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
Jul 9, 2018	2018_505103_0018	007895-18	Resident Quality Inspection

Licensee/Titulaire de permis

Eden House Care Facility Inc.
R.R. #2 GUELPH ON N1H 6H8

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

Eden House Nursing Home
5016 Wellington County Road 29, R.R. #2 GUELPH ON N1H 6H8

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

DARLENE MURPHY (103), CATHI KERR (641)

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): June 18-22, 2018.

The following intakes were inspected:
008462-18 (CIS #2777-000003-18) and 005631-18 (CIS #2777-000002-18)- resident falls that resulted in injuries,
025648-17 (CIS #2777-000009-17)- environmental hazard,
000462-17 (CIS #2777-000001-17), 030885-16 (CIS #2777-000006-16) and 005890-16 (CIS #2777-000001-16)-alleged staff to resident abuse.
The following intake was completed: 030827-16 (CIS #2777-000005-16)-alleged staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with residents, family members, Resident Council President, Family Council President, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), RAI Coordinator, Life Enrichment Coordinator, Unit Clerk/Resident Council Liaison, Director of Care (DOC), and the Administrator.

During the course of the inspection, the inspector(s) completed a tour of the resident care areas, made observations related to resident care, medication administration, medication storage and infection control practices, reviewed resident health care records and applicable policies.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

4 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	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 following non-compliance relates to Logs #005890-16 and #000462-17:

The licensee has failed to ensure the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

O. Reg.79/10, s. 2 (1) defines physical abuse as the use of physical force by anyone other than a resident that causes physical injury.

O. Reg 79/10, s. 5 defines neglect as 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 (CIS) #2777-000001-16 to report an alleged incident of staff to resident abuse/neglect. The CIS outlined that on a designated date, resident #023 stood up from their wheelchair in front of the nursing station. RN #114, who was seated at the nursing station, asked the resident what they were doing and the resident responded they wanted to go to their room. PSW #113 was reported to have been in the area and saw RN #114 take their right hand and "shoved" the resident into the chair. The resident reported pain in their abdomen as a result of this action. At a later time during the same shift, resident #023 rang their call bell to ask for assistance to the bathroom. RN #114 responded to the call and advised the resident they couldn't help them and that a PSW would be along to provide the assistance. The resident reported they ended up taking themselves to the bathroom as no one came to assist.

The DOC was interviewed in regards to this incident. They indicated PSW #113 returned

to the home the following day to report the incident as they believed it was resident abuse. As a result of the report, an immediate investigation into the incident was initiated by the home. The DOC was asked about the home's expectations in regards to the reporting process for an alleged incident of abuse/neglect. The DOC stated they are on call 24/7 and staff are to immediately speak with the RN in charge of the home or, if this is not possible, to contact the DOC by telephone. [s. 20. (1)]

2. On a designated date, the home submitted a CIS, #2777-000001-17, to report an alleged incident of staff to resident physical abuse. The CIS outlined that on a specified date, PSWs #115 and #116 were assisting resident #014, who had known responsive behaviours. According to the CIS, PSW #116 awakened the resident in a rough manner by removing the resident's pants and began roughly changing their brief. PSW #115 reminded PSW #116 that a gentle approach was most effective with this resident. The resident became agitated in response and PSW #115 advised PSW #116 they would complete the care.

The DOC was interviewed about the incident and stated the PSW did not report the alleged incident of staff to resident abuse until the night shift three days later when they reported it to the RN in charge. Additionally it was noted that the resident's family were not made aware of the alleged incident of staff to resident physical abuse. The DOC reviewed the home's investigation notes in regards to this incident, but was unable to determine why this notification did not occur.

The home's abuse policy was reviewed, #3.2 "Abuse and Neglect Prevention" outlines, any person witnessing or having knowledge of an alleged/actual abuse or becoming aware of one shall immediately report the information to the Registered Staff/Director of Care. In regards to family notification, the policy indicates, the Administrator/Designate shall notify the Power of Attorney (POA)/Substitute Decision Maker (SDM) immediately upon becoming aware of an incident of abuse or neglect.

The licensee failed to ensure the home's zero tolerance of abuse policy was complied with by failing to ensure an alleged incident of resident abuse was immediately reported and to immediately inform the POA/SDM of the alleged incident as outlined in the zero tolerance of abuse 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 all suspected, alleged or witnessed incidents of resident abuse/neglect are immediately reported and family notifications are made in accordance with the zero tolerance of abuse policy, to be implemented voluntarily.

WN #2: 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 following non-compliance relates to Log #030885-16 and #000462-17:

The home has failed to ensure an alleged incident of resident abuse was immediately reported to the Director (MOHLTC).

The home submitted a critical incident (CIS) #2777-000006-16 to report an alleged incident of staff to resident abuse/neglect. The CIS outlined that on a specified date, resident #022 reported to the RPN and PSW working the day shift that the PSW that had worked the night shift had not been nice to them. The resident stated the PSW had refused to assist them with their slippers and left them in the bathroom. The RPN and the PSW immediately reported the incident to the RN in charge who in turn reported it to the DOC. An immediate investigation was initiated by the home.

The DOC was interviewed in regards to this incident and indicated the CIS was the method by which the MOHLTC was notified of the alleged incident of staff to resident abuse. The CIS was not submitted until the following day. The DOC was unsure why there was a delay in the reporting of the incident. [s. 24. (1)]

2. As outlined in WN #1, on a specified night shift, PSW #115 reported the alleged incident of staff to resident abuse involving resident #014 to RN #117 who was in charge at the time. According to the CIS, the RN wrote a note to the DOC outlining the incident. The DOC was not working and the designate covering for the DOC did not receive the letter until the following afternoon which further delayed the reporting of the incident. PSW #116 continued to work with the residents of the home for three days following the alleged incident, but did not directly work with resident #014.

During an interview with the DOC, they indicated the RN should have immediately notified the DOC/designate upon being informed of the incident. According to the DOC, the CIS was the means by which the Director (MOHLTC) was informed of the alleged incident of staff to resident abuse. The CIS was submitted eight days following the incident.

The licensee failed to ensure the Director (MOHLTC) was immediately notified of alleged incidents of resident abuse/neglect. [s. 24. (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 alleged, witnessed or suspected incidents of resident abuse/neglect are immediately reported to the Director (MOHLTC), to be implemented voluntarily.

WN #3: 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. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee failed to ensure no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident.

Inspector #641 reviewed a medication incident with a specified date related to resident #026 receiving medications at 0800 hours that were not prescribed to the resident. The medication incident indicated that RPN #104 prepared resident #007's 0800 hour medications, but then administered them to resident #026.

During an interview with Inspector #641 on June 20, 2018, the Director of Care (DOC) reviewed the medication incident involving resident #026 and resident #007 with the Inspector. The DOC indicated that this incident had occurred because RPN #104 had been reviewing resident #026's electronic medication administration record (eMAR) and then had switched to resident #007's eMAR, dispensing resident #007's medications while thinking about resident #026. RPN #104 then gave resident #007's medications to resident #026. The DOC advised that resident #026 received medication that had not been prescribed to the resident and that the resident had been assessed and there was no ill effect to the resident.

The licensee failed to ensure that resident #026 received medications that had been prescribed to the resident. [s. 131. (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 no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

s. 101. (3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and O. Reg. 79/10, s. 101 (3).
(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).

Findings/Faits saillants :

1. The following non-compliance relates to Logs #005890-16, #030885-16, and #000462-17:

The licensee has failed to ensure a documented record was kept in the home that included the nature of each verbal or written complaint.

As outlined in WN #1, on a specified date, PSW #113 reported to DOC #111 they had witnessed RN #114 assisting resident #023 back into the wheelchair with what they considered to be excessive force.

As outlined in WN #1, on a specified date, PSW #115 reported an incident of alleged staff to resident abuse when they witnessed PSW #116 being rough during the provision of the care.

As outlined in WN #2, on a specified date, resident #022 reported to staff members that the PSW who had cared for them on the previous night shift had refused to provide assistance when asked by the resident.

The home's documented record of complaints was reviewed for 2016 and the above noted complaints were not included. The DOC was interviewed and indicated they were unaware these incidents needed to be included in the documented record as they were reported to the MOHLTC by means of a critical incident submission. All verbal and written complaints are legislated to be included in the documented record. [s. 101. (2)]

2. The licensee has failed to ensure the documented record was reviewed and analyzed for trends at least quarterly and the results and analysis are taken into account in determining what improvements are required in the home and a written record is kept of each review and of the improvements made in response.

During an interview with the DOC, they indicated individual complaints are discussed as required on a weekly basis with the Administrator. Additionally, the DOC indicated serious incidents are discussed during the quarterly Professional Advisory Meetings (PAC). According to the DOC, the remainder of the complaints are reviewed and analyzed on a yearly basis, not quarterly as outlined in the legislation. [s. 101. (3)]

Issued on this 9th day of July, 2018

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

Original report signed by the inspector.