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
Jun 29, 2018	2018_606563_0010	017815-16, 019241-16, 023805-16, 024981-16, 027639-16, 028316-16, 030336-16, 002251-17, 003939-17, 004393-17, 007063-17, 013569-17, 015918-17, 017310-17, 027852-17, 028604-17, 028858-17, 029436-17, 000150-18, 001774-18, 003277-18	Critical Incident System

Licensee/Titulaire de permis

The Corporation of the County of Elgin Municipal Homes
450 Sunset Drive ST. THOMAS ON N5R 5V1

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

Elgin Manor
39262 Fingal Line, R.R. #1 ST. THOMAS ON N5P 3S5

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

MELANIE NORTHEY (563), ALI NASSER (523), CASSANDRA ALEKSIC (689), DONNA TIERNEY (569), NATALIE MORONEY (610)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System

inspection.

This inspection was conducted on the following date(s): May 22, 23, 24 and 25, and June 28, 2018

The following intakes were completed within this inspection:
017815-16 - M518-000013-16 - Critical Incident related to suspected staff to resident abuse
019241-16 - M518-000016-16 - Critical Incident related to a fall
023805-16 - M518-000022-16 - Critical Incident related to suspected staff to resident abuse
024981-16 - M518-000024-16 - Critical Incident related to suspected family to resident abuse
027639-16 - M518-000028-16 - Critical Incident related to a fall
028316-16 - M518-000032-16 - Critical Incident related to suspected staff to resident abuse
030336-16 - M518-000033-16 - Critical Incident related to suspected resident to resident abuse
002251-17 - M518-000001-17 - Critical Incident related to a fall
003939-17 - M518-000004-17 - Critical Incident related to a fall
004393-17 - M518-000003-17 - Critical Incident related to a fall
007063-17 - M518-000010-17 - Critical Incident related to a fall
013569-17 - M518-000017-17 - Critical Incident related to responsive behaviours
015918-17 - M518-000019-17 - Critical Incident related to a fall
017310-17 - M518-000021-17 - Critical Incident related to improper medication administration
027852-17 - M518-000040-17 - Critical Incident related to a personal care
028604-17 - M518-000041-17 - Critical Incident related to a fall
028858-17 - M518-000042-17 - Critical Incident related to suspected resident to resident abuse
029436-17 - M518-000043-17 - Critical Incident related to suspected resident to resident abuse
000150-18 - IL-37680-LO - Complaint related to improper medication administration
001774-18 - M518-000001-18 - Critical Incident related to a fall
003277-18 - M518-000006-18 - Critical Incident related to suspected staff to resident abuse

During the course of the inspection, the inspector(s) spoke with the Administrator,

the Director of Homes and Senior Services, the Resident Care Coordinator, Registered Nurses, Registered Practical Nurses, Personal Support Workers and housekeepers.

The inspector(s) also made observations of residents and care. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed. The home's investigation notes and medication records and audits were also reviewed.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **4 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

The home submitted a Critical Incident System (CIS) Report to the Ministry of Health and Long-Term Care (MOHLTC) which was identified as an incident of staff to resident abuse/neglect. The CIS report stated that a resident was left unattended with a safety intervention absent.

The care plan in Point Click Care (PCC) was reviewed and showed specific interventions related to the resident's transfer and environmental safety needs.

The "Request/Concern Response Form" stated the resident was left without a specific safety intervention in place.

A review of the documented interview with a Personal Support Worker (PSW) stated the resident was left without a specific safety intervention in place.

The Director of Home and Senior Services (DHSS) stated that the resident did not have their specific safety intervention in place. When asked what the expectation was for staff to look for a resident's transfer status, the DHSS stated that it was expected that the resident would be transferred according to their Point of Care (POC).

The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan. [s. 6. (7)]

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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: 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.

Elgin Manor submitted a Critical Incident System (CIS) Report to the Ministry of Health and Long Term Care (MOHLTC) in response to a family complaint where the family member of a resident accused the registered staff of incorrectly administering a specific medication. A complaint log was also submitted to the MOHLTC where the complainant reported improper administration of a specific medication. The complainant reported the medication was ordered to be administered at specific times per day. The complainant reported the medication was not routinely administered at the specific prescribed times.

The "Homes and Senior Services Request/Concerns Response Form" documented the resident and their family reported allegations of neglect related to medication administration.

There was an email correspondence to the registered staff from the Director of Homes and Senior Services (DHSS) with the subject line “medication administration times”. The registered staff were to review the two notes on the Elgin Manor Point Click Care (PCC) communications board. The note stated the specific medication "MUST be administered as scheduled/ordered." "The timing of administration is critical" for resident's with a specific diagnosis. "Please ensure that all medications are administered as ordered/scheduled - i.e. On time."

The home's investigation notes were reviewed where the complainant reported improper dispensing of a specific medication. This concern was reported in writing to the County of Elgin Chief Administrative Officer (CAO). A typed letter from the COA to the complainant documented that an investigation included the following outcomes: adjustment of medication administration, diagnosis education for all direct care staff, one on one education for registered staff regarding timely administration of this specific medication, medication review by the physician, and that this medication packaging was to be

separate with notation on the packaging and eMAR.

The care plan in Point Click Care (PCC) documented that the specific medication was to be administered as ordered with a family request that the medication not be given with meals to enhance effectiveness of the medication.

The Medication Admin Audit Reports over a three month period documented multiple dates where at multiple times, the resident was not administered this specific medication in accordance with the directions for use specified by the prescriber.

The electronic Medication Administration Reports (eMAR) for the resident for over a three month period did not document the reason for the late or early administration of the specific medication. There was no code of "9" in the eMAR report to indicate "Other / See Nurse Notes".

The Director of Homes and Senior Services (DHSS) reviewed of the "Medication Admin Audit Report" for multiple residents currently residing in the home and their specific medication administration times over a one month period of time. The DHSS verified the medication was not provided in accordance with the directions for use specified by the prescriber on multiple dates.

The "Medication Admin Audit Report" for the following residents and the medication administration times for a one month period of time documented multiple residents did not receive the specific medication in accordance with the directions for use specified by the prescriber on multiple dates at specific times.

The Administrator reviewed the eMAR reports and the Medication Admin Audit Report in PCC and verified that there was no progress note to indicate the reason for the late administrations and there was no code of "9" in the eMAR report to indicate "Other/See Nurse Notes" on multiple dates; and there was no documented evidence of that administration of the specific medication was given on a specific date. The Administrator also verified that the evening registered nursing staff would administer the specific medication due on the day shift. The Administrator reviewed the excel report generated by SmartMed Pharmacy for this medication and the administration times, as well as, the eMAR Administration Details in PCC and on multiple dates for a specific resident, there was no documentation to support that the medication was administered at the prescribed time and that it was at that time the resident was asleep.

The licensee failed to ensure that the specific medications were administered to multiple 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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #3: 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 home's written policy on the prevention of abuse and neglect was complied with.

Section 20 (1) of the Ontario Regulation 79/10 defines physical abuse as the use of physical force by anyone other than a resident that causes physical injury or pain.

The home submitted a Critical Incident System (CIS) Report to the MOHLTC related to alleged staff to resident physical abuse. The CIS identified that a resident informed a Personal Support Worker (PSW) that another PSW was rough with them and hurt them.

The internal investigation notes included a statement submitted by the PSW identified that the resident reported an allegation of "rough" handling.

The investigation notes completed by Corporate Investigation Service was reviewed with Director of Homes and Senior Services (DHSS). The notes showed that the PSW heard the resident state that another PSW hurt them three times.

The DHSS said it was the expectation that the PSW would report to the nurse immediately any allegations of abuse or neglect and not to wait couple of hours to do so and said that the staff did not comply with the home's policy at that time.

The licensee has failed to ensure that the home's written policy on the prevention of abuse and neglect was complied with. [s. 20. (1)]

WN #4: 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 had failed to ensure that when a person had reasonable grounds to suspect neglect of a resident by staff that resulted in a risk of harm to the resident, immediately reported the suspicion and the information upon which it was based to the Director.

The home submitted a Critical Incident System (CIS) Report to the Ministry of Health and Long Term Care which was identified as an incident of staff to resident abuse/neglect. The CIS Report stated that a resident was left unattended with a safety intervention absent.

The “Request/Concern Response Form” stated the resident was left without a specific safety intervention in place.

The Director of Homes and Senior Services (DHSS) said that the resident's family member expressed concern that the resident was left unattended. When asked what the expectation was of staff for reporting incidents of neglect, the DHSS stated that this incident should have been immediately reported.

The “Homes and Senior Services, Department: Administration, Subject: Resident Abuse” policy with review date March 2016, stated under “Procedure” the following:
“In any case of alleged or suspected abuse the employee witnessing or having knowledge of an incident shall verbally report the abuse immediately to her/his direct supervisor or delegate and provide a written statement upon reporting the alleged abuse. Upon receipt of the written statement, the Director of Homes and Seniors Services/Administrator/designate shall report the allegation to the Ministry of Health and Long-Term Care Director.”

The licensee has failed to ensure that when a person had reasonable grounds to suspect neglect of a resident by staff that resulted in a risk of harm to the resident, immediately reported the suspicion and the information upon which it was based to the Director. [s. 24. (1)]

Issued on this 29th day of June, 2018

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

Original report signed by the inspector.