Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 31, 2020	2020_771609_0013	005963-20, 014587-20	Critical Incident System

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

CHAD CAMPS (609)

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): July 20-23, 2020.

The following intakes were inspected upon during this Critical Incident System (CIS) Inspection:

- One intake related to an incident of resident to resident abuse; and

- One intake related to a missing resident who returned to the home with an injury.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Administrative Assistant, Educator, Facilities Supervisor (FS), Social Worker (SW), Registered Dietitian (RD), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), maintenance staff and residents.

The Inspector(s) also conducted a daily tour of the home, reviewed relevant resident records, internal investigations, policies and procedures of the home and observed the delivery of resident care and services, including staff to resident and resident to resident interactions.

The following Inspection Protocols were used during this inspection:
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **2 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	Légende 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. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas were locked when they were not being supervised by staff.

A Critical Incident System (CIS) report was submitted to the Director which described how resident #003 had eloped from the home and sustained injuries. At the time of the elopement, it was identified that the magnetic (Mag) lock system for the doors was not working properly and that the resident exited most likely out a specific door, as it likely was unlocked during this time.

a) During an interview with RN #114, they described to Inspector #609, how on the day of resident #003's elopement, they were informed that the front door Mag lock was not working. They tried to reset the Mag lock system, but it still wasn't working. The RN acknowledged that they were unsure at the time, how to reset the Mag lock system and were aware that the Mag lock system controlled all the exit doors, but only had the front door monitored. The RN indicated that there was a short window of time whereby the resident could have exited the building before the Mag lock system was fixed.

A review of the home's policy titled "Fire Rated Door and Doors to Non-Residential Areas" last revised January 4, 2017, instructed that all doors leading to storage rooms, janitor's closets, stairwells or exterior shall remain closed and locked at all times, except when any such door was in immediate use.

A review of the home's internal investigation notes found that the front door video surveillance footage was evaluated by the Director of Care (DOC) and verified that resident #003 did not leave the building through the front.

During an interview with the RD, they verified that they were the supervisor-on-call, on the day of resident #003's elopement and received a call that the front doors were not working. When the RD arrived at the home, they reset the Mag lock system after finding that RN #114 had turned the Mag lock control box counter-clockwise instead of clockwise, which released the magnetic locks and turned off the system.

The RD acknowledged that the Mag lock system controlled the front, receiving and physiotherapy doors, which all lead outside of the home and that the receiving and physiotherapy doors were not being monitored on the day of resident #003's elopement, when the Mag lock system went down.

b) During a tour of the home Inspector #609 opened the specified door without using the keypad and walked out of the building.

During an interview with Maintenance Staff #111, they verified the Inspector’s observations and stated that the specified door was always to be locked.

As staff were coming through the specified door, the Inspector observed that when the door was partially opened, the self-latching device at the top of the left side would not activate, which prevented the Mag lock from engaging.

The Inspector was able to open the specified door without the keypad two more times after staff passed through the door.

During an interview with the Facilities Supervisor (FS), they verified that if the specified door was not opened fully when used, then the door may not have enough force when closing to activate the self-latching device and engage the Mag lock. The FS stated that the door should always be locked and that they would fix the door.

c) During a tour of the home Inspector #609 found the servery doors on the East and West units on the main floor, unlocked and unattended. The East Unit’s soiled utility room was also found unlocked and unattended, with cleaning chemicals noted on the counter.

During an interview with Personal Support Worker (PSW) #108, they described how the door knobs had been changed and that they now had to do a 360 degree turn with the key in order to lock the doors, which they were not aware of until the Inspector’s observations.

During an interview with the DOC, they verified that the doors to the serveries and the soiled utility room should have been locked when not attended by staff.

During an interview with the Administrator, they indicated that all doors leading to the outside or to non-residential areas should be kept locked when not in use. The Administrator further indicated that they were made aware of the unlocked serveries and soiled utility room and that staff should have been made aware of the change in practice

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 doors leading to non-residential areas are locked when they are not being supervised by staff, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001's responsive behaviour plan of care was based on an interdisciplinary assessment of the resident that included any mood and behaviour patterns.

A CIS report was submitted to the Director which described how resident #001 was observed by staff to be responsive towards resident #002 in an identified manner which resulted in injuries.

Inspector #609 reviewed resident #001's health care records and found an assessment by the home's Social Worker (SW), which outlined how the resident had previous altercations towards other residents.

During an interview with the home's SW, they outlined how previous to the CIS report:

-On a particular day, resident #001 caused injuries to resident #005 when they were responsive towards them in the identified manner; and

-On another particular day, resident #001 caused injuries to resident #006 when they

were responsive towards them in the identified manner.

A review of resident #001's plan of care found no mention that the resident would become responsive towards other residents in the identified manner.

During interviews with PSW #117 and RPN #110, both indicated that they were familiar with resident #001 and were unaware of the resident's identified responsive behaviour.

A review of the home's policy titled "Resident Care Planning" last reviewed July 24, 2020, indicated that the resident's plan of care was to be based on an assessment of the resident and cover all aspects of their care.

During interviews with the SW and the Responsive Behaviours Program Lead (RN #117), a review of the incidents involving resident #001 was conducted. Both verified that resident #001 demonstrated a pattern of identified responsive behaviour. Both further verified that the pattern of behaviour should have been identified in the resident's plan of care.

During an interview with the DOC, they verified that any identified patterns of behaviour exhibited by residents should be in their plans of care, which should have included resident #001's pattern of identified responsive behaviour. [s. 26. (3) 5.]

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 resident #001's (and all other residents exhibiting responsive behaviours) responsive behaviour plan of care is based on an interdisciplinary assessment of the resident that includes any mood and behaviour patterns, to be implemented voluntarily.

Issued on this 6th day of August, 2020

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

Original report signed by the inspector.