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

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 apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 10, 2018	2018_609569_0010	025193-18	Resident Quality Inspection

Licensee/Titulaire de permis

Blue Water Rest Home
37792 Zurich-Hensall Rd RR #3 ZURICH ON N0M 2T0

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

Blue Water Rest Home
37792 Zurich-Hensall Road ZURICH ON N0M 2T0

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

DONNA TIERNEY (569), HELENE DESABRAIS (615), RHONDA KUKOLY (213)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): September 17, 18, 19, 20, 21, 24, and 25, 2018.

The following Complaint intakes were completed within this inspection:

Complaint Log #010672-18 related to bed refusal.
Complaint Log #017939-17 / IL-54428-LO related to medications

The following Critical Incidents intakes were completed within this inspection:

Critical Incident Log #013125-18 / CI C508-000005-18 related to the prevention of abuse and neglect - resident to resident
Critical Incident Log #015290-18 / CI C508-000006-18 related to the prevention of abuse and neglect - resident to resident

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), the Director of Care (DOC), the Nurse Clinician, the Resident Assessment Instrument (RAI) Coordinator, the Activity Volunteer Coordinator, the Behavioural Supports Ontario (BSO) lead, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), family members and over 20 residents.

The inspectors also observed resident rooms and common areas, observed medication storage areas, observed medication administration, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, reviewed policies and procedures of the home, reviewed staff schedules, reviewed various meeting minutes, and reviewed written records of program evaluations.

The following Inspection Protocols were used during this inspection:

Admission and Discharge
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

- **2 WN(s)**
- **0 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 LTCHA, 2007 S.O. 2007, c.8, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,
(a) the home lacks the physical facilities necessary to meet the applicant's care requirements; 2007, c. 8, s. 44. (7).
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or 2007, c. 8, s. 44. (7).
(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval. 2007, c. 8, s. 44. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home approved the applicant's admission to the home unless, (a) the home lacked the physical facilities necessary to meet the applicant's care requirements; (b) the staff of the home lacked the nursing expertise necessary to meet the applicant's care requirements; or (c) circumstances existed which are provided for in the regulations as being a ground for withholding approval.

A complaint from resident #013's POA related to being refused admission to Blue Water Rest Home was received by the Ministry of Health and Long Term Care.

Application documentation was reviewed during the inspection including the bed refusal letter to the complainant, a Behavioural Assessment Tool and other admission assessments completed by the South West Local Health Integration Network (SWLHIN).

The bed refusal letter indicated: "According to the behavioural assessment completed .... [the resident] has a history of becoming agitated and displays verbal and physical aggression including attempts to strike out at staff members". It also indicated: "Based on the applicants documented assessments of responsive behaviours, we are unable to provide the necessary resources that the applicant requires for safe and secure care. The risk of aggression towards members of our vulnerable population would be of concern. Blue Water Rest Home has a multigenerational environment and lacks the ability to manage any potential for interactions with vulnerable individuals. The home's layout of long halls with no direct staff surveillance puts the applicant at risk responsive

behaviours towards other residents. The decision to deny this application is based on ongoing risks within a LTCH environment that predisposes the applicant and others to potential harm. Blue Water Rest Home lacks the physical facility to continuously observe the applicants activities. The Resident Room configuration at Blue Water Rest Home includes long hallways out of direct staff surveillance."

In a staff interview with the BSO lead, Registered Nurse (RN) #115 by Inspector #569 on September 25, 2018, they said the home does have an interdisciplinary BSO team consisting of an RN, two Registered Practical Nurses, three Personal Support Workers and two Activation Staff members. They have a referral process for BSO and any registered staff can refer to BSO. They said the team meets monthly with other homes in the county as well as Seniors Mental Health at Parkwood Institute and are all part of the Ontario Telemedicine Network hub where concerns and issues are shared and strategies developed.

In interviews with the Director of Care (DOC) #101 and the Chief Executive Officer (CEO) #100 on September 25, 2018, they both said that they refused admission for resident #013 based on a fear that this person had the potential to physically harm other residents or staff. When asked if the home currently had residents with agitation, verbal and physical aggression, they both said yes. When asked if they were managing these residents and their responsive behaviours with the staff of the home and the home's BSO program, they both said yes.

The DOC also said that the complainant called the home and was quite upset by the refusal and that the complainant reported that the agitation and aggression was only present at the one hospital with the use of a specific medication and a reaction. With this information, the DOC encouraged the complainant to speak with the LHIN case worker and reapply to the home for admission.

The licensee has failed to ensure that the home approved the applicant's admission to the home unless, (a) the home lacked the physical facilities necessary to meet the applicant's care requirements; (b) the staff of the home lacked the nursing expertise necessary to meet the applicant's care requirements; or (c) circumstances existed which are provided for in the regulations as being a ground for withholding approval. [s. 44. (7)]

WN #2: 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 has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

Medication incidents over a specified time period were reviewed. A medication incident for resident #007 was reviewed and indicated that the resident was to receive certain medications at a specified time frame. These medications were found in the resident's room at a specific area the following day by another nurse, not having been administered, but having been signed for as administered. The incident was documented as a "missed dose".

Medication orders were reviewed for resident #007 for a specific time frame, and indicated specific medications to be administered at specific doses at a specified time.

In a staff interview with Registered Practical Nurse (RPN) #103, the RPN said that resident #007 had some medical issues and that their pills should not be left with them to take on their own.

In a staff interview with the Director of Care (DOC) #101, the DOC said that they followed up with the Registered Nurse (RN) who committed the medication error where resident #007's medications were not given and reminded the RN not to leave medications with residents, to ensure that they are taken in the future.

The licensee has failed to ensure that drugs were administered to resident #007 in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

Issued on this 11th day of October, 2018

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

Original report signed by the inspector.