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 sions 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
May 26, 2017	2017_665551_0011	007618-17	Resident Quality Inspection

Licensee/Titulaire de permis

DUNDAS MANOR LIMITED
533 CLARENCE STREET P.O. BOX 970 WINCHESTER ON K0C 2K0

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

DUNDAS MANOR NURSING HOME
533 CLARENCE STREET P.O. BOX 970 WINCHESTER ON K0C 2K0

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

MEGAN MACPHAIL (551), ANANDRAJ NATARAJAN (573), MELANIE SARRAZIN (592), SUSAN LUI (178)

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): May 8-12 and 15-19, 2017.

The following logs were inspected: 000730-17 (alleged staff to resident abuse), 034119-16 (related to the fall of a resident), 002468-17 (alleged staff to resident abuse), 003598-17 (alleged resident to resident abuse) and 007804-17 (alleged staff to resident abuse).

During the course of the inspection, the inspector(s) spoke with Residents, Family Members, Personal Support Workers (PSWs), Dietary Aides, Registered Nursing Staff, the PSW Support Manager, the Nutritional Manager, the Activity Director, the RAI Co-ordinator, the Assistant Director of Care (ADOC), the Director of Care (DOC) and the Administrator.

During the course of the inspection, the inspector(s) toured residential and non-residential home areas, observed meal services and reviewed health care records and select policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
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.

6 WN(s)
4 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. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the planned menu items are offered and available at each meal.

Inspector #573 observed the lunch meal service in the unit three and four dining room on May 08 and May 11, 2017.

According to the menu, on Monday, May 08, 2017, the planned menu for the puree texture were salmon in dill or lemon asparagus chicken, boiled potato or whipped potato, New England vegetables or creamed corn and ice cream or apricot halves. It was noted by Inspector #573 that pureed salmon, pureed creamed corn and pureed apricot halves menu items were not offered and available for the residents with pureed texture diet.

The Inspector spoke with the Dietary Aide (DA) #104, who indicated that pureed salmon and creamed corn were not available. DA #104 indicated that apple sauce was offered as the alternate dessert choice for pureed apricot halves. Further she indicated that for the pureed texture menu, there was no alternative choice of entree and vegetable as only the pureed chicken and new england blend vegetables were available.

On May 11, 2017, Inspector #573 observed the lunch meal in unit three-four dining room. The planned menu items for the puree texture were twisted potatoes or rice. The inspector noted that pureed rice was not offered and available for the residents on a pureed texture diet. DA #103 indicated to the inspector that pureed rice was not available at the meal service. Further the inspector noted that the menu stated that whole wheat bread is to be offered at all lunch and dinner while the therapeutic menus also stated that pureed bread is offered at meals for the puree menu. During the lunch meal service on May 08 and May 11, 2017, it was observed that bread was not offered to any of the residents in the dining room.

On May 12, 2017, Inspector #573 reviewed the therapeutic diet sheet and production sheet for May 08 and May 11, 2017 in the presence of the Nutritional Manager. The Nutritional Manager indicated that residents are to be offered and to have available the modified texture diet as per the planned menu in the home. Further she indicated residents are to be offered bread at lunch and dinner as per the menu. [s. 71. (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 the planned menu items are offered and available at each meal, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007, 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 written policy to promote zero tolerance of abuse and neglect of residents was complied with.

As per the LTCHA, 2007, s. 20 (2) (e), at a minimum, the policy to promote zero tolerance of abuse and neglect of residents, shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents.

A review of the licensee's policy titled "Prevention of Abuse and Neglect-Resident Abuse Policy" /ADM 4-20, last revised October 25, 2016 indicated under Procedure:

1. Any staff/volunteer witnessing or having knowledge of an alleged/actual act of abuse or becoming aware of one shall immediately report to his/her immediate manager, the charge nurse of the shift, the Director of Care or the Administrator.

5. The Registered Nursing Staff/Director of Care shall document a detailed description of the incident as it is explained to them. The documentation is to outline a description of the incident and physical findings and the care and treatment provided.

6. An investigation shall be commenced immediately. While the investigation is being conducted:

(a) The suspected/accused staff member shall be relieved of their duties with pay and a member of the Union Executive will be notified of this decision.

A Critical Incident Report (CIR) was submitted to the Director related to an incident of alleged staff to resident verbal abuse on a specified date.

The CIR indicated that on a specified date, at a specified time, RPN #115 was walking past the resident lounge and heard yelling. The CIR indicated that upon entering the room, RPN #115 witnessed PSW #116 and resident #020 having a verbal altercation over toileting.

A review of resident #020's health care records was done by Inspector #592. Inspector #592 was unable to locate any documentation relating to the incident.

A review of the home's internal investigation report was done by Inspector #592. The report indicated that the investigation of the incident was initiated the day following the incident, when the DOC became aware. The report further indicated that PSW #116 provided personal care to resident #020 after the incident and completed the scheduled shift.

On May 17, 2017, during an interview with Inspector #592, RPN #115 indicated that she witnessed the incident between resident #020 and PSW #116 but did not document the incident as expected by the home. She further indicated that she did not follow the home's process as she was unsure which steps to take, however she did send an email to the DOC that evening. When the Inspector inquired about the process for the reporting of incidents, RPN #115 indicated that she did not report the incident to the RN who was working at the time of the incident, however she was supposed to. When Inspector #592 inquired about the steps to be taken after witnessing the incident, RPN #115 indicated that no other steps were taken, and that PSW #116 stayed until the end of the shift.

On May 17, 2017, during an interview with the DOC, she indicated to Inspector #592 that the home's expectation is that each time there is an incident of alleged abuse, the registered nursing staff are to document on the resident's record a detailed description of the incident as per the home's policy. She further indicated that any registered nursing member is responsible to start an investigation immediately after becoming aware of an

incident and immediately relieve the staff involved in the incident of their duties, which was not done on this particular incident. The DOC indicated that she was aware that some steps in the home's policy were not followed/implemented for that particular incident, therefore some interventions and follow-up was provided to all staff members. [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 on abuse, specifically related to the investigation process when responding to alleged, suspected or witnessed abuse is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

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 has failed to ensure that when the plan of care is being revised because the care set out in the plan has not been effective, the licensee failed to ensure that different approaches were considered in the revision of the care plan.

A Critical Incident Report (CIR) was submitted to the Director by the home, and indicated that on a specified date, resident #046 was found on the floor in his/her bathroom. The CIR further indicated that resident #046 was sent to the hospital for an assessment and returned with a specific diagnosis that resulted in a significant change in his/her condition.

Inspector #573 reviewed resident #046's health care record (progress notes) for a specific time period, which indicated that resident #046 had multiple falls during this time frame. Upon review of the resident's post fall assessments for specified dates, it was documented that the falls were all un-witnessed, and occurred in the resident's bathroom.

Inspector #573 reviewed resident #046's written plan of care in place at the time of incident, specific to falls and toileting, and it was noted that specific interventions were listed.

On May 18, 2017, the Inspector spoke with RPN #100, who indicated that at the time of the fall incident on a specified date, the resident was independent for toileting. She indicated that the resident was encouraged to call/ ask for staff assistance when he/she required assistance for toileting.

During the interview with RPN #100, she indicated that after the fall on the specified date, changes were made to the resident's plan of care to include that the resident required one person constant supervision and physical assist for toileting.

On May 18, 2017, Inspector #573 reviewed resident #046's written plan of care/ post fall assessment related to the resident's falls in the presence of the DOC. The DOC indicated that at the time of fall incident on the specified date, other than the fall preventions interventions identified in the resident's written plan of care, other different approaches were not considered in mitigating resident #046 falls.

[log 034119-16] [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 when resident #046's plan of care related to falls is being revised because the care set out in the plan has not been effective, different approaches are considered, to be implemented voluntarily.

WN #4: 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 all staff participate in the implementation of the Hand Hygiene Program.

The home's infection prevention and control program policy IC-5-10 and IC-7-50 includes a detailed Hand Hygiene Program for all staff under the Routine Practices. Policy IC -5-10 (Hand Hygiene training) described that hand hygiene must be performed following the four moments of hand hygiene. In IC-7-50 (Routine Precautions) under Hand hygiene in bullet 3 and 8, it clearly indicates Hand hygiene is performed using alcohol-based hand rub or soap and water:
- Before preparing, handing and serving food
- After contact with items in the resident's environment

On May 08, 2017, during the lunch meal service in the unit three and four dining room, Inspector #573 observed DA #103 removing residents' dirty dishes, clearing the remaining food in the garbage bin and placing the dirty dishes in a clearing tray. After placing the dirty dishes in a clearing tray, it was observed that the staff member was rubbing his hands without alcohol based hand rub and returned to serve a dessert cup to resident #033. Further DA #103 proceeded to the servery where he plated and served food for resident #044 and then continued to clear several dirty dishes. At no time was

hand washing/ hygiene was observed.

During the same lunch service, Inspector #573 observed DA #104 removing several residents' dirty dishes, clearing the remaining food in the garbage bin and placing the dirty dishes in a clearing tray. After placing the dirty dishes in a clearing tray, it was observed that the staff member was rubbing her fingers on her apron and returned to serve dessert cup to several residents. At no time hand was washing/ hygiene was observed.

On May 11, 2017, during lunch meal service, Inspector #573 observed DA #105 clearing dirty dishes from residents' tables, and after placing the dirty dishes in a clearing tray, it was observed that the staff member wiped her hand on her apron and went to serve a hot beverage to resident #045. At no time was hand washing/ hygiene was observed.

Inspector #573 observed a hand washing sink and alcohol based hand hygiene dispensers in the dining room. During the lunch meal service not all staff members were observed to participate in the home's infection prevention and control program, specifically with the hand hygiene and hand washing. The Inspector spoke with the DOC/Infection Prevention and Control lead who indicated that all staff were expected to follow hand hygiene and to hand wash as per the policy. [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 hand hygiene program, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007, 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 abuse of a resident by anyone has occurred or may occur immediately reported the suspicion and the information upon which it was based to the Director.

According to O.Reg.79/10, s.2.(1) verbal abuse is defined as:

(a) any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

A Critical Incident Report (CIR) was submitted to the Director on a specified date regarding an allegation of verbal abuse, involving a staff member and a resident.

A review of the CIR was completed by Inspector #592.

The CIR indicated that on a specified date, at a specified time, RPN #115 was walking past the resident lounge and heard yelling. The CIR indicated that upon entering the room, RPN #115 witnessed PSW #116 and resident #020 having a verbal altercation over toileting.

The CIR indicated that RPN #115 sent an email to the Director of Care that evening

informing her of the incident between the staff member and the resident. The CIR further indicated that the Director of Care responded to RPN #115 the following day asking for clarification and questioning RPN #115 on the incident and informed/reminded the RPN of MOHLTC notification process concerning verbal abuse.

On May 17, 2017, in an interview with RPN #115 who witnessed the incident, she indicated to the Inspector that each registered staff member is responsible to immediately inform the MOHLTC after becoming aware of an alleged incident of abuse. She further indicated that she was the registered staff responsible for resident #020 on that shift, and that after witnessing the incident she did not contact the MOHLTC as was the home's expectation. She further indicated that she did not report the incident to the RN present at the time of the incident but did send an email for clarification to her DOC.

On May 17, 2017, in an interview with the DOC, she indicated to Inspector #592 that each registered staff member is accountable/responsible to notify the MOHTLC immediately after becoming aware of an incident of alleged abuse. She further indicated that the registered staff should contact the MOHTLC immediately by using the after hour line and then phone the Manager on call which was not done in that particular incident.

[log 002468-17] [s. 24. (1)]

WN #6: The Licensee has failed to comply with LTCHA, 2007, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. 1. The licensee has failed to ensure that the written policy to minimize the restraining of residents, is complied with.

A review of the home’s restraints policy, NURS 5-20 titled “Least Restraint Policy”, revised date June 2015, under procedure for RESTRAINT PROCESS AND CONSENT FORM indicated that - “The Registered staff member obtains written consent from the resident and or POA/ SDM. At this time, the registered staff member is to explain the risks associated with restraint use.
- The signed consent is witnessed by the Registered Staff member
- The resident and or POA/ SDM will review this consent annually (or most often as indicated) and re- sign consent at Annual Care Conferences”.

A review of resident #022’s health care record indicated that a physician's order was obtained for the use of a specific restraint. The use of the specific restraint was also included in resident #022’s plan of care. However, there was no documentation found in the resident's health care record regarding a written signed consent from the resident or the Substitute Decision-Maker (SDM) for the use of the specific restraint.

On May 16, 2017, during an interview with the home’s DOC, she indicated to Inspector #573 that before any type of restraint is initiated, the registered nursing staff would obtain a consent from the resident or the Substitute Decision-Maker (SDM). After reviewing resident #022’s health care record with the inspector, the DOC indicated that resident #022’s SDM was made aware, and a verbal consent was obtained on a specified date, regarding the use of a specific restraint. Further she indicated that to date a written signed consent from the resident’s SDM for the use of the specific restraint was not obtained, as per the home’s Least Restraint policy. [s. 29. (1) (b)]

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Issued on this 26th day of May, 2017

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

Original report signed by the inspector.