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 |
|---|---|---|---|
| Oct 17, 2017 | 2017_395613_0012 | 012194-17 | Resident Quality Inspection |

**Licensee/Titulaire de permis**

The Corporation of the City of Timmins
481 Melrose Blvd. TIMMINS ON P4N 5H3

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

GOLDEN MANOR
481 MELROSE BOULEVARD TIMMINS ON P4N 5H3

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

LISA MOORE (613), ALAIN PLANTE (620), NATASHA MILLETTE (686), SARAH CHARETTE (612)

## 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 26 - 30 and July 4 - 7, 2017.**

**The following intakes were completed during this inspection:**
**One Follow up related to compliance order # 001 under s. 6. (7) of the LTCHA issued during inspection #2017_264609_0024 related to ensuring that the care set out in the plan of care was provided to the residents as specified in the plan;**

**One Follow up related to compliance order #002 under s. 20. (1) of the LTCHA issued during inspection #2017_264609_0024 related to ensuring that all staff comply with the home's written policy to promote zero tolerance of abuse and neglect of residents;**

**One complaint related to concerns regarding the discharge of a resident;**

**Three Critical Incidents (CIs) the home submitted to the Director related to resident falls resulting in a significant change in condition;**

**Two CIs the home submitted to the Director regarding alleged resident to resident abuse;**

**Two CIs the home submitted to the Director regarding alleged staff to resident abuse.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Infection Control and Education (IC & ED) Coordinator, Resident Services Supervisor (RSS), Facilities Supervisor (FS), Community Home Support Coordinator (CHSC), Health Informatics Nurse (HIN), Dietitian, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeeping staff, Behavioural Supports Ontario (BSO) Clinical Behaviour Response Specialist, family members and residents.**

**The Inspector(s) also conducted a tour of resident care areas, observed the provision of care and services to residents, as well as observed staff to resident interactions, reviewed relevant health care records, various licensee policies, procedures and programs, as well as staff personal files, training records, the home's internal investigation files and resident and family council meeting minutes.**

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

**Accommodation Services - Maintenance**
**Admission and Discharge**
**Continence Care and Bowel Management**
**Falls Prevention**
**Family Council**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Nutrition and Hydration**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Residents' Council**
**Responsive Behaviours**
**Safe and Secure Home**
**Skin and Wound Care**

**During the course of this inspection, Non-Compliances were issued.**
- **8 WN(s)**
- **1 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 |
|---|---|---|---|
| LTCHA, 2007 S.O. 2007, c.8 s. 20. (1) | CO #002 | 2016_264609_0024 | 613 |
| LTCHA, 2007 S.O. 2007, c.8 s. 6. (7) | CO #001 | 2016_264609_0024 | 613 |

## 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 | Legendé<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 O.Reg 79/10, s. 142. Care during absence**
**Every licensee of a long-term care home shall ensure that before a long-stay resident of the home leaves for a casual absence or a vacation absence and before a short-stay resident of the home leaves for a casual absence,**
**(a) a physician or a registered nurse in the extended class attending the resident or a member of the registered nursing staff of the home sets out in writing the care required to be given to the resident during the absence; and**
**(b) a member of the licensee's staff communicates to the resident, or the resident's substitute decision-maker,**
**(i) the need to take all reasonable steps to ensure that the care required to be given to the resident is received by the resident during the absence,**
**(ii) that the licensee will not be responsible for the care, safety and well-being of the resident during the absence and that the resident or the resident's substitute decision-maker assumes full responsibility for the care, safety and well-being of the resident during the absence, and**
**(iii) the need to notify the Administrator of the home if the resident is admitted to a hospital during the absence or if the date of the resident's return changer. O. Reg. 79/10, s. 142.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that before a long-stay resident of the home left for a casual absence or a vacation absence and before a short-stay resident of the home left for a casual absence, (a) a physician or a registered nurse in the extended class attending the resident or a member of the registered nursing staff of the home set out in writing the care required to be given to the resident during the absence.

Inspector #620 reviewed a complaint received by the Director in December 2016, regarding a concern that resident #011 was going to be discharged from the home. The complainant reported that in December 2016, resident #011 had eloped from the home by performing a specific action which subsequently unlocked the door, allowing the resident to exit the home. The complainant indicated that the home had arranged a meeting in December 2016, following the resident's elopement. They stated that they were advised by the home to take resident #011 on a 21 day leave of absence (LOA).

On July 4, 2017, Inspector #620 interviewed the complainant who was the substitute decision-maker (SDM) of resident #011. The complainant stated in December 2016, the licensee had called them to attend to the home to discuss the resident's elopement. They indicated that they felt as though the home was asking them to take resident #011 on a 21 day vacation. The complainant agreed to take the resident on a LOA. When asked by the Inspector, if the home had provided them with care instructions or any written documentation with regards to resident #011's leave, the complainant indicated no such information had been provided to them.

A review of resident #011's electronic progress notes on Point Click Care (PCC) identified a documented family meeting had occurred in December 2016. The progress note indicated that the family had agreed to take the resident home and exercise their 21 day LOA. In the interim, the family was advised that should they feel unable to manage resident #011 safely at home, they were to call 9-1-1 for transfer to the hospital. The meeting was attended by the complainant, Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), and the Resident Services Supervisor (RSS).

A review of resident #011's documented clinical records from their date of admission to December 2016, did not identify that a physician or a registered nurse in the extended class attending the resident or a member of the registered nursing staff of the home set out in writing the care required to be given to the resident during their absence.

A review of the home's policy titled, "Absences from the Home: COT-GMA-E-65-v04" last revised on April, 2017, identified that when a resident left on vacation or a casual absence, the Physician, Medical Director or Nurse Practitioner, was to ensure there was a plan of care for the resident while they were away.

During an interview with the DOC, they confirmed that in December 2016, when resident #011 left the home on an absence, that no written documentation detailing the resident's care needs had been provided to the resident or their family. The DOC stated that they were unaware that a resident leaving on an absence required written correspondence detailing the resident's care during their absence. [s. 142. (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 before a long-stay resident of the home leaves for a casual absence or a vacation absence and before a short-stay resident of the home leaves for a casual absence, (a) a physician or a registered nurse in the extended class attending the resident or a member of the registered nursing staff of the home set out in writing the care required to be given to the resident during the absence, to be implemented voluntarily.***

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**WN #2: 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,**
**(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).**
**(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).**
**(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or the care set out in the plan was no longer necessary.

Resident #002 was identified through the Minimum Data Set (MDS) assessment in June 2017, as having an urinary intervention.

Inspector #612 reviewed the resident's progress notes and noted that the urinary intervention had been discontinued in May 2017.

On July 5, 2017, resident #002 was observed sitting in their wheelchair in their room and there was a incontinent product on the resident's bedside table.

A review of resident #002's care plan identified that the resident was not to wear an incontinent product.

A review of the last continence assessment that was completed in May 2017, indicated that the resident's urinary intervention was discontinued and the resident required an incontinent product for occasional incontinence.

During an  interview with PSW #122, they confirmed that resident #002 was wearing a incontinent product, and had been for approximately a couple weeks. The PSW stated that since the resident's fall in May 2017, which resulted in an injury, they were occasionally incontinent of bladder, although resident #002 still requested to go to the bathroom. PSW #122 stated that the resident now wore an incontinent product as a result of their occasional incontinence.

During an interview on July 6, 2017, with the Infection Control and Education Coordinator, who was also the lead for the home's Bowel and Bladder Continence Program, stated that resident #002's care plan should have been updated when their care needs had changed. [s. 6. (10) (b)]

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**WN #3:  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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Inspector #612 requested to review the home's medication incident reports and was provided with a binder by the ADOC. The Inspector reviewed a medication incident report related to an extra tablet of a controlled substance that had been found lying unpackaged in the bottom of the narcotic bin in March 2017. The medication tablet had been placed in a small brown envelope and was attached to the medication incident report in the binder. The binder which contained the medication tablet in the small brown envelope, was stored in the ADOC's office.

A review of the home's policy titled, "Drug Inventory Control", last revised January 17, 2017, identified that narcotic and controlled substances to be destroyed were to be stored in a double locked storage area within the facility, separate from any narcotic and controlled substance available for administration to a resident (i.e wooden narcotic box or centralized double locked storage area in the home).

During an interview with the ADOC, they stated that they were going to destroy the medicaiton tablet, as per the home's policy; however, they had not done it yet. The ADOC confirmed that it was not an appropriate place to store the medication until destruction.

During an interview with the DOC, they confirmed that the controlled substance tablet should have been destroyed, as per the home's policy and not stored in the medication incident binder, which was kept in the ADOC's locked office. [s. 8. (1) (b)]

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**WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services**

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

**s. 15. (2) Every licensee of a long-term care home shall ensure that,**
**(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).**
**(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).**
**(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

During the tour of the home on June 26, 2017, Inspector #612 observed the following maintenance concerns:

On a Specific Unit:
- two 24 x 48 centimeter (cm) ceiling tiles missing and two ceiling tiles with water damage measuring approximately 10 cm x 16 cm.

On a Specific Unit:
- elevator on the right side, had bumper pads with torn and missing sections on the pads. The missing/damaged material was exposing the foam padding beneath. The damage measured approximately 10 cm x 18 cm.

On a Specific Unit:
- Two ceiling tiles showed signs of previous water damage measuring approximately 33cm x 33cm.
- The tub room had wall damage (visible wall board substrate) measuring approximately 30 cm x 90 cm, a 22 x 22 cm hole in the wall behind the tub, and a rust coloured stain to the flooring below that measured approximately 50 cm x 64 cm around the perimeter of the tub.

On a Specific Unit:
- The tub room had damage to more than 50 per cent of the wall surface that included holes, partially repaired unpainted drywall repairs, and scuffs; more than 30 per cent of the flooring below and around the perimeter of the tub had rust coloured stains.

On a Specific Unit:
- The tub room had wall damage that included holes, partially repaired unpainted drywall repairs, and scuffs that measured approximately 45 cm x 45 cm; there was a rust coloured stain to the flooring below that measured approximately 30 cm x 30 cm around the perimeter of the tub.

Main Entrance:
- The carpet which was approximately 330 square meters had numerous stains of various sizes that were evident more than every three square meters.
- A broken mirror adjacent to the public washroom facilities, was cracked in four separate locations. The mirror measured approximately 90 cm x 270 cm. The cracks in the mirror measured approximately 400 cm in cumulative length.

On June 29, 2017, Inspector #620 interviewed the home's Facilities Supervisor (FS) #104, who stated that a particular unit was the oldest section of the Long Term Care Home and that the roof had leaks that were not yet resolved and that was why the ceiling, as observed by the Inspector, was damaged and had ceiling tiles missing. They indicated that the home was currently out of stock for the roof tiles and that they needed to be replaced. The FS #104 confirmed that the observed elevator bumper pads were in disrepair and that they needed to be repaired. They stated that the ceiling tiles were water damaged and that they needed to be replaced. The FS #104 indicated that the holes in the tub room, as observed by the Inspector, were there as a result of maintenance staff needing to access the plumbing behind the wall; they needed to repair the holes with an access port, but that the access ports were not yet installed. They indicated that the damage to the tub room floors, identified by Inspector #612, were a result of the cleaning agents used to sanitize the tub and there currently was no plan in place to address the disrepair in the tub rooms. The FS #104 indicated that the carpet in the main entrance was in need of cleaning and that they were still waiting for an external contractor to clean the carpets. They indicated that the carpet in the main entrance contained many stains throughout and that the cleaning was not going to address the stains that were in the carpet; there was no plan in place to address the stains in the carpet. [s. 15. (2) (c)]

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management**

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

**s. 51. (2) Every licensee of a long-term care home shall ensure that,**
**(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the resident who was incontinent had an individualized plan of care to promote and manage bowel and bladder continence based on the assessment, and that plan was implemented.

Inspector #612 reviewed a Critical Incident (CI) report that was submitted to the Director in December 2016, which alleged abuse and neglect by PSW #106 and #107 towards resident #001. The CI report stated that resident #001 had reported to the DOC that PSW #106 and #107 were unprofessional while providing care, had removed their wet incontinent product and replaced it with a clean incontinent product; however, they did not provide resident #001 personal care when the resident had requested to be cleaned. The CI report further indicated that PSW #106 and #107 had responded to resident #001 that they would be having a bath later on that day. Resident #001 asked a second time to be dried, but the staff still did not dry them. The CI report identified that resident #001 had stated that they had heard one of the staff members swear, and then they had transferred the resident to their wheelchair, and they remained uncomfortable as they had not been dried. When the resident asked the staff to adjust the pad on their wheelchair, the staff had informed the resident that there was nothing that could be done to assist them to be more comfortable. After resident #001 became insistent, the staff then adjusted the pad on their wheelchair. The resident requested the other staff member's name; however, the staff member laughed, refused to provide their name and walked away. PSW #106 and PSW #107 received disciplinary action.

During an interview with resident #001, they stated that PSW #106 and PSW#107 had refused to dry them after performing personal care and they remained uncomfortable, as a result. The resident stated that they required the assistance of staff for personal care and to change their incontinent product.

A review of resident #001's care plan, revealed under the urinary incontinence focus that the resident wore an incontinent product and the goal was for the resident to remain clean, dry and odour free. Under the toileting focus, it identified that the resident required extensive assistance from two staff to complete the task.

During an interview on July 5, 2017 with the DOC, they confirmed that resident #001 was not provided with the appropriate personal care as per their continence care plan, that they had required, despite resident #001 requesting the assistance from staff. [s. 51. (2) (b)]

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**WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council**

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

**s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).**

**Findings/Faits saillants :**

1. The licensee has failed to respond in writing within 10 days of receiving Residents' Council advice related to their concerns or recommendations.

During an interview with resident #020, who was the President for the Residents' Council, they informed Inspector #613 that the licensee did not respond in writing within 10 days of receiving Residents' Council concerns or recommendations. Resident #020 revealed that responses were provided at the next Residents' Council meeting, which were held monthly.

Inspector #613 reviewed the Residents' Council meeting minutes from February 2017, to June 2017, which did not identify that a written response was provided to the Resident Council with in 10 days of receiving their concerns or recommendations.

During an interview on June 29, 2017, with Resident Services Supervisor (RSS) #102, who was the appointed Assistant to the Residents' Council, stated that they used to provide a written response, but they have not done that this year. RSS #102 revealed they meet with the President to provide a response, but confirmed that they do not provide a written response to the Residents' Council within 10 days of receiving their concerns or recommendations. [s. 57. (2)]

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**WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council**

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

**s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that if the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing.

During an interview with the Community Home Support Coordinator (CHSC) #128, who was the appointed Assistant to the Family Council, they reported to Inspector #612 that when concerns or recommendations arise, they would bring that information forward to the appropriate supervisor after the meeting and then bring the response at the next family meeting, which were held monthly. CHSC #128 stated that there was no formal written response by the licensee to the Family Council.

Inspector #612 reviewed the Family Council meeting minutes from May 2017, and noted that there was a standing item titled "Business Arising from Minutes". It stated, "DOC and ADOC looking into staff approach when they have not been on a unit in a long time, employee of the month will be revised by Management and the parking lot safety will be brought up at the Supervisor meeting in May". There was no corresponding letter from the licensee from the previous meeting held April 17, 2017.

During an interview on July 5, 2017, with the Administrator, they confirmed they did not provide a written response to the Family Council with in 10 days of receiving their concerns or recommendation, and that the information was included in the minutes from the previous meeting. [s. 60. (2)]

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**WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services**

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

**s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,**
**(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks; O. Reg. 79/10, s. 90 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks.

On June 27, 2017, Inspector #620 observed the following items to be in disrepair, in specific rooms:
- a towel bar was observed to be broken in two with both ends of the towel bar hanging loosely from their mounts on the wall.
- a towel bar was observed to be hanging loosely from its mounts on the wall.
- the caulking around the vanity was observed to be cracked and the edge banding on the left side of the vanity was missing; the vanity surface was also observed to be delaminating from its substrate.
- the p-trap and downspout were observed to be corroded; a rust coloured stain on the flooring below the p-trap was visible.
- the grab bar adjacent to the toilet was observed to be loose.
- the p-trap and downspout were observed to be corroded and there was a cloth tethered to the p-trap; a rust coloured stain on the flooring below the p-trap was visible.

During an interview on June 29, 2017, with the Facilities Supervisor #104, they indicated that the towel bars that were mounted in the resident rooms were not of a robust quality; as a result, the towel bars would often become loose or would be damaged. The FS stated that they recognized that the towel bars were not suitable to be used as grab bars and that if a resident inadvertently used the towel bar for support while ambulating, it posed a falls risk. The FS indicated that many of the p-traps and down spouts were beginning to corrode and that they were leaking as a result. They indicated that the p-traps needed to be replaced with a PVC assembly to prevent further corrosion. [s. 90. (2) (d)]

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**Issued on this 14th day of November, 2017**

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

**Original report signed by the inspector.**