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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

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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
Dec 6, 2018	2018_739694_0017	004865-18, 004866-18, 027822-18	Resident Quality Inspection

Licensee/Titulaire de permis

Corporation of the County of Grey
595 9th Avenue East OWEN SOUND ON N4K 3E3

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

Grey Gables Home for the Aged
206 Toronto Street South MARKDALE ON N0C 1H0

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

AMANDA COULTER (694), JANET GROUX (606), KATHLEEN MILLAR (527)

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): October 18, 19, 22, 23, 24, 26, 29, 30, 31, November 1 and 2, 2018

The following Critical Incidents and Complaints were inspected concurrently with the
Resident Quality Inspection (RQI):

Critical Incident System (CIS):
Log #003073-16, related to abuse;

Log #019829-18, related to abuse;
Log #029105-16, related to a fall; and
Log #002717-18, related to missing controlled substance.

Complaints:
Log #002164-18, related to plan of care, nutrition and hydration, medication administration and restraints; and
Log #011596-18, related to staffing.

Follow up inspections:
Log #004865-18, Compliance Order (CO) #001, related to inspection #2017_580568_0028, for s. 50 (2) (b) (i) (iv), follow up to the CO #001 related to skin assessments
Log #004866-18 CO #002, related to inspection #2017_580568_0028, for s. 51 (2) (d), follow up to the CO #002 related to Continence.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), the Resident Assessment Instrument (RAI) Coordinator, Behavioural Support Ontario (BSO), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), maintenance manager, maintenance aides, activation aides,dietary aides, scheduling staff, physiotherapist, physiotherapist assistant, the Residents' Council President, residents and family members.

During the course of the inspection, the inspector(s) toured the home, observed the provision of care and services, reviewed relevant documents, including but not limited to, clinical records, policies and procedures, internal investigation notes, training records and meeting minutes.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
12 WN(s)
5 VPC(s)
2 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
O.Reg 79/10 s. 50. (2)	CO #001	2017_580568_0028	527
O.Reg 79/10 s. 51. (2)	CO #002	2017_580568_0028	606

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Légende
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that at least one registered nurse (RN) who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times, except as provided for in the regulations.

On a specific number of occasions during a six month period, the home's nursing schedules showed that the home did not have an RN on duty and present in the home during various shifts.

The home's staffing plan, staffing schedules, registered staff shift replacement information and daily roster sheets were reviewed and confirmed that there was no RN on duty for a specific number of shifts during the six month period reviewed.

The DOC acknowledged that they were aware there was to be an RN on duty and present in the facility at all times.

The licensee failed to ensure that at least one RN who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home, except as provided for in the regulations. [s. 8. (3)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to protect resident from abuse by anyone.

For the purposes of the definition of "abuse"in subsection 2 (1) of the Act, "verbal abuse" means, (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, or (b) any form of verbal communication of a threatening or intimidating nature made by a resident that leads another resident to fear for his or her safety where the resident making the communication understands and appreciates its consequences. "mauvais traitement d'ordre Verbal"O. Reg. 79/10, s. 2 (1).

A review of the home's investigation notes showed staff had used inappropriate language in the presence of residents #003, #006, #021, #022, #023, and the incidents were witnessed by another staff member.

In separate identified incidents, staff were overheard using profane language or complaining about the tasks while providing care or assistance to five residents.

Staff acknowledged that they heard other staff make comments about the residents while they were providing care to them. Staff told the Long Term Care Homes (LTCH) Inspector that they felt uncomfortable with what they had heard and recognized the language to be abusive.

The Administrator acknowledged that the home's investigation concluded that staff were abusive towards the residents.

The licensee failed to protect residents #003, #006, #021, #022 and #023 from abuse by anyone. [s. 19. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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 failed to ensure that their written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

Resident #018 had money missing from their bedroom on a specific day in May, 2018.

The licensee's policy titled "Prevention of Abuse and Neglect of a Resident", directed all employees to immediately report any suspected or known incident of abuse or neglect to the Director.The alleged misappropriation of the resident's money was not reported to the Director until two days after the incident occurred.

The Administrator acknowledged that the incident was not reported to the Director until two days after the incident occurred rather than immediately.

The licensee failed to ensure that their written policy that promoted zero tolerance of abuse and neglect of residents was complied with. [s. 20. (1)]

2. A review of the home's investigation notes regarding an allegation of abuse, was completed.

The home's policy entitled, "Prevention of Abuse and Neglect of a Resident", stated that if any employee or volunteer witnesses an incident, or has any knowledge of an incident, that constitutes resident abuse or neglect, all staff witnessed incident of resident abuse, the employee must immediately 1) intervene and stop the abuse, if safe to do so, and 2) inform the Executive Director (ED) or charge nurse.

In an interview with staff who witnessed other staff verbally abuse residents, but did not report the incidents to the ED or charge nurse until the following day. The staff stated that they were aware that they should have reported the incident immediately. [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 written policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that, a written record was kept relating to the annual evaluation of the nutrition care and hydration program, that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The 2017 annual program evaluation for the nutrition care and hydration program was reviewed and the written record included the summary of changes made; however the date that those changes were implemented was not documented in the written record.

The Administrator was interviewed and acknowledged that the date(s) their changes and accomplishments were implemented for the nutrition care and hydration program were not documented in the written record for their 2017 annual program evaluation.

The licensee failed to ensure that the written record of the 2017 annual evaluation for the nutrition care and hydration program included the date that the changes and improvements were implemented. [s. 30. (1) 4.]

2. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A specific resident's plan of care identified the resident required exercises a certain number of times per week based on the physiotherapy assessments. The Therapy Minutes report for August, September and October 2018, indicated that the resident had not been completing the exercises as assessed and implemented by the physiotherapist and the physiotherapy assistant (PTA) was responsible to ensure these exercises were completed and documented.

The clinical record was reviewed and on the POC documentation by the PTA for August, September and October 2018, was inconsistent.

The physiotherapist was interviewed and acknowledged that the PTA was responsible for documenting the exercises and the documentation did not reflect the therapy services provided to the resident.

The licensee failed to ensure that any actions taken with respect to a resident's exercises were documented. [s. 30. (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 a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented and to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 31 (4).

Findings/Faits saillants :

1. The licensee failed to ensure a written record relating to the evaluation of the home's staffing plan included the date any changes were implemented.

The Quality Management – Long Term Care (LTC) Program/Committee evaluation tool showed the home's staffing plan was last reviewed by the home's Leadership for the period November 2016-November 2017. A summary of accomplishments was included but the dates of any changes that were implemented was not included.

The home failed to keep a written record of the summary of the changes made to the home's staffing plan and the date those changes were implemented. [s. 31. (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 a written record relating to the evaluation of the home's staffing plan included the date any changes were implemented, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that, a written record was kept relating to each evaluation that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The 2017 annual program evaluation for responsive behaviours was reviewed and the written record included the summary of changes made; however the date that those changes were implemented were not documented in the written record.

The Administrator acknowledged that the date(s) their changes and accomplishments were implemented for the responsive behaviour program were not documented in the written record for their 2017 annual program evaluation.

The licensee failed to ensure that the written record of the 2017 annual evaluation for the responsive behaviour program included the date that the changes and improvements were implemented. [s. 53. (3) (c)]

2. The licensee failed to ensure that, for each resident demonstrating responsive behaviours, the behavioural triggers for the resident were identified, where possible.

Resident #004 had a history of responsive behaviours related to resisting care.

The clinical record was reviewed, which identified the resident being resistant to care. The written plan of care dated a specific date in October, 2018, identified the resident was resistive to treatment and care and interventions were implemented; there were no behavioural triggered identified.

PSW #103 was interviewed and they acknowledged the resident's responsive behaviours of resisting care and treatment and was able to identify the interventions implemented to manage the resident's behaviours. The PSW was unable to identify what triggered the resident to resist care.

RPN #102 and RPN BSO #108 were not aware of the triggers that caused the resident's responsive behaviour related to resisting care and treatment and were unable to locate the triggers on the resident's plan of care.

The licensee failed to ensure that, for resident #004, who was demonstrating responsive behaviours, that the behavioural triggers for the resident were identified, where possible.

[s. 53. (4) (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 a written record is kept relating to each evaluation that includes a summary of the changes made and the date that those changes were implemented and that for each resident demonstrating responsive behaviours, the behavioural triggers for the resident are identified, where possible, to be implemented voluntarily.

WN #7: 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 a resident was administered drugs as directed by the prescriber.

A resident was ordered a specific medication by the physician.

The clinical record was reviewed and the LTCH Inspector identified that a nursing student working with staff #133 had administered an additional dose of medication to the resident.

The home's investigation notes confirmed the resident was administered an additional dose by a nursing student who was administering medications under the supervision of a staff member.

The DOC confirmed that the resident was not administered the correct medication as specified by the physician, and as a result the resident was administered the wrong dose of medication.

The home failed to ensure that a resident was administered medication in accordance with the directions for use specified by the physician. [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 #8: 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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).

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 failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

A resident was admitted to the home on a specific date in January 2018. The resident was considered a certain level of risk for falls until completion of the six week post admission assessment was completed. The resident subsequently had a number of falls with no injuries.

The clinical record showed there was no collaboration between registered staff and the physiotherapist related to the discrepancies in the falls risk assessments by the two disciplines, therefore they were not integrated, consistent and complemented each other.

Registered staff were interviewed and acknowledged that they were not aware that the

physiotherapy assessments identified the resident as a different level of risk for falls. The registered staff acknowledged that there was no collaboration between physiotherapy and nursing related to the resident's falls risk assessments to ensure they were consistent and integrated.

The DOC was unsure of why there was a discrepancy in the nursing and physiotherapy falls risk assessments. The DOC stated that because the physiotherapist works on certain days the interdisciplinary discussions with the whole team does not occur. The DOC acknowledged that the falls risk assessments for the resident, were not integrated, consistent and complemented each other.

The licensee failed to ensure that the staff and others involved in the different aspects of care for the resident, collaborated with each other, in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other. [s. 6. (4) (a)]

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

Resident #008 was assessed by the registered dietitian (RD). The RD also met with the resident's substitute decision maker (SDM). During this time the SDM provided information related to the residents likes, dislikes and preferences.

The resident's clinical record was reviewed and the initial nutrition assessment identified the resident was a moderate nutritional risk and the SDM identified the resident was to have specific food and drink items at certain times of the day.

The resident was observed by LTCH Inspector at meal time and the specific food and drink items were not offered to the resident. A Dietary Aide was not a regular staff member on this unit and rather than checking the resident's diet list in the servery, the aide asked a PSW what to serve the resident.

PSWs were interviewed individually and were not aware of the resident's likes, dislikes and preferences as outlined in the resident's nutritional plan of care.

The RD acknowledged the resident's likes/dislikes and preferences as identified by the SDM and documented in the nutritional plan of care. The RD was not aware that the resident's nutrition and hydration interventions were not being implemented for the

resident.

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

3. A resident was assessed by the physiotherapist on a particular day in May 2018 and recommended the resident participate in physiotherapy. The resident would participate in exercises, a certain number of times a week.

A clinical record review was completed, the resident was evaluated by the physiotherapist and received individual therapy with a PTA on a number of dates in October 2018, less than the number of times the resident was assessed to participate in exercise programs. According to the resident's plan of care, exercises were to be provided a number of times a week. [s. 6. (7)]

4. A resident was assessed by the physiotherapist on a specific date in January 2018 and recommended the resident participate in a specific program a number of times a week.

A clinical record review was completed, the resident received individual therapy with a PTA on a specific number of dates in October 2018, less than the number of times the resident was assessed to participate in exercise programs. According to the resident's plan of care, exercises were to be provided a specific number of times a week.

The licensee failed to ensure that the care set out in the plan of care for residents related to exercise therapy was provided as specified in the plan. [s. 6. (7)]

5. The licensee 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 care set out in the plan was no longer necessary.

The resident had a history of responsive behaviours related to aggression and resisting care and treatment.

The clinical record was reviewed and the current written plan of care indicated that the responsive behaviours related to aggression and resisting care/treatment were current and there were interventions implemented. There was no evidence on the clinical record to determine when the resident's care needs changed or the care/intervention was no

longer necessary.

Staff were interviewed individually and acknowledged that the resident was not aggressive and the only responsive behaviour the resident was experiencing was related to resisting care and treatment. The BSO staff, said that when they reviewed the plan of care, they should have resolved the aggression responsive behaviour and updated the plan of care.

The licensee failed to ensure that when the resident was reassessed and their care needs changed or care set out in the plan was no longer necessary, the plan of care was reviewed and revised. [s. 6. (10) (b)]

WN #9: 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 failed to ensure that any plan, policy, protocol, procedure, strategy or system Instituted or otherwise put in place was complied with.

A review of a CIS reported a missing controlled substance.

On a specific date in January 2018, Staff # 139 assessed resident #014 and was unable to locate the transdermal patch on the resident and applied a new transdermal patch.

The licensee's policy titled “Medication Management- Security and Storage” directed registered staff to notify the DOC and initiate a Medication Incident Report. The policy directed the DOC to investigate drugs that were missing and notify proper authorities.

RN # 116 and the DOC were interviewed individually, both registered staff acknowledged that any lost or missing narcotic or controlled substance should be reported to the local police. The DOC acknowledged the police were not notified of the lost transdermal patch.

The licensee failed to comply with the home's Medication Management policy when they failed to ensure that the proper authorities were notified. [s. 8. (1) (b)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system that, can be easily seen, accessed and used by residents at all times.

During stage one of the RQI, LTCH Inspector #606 observed resident #005 and #026's call bell buttons were under their beds, was not visible and not in reach of the residents.

Resident #005's call bell activator button was observed under the bed and was under a part of the bed frame. Resident #026's call bell activator was under the bed and was pinned under the bed frame bar.

Interview with staff #102 stated that resident #005 will at times play with their call bell and required staff to monitor to make sure the call bell was on their bed. Staff #102 stated that resident #026 was able to come out of their room to call for staff assistance. However, staff #102 stated that the home's practice is that call bells must always be in reach of the resident and confirmed that resident #005 and #026's call bells were not.

Interview with the Administrator stated that the home's policy is for staff to ensure that resident call bells are visible and accessible to the resident.

The licensee has failed to ensure that the home was equipped with a resident-staff communications and response system that, was easily seen, accessed and used by residents at all times. [s. 17. (1) (a)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure the Director was notified of a missing narcotic patch.

Resident #014 was ordered by the physician on a specific date in December 2017, a transdermal patch.

A clinical record review was completed including the home’s Medication Incident Report and Analysis form. On a specific date in January 2018, RPN#139 assessed the resident and was unable to locate the transdermal patch. Staff notified the Director of Care (DOC) and after a search the patch was not found. Staff applied a new transdermal patch.

In an interview with the DOC, they confirmed the transdermal patch was not located and notification was sent to the Director seven days after the patch was discovered missing.

The licensee failed to notify the Director one business day after the occurrence of a missing controlled substance. [s. 107. (3)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a medication incident was reported to the Substitute Decision Maker (SDM)

A transdermal patch was ordered for resident #014 in December 2017.

A clinical record review was completed including the home's Medication Incident Report and Analysis form. On a specific date in January 2018, RPN #139 assessed the resident and was unable to locate the transdermal patch. Staff notified the Director of Care (DOC) and after a search, the patch was not found. Staff applied a new transdermal patch.

The physician was notified the next date they attended the facility on a specific date in January 2018 and the resident or SDM were not notified. A Medication Incident and Analysis form was sent to the pharmacy on a specific date in January 2018.

The home failed to ensure that the resident or SDM were notified of a medication incident. [s. 135. (1)]

2. The licensee failed to ensure that a quarterly review of all medication incidents and adverse drug reactions to reduce and prevent medication incidents and adverse reactions, any changes and improvements made were implemented and that a written record of this review was kept.

On a specific date in September 2018, resident #024 was sent another resident's medications by the pharmacy in a strip with resident #027's name on the strip. This was discovered by nursing staff prior to medications being administered, the medication strip was removed from the medication cart, a Medication incident and Analysis form was completed and the pharmacy was notified.

A review of the home's policy by Classic Care pharmacy titled "Reporting Medication Incidents", stated Classic Care Pharmacy collates and tracks all incidents regardless of origin for quantitative and qualitative purposes. As a member of the home's team, Classic Care Pharmacy contributed to the review, analysis and corrective action or quality improvement planning.

The DOC acknowledged there was no meeting with the pharmacist to review and no changes or improvements were made as a result this incident.

The medication incident report, non-pharmacy Origin Qualitative Medication Incident Analysis Grey Gables for Q4 2017-Q3 2018 document and the PAC meeting minutes of a specific date in October 2018 were reviewed. There was no written record of a review, changes or improvements that included this medication incident.

The home failed to ensure that a quarterly review, and any changes or improvements made as a result of a medication incident was undertaken and a written record of this was kept. [s. 135. (3)]

Issued on this 14th day of January, 2019

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	AMANDA COULTER (694), JANET GROUX (606), KATHLEEN MILLAR (527)
Inspection No. / No de l’inspection :	2018_739694_0017
Log No. / No de registre :	004865-18, 004866-18, 027822-18
Type of Inspection / Genre d’inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Dec 6, 2018
Licensee / Titulaire de permis :	Corporation of the County of Grey 595 9th Avenue East, OWEN SOUND, ON, N4K-3E3
LTC Home / Foyer de SLD :	Grey Gables Home for the Aged 206 Toronto Street South, MARKDALE, ON, N0C-1H0
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Jennifer Cornell

To Corporation of the County of Grey, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d’ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

The licensee must be compliant with s. 8 (3) of the Long-Term Care Homes Act (LTCHA). Specifically, the licensee shall ensure that at least one Registered Nurse is on duty and present in the home at all times, except as provided for in the regulations.

Grounds / Motifs :

1. The licensee failed to ensure that at least one registered nurse (RN) who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times, except as provided for in the regulations.

On a specific number of occasions during a six month period, the home's nursing schedules showed that the home did not have an RN on duty and present in the home during various shifts.

The home's staffing plan, staffing schedules, registered staff shift replacement information and daily roster sheets were reviewed and confirmed that there was no RN on duty for a specific number of shifts during the six month period reviewed.

The DOC acknowledged that they were aware there was to be an RN on duty and present in the facility at all times.

The licensee failed to ensure that at least one RN who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home, except as provided for in the regulations.

This order is based upon three factors where there has been a finding of non-compliance. The factors include scope, severity and history of non-compliance. The scope of the non-compliance was pattern, the severity of the non-compliance was potential for actual harm to residents and the history of non-compliance is despite Ministry of Health (MOH) action, non-compliance continues with the original area of non-compliance. (694)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 01, 2019

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with s.19 (1) of the LTCHA, 2007.

Specifically, the licensee must ensure that:
a) Residents #003, #006, #021, #022, #023 and any other resident are protected from abuse by anyone.

Grounds / Motifs :

1. The licensee failed to protect resident from abuse by anyone.

For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "verbal abuse" means, (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, or (b) any form of verbal communication of a threatening or intimidating nature made by a resident that leads another resident to fear for his or her safety where the resident making the communication understands and appreciates its consequences.

A review of the home's investigation notes showed staff had used inappropriate language in the presence of residents #003, #006, #021, #022, #023, and the incidents were witnessed by another staff member.

In separate identified incidents, staff were overheard using profane language or complaining about the tasks while providing care or assistance to five residents.

Staff acknowledged that they heard other staff make comments about the residents while they were providing care to them. Staff told the Long Term Care

Homes (LTCH) Inspector that they felt uncomfortable with what they had heard and recognized the language to be abusive.

The Administrator acknowledged that the home's investigation concluded that staff were abusive towards the residents.

The licensee failed to protect residents #003, #006, #021, #022 and #023 from abuse by anyone.

This order is based upon three factors where there has been a finding of non-compliance. The factors include scope, severity and history of non-compliance. The scope of the non-compliance is widespread as five residents out five residents were abused, the severity of the non-compliance was minimal harm to residents and the history of non-compliance is despite Ministry of Health (MOH) action, non-compliance continues with the original area of non-compliance. (694)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Dec 18, 2018

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l’article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l’ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l’ordre qui font l’objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l’adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 6th day of December, 2018

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Amanda Coulter

Service Area Office / Bureau régional de services : Central West Service Area Office