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
Jan 16, 2019	2019_722630_0001	025761-17, 025771-17, 028682-17, 029719-17, 001059-18, 005417-18, 012604-18, 025744-18, 026073-18, 026553-18, 027086-18, 027094-18, 027351-18, 027881-18, 028812-18, 031913-18, 032319-18	Critical Incident System

Licensee/Titulaire de permis

CVH (No. 3) GP Inc. as general partner of CVH (No. 3) LP
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes CAMBRIDGE ON N3H 5L8

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

Chelsey Park
310 Oxford Street West LONDON ON N6H 4N6

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

AMIE GIBBS-WARD (630), DONNA TIERNEY (569), KRISTEN MURRAY (731), MELANIE NORTHEY (563)

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): January 7, 8, 9, 10 and 11, 2019.

The following Critical Incident intakes were completed within this inspection:

Related to falls prevention
Critical Incident Log #026073-18 / CI 2655-000074-18
Critical Incident Log #027351-18 / CI 2655-000079-18
Critical Incident Log #032319-18 / CI 2655-000095-18

Related to the prevention of resident to resident abuse and responsive behaviours:
Critical Incident Log #005417-18 / CI 2655-000020-18
Critical Incident Log #012604-18 / CI 2655-000055-18

Related to the prevention of abuse and neglect:
Critical Incident Log #028682-17 / CI 2655-000131-17
Critical Incident Log #029719-17 / CI 2655-000139-17
Critical Incident Log #026553-18 / CI 2655-000076-18
Critical Incident Log #027094-18 / CI 2655-000078-18
Critical Incident Log #031913-18 / CI 2655-000094-18

Related to medication administration and management system:
Critical Incident Log #025744-18 / CI 2655-000073-18
Critical Incident Log #027086-18 / CI 2655-000081-18
Critical Incident Log #027881-18 / CI 2655-000083-18
Critical Incident Log #028812-18 / CI 2655-000087-18

The following medication administration and management system Critical Incident intakes were reviewed within this inspection:
Critical Incident Log #025761-17 / CI 2655-000110-17
Critical Incident Log #025771-17 / CI 2655-000112-17
Critical Incident Log #001059-18 / CI 2655-000002-18

Inspector #740 (Samantha Perry) was also present during this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator,

the Directors of Resident Care (DRCs), the Quality Nurse Coordinator, the Falls Prevention Lead Registered Nurse (RN), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) and residents.

The inspectors also observed resident rooms and common areas, 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 the home's investigation documentation for specific Critical Incidents and reviewed various meeting minutes.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Medication
Prevention of Abuse, Neglect and Retaliation
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 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 Regulation required 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 was required to ensure that the plan, policy, protocol, strategy or system was complied with.

A) O. Reg. 79/10, s. 114 (2) states, "The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home."

The home submitted three Critical Incident System (CIS) reports to the Ministry of Health and Long Term Care (MOHLTC) on specific dates related to missing controlled substances for three identified residents.

The "Narcotic Count Sheets" for specific time periods for these residents were reviewed by Inspector #563 and it was identified that there were missing signatures at specific times.

The Medical Pharmacies "Monitored Medication Record for 7-Day Card" for the identified residents were reviewed by Inspector #563 for a specific time period and it was found that the records were missing documentation.

During an interview the Quality Nurse Coordinator (QNC) verified the process in the home related to the resident's individual controlled substance count. The QNC stated that when the controlled substance was removed from the narcotic bin, the registered staff were to sign the individual monitored count sheet or the combined count record for

PRNs. The process in the home related to the shift count of controlled substances included two staff signatures where the staff leaving would count with the staff coming on. Together the staff would physically look at the controlled substances verifying the number on the card or box with the count on the sheets ensuring that the counts were the same. QNC verified that the two registered staff members would initial the shift count sheets at that time of the count and the count was done every change of shift or if any other registered staff member was to take over the medication cart at any other time. The QNC acknowledged that there were missing signatures on the “Narcotic Count Sheets”. The QNC shared that the expectation was that two registered staff were to sign as received and witnessed and the initial quantity recorded with the date and time. The QNC verified that there was missing required documentation on the “Monitored Medication Record for 7-Day Card” for identified residents for a specific time period.

The Medical Pharmacies "The Medication Pass" policy 3-6 last revised January 2018, documented to "administer medications and ensure that they are taken. Document on MAR in proper space for each medication administered or document by code if medication not given. For medications with a dosing range, document actual dose administered." "Chart administration of PRN medications on MAR, the resident progress note, on an 'Individual PRN Administration Record'".

The Medical Pharmacies "Shift Change Monitored Drug Count" policy 6-6 last revised November 2018, documented that "the shift count must be reconciled with the actual amount of drug in the packaging (not just the last blister or doses). If an individual count is used, the shift count should be reconciled with this as well to account for actual daily use." "Two staff (leaving and arriving), together: count the actual quantity of medications remaining; record the date, time, quantity of medication and sign in the appropriate spaces on the 'Shift Change Monitored Medication Count' form; and confirm actual quantity is the same as the amount recorded on the 'Individual Monitored Medication Record' for PRN, liquid, patches or injectable".

The licensee has failed to ensure that "The Medication Pass" policy 3-6 was complied with. The registered nursing staff did not document on the eMAR in the proper space for each medication administered and the actual dose administered. The Medical Pharmacies "Shift Change Monitored Drug Count" policy 6-6 stated that two staff (leaving and arriving), count the actual quantity of medications remaining together and this did not occur for two shift counts. The Medical Pharmacies "Individual Monitored Medication Record" policy 6-5 stated that there must be an initial for "received by" and "witnessed by" on the 'Individual Monitored Medication Record' in appropriate section at top of page

and this was missing for multiple records. The policy also directed the registered staff to document for the administration of the monitored medication on the resident's eMAR and this did not occur for each administration. The staff were also to sign on the 'Individual Monitored Medication Record' each time a dose was administered and this was not done for each administration. 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 in place any plan, policy, or system, the plan, policy or system was complied with. (563)

B) Section 8 (1) of the Long Term Care Homes Act, 2007 states "every licensee of a long-term care home shall ensure that there is an organized program of nursing services for the home to meet the assessed needs of the residents."

In accordance with O. Reg. 79/10, s 30. (1) the licensee was required to ensure that the following was complied with in respect of each of the organized programs required under sections 8 to 16 of the Act: there must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

Specifically, staff did not comply with the licensee's "Diabetes Management - Hypoglycemia" policy RC-24-01-02 last updated February 2017, which was part of the licensee's nursing services program in the home. This policy stated:
-"Residents experiencing a low blood glucose level will be treated promptly to raise the blood glucose to a safe level (greater or equal to 4mmol/L)"
-"Treat all episodes of hypoglycemia (BG less than or equal to 3.9mmol/L) immediately."

The home submitted a Critical Incident System (CIS) report to the MOHLTC on a specific date which was an allegation of "Improper/incompetent treatment of a resident that results in harm." This report details the incident and stated that staff were re-educated on the home's Diabetes's Management policy and protocol related to hypoglycemia management.

During interviews with identified staff members they reported that a specific resident had experienced an incident of low blood sugar on an identified shift. The staff described their recollection of the incident to Inspector #630 and said that when the resident's blood sugar was found to be low the staff members involved did not treat the low blood sugar immediately.

The home's investigation documentation included a summary of the incident documented by another staff member which described their recollection of the incident and identified that when the resident's blood sugars were found to be low the staff members involved did not treat the low blood sugar immediately.

During an interview one of the home's Directors of Resident Care (DRC) told Inspector #630 said they were involved in responding to and investigating this incident. The DRC said that based on the investigation it was identified that the resident blood sugar was low and the staff did not respond appropriately at the time. The DRC said that due to the severity of the incident the staff were re-educated on the home's "Diabetes Management-Hypoglycemia" policy which was part of the home's resident care and nursing programs. The DRC said it was the expectation in the home that this policy would be followed and that resident's with hypoglycemia would be treated immediately.

The licensee has failed to ensure that the home's Diabetes Management-Hypoglycemia policy, which was part of the nursing services program, was complied with. (630) [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 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, that plan, policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

A) For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "physical abuse" means "the use of physical force by anyone other than a resident that causes physical injury or pain."

O. Reg. 79/10, s. 5 states "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

The home submitted a Critical Incident System (CIS) report to the MOHLTC for an identified resident which alleged staff to resident abuse on a specific date by a staff member. The report stated that one of the Directors of Resident Care (DRC) met with resident and the resident told them the details of the actions of this staff member. The management also interviewed a staff witness who described similar details of the actions of this staff member towards the resident and that they had prior concerns about how this staff member cared for residents. The report stated that a staff members received re-education and disciplinary actions.

During an interview one of the DRCs told Inspector #563 that this incident did meet the definition of abuse as stated in the legislation. The DRC also said that if they been made aware of the concerns with the care provided by this former staff member sooner the incident may have been avoided as the staff member would have been retrained and educated related to the policy that promotes zero tolerance of abuse and neglect.

The Extendicare "Zero Tolerance of Resident Abuse and Neglect Program" policy RC-02-01-01 last updated April 2017, stated "Extendicare is committed to providing a safe and secure environment in which all residents are treated with dignity and respected and protected from all forms of abuse or neglect at all times." The policy identified physical abuse as slapping, rough handling and striking with any object as a form of physical abuse. Neglect was defined as, "failure to provide a resident with treatment, care, services or assistance for health, safety or well-being".

The licensee failed to ensure that residents were protected from abuse by anyone and free from neglect by a specific former staff member in the home. (563)

B) The licensee failed to ensure that residents were protected from neglect by the licensee or staff in the home.

O. Reg. 79/10, s. 5 states "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

The home submitted a CIS to the MOHLTC regarding alleged neglect of an identified resident on a specific date. The report indicated the home completed an investigation and a staff member received disciplinary actions due to specific types of care that were not provided to the resident.

The clinical record for the resident was reviewed by inspector #740 and #630 and the progress notes for specific dates showed the care that the resident required, the details of the incident on the specific date and specific concerns identified through assessments related to the resident after the incident. The plan of care showed that the resident required specific types of care from staff.

The home's investigation documentation was reviewed by Inspector #740 and included statements from staff about the incident, a "disciplinary suspension" letter to an identified staff member and a memo to staff which indicated there was a "serious and concerning incident involving a resident" and that "although the incident was not intentional and fortunately the resident was not harmed the investigation uncovered some safety gaps (there was potential for resident to suffer harm)."

During an interview one of the DRCs told Inspector #740 that they had been directly involved in investigating this incident. The DRC said that as part of the investigation they reviewed the cameras and interviewed staff. The DRC said based on their investigation they provided discipline and re-education to staff and were implementing changes regarding procedures when residents were relocated to another room in the home. The DRC said that the investigation had been inconclusive regarding whether or not neglect had occurred as they did not know for sure how long the resident had been without receiving the care they required. The DRC acknowledged that the care was not provided as needed by this resident on a specific shift and that it was the expectation that

residents would receive their care as per the plan of care.

Based on the record reviews and interview this resident was not provided with the care or assistance required for their safety or well-being during the evening shift on a specific shift due to a pattern of inaction during that shift. (740)(630) [s. 19. (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 to ensure all residents are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #3: 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 has failed to ensure that the home's written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

The home submitted a Critical Incident Report (CIS) to the Ministry of Health and Long-Term Care (MOHLTC) which documented an alleged incident of staff to resident abuse to an identified resident by a specific staff member.

Section 2(1) of Ontario Regulation 79/10 defines verbal abuse as "any form of verbal communication of a belittling or degrading nature which may diminish the resident's sense of well-being, dignity or self worth made by anyone other than a resident."

During interviews with specific staff members they reported to Inspector #731 that the home had a zero tolerance policy for abuse and neglect that they would immediately report incidents to either the registered staff member on duty or management within the home. They stated they had training on the home's zero tolerance prevention of abuse and neglect policy annually. The staff said they had concerns with the behaviour of this identified staff member prior to this incident but had not reported it.

The home's policy RC-02-01-02 titled "Zero Tolerance of Resident Abuse and Neglect Program", which was last revised April 2017, stated "Any employee or person who becomes aware of an alleged, suspected or witnessed resident incident of abuse or neglect will report it immediately to the Administrator/designate/reporting manager or if unavailable, to the most senior Supervisor on shift at that time."

A review of the home's investigation notes identified that staff stated that residents may have felt threatened by the way this staff member spoke to them at times and that they thought this staff member was verbally abusive. The home's investigation notes identified that the staff member involved had received disciplinary actions from the home. The home's investigation notes indicated that all staff members involved in the incident were given a verbal warning and provided re-education on the home's Zero Tolerance of Resident Abuse and Neglect policy.

During an interview with one of the DRCs they told Inspector #731 that they had interviewed several staff who confirmed their concerns of this staff member's tone and approach when speaking with residents and the approach was abusive in nature at times and they felt uncomfortable with this. The DRC said that all staff members involved in the incident were given a verbal warning and provided re-education on the home's Zero Tolerance of Resident Abuse and Neglect policy. The DRC indicated that they felt this incident could have been prevented had staff come to management sooner with concerns.

The licensee has failed to ensure that the home's written policy that promoted zero tolerance of abuse and neglect of residents was complied with. (731) [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 to ensure that, without in any way restricting the generality of the duty provided for in section 19, the written policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

Issued on this 17th day of January, 2019

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

Original report signed by the inspector.