and neglect to the Administrator/designate/reporting manager or if unavailable, to the most senior Supervisor on shift at that time.

An anonymous complaint was received by the Ministry of Health and Long Term Care Action Line alleging the caller witnessed staff to resident abuse towards resident #004. The caller confirmed that they had witnessed the alleged incident and had not reported what they saw to the Administrator, reporting manager, or most senior Supervisor. The caller stated that they were aware of the home's policy for reporting abuse, however, assumed that someone else would report the incident. Inspector #107 was unable to find any evidence that the incident was ever reported to any manager at the home.

During interview with Inspector #107, staff member #127 reported that they witnessed an incident of alleged staff to resident abuse towards resident #002 and confirmed to Inspector #107 that they did not report the incident to anyone. The staff member confirmed that they were aware of the home's policy requirement for reporting but did not report the incident. [s. 20. (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 with 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, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints**

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

**s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that a written complaint concerning the care of a resident or the operation of the long-term care home was immediately forwarded to the Director.

A. The Director Of Care (#101) received an e-mail complaint that identified concerns related to the care of two residents and the behaviour of a home staff member.

During a discussion with the Administrator they confirmed they had received the above noted e-mail and acknowledged that they had not forwarded the written complaint to the Director.

B. During a discussion with the Administrator they verified that they received a written complaint about the care of resident #011.

A review of the home's investigative package indicated that they had taken a copy of a document related to resident #011, that described a series of events that occurred on a specific date. The document identified concerns related to the care of the resident.

The Administrator verified that the written document, that identified concerns with the care of resident #011, was not forwarded to the Director. [s. 22. (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 with s. 22(1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director, to be implemented voluntarily.***

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**WN #3: 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).**

**Findings/Faits saillants :**

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

Resident #003's written plan of care did not provide clear directions to staff and others who provided direct care to the resident related to the provision of continence care and the method used to assist the resident with transfers.

During discussions held with PSW #103 and PSW #106, both staff members confirmed that resident #003 required specific interventions related to continence care and transfers. During an interview with resident #003, they confirmed the same interventions as stated by the PSWs.

RPN #112 confirmed that staff referred to the care plan and the Kardex for care directions.

A review of resident #003's above noted written plan of care indicated that the written documents did not contain the specific direction related to the resident's continence care and transfers.

During a discussion with RN #113 they confirmed that resident #003 required the specific directions related to continence care and transfers. RN #113 reviewed the written care directions and verified that clear direction to staff providing care was not provided when the written documents did not include the specific directions related to continence care and transfers that the resident required.

RN #113 and clinical documentation confirmed that the written plan of care did not provide clear direction to staff related to the provision of continence care and the method used to assist the resident with transfers. [s. 6. (1) (c)]

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints**

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

**s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:**
**1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).**

**s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,**
**(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).**

**s. 101. (3) The licensee shall ensure that,**
**(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that a response was provided to a complainant within 10 business days of receipt of a complaint concerning the care of a resident or the operation of the home.

Staff member #102 forwarded an e-mail to the Director of Care (DOC) #101, that identified concerns related to the care for two residents and the behaviour of a staff member. The DOC received the e-mail on a specified date, and records provided by the home indicated an investigation was initiated on that date.

During a discussion with the Administrator (#100) and DOC (#101), the DOC indicated they had not provided a response to staff member #102 because they were unable to contact the complainant. The DOC verified that they were unable to provide documentation of attempts to contact the complainant.

The Administrator, and a review of scheduling information, verified that staff member

#102 worked 20 shifts over a two month period of time following the submission of the e-mail complaint.

The Administrator and DOC verified that a response was not provided to staff member #102 following the receipt and investigation of a written complaint about the care of two residents and the behaviour of a staff member. [s. 101. (1) 1.]

2. The licensee failed to ensure that a documented record was kept in the home that included, the type of action taken to resolve the complaint, including the date of the action, time frames for actions to the taken, and any follow-up action required.

A complainant forwarded an e-mail letter to the home which identified care concerns for two identified residents. The home received the e-mail on a specified date, and documentation provided by the home indicated that an investigation was initiated on that date.

The home provided the investigative package for the above noted complaint that included:
a) A typed page which was signed by the DOC (#101) on a specified date. The document outlined a "Conclusion" and a "Plan of Action".

b) A copy of the computerized complaint log used in the home that included the above noted complaint details.

During a discussion with the Administrator (#100) and DOC (#101), the DOC reviewed both of the above noted records and confirmed the documented record of the complaint did not contain the date of the action taken to resolve the complaint, time frames for actions to the taken, or follow-up action required. [s. 101. (2) (c)]

3. The licensee failed to ensure that the documented record of complaints was reviewed and analyzed for trends at least quarterly.

During a discussion with the Administrator (#100), they reviewed their records and confirmed that the record of complaints was not reviewed or analyzed for trends at least quarterly. [s. 101. (3) (a)]

**WN #5: 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 were stored in an area or a medication cart that was secured and locked.

On a specified date, while observing the process of medication administration on a specific home area, it was noted that the medication cart was left unlocked and unattended in the nursing station.

RN #114 left the medication cart to go around the corner to administer medication to a resident that was sitting in the hallway. The nursing station was not secure and was accessible to anyone in the hallway. At the time of this observation, residents and staff were moving in and out of the area.

When RN #114 returned to the medication cart, they verified that they had not locked the medication cart and had not maintained visual contact with the cart when they left the area to administer medications to a resident that was not within visual range of the medication cart.

RN #114 and observations confirmed that drugs stored in the medication cart were not secure and the medication cart was unlocked. [s. 129. (1) (a)]

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**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 213. Director of Nursing and Personal Care**

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

**s. 213. (1) Every licensee of a long-term care home shall ensure that the home's Director of Nursing and Personal Care works regularly in that position on site at the home for the following amount of time per week:**
**5. In a home with a licensed bed capacity of 65 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 213 (1).**

**Findings/Faits saillants :**

1. Blackadar Continuing Care is an 80 bed care home which requires the Director of Care (DOC) to work at least 35 hours per week.

The Director of Care (#101) and Administrator (#100) were scheduled to be away from the home on a specified date. During interview with Inspectors #107 and #129 about the coverage for the Director of Care position, the Administrator indicated that the Quality Manager (#119), who was a Registered Practical Nurse (RPN), was covering for the Director of Care. The Administrator confirmed the home did not have a plan to cover the required hours with a qualified individual while the DOC and Administrator were out of the building. [s. 213. (1) 5.]

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**Issued on this 26th day of September, 2019**

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

**Original report signed by the inspector.**