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
Dec 19, 2017	2017_668543_0012	026454-17	Resident Quality Inspection

Licensee/Titulaire de permis

Schlegel Villages Inc
325 Max Becker Drive Suite 201 KITCHENER ON N2E 4H5

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

COLEMAN CARE CENTRE
140 CUNDLES ROAD WEST BARRIE ON L4N 9X8

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

TIFFANY BOUCHER (543), LOVIRIZA CALUZA (687), NATASHA MILLETTE (686), SYLVIE BYRNES (627)

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): December 4-9, 2017

Additional intakes/logs inspected during this Resident Quality Inspection (RQI) include:

Two follow-up intakes from inspection report #2017_168202_0001; one regarding compliance order #001, related to Falls Prevention and Management, and one regarding compliance order #002, related to Plan of Care,

Three complaints; all related to the Prevention of Abuse, were submitted to the Director and,

Nine critical incident reports; two were related to Falls Prevention and seven related to abuse, were submitted to the Director.

Throughout the inspection, the Inspectors directly observed the delivery of care and services to residents in all home areas, reviewed resident health care records and various home policies and procedures.

During the course of the inspection, the inspector(s) spoke with the Administrator/General Manager, Director of Nursing Care (DNC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Registered Dietitian (RD), Kinesiologist, Neighbourhood Coordinators, Physiotherapy Assistant, Resident Assessment Instrument (RAI) Coordinator, Recreational staff, Housekeeping staff, residents and family members.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 49. (3)	CO #002	2017_168202_0001	543
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2017_168202_0001	543

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. 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 policy that promotes zero tolerance of abuse

and neglect of residents was complied with.

According to the Long-Term Care Homes Act (LTCHA), 2007, and Ontario Regulations (O. Reg.) 79/10, verbal abuse means any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature where the resident’s sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

During an interview with Inspector #543, resident #002 indicated that PSW #120 had provided them with care and spoke to them in an inappropriate manner. Resident #002 had indicated that they asked PSW #120 what they had done to them to cause the verbal response.

The home submitted a critical incident (CI) report to the Director on a date in 2017. According to the CI report, PSW #120 and #125 were assisting resident #002 after providing care, and PSW #120 was verbally inappropriate.

Inspector #543 reviewed the home's investigation notes related to the incident that occurred between resident #002 and PSW #120 and #125. The notes indicated that resident #002 verified that PSW #120 had been verbally inappropriate with them. An additional note, of a meeting held between the Administrator, the DNC and PSW #120 identifying that the PSW acknowledged being verbally inappropriate with resident #002.

A review of the home's "Prevention of Abuse and Neglect" policy identified that the home has zero tolerance to abuse of any kind. The zero tolerance for resident abuse and neglect would be enforced and reported as per the mandatory reporting obligations of the Long-Term Care Act. All team members are required to report any suspicions, incidents, or allegations of neglect and/or abuse immediately to any supervisor or any member of the leadership team for further investigation.

Inspector #543 interviewed the Administrator who indicated that PSW #120 and #125 had not followed the home’s Prevention of Abuse and Neglect policy. PSW #120 by way of inappropriately speaking to the resident which constituted verbal abuse and PSW #125 for not immediately reporting the incident to a supervisor. [s. 20. (1)]

2. A CI report was submitted to the Director on a date in 2017, that identified alleged staff to resident verbal abuse. According the CI report, PSW #137 had witnessed PSW #138 to be verbally abusive towards resident #012 on a date in 2017.

Inspector #686 reviewed the home's investigation notes which identified that PSW #137 heard PSW #138 speaking inappropriately toward resident #012. While assisting the resident during an evening shift, PSW #137 again observed PSW #138 speak in an inappropriate manner towards resident #012.

Inspector #683 interviewed PSW #118 who indicated that the home's policy was to report suspected abuse immediately.

Inspector #686 interviewed PSW #137 who indicated that they were unsure of the home's policy to report suspected abuse but they believed it was right away.

A review of the home's Prevention of Abuse and Neglect policy identified that the home has zero tolerance to abuse of any kind. The zero tolerance for resident abuse and neglect would be enforced and reported as per the mandatory reporting obligations of the Long-Term Care Act. All team members are required to report any suspicions, incidents, or allegations of neglect and/or abuse immediately to any supervisor or any member of the leadership team for further investigation.

Inspector #686 interviewed the DNC who indicated that PSW #137 reported the verbally inappropriate incident to them the following morning. The DNC acknowledged that the home's policy was to report abuse immediately and that PSW #137 did not follow the home's policy. [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 the policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program.

On December 4, 2017, Inspector #543 observed in a resident's room a denture cup on the back of the toilet reservoir.

On December 8, 2017, Inspector #627 observed the following in various resident rooms in different home areas:

- a K basin was on the floor, under the shelf below the sink, a Catheter bag with 25 millimeters (ml) of urine, was labelled, and hanging from a towel rack, a dirty urine specimen collector on the shelf below the sink.
- a dirty urinal was on the toilet reservoir beside a labelled denture cup, a drinking cup was on top of the toilet reservoir.
- a labelled denture cup and a urinal were on the toilet reservoir.

On December 9, 2017, during a tour of the home, Inspector #627 and #543 observed the following in various resident rooms in different home areas:

- a dirty urine specimen collector with dried urine was on the white shelf below the sink.
- a labelled denture cup and a urinal were on the toilet reservoir.
- an unlabeled denture cup was on top of the toilet reservoir.

The home's policy titled "Sanitization/Risk Management", a component of the home's Infection Prevention and Control Program, indicated to "wash basin, cups, urinals, bedpans using the appropriate dishwasher cycle. If no dishwasher was available, a thorough cleaning with soap and water will be done by the PSW".

Inspector #627 interviewed PSW #134 who stated that resident #020 had a urinary continence device, that was to be rinsed and cleaned. The urinary continence device was to be stored in a clear container under the sink, along with alcohol swabs and other

urinary continence device products. The PSW further stated that soiled urine specimen collectors should not be kept in the resident’s bathroom; they were to be cleaned and stored in the soiled utility room.

Inspector #627 interviewed PSW #133 who stated that all denture cups were to be labelled and stored in the resident’s basket which was kept on top of their cupboard. Urinary continence devices were to be kept at the resident’s bedside during the day and were replaced and sanitized in the soiled utility room during the night shift.

Inspector #627 interviewed RPN #135 who stated that used urinary continence devices should not be hung on towel racks. They were to be emptied, sanitized and stored in a safe place, basins were to be stored on the shelf below the sink, not on the floor, hats were to be brought to the dirty utility room and that this was an infection control issue.

Inspector #627 Interviewed Neighborhood Coordinator #117 who stated that nothing was to be left on the floor; urinary continence devices were kept at the bedside, urinary continence devices were to be emptied using a urine specimen collector, sanitized and stored in the clear container, which was kept under the sink. Denture cups were to be labelled and placed in the resident's basket which was kept on top of the cupboard. Used urine specimen collectors were to be returned to the dirty utility room after usage . They acknowledged that this was an infection control issue.

Inspector #627 interviewed RN #102 the infection prevention and control (IPAC) lead who stated that nothing was to be left on the resident's floor. Residents’ urinary continence devices were to be kept at their bedside and replaced every night. The urine specimen collectors used to empty urinary continence devices should only be used once and returned to the soiled utility room for sanitizing. They further stated that used urinary continence devices were not to be hung on the towel racks; they were to be emptied, sanitized and stored in the clear container under the sink. The denture cups were to be labelled and stored in the resident’s basket which was stored in the resident’s cupboard. They acknowledged that this was an infection control issue. [s. 229. (4)]

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 staff participate in the implementation of the home's Infection Prevention and Control Program, specifically the Sanitization/Risk Management policy, to be implemented voluntarily.

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. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was 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 changed or care set out in the plan was no longer necessary.

In an interview with Inspector #543, RN #102 indicated that resident #001 had an area of impaired skin integrity.

A review of resident #001's most recent care plan, related to lack of skin integrity actual/potential wound care was completed. The care plan indicated, but was not limited to, completing skin assessments at least twice weekly, keeping skin clean and referring skin concerns to registered staff.

On December 7, 2017, Inspector #687 observed resident #001 with an intervention applied to the area of impaired skin integrity, which was not listed within their care plan.

Inspector #687 interviewed PSW #123, who identified that resident #001 had an area of impaired skin integrity and the intervention was applied to prevent their skin from deteriorating.

Inspector #687 interviewed RPN #121, who indicated that any impaired skin integrity interventions would be identified in the resident’s care plan.

Inspector #687 interviewed RPN #122, who indicated that resident #001 required the applied intervention on at all times to prevent their skin from deteriorating.

Inspector #687 interviewed RN #102 who identified that resident #001 had an area of impaired skin integrity. The RN further indicated that the physician ordered the intervention to be applied at all times.

The home’s "Skin and Wound Program (04-78)" indicated that the registered staff participated in the development of the plan of care to reduce identified risks. The policy also identified that registered staff developed interventions that addressed the risk items identified and implemented in the inter-professional plan of care to prevent impaired skin integrity.

Inspector #687 interviewed the Administrator who identified that resident #001 required the applied intervention related to their area of impaired skin integrity. The Administrator verified that the intervention was not updated in the care plan. [s. 6. (10) (b)]

2. A CI report, was submitted to the Director on a date in 2017, related to resident #017 falling and sustaining an injury.

Inspector #686 reviewed resident #017’s current care plan which had specific interventions implemented related to falls.

Inspector #686 observed resident #017 on six separate occasions and each time the interventions identified in the resident’s care plan were not implemented accordingly.

Inspector #686 interviewed RPN #119 who verified that resident #017’s identified specific falls related interventions. The Inspector and the RPN observed the resident, and verified that a specific intervention was not being implemented. RPN #119 verified that another specific intervention identified in the care plan was no longer necessary.

Inspector #686 interviewed the RAI Coordinator, who verified that one of the specific falls related interventions should have been removed to address the resident's current care needs. [s. 6. (10) (b)]

3. A CI report, was submitted to the Director on a date in 2017, related to resident #001 and to a fall that resulted in an injury.

Inspector #686 reviewed resident #001's current care plan for fall prevention which identified a specific fall related intervention, however under the locomotion focus a different intervention was identified. The care plan also provided specific directions related to the resident's bed rails.

Inspector #686 observed resident #001 in their bed on December 6, 2017, with the bed rails contrary to what was indicated in the care plan. On three other observations the Inspector observed resident #001's locomotion intervention contrary to what was indicated in the care plan.

Inspector #686 interviewed RPN #122, who verified that resident #001's care plan identified specific fall related interventions and verified that the resident's care plan had not been updated to reflect that the resident's current needs had changed related to falls.

Inspector #686 interviewed RAI Coordinator #112, who acknowledged that the interventions related to falls, should have been updated to address the resident's current care needs. [s. 6. (10) (b)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was equipped with a resident-staff communication system that can be easily seen, accessed and used by residents, staff and visitors at all times.

During observations on December 5, 2017, Inspector #627 noted that resident #003 was sitting by their bed. The call bell was attached to the blanket on the other side of the bed out of the resident's reach.

On December 5, 2017, Inspector #627 observed resident #015 sitting in a chair, their call bell was clipped to a cushion on their bed, out of the resident's reach.

On December 5, 2017, Inspector #627 observed that the call bell in resident #006's bathroom was wrapped around the transfer bar. The Inspector was unable to ring the bell.

During an observation on December 6, 2017, Inspector #686 observed resident #001 lying in bed. Their call bell was observed to be wrapped around the outside of the lower bar of the bed rail, below the top of the mattress, out of the resident's reach.

During separate interviews with PSW #106, #127, and Neighborhood Coordinator #117 they each verified that call bells should be within the residents' reach and easily accessible. Neighborhood Coordinator #117 further stated that the call bell should not have been wrapped around the transfer bar as resident #006 could not have rang it to call for assistance.

During an interview with the Inspector #627, Neighborhood Coordinator #117 indicated that the call bells were to always be within reach of the resident's hands. When residents were taken out of their bed, the call should be within reach of the resident. [s. 17. (1) (a)]

WN #5: 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 that any of the following had occurred or may occur shall immediately report the suspicion and the information upon which it was based to the Director.

A complaint was submitted to the Director, regarding improper care and a specific form of alleged abuse of resident #010.

Inspector #627 reviewed the complaint, which indicated that resident #010, was observed by the complainant on a unspecified date, to have a large bruise on a specific part of their body, as well as another bruise of unknown origin.

Inspector #627 reviewed a picture of the bruising submitted by the complainant and observed that the resident had a yellow, blue bruise to a specific part of their body and another bruise of unknown origin.

During a telephone interview with Inspector #627, the complainant indicated that they had spoken with management and had showed them the picture of the bruising. The complainant indicated to the Inspector that they had felt this was a specific form of abuse.

Inspector #627 reviewed a "Resident/Family Concerns Response Form", dated on a date

in 2016, which indicated that the resident had showed the complainant a bruise to a specific part of their body. The complainant was concerned that there had been bruises to that specific part of the resident's body in the past. The complainant was also concerned why they had not been notified of the bruises. Another "Resident/Family Concerns Response Form", dated a different date in 2016, identified that the complainant questioned a specific form of abuse during a follow up conversation.

Inspector #627 reviewed the home's policy titled "Prevention of Abuse and Neglect" last reviewed November 20, 2016, which indicated that a possible indicator of a specific form of abuse were bruises to specific parts of the resident's body.

According to the home's "Mandatory Reporting" policy, team members are obligated to report certain specific matters immediately to a manager so that the issue can be reported to the MOHLTC as is required under the Long-Term Care Homes Act, 2007. The policy identified that any team member who had reasonable grounds to suspect that abuse has occurred, or will occur, shall immediately report the suspicion and the information which it is based to a manager or charge nurse. The manager or charge nurse will immediately contact the general manager who would immediately initiate the on-line Mandatory Critical Incident System.

During separate interviews with the Administrator and the DNC, they indicated that they had investigated the bruising on the resident's specific body parts and had not felt that the bruising was caused by a specific form of abuse and therefore had not reported the concern to the Director. [s. 24. (1)]

Issued on this 20th day of December, 2017

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

Original report signed by the inspector.