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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 25, 2016	2016_199626_0025	013447-16	Resident Quality Inspection

Licensee/Titulaire de permis

The Royale Development GP Corporation as general partner of The Royale Development LP
302 Town Centre Blvd Suite 300 MARKHAM ON L3R 0E8

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

Case Manor Care Community
28 BOYD STREET P.O. BOX 670 BOBCAYGEON ON K0M 1A0

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

DENISE BROWN (626), LYNDA BROWN (111)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 26, 27, 28, 29, 30 and October 3, 2016

The following were inspected during the course of the Resident Quality Inspection:

Critical Incident Logs:
Intake Log #025401-16: Related to resident abuse
Intake Log #026207-16: Related to falls

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Environmental Services Manager (ESM), Restorative Care Coordinator (RCC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), House Keeping Workers, Family and Resident Council Presidents, Residents and Family members.

During the inspection, the inspector (s), toured the resident home areas, observed staff to resident provision of care, infection control practices and medication administration. The inspectors reviewed residents' health records, internal related investigations, maintenance records, applicable policies, resident and family council minutes and critical incidents.

The following policies were reviewed:
Falls Prevention, Prevention of Abuse and Neglect of a Resident, Skin and Wound Care Management, Medication Administration, Pain and Symptom Management and Behaviour Management.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

- **3 WN(s)**
- **1 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. 6. Plan of care

Specifically failed to comply with the following:

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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as indicated in the plan related to risk for falls.

Related to Intake Log #026207-16 which involved resident #021:

Review of resident #021's progress notes for a four month period in 2016, indicated that the resident had multiple falls. In all but one of the falls, the resident had removed the alarming device before the fall.

An interview with PSW #108 and #107, indicated that resident #021 was at high risk for falls because of the resident's attempts to self-transfer. Personal Support Worker #107 indicated that the resident had a anti-sliding device on the mobility aid and was on documented monitoring every 15 minutes.

Review of the current written plan of care for resident #021 indicated that the resident was at risk for falls related to a history of falls/injury and unsteady gait. The plan of care included four falls prevention interventions including specific interventions when the

resident was seated in a mobility aid.

Observation of resident #021 on a specified date, indicated that the resident was sitting in a mobility aid in the hallway. On observation, the interventions specified in the plan of care were not implemented. The Observation Records for resident #021 indicated that, the monitoring records were only in place for five days in a specified one month period in 2016.

The care set out in the plan of care related to risk for falls was not provided to resident #021 as specified in the plan of care. [s. 6. (7)]

2. The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months, and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

Related to Intake Log #025401-16 which involved resident #001 and #002:

Critical Incident Report (CIR) was submitted to the Director on a specified date related to a resident to resident physical abuse, which occurred between resident #001 and resident #002. During the incident resident #002 sustained an injury. A review of the resident's health records indicated that following the incident, resident #001's plan of care was not revised to indicate the potential for physical aggression and related interventions.

During an interview, RPN #102 indicated that there was a plan of care for behaviours but not to address physical aggression. Registered Practical Nurse #102, also indicated that the plan of care should include interventions for physical aggression.

During an interview, ADOC #112 acknowledged that resident #001's plan of care did not include interventions for physical aggression and should have been revised after the incident.

During an interview, the Administrator indicated that when there is a change in a resident's behaviour, the plan of care should be updated.

The plan of care for resident #001 was not reviewed and revised when the resident's care needs changed. [s. 6 (10) (b)]

3. Review of the progress notes and post fall assessments for resident #016, over a four month period in 2016, indicated that the resident sustained multiple falls.

-On a specified date in 2016, a care conference was held with staff and the Substitute Decision Maker (SDM). Resident #016 was reported to be at high risk for falls related to specific diagnoses and medications. Specific falls prevention interventions were in place.

-On a specified date in 2016 (post fall), the resident was assessed by Physiotherapy (PT), who indicated that the resident was independently using a walker but was provided with a different mobility aid because of weakness.

Review of the current written plan of care for resident #016 indicated that the resident used a walker and required one staff to assist with transfers. The resident also had to be reminded to use the walker. The plan of care indicated that the resident was at risk for falls, which was related to a history of falls/injury. The plan of care also noted that two related falls prevention interventions had been implemented. The plan of care was revised on a specified date (after the fifth fall), to include interventions such as the use of non-slip socks at night and the use of an alarming device when in bed.

There was no indication in the written plan of care, that it was revised when the resident's care needs changed, to indicate: the level of risk for falls (moderate or high), that other contributing factors included the use of medications and to note specific interventions currently in place. Additional interventions were not considered in the revision of the plan of care, when the interventions in place were noted to be ineffective as the resident continued to fall, until after the fifth fall. [s. 6. (10) (b)]

4. The licensee has failed to ensure when the resident was being reassessed and the plan of care was being revised because care set out in the plan had not been effective, different approaches were not considered in the revision of the plan of care.

Related to Intake Log #026207-16 which involved resident #021:

A critical incident report (CIR) was received by the Director on a specified date related to a fall incident that occurred on a specified date in 2016. The CIR indicated that resident #021 fell and sustained an injury. The CIR indicated the resident was at very high risk for falls and had multiple previous falls in the last quarter.

Review of resident #021's progress notes over a four month period in 2016, indicated that the resident sustained multiple falls during that time. In all but one of the falls, the resident had removed the alarming device before the fall.

-On a specified date, the SDM requested the use of a restraint. The restraint was not implemented as an intervention.

Interviews with PSW #108 and #107, indicated that resident #021 is at high risk for falls because of the resident's attempts to self-transfer without staff assistance. Personal support Worker #107, indicated that the resident had four falls prevention interventions in place and was also on documented monitoring which was done every 15 minutes.

Review of the current written plan of care for resident #021 indicated that the resident is at risk for falls related to a history of falls/injury, unsteady gait and specific diagnoses. Four specific falls prevention interventions were noted on the plan of care, in addition to the documented monitoring which was done every 15 minutes.

Observation of resident #021 on a specified date, indicated that the resident was sitting in a mobility aid in the hallway. There was an alarming device in place but three out of the four specific falls prevention interventions that were noted in the plan of care were not implemented.

The alarming device intervention was noted to be ineffective, as the resident would remove this device and continued to sustain ongoing falls. The plan of care was not revised when the plan was not effective in reducing the number of falls and different approaches were not considered as requested by the SDM. [s. 6. (11) (b)]

5. Review of progress notes, for resident #002 over a four month period in 2016 indicated that the resident sustained multiple falls during that time with an incident of injury related to one of the falls.

Interview of PSW #108 and #107, on a specified date indicated resident #002 required 1-2 staff to assist with transfers into the mobility aid. Both PSWs, indicated that the resident was at high risk for falls and that falls prevention interventions were in place and listed four specific interventions. In another interview, the Restorative Care Coordinator #124 (and Falls Prevention Lead) indicated that residents at high risk for falls are to have a logo placed at the resident's doorway on name plate.

Observation of resident #002 on a specified date, indicated that the resident was in the hallway with an alarming device applied to the mobility aid. On observation, the falls prevention interventions specified in the plan of care were not implemented.

Review of the current plan of care for resident #002 indicated that the resident was at moderate risk for falls. Interventions for falls preventions were implemented at a specified date in 2016, after the resident had sustained multiple falls.

The plan of care was reviewed but not revised, when the plan was not effective in reducing the number of falls. Different approaches were not considered when the resident had multiple falls, which was evident at the start of the four month period that was reviewed. New fall interventions were added to the written plan of care on a specified date, at the end of the four month period that was reviewed. In addition, the plan indicated that the resident was only at moderate risk for falls despite falling multiple times and staff indication that the resident was at high risk. [s. 6. (11) (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 residents are reassessed and the plans of care are revised when these plans have not been effective. Different approaches must be considered in the revision of the plans of care to reflect effective falls prevention strategies specific to the care needs of residents #002, #016 and #021, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect abuse of a resident by any one has occurred or may occur, shall immediately report the suspicion of the abuse and the information upon which it was based to the Director.

Related to Intake Log #025401-16 which involved resident #001 and #002:

A Critical Incident Report (CIR) was submitted to the Director on a specified date in 2016 for an allegation of resident to resident physical abuse, which occurred on a specified date in 2016. During the incident resident #002 sustained an injury. The CIR noted that the incident occurred on a specified date in 2016 and was reported to the Director one day after the incident had occurred.

During an interview, RPN #102 was uncertain if the incident was reported to the Director and indicated that abuse must be reported promptly.

In another interview, the ADOC #112 indicated that the incident was reported to the Director on the next day after it occurred.

During an interview, the Administrator indicated that in the case of abuse the Director must be notified immediately.

The licensee failed to immediately notified the Director of the resident to resident abuse. [s. 24. (1)]

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 has failed to ensure that 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.

Observation on a specified date in 2016, indicated that more than one topical medications were found in resident #009 shared bathroom.

Interview with resident #009 on a specified date, indicated that the treatment creams are usually stored in the resident's bathroom and staff apply the treatment creams.

Interview with RN #115, RPN #102 and PSW #114, all indicated that prescribed treatment creams are applied by the PSWs and are to be locked in the PSWs' tackle boxes and kept on the care carts.

On specified date, the door to the Wellness Center was observed unlocked and there was no staff present in the room. This room contained a fridge which did not have a lock and in which vaccines were stored.

In an interview with ADOC #112, confirmed that the room was used as an office and was not usually locked.

The licensee failed to ensure that drugs were stored in a locked and secured area or a medication cart that is exclusively used for drugs and drug related supplies. [s. 129. (1)]

Issued on this 6th day of December, 2016

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

Original report signed by the inspector.