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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## Public Copy/Copie du public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Mar 11, 2019 | 2019_781729_0003 | 009015-18, 009043-18, 013154-18, 016937-18, 019231-18, 019232-18, 021663-18, 024908-18, 025890-18, 031416-18, 031711-18, 000412-19, 001105-19, 003827-19 | Follow up |

### 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

KIM BYBERG (729), SHARON PERRY (155)

### Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Follow up inspection.**

**This inspection was conducted on the following date(s): February 7, 8, 11, 13, 14, 15, 19, 20, 21, 22, 26, 27, 28, and March 1, 2019.**

**The following intakes were completed in this follow up inspection;**

**-Log #019231-18, Follow up to compliance order #001 related to polices not complied for falls, emergency care and disposal of controlled substances**
**-Log #019232-18, Follow up to compliance order #002 related to initial and weekly skin assessments;**
**-Log #000412-19, Log #024908-18, Log #013154-18, Log #009015-18, were all related to injury that resulted in the transfer to hospital with significant change in status;**
**-Log #009043-18, Log #021663-18, Log #025890-18, Log #031711-18, were all related to allegations of staff to resident abuse;**
**-Log #016937-18, Log #031416-18, were all related to a missing controlled substance;**
**-Log #001105-19, related to plan of care; and Log #003827-19, related to medication administration error.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), Nursing Agencies, Residents, family members, and Nurse Practitioner (NP)**

**The inspector(s) also completed observations for staff to resident interactions; medication administration practices, general hygiene and grooming. A review of relevant records including but not limited to assessments, care plan, physician's orders, Point of Care, staff schedules and documentation.**

**The following Inspection Protocols were used during this inspection:**

**Falls Prevention**
**Infection Prevention and Control**
**Medication**
**Pain**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Skin and Wound Care**
**Training and Orientation**

**During the course of this inspection, Non-Compliances were issued.**
**7 WN(s)**
**6 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. 50. (2) | CO #002 | 2018_737640_0011 | 729 |
| O.Reg 79/10 s. 8. (1) | CO #001 | 2018_737640_0011 | 155 |

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,**
**(a) the planned care for the resident; 2007, c. 8, s. 6 (1).**
**(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).**
**(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).**

**Findings/Faits saillants :**

1. The Licensee has failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

A Critical Incident was submitted to the Ministry of Health and Long Term Care (MOHLTC) related to resident #012 not being provided a specified intervention for continence care requiring additional care to be provided by staff.

Resident #012 shared that they were upset with a PSW staff member as they felt that the PSW would rather they be incontinent in their pyjamas then provide the specific intervention. They shared that it depended on which staff were working as to whether they were provided with the continence care they preferred.

A review of resident #012's plan of care stated that the resident had a scheduled toileting plan. The plan of care did not include resident #012's preference for the specified intervention for continence care on night shift.

The incontinence task on POC indicated that resident #012 would have documentation completed on each shift, specifically days, evenings and nights that would state if the resident was continent or incontinent, and the level of assistance required for toileting. The POC did not indicate specified times that resident #012 was to be taken to the toilet.

PSW #117 shared that staff review the kardex and POC to determine what interventions each resident required.

The DOC reviewed the care plan for resident #012 and indicated they did not have a toileting routine specified, and their preference for continence care at night was not identified.

The licensee has failed to ensure that the plan of care provided interventions and resident preferences related to resident #012's preferred toileting preferences, and a clear toileting plan. [s. 6. (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 plan of care provides interventions that accurately reflect the residents needs and preferences, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.**

**Findings/Faits saillants :**

1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A CI was submitted to the MOHLTC that reported resident #013 had been injured during resident care.

A review of the progress note documentation for resident #013 showed that the resident had areas of altered skin integrity resulting from the identified incident.

Resident #013's plan of care for activities of daily living showed that they required staff assistance for bed mobility.

PSW #122 shared that staff should use safe transferring techniques when working with the resident.

The DOC shared that during the homes internal investigation, they determined, that during the night staff did not use safe positioning techniques during the care of resident #013. [s. 36.]

***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 safe transferring and positioning devices and techniques are used when assisting residents, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management**

**Specifically failed to comply with the following:**

**s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A call was placed to the MOHLTC action line with concerns related to resident #001's care. The complainant shared that the resident had a fall and when they visited the resident, they seemed in pain and could not mobilize. The complainant insisted that resident #001 be taken to the hospital for assessment and to have their pain controlled.

A review of resident #001's electronic medication record (eMAR) showed that on a number of occasions the resident required analgesics to manage their pain. On all of the occasions the resident's pain was not assessed using a clinically appropriate assessment instrument.

RPN #106 and the DOC shared that pain assessments were to be completed on a quarterly basis, for any new pain, when a resident had a fall, and any change in pain medication. RPN #106 shared that the pain assessments were done through eMAR whenever a pain medication was administered, and that they were unable to locate pain assessments for the identified dates. The DOC stated that resident #001 should have had pain assessments completed.

The licensee failed to ensure that when resident #001 had a change in pain medication as their pain was not relieved by initial interventions, that they were assessed using a clinically appropriate assessment instrument. [s. 52. (2)]

***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 when a resident requires a pain assessment, that the assessment is completed using a clinically appropriate assessment instrument, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training**

**Specifically failed to comply with the following:**

**s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:**
**1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).**
**2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).**
**3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).**
**4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).**
**5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).**
**6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).**
**7. Fire prevention and safety. 2007, c. 8, s. 76. (2).**
**8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).**
**9. Infection prevention and control. 2007, c. 8, s. 76. (2).**
**10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).**
**11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).**

**Findings/Faits saillants :**

1. The Licensee failed to ensure that no person performed their responsibilities before receiving training.

A CI was submitted to the MOHLTC that reported resident #013 had a new area of altered skin integrity identified on a specified date.

The home completed an investigation and determined that there were two agency staff providing care for resident #013 the night before the altered skin integrity was identified.

The manager of the nursing agency shared that they were aware of the altered skin integrity found on resident #013 after care was provided by two of their staff. The manager from the agency shared that they did not provide their staff with orientation, and that it was the home's responsibility. They shared that their staff were to be provided one day of orientation at the home before they were to start their shift.

The DOC shared that agency staff were to be provided orientation in the home and they were to complete an agency staff orientation checklist. The DOC was not able to provide any orientation documents that ensured the two staff involved in the incident had received training. [s. 76. (2)]

***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 all staff, including any agency staff have completed training and orientation before performing their responsibilities in the home. The training must include:***
***1. The Residents' Bill of Rights.***
***2. The long-term care home's mission statement.***
***3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.***
***4. The duty under section 24 to make mandatory reports.***
***5. The protections afforded by section 26.***
***6. The long-term care home's policy to minimize the restraining of residents. Note: On a day to be named by proclamation of the Lieutenant Governor, paragraph 6 of subsection 76 (2) of the Act is amended by striking out "restraining" and substituting "restraining and confining". (See: 2017, c. 25, Sched. 5, s. 18 (1))***
***7. Fire prevention and safety.***
***8. Emergency and evacuation procedures.***
***9. Infection prevention and control.***
***10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.***
***11. Any other areas provided for in the regulations. 2007, c. 8, s. 76 (2)., to be implemented voluntarily.***

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**WN #5: 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 failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

Resident #010 was readmitted to the home with orders that included a specified medication with a sliding scale based on assessment.

A record review revealed that on three occasions RPN #129 administered the incorrect dose of the medication. One month later, a second RPN #128 administered the incorrect dose of the medication. As a result, the physician was called and orders received to assess the resident and call them back before the next dose of the medication.

A further review of the medication administration record and progress notes for resident #010 revealed that on three occasions, when the resident was assessed, RN #111 administered a specified dose of medication.

During an interview with RN #111, they were asked what would be done, and how much medication would be administered if resident #010 was assessed with less than a specified level. RN #111 shared that the order did not say how much medication would be given. RN #111 shared that they would assess specific factors for resident #010 and give the medication accordingly. When asked where the reassessment would be documented they shared that it would be in their progress notes.

During an interview with DOC #101 and Assistant Director of Care (ADOC) #108 they shared that if resident #010 was assessed below a specified level, no medication was to be administered. DOC #101 and ADOC #108 could not find any documented reassessments when RN #111 administered the medication. DOC #101 shared that the way the order for the medication was written was confusing and they had approached the physician to get the order written more clearly but the physician refused. DOC #101 shared that the Nurse Practitioner was approached and the order for the medication was changed and clearly written.

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

***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 any resident is administered medication as specified by the prescriber, to be implemented voluntarily.***

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**WN #6: 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. (5) The licensee shall ensure that on every shift,**
**(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).**

**Findings/Faits saillants :**

1. The Licensee failed to ensure that on every shift the symptoms of infection were recorded and that immediate action was taken as required. O. Reg. 79/10, s. 229 (5)(b)

A call was placed to the MOHLTC action line with concerns related to resident #001's care. In an interview with the complainant they shared that at a specified time, resident #001 was ill with multiple health concerns and spent time in the hospital.

The complainant also shared that resident #001 exhibited symptoms a few days prior to a recent outbreak, and was not improving with care. The complainant shared that only after they notified the DOC, was resident #001 treated with an identified medication, and other interventions were ordered.

A review of the charge nurse report sheet indicated that resident #001 exhibited signs and symptoms of infection, but there was no assessment found in the clinical record. A review of the plan of care did not indicate any assessment of resident #001 to indicate a reason for steps that had been taken.

The DOC documented in the progress notes that the complainant called and was concerned that resident #001 was not doing well. The DOC indicated the resident would

be monitored over the next few days.

After the DOC spoke to the complainant, the nurse practitioner (NP) documented that the nurses were concerned about resident #001's condition. The NP then ordered several interventions.

RPN #106, RN #107, the infection control lead, and the DOC shared that an assessment would include a full set of vital signs, listening to a resident's chest, a chest assessment, monitoring for any shortness of breath and listening to the resident's complaints. They shared that it was the home's process to record symptoms of infection daily and to complete a progress note. RPN #106 was unable to find an assessment or any interventions related to resident #001's status when symptoms were identified prior to the documentation that occurred on the registered staff report sheet. RPN #106, RN #107 and the DOC were unable to locate the results of investigations ordered by the NP, and no further follow up was completed by the home related to these investigations.

The licensee failed to ensure that resident #001 was assessed, the ordered investigations completed, and symptoms were recorded on every shift and that immediate action was taken as part of the infection prevention and control program O. Reg. 79/10, s. 229 (5)(b) [s. 229. (5) (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 all residents are assessed and their symptoms of infection are recorded and immediate action is taken as required, to be implemented voluntarily.***

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**WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act**

**Specifically failed to comply with the following:**

**s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:**
**2. A description of the individuals involved in the incident, including,**
**i. names of all residents involved in the incident,**
**ii. names of any staff members or other persons who were present at or discovered the incident, and**
**iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the report to the Director included names of any staff members or other persons who were present at or discovered an incident of alleged neglect.

A CI report was submitted to the MOHLTC that alleged resident #011 was neglected on an identified night shift.

The report did not include the staff members names that were involved in the incident.

The DOC shared that the CI report did not include the names of the staff members involved in the incident. They shared that they were aware that the reports to the director must include the names of the staff members or other persons who were present at or who discovered the incident. [s. 104. (1) 2.]

**Issued on this 22nd day of March, 2019**

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

**Original report signed by the inspector.**