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
Aug 14, 2018	2018_601532_0012	015271-18	Complaint

Licensee/Titulaire de permis

Collingwood Nursing Home Limited
250 Campbell Street COLLINGWOOD ON L9Y 4J9

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

Collingwood Nursing Home
250 Campbell Street COLLINGWOOD ON L9Y 4J9

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

NUZHAT UDDIN (532)

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): July 4, 5, 6, 10,11,12, 2018.

Complaint was received related to fall prevention, resident abuse and misappropriation of drugs.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Associate Director of Care, Nurse Practitioner, Manager for Convalescent Care, Environmental Service staff, Local Health Integration Network (LHIN) Director, LHIN Placement Coordinators, Baycrest Social Worker, Registered Nurses, Registered Practical Nurses, Personal Support Workers, and residents.

Inspector also toured the resident home areas, observed resident care provision; resident/staff interaction, medication administration, medication storage areas, reviewed relevant resident's clinical records, relevant policies and procedures, as well as notes pertaining to the inspection.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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 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 the any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

In accordance with Ontario Regulation 79/10 s. 136. (2) the licensee was required to ensure that the drug destruction and disposal policy must also provide for the following: that drugs that were to be destroyed and disposed of shall be stored safely and securely within the home, separate from drugs that were available for administration to a resident, until the destruction and disposal occurred.

Specifically, staff did not comply with the licensee's policy called "Destruction and Disposal of Surplus Drugs 3-009", which was part of the licensee's medication management system program.

Anonymous complaint was received related to fall prevention, resident abuse and misappropriation of drugs.

The Medication Administration Record (MAR) for an identified resident indicated that a controlled drug was discontinued.

During medication administration observation it was noted that the discontinued drug card was stored with drugs that were available for administration.

The DOC indicated that the controlled substance for destruction should be counted by two registered staff and taken to the drop box for destruction. Controlled substances should not be stored in the locked narcotic box within the medication cart with other controlled substances. Both ADOC and DOC acknowledged that the drug should have been removed and stored in a double locked storage separate from any controlled substance that was available for administration.

The licensee has failed to ensure that home's policy called Destruction and Disposal of Surplus Drugs 3-009 put in place was complied with. [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 the drug destruction and disposal policy must also provide for that drugs that were to be destroyed and disposed of shall be stored safely and securely within the home, separate from drugs that are available for administration to a resident, until the destruction and disposal occur is complied with, to be implemented voluntarily.

WN #2: 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 resident-staff communication and response system be easily seen, accessed and used by residents, staff and visitors at all times.

An identified resident in an interview shared that on a specified date they rang the call

bell to request medication. They waited for an hour and when no one responded, they walked to the nursing station to request pain medication. An identified staff told them that the pager did not go off. The staff returned the resident to their room and checked the call bell and noted that it was not working. A call bell was shared between the two residents until following morning.

The Administrator explained that maintenance staff look after the call bell system. The Administrator indicated that the resident home area had a call bell system that was completely wireless and when a resident rang the bell it went to the pager. They said that the system was available in every area accessible by residents. They said that maintenance staff maintain the call bell system and the Manager ordered the parts.

Maintenance staff shared that they look after the malfunction and battery replacement related to the call bell. They indicated that they were not certain how long the batteries lasted but there was a warning that displayed on the computer system. The call bell on the resident home area was a maintenance free system. They said that it gave a warning ahead of time when the battery was low. Maintenance staff indicated that this was the first time that a battery was dead and the call bell did not function and there was no warning sign. Maintenance staff reported that there was a computer system that indicated if the battery was low and since it was a good system there was no need to do audits. They also explained that residents using the call bell was an audit to ensure that the communication and response system was working. They explained that if it was not working then either the resident or the PSW would contact the maintenance staff through Maintenance Care and fill out the appropriate requisition. They stated that they did not call the company to find out why the system malfunctioned since it was the first time. Maintenance staff indicated that as a preventative maintenance they could change the battery every three months. They did acknowledged that the system was dependent on staff to check and notify maintenance when the battery was low.

The manager showed the computer screen that was situated behind their desk on a filing cabinet. They said that the message on the screen would flash alerts and that was how they knew if something was malfunctioning or the battery was low. The manager said they could not remember any messages for that weekend when the identified resident's call bell was not working.

The administrator indicated that they reviewed their nurse call system to see if there was additional electronic documentation showing battery warnings, there was none. They indicated that the home also contacted the maker of the call system. They informed the

home that there was no reporting available to show low battery for the pendants. The Administrator stated that as a follow up to this, the home started daily checks on all of the pendants and maintenance staff were performing monthly audits for the pendants and also changing the batteries on a monthly basis.

The licensee has failed to ensure that the resident-staff communication and response system be easily seen, accessed and used by residents, staff and visitors at all times. [s. 17. (1) (a)]

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 resident-staff communication and response system is easily seen, accessed and used by residents, staff and visitors at all times, to be implemented voluntarily.

WN #3: 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 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 was based to the Director: 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.

Ontario Regulation 79/10 defines emotional abuse as "any threatening, insulting, intimidating, or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

An anonymous complaint was received related to resident abuse.

An identified resident shared that they rang the call bell to request for medication and waited and no one responded to the call bell. They said that they walked over to the nursing station. They saw two identified staff sitting at the nurse's desk. Resident told both staff that they had rung the call bell and no one responded. Resident indicated that one of the identified staff became argumentative with the resident. The resident alleged that the identified staff called them a "liar". The resident acknowledged that they were upset by the comment made by the identified staff. The identified resident admitted that they were frustrated, angry and in pain and waited for an hour for someone to respond and instead the identified staff was confrontational. The resident stated that they reported the incident to the manager after they had returned from the weekend.

The manager said that the resident came to them and alleged that the identified PSW called them a "liar" and the resident was upset over the situation. The manager went back to the resident to ask if they wanted a Client Service Form completed and the resident said that they did not and therefore, they did not document or report the allegations to the Director.

The identified resident was asked if the manager had reported the results of the investigation to them and whether they asked the resident if they wanted to complete a form. The resident did not recall the manager coming and discussing the results of the investigation or asking them if they wanted a form completed.

The manager acknowledged that the report to the Director was not made after becoming aware of the alleged abuse.

The licensee failed to ensure that a person who had 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 was based to the Director 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. [s. 24. (1) 2.]

Issued on this 14th day of August, 2018

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

Original report signed by the inspector.