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

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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 6, 2017	2017_687607_0017	008223-17	Resident Quality Inspection

Licensee/Titulaire de permis

HALIBURTON HIGHLANDS HEALTH SERVICES CORPORATION
7199 Gelert Road Box 115 HALIBURTON ON K0M 1S0

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

HIGHLAND WOOD
7199 Gelert Road P.O. Box 115 HALIBURTON ON K0M 1S0

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

JULIET MANDERSON-GRAY (607), KELLY BURNS (554)

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): September 25, 26, 27, 28, and 29, 2017

During this Resident Quality Inspection intake Log #018594-17 was inspected concurrently.

Summary of Intake:
1) Log #018594-17: regarding an alleged abuse of resident.

During the course of the inspection, the inspector(s) spoke with the Director of Care/Administrator (DOC/ADM) Life Enrichment Manager, (LEM), Food and Service Manager (FSM), Resident Care Manager (RCM), Resident Assessment Instrument (RAI) Coordinator, Registered Practical Nurses (RPN), Personal Support Workers (PSW), housekeeping staff (HSK), a Substitute Decision Maker (SDM), members of the Resident and Family Council and residents.

During the course of the inspection, the Inspector(s) toured the home, reviewed clinical health records, training records, medication incidents, audit reports and evaluation of the medication process, home applicable policies; observed staff during medication administrations and staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Skin and Wound Care

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

14 WN(s)
11 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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

Findings/Faits saillants :

1. The licensee failed to ensure that there is a written plan of care for each resident that sets out, the planned care for the resident.

Related to Intake Log #018594-17 involving resident #021:

The Resident Care Manager (RCM) submitted a Critical Incident Report (CIR) to the Director, on an identified date, related to an allegation of emotional, physical and verbal abuse involving resident #021 and a visitor.

The Director of Care/Administrator (DOC/ADM) and the RCM investigated the alleged abuse, involving resident #021. The police were also notified of the alleged abuse. The investigation concluded that the allegation was founded and visiting restrictions were developed and communicated to the visitor.

The written plan of care for resident #021 was reviewed by Inspector #554 and failed to set out the planned care related to visiting restrictions.

During an interview, the DOC/ADM indicated to Inspector #554, that the visiting restrictions that were put in place on an identified date and time, were not accessible to staff. The DOC/ADM indicated that he/she should have documented visiting restrictions in resident #021's written plan of care at the identified time, when the visiting restrictions

were drafted. [s. 6. (1) (a)]

2. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

Related to resident #010:

A review of resident #010's current written care plan indicated the resident required one staff assistance with transferring, there were no interventions in the written care plan indicating the resident used a mechanical device for transfers.

On an identified date and time, Inspector #607 observed a transfer symbol/log located on an identified area belonging to resident #010. The transfer symbol/logo indicated one staff to assist for transfers. Below the symbol it was noted in writing that two staff were required to assist with transfers.

During interviews, Personal Support Workers (PSW) #102 and #112, both indicated to Inspector #607, that resident #010 was being transferred with the use of a mechanical device and required two staff assistance.

During an interview, Registered Practical Nurse (RPN) #100 indicated to Inspector #607, that resident #010 required a one person assist with transfers.

During an interview, the DOC/ADM indicated to Inspector #607, that the licensee expectation is that with any change in the resident's care, the written care plan should be updated to reflect the changes.

The licensee failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident, specifically related to resident #010's care plan indicated, the resident required a one person assist with transfers, while interviews with staff indicated the resident required two person assist with the use of mechanical device. [s. 6. (1) (c)]

3. The licensee has failed to ensure that care set out in the plan of care, provided to resident #010 as specified in the plan related to restraints.

Related to resident #010:

On an identified date and time, resident #001 was observed by Inspector #607 in an identified area, using a specific mobility aid with no restraint device in place.

A review of the physician order with an identified date, indicated "restraint device should be in place while using mobility aid."

A review of the Progress Notes for resident #010 indicated the resident had several falls over a five month time period.

During an interview, PSW #102 indicated to Inspector #607, that resident #010 does not use a restraint device when using the identified mobility aid.

During an interview, RPN #100 indicated to Inspector #607, that resident #010 had a physician order in place for the identified restraint device.The RPN further indicated that the identified restraint device was not being used for resident #010, as there were other interventions in place to reduce the resident's fall.

During an interview, the RCM indicated to Inspector #607, that the registered staff had not followed through with the physician orders for resident #010, in relation to the application of the restraint device. The RCM further indicated that the licensee expectation is that care be provided to the resident as per plan of care.

The licensee failed to ensure that the care set out in the plan of care, was provided to resident #010 as specified in the plan. This was specifically related to not ensuring that an ordered restraint device was applied to resident #010. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there was a written plan of care for each resident that sets out, the planned care for each resident, specifically related to resident #021's visiting restrictions, ensuring that the plan of care set out clear directions to staff and others who provide direct care to the resident, specifically related to resident #010's transfer status and to ensure that the care set out in the plan of care, was provided to resident #010 as specified in the plan, specifically related to not ensuring that an ordered restraint device was applied, to be implemented voluntarily.

WN #2: 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 is complied with.

Under O. Reg. 79/10, s.48(1)1 every licensee of a long-term care home shall ensure that the following interdisciplinary program is developed and implemented in the home: a falls prevention and management program to reduce the incidence of falls and the risk of injury.

A review of the licensee Fall Prevention and Management Program Policy # VII-G-60.00

with a date of January 2017 directs:

The Registered staff will:

1.Conduct the falls risk Assessment in PCC at the following times:
-Within 24 hours of admission or readmission;
- As triggered by the Minimum Data Set (MDS) resident Protocol;
- All newly admitted residents are considered a high risk for falls regardless of the assessment scoring until completion of the six week post admission assessment;

Related to resident #010:

Resident #010 was admitted to the home on an identified date.

A review of the pre-admission assessment record for resident #010 indicated, the resident was at moderate risk for falls.

A review of resident #010's written care plan with an identified date that was currently in place, indicated that resident #010 was at moderate risk for falls.

Further review of the Progress Notes for resident #010 indicated resident #010 had several falls and was at moderate risk for falls.

A review of the Fall Risk Assessment in the licensee documenting software, indicated a Fall Risk Assessments was completed 26 days after admission.

A review of the MDS Resident Assessment Protocol (RAPS) with for two identified dates, indicated the resident was triggered for falls within the past 30 days and 31 to 180 days, respectively. The Fall Risk Assessment was completed 26 days after triggered assessment was completed.

The licensee failed to comply with its Fall Prevention and Management Program Policy # VII-G-60.00, specifically related to:
1. Within 24 hours of admission or re-admissions; conduct a fall risk assessment in PCC as triggered by the MDS resident Protocol, as well as, all newly admitted residents are considered a high risk for falls regardless of the assessment scoring until completion of the six week post admission assessment. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

Under O. Reg. 79/10, s. 131 (6) - Where a resident of the home is permitted to administer a drug to himself or herself under subsection (5), the licensee shall ensure that there are written policies to ensure that the residents who do so understand, (a) the use of the drug; (b) the need for the drug; (c) the need for monitoring and documentation of the use of the drug; and (d) the necessity for safekeeping of the drug by the resident where the resident is permitted to keep the drug on his or her person or in his or her room under subsection (7).

The licensee's policy, Resident Self Administration of Medication (#4-007) states that 'for residents who wish to self-administer medication(s), the following criteria are to be followed:
- Obtain a doctor's order authorizing staff to leave the medication(s) at bedside of the resident;
- Ensure resident is capable of self-administration of medication(s);
- Ensure safe and proper storage of medication(s) to protect integrity of medication and to restrict access to anyone other than the resident.
The policy, Resident Self-Administration of Medication, directs that the resident who makes a request to have medication(s) left at the beside should be assessed on an ongoing basis, to be determined by the facility (at least annually), by registered nursing staff, or physician and pharmacist to ensure that they are capable of self-medicating and safe-guarding any medications left at the bedside. The policy directs that a copy of this evaluation (Self-Medication Resident Evaluation Form) of the resident is kept in the resident's chart.

Related to resident #023:

Resident #023 was admitted to the long-term care home on an identified date and had a medical diagnosis which included Cognitive Impairment.

Registered Practical Nurse (RPN) #100 was observed by Inspector #554 on an identified date, administering medications to resident #023. Registered Practical Nurse #100 indicated that resident #023 self-administered a topical medicated cream.

The clinical health record, including physician's orders, were reviewed for a two month period. The physician's order form indicated, a topical cream may be self-applied at a

specific time period.

During an interview, resident #023 indicated, to Inspector #554 on an identified date, that he/she self-administers the topical cream at a specified time. The resident indicated the topical medicated cream was provided by the registered nursing staff, and does not recall any registered nursing staff, or a Physician speaking to him/her about the topical medicated cream. Resident #023 indicated storing the topical medicated cream in his/her mobility device.

During an interview, RPN #100 indicated, being unaware of any policy or procedure specific to resident's self-administering medications and how resident's would safe-guard medications left in an identified area. RPN #100 indicated, that it would be up to the Physician to determine the resident's capability.

The attending Physician for resident #023 indicated, to Inspector #554, that it would be up to the registered nursing staff to determine if a resident is capable of self-administering medications, as they are the one's who requested the orders. The Physician further indicated, that he/she was not aware of the Self-Medication Resident Evaluation Form, and had not completed any forms, as specified by the licensee's policy (Resident Self-Administration of Medications).

There was no copy of the Self-Medication Resident Evaluation Form on file for resident #023, nor was there any documentation to support that resident was assessed by registered nursing staff, the Physician and or the Pharmacist to ensure resident #023 was capable of self-medicating and safe-guarding medications left at an identified area, specifically related to the medicated topical cream the resident was using.

2. Related to resident #001:

During interviews, PSW #102, and RPN #100 both indicated to the Inspector, that resident #001 self applied a medicated topical cream to specific body part.

The physician's order for resident #001 was reviewed and indicated on an identified date, may self-apply a medicated topical cream, when needed.

During an interview resident #001 indicated, to Inspector #554, that he/she self-applies the ordered medicated topical cream at two identified times. Resident #001 indicated storing the medication in an identified area.

There was no copy of the Self-Medication Resident Evaluation Form on file for this resident, nor was there any documentation to support that the resident was assessed by registered nursing staff, the Physician and or the Pharmacist, to ensure resident #001 was capable of self-medicating and safe-guarding medications left in an identified personal space belonging to the resident.

During an interview, the RCM indicated to Inspector #554, being unsure of how the licensee was ensuring safe and proper storage of medications, in resident identified areas. Primarily for those residents with orders to self-administer as residents do not have secured areas. The RCM indicated, that there were residents residing in the long-term care home that do exhibit responsive behaviours, specifically related to wandering into other residents identified areas.

The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with, specifically, failed to ensure, that resident #001 and or #023 were assessed by a registered nursing staff, the Physician or the Pharmacist, to ensure the residents were capable to self administer identified medications, and to safe-guard medications left in their identified personal space. The licensee further failed to ensure that a copy of an evaluation Self-Medication Resident Evaluation Form was contained within the clinical health record, for resident #001 and or #023. [s. 8. (1) (b)]

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 any plan, policy, or system instituted or otherwise put in place is complied with, specifically related to Fall Prevention and Management Program Policy # VII-G-60.00 and resident #010's falls, as well as Resident Self Administration of Medication policy #4-007 for resident #001 and #023 related to medication self administrations, to be implemented voluntarily.

WN #3: 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 failed to ensure that the home is equipped with a resident-staff communication and response system that, is available in every area accessible by residents.

During the initial tour of the long-term care home it was observed, by Inspector #554, that there was not a resident-staff communication and response system in two identified areas within the home and one identified area outside of the home.

Residents were observed, by Inspector #554, using the identified areas on an identified date, and throughout the inspection.

During interviews, PSW #103, and RPN #100, all indicated to the Inspector, that the three identified areas were resident accessible areas.

During an interview, the DOC/ADM indicated to the Inspector, that two of the identified areas within the home were created this year. The DOC/ADM indicated that the areas identified did not have a resident-staff communication and response system available. The DOC/ADM also indicated, that there had not been any incidents involving residents, specific to the identified areas not having have a resident-staff communication and response system available. [s. 17. (1) (e)]

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 home is equipped with a resident-staff communication and response system that, is available in every area accessible by residents, specifically related to the three identified areas, to be implemented voluntarily.

WN #4: 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 there written policy that promotes zero tolerance of abuse and neglect of resident's is complied with.

The licensee's policy, Zero Tolerance of Abuse and Neglect (#VII-G-10.00) (revision July 2016) states that every resident has the right to be protected from abuse; and that all staff members have an obligation to report any incident of suspected, alleged abuse.

The policy, Zero Tolerance of Abuse and Neglect directs that staff members who becomes aware of potential, actual or alleged abuse, be it by a staff, volunteer, family member co-worker or other person, must take the following steps: Safe-Guard the resident immediately and notify the Charge Nurse.The policy further directs that the Charge Nurse will:
- Safe-Guard the resident immediately, assess for injuries and provide medical intervention if indicated;
- Assess the situation, remove the suspected or alleged perpetrator from resident access;
- Notify oncoming nurse of need for ongoing documentation;
- Notify the Director of Care via email and/or voice mail. Notify the Manager on call.

Related to Intake #018594-17 involving resident #021:

The RCM submitted a CIR to the Director on an identified date, pertaining to an allegation verbal, emotional and physical abuse involving resident #021 and a visitor. The CIR indicated resident #021's had a visitor. PSWs #106, and #109, Dietary Aid (DA) #107, RPN #108, a visitor, and resident #014, all reported witnessing resident #021 being abused by the identified visitor.

A review of the licensee investigations notes by Inspector #554 indicated, PSWs #106, #109, Dietary Aid (DA) #107 and RPN #108, all reported witnessing resident #021 being

abused by the identified visitor, but did nothing to safeguard the resident.

During an interview, RPN #100, the Charge Nurse who was working the shift when the incident occurred, indicated to Inspector #554, that RPN #108 reported the alleged abuse incident involving resident #021 to RPN #100 at an identified time. Registered Practical Nurse #100 indicated that he/she documented the alleged incident in the progress notes and left a voice mail message for the DOC/ADM. Registered Practical Nurse #100 indicated being aware that RPN #108 had not notified the Ministry of Health and Long-Term Care (MOHLTC) of the alleged abuse, and had not notified the Manager on call. The RPN #100 indicated that he/she had not notified the MOHLTC, or the Manager on call as it was RPN #108's responsibility to notify them.

During an interview, the DOC/ADM indicated that the identified PSWs, a DA and a RPN, all failed to follow the licensee's policy, Zero Tolerance of Abuse and Neglect as supported by the following:
i) Resident #021 and/or other resident's should have been immediately safe-guarded from the identified visitor;
ii) RPN #108, who was the assigned Charge Nurse, should have taken charge and stopped the situation from continuing. The DOC/ADM indicated that if RPN #108 was uncomfortable in addressing the visitor then RPN #108 should have contacted a Registered Nurse, from the emergency department at hospital attached to the long-term care home, or the police should have been called for assistance.
iii) RPN #108 should have notified the Manager on call of the abuse incident.
iv) RPN #100 should have notified the MOHLTC and the Manager on call, when he/she was aware that neither had been notified of the abuse incident involving resident #021.

The DOC/ADM indicated all staff are expected to comply with the licensee's zero tolerance of abuse and neglect policy. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the licensee's written policy that promotes zero tolerance of abuse and neglect of resident's is complied with, specifically related to safeguarding of resident #021 and notifying a charge nurse of alleged abuse, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any person who had reasonable grounds to suspect, abuse of a resident by anyone, had occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

Related to Intake Log #018594-17 involving resident #021:

The RCM submitted a CIR to the Director on an identified date, pertaining to an allegation verbal, emotional and physical abuse involving resident #021 and a visitor. The CIR indicated resident #021's had a visitor. PSWs #106, #109, Dietary Aid (DA) #107, RPN #108, a visitor, and resident #014, all reported witnessing resident #021 being abused by the identified visitor.

During an interview, the DOC/ADM indicated to Inspector #554, that RPN #108 was the assigned Charge Nurse on an identified date, and that RPN #108 had been aware of the abuse incident. The RPN directly witnessed the incident and had reported what he/she saw to the oncoming shift, on that same date. The DOC/ADM indicated that RPN #108 had not reported the alleged abuse, involving resident #021, to the Director, of the Ministry of Health and Long-Term Care (MOHLTC), on an identified date. The DOC/ADM indicated that it is the expectation and the licensee's policy that the designated charge nurse immediately report allegations, suspicion and or witnessed abuse immediately to MOHLTC. The DOC/ADM indicated that RPN #108 is aware of required reporting specific to allegations, suspected or witnessed abuse.

Registered Practical Nurse #108 who had reasonable grounds to suspect abuse of a resident #021 by a visitor had occurred, failed to immediately report the suspicion and the information upon which it was based to the Director.

The allegation of abuse, which occurred on an identified date and time, was not reported to the Director until a day later. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that any person who had reasonable grounds to suspect, abuse of a resident by anyone, had occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director, specifically related to resident #021, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there policy to minimize the restraining of residents is complied with.

A review of the licensees Restraint Implementation Protocols Policy # VII-F-10.08 indicated the following:

Prior to the application of a restraint, the Physician and staff will seek to identify and address the physical psychological condition for which the restraint was being considered.

The Registered staff will:
10. Obtain Consent for restraint use or refusal to use restraint from the resident/SDM at the initiation of the restraint, annually and thereafter, and upon any change in the restraint order;

Related to resident #010:

A review of the physician order with an identified date by Inspector #607, indicated "restraint device while using mobility device to aid in falls prevention." Further review of resident #010's clinical health record, failed to locate a written consent form for the physician ordered restraint device as per the licensee's policy.

During interviews, the RCM and the DOC/ADM both indicated to Inspector #607, that the registered staff had not follow through with the physician orders for resident #010 in relation to the restraint device or obtained a written consent as per the licensee's policy.

The failed licensee to ensure that its Restraint Implementation Protocols Policy # VII-F-10.08 was complied with specifically related to:
10. Obtain Consent for restraint use or refusal to use restraint from the resident/SDM at the initiation of the restraint, annually and thereafter, and upon any change in the restraint order. [s. 29. (1) (b)]

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 ensuring that its Restraint Implementation Protocols Policy # VII-F-10.08 is complied with, specifically related to restraint device for resident #010, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that staff receive training on the licensee policy to promote zero tolerance of abuse and neglect of residents, prior to performing their responsibilities.

Related to Intake Log #018594-17 involving resident #021:

The Resident Care Manager (RCM) submitted a Critical Incident Report (CIR) to the Director, on an identified date, related to an allegation of emotional, physical and verbal abuse involving resident #021 and a visitor.

Personal Support Worker #106, and DA #107 were identified, by the DOC/ADM, as staff who witnessed the alleged abuse incident involving resident #021.

During an interview, the RCM indicated, Inspector #554, that there was no documentation to support that PSW #106 and DA #107 was provided training, specific to the licensee's policy to promote zero tolerance of abuse and neglect of residents, before performing their responsibilities.

During interviews, the DOC/ADM and the RCM both indicated to Inspector #554, that three additional staff were newly hired during the past six months, and those staff also did not receive the required training, specific to zero tolerance of abuse and neglect.

The licensee failed to ensure that staff receive training on the home policy to promote zero tolerance of abuse and neglect of residents, prior to performing their responsibilities, specifically related PSW #106 and DA #107. [s. 76. (2) 3.]

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 ensuring that staff receive training on the home policy to promote zero tolerance of abuse and neglect of residents, prior to performing their responsibilities, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee failed to ensure that the appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

Related to Intake Log #018594-17 involving resident #021:

The Resident Care Manager (RCM) submitted a Critical Incident Report (CIR) to the Director, on an identified date, related to an allegation of emotional, physical and verbal abuse involving resident #021 and a visitor.

During an interview, the DOC/ADM indicated, to Inspector #554, that RPN #108 was the assigned Charge Nurse on the date the incident occurred, and had been aware of the abuse incident, as he/she directly witnessed the incident, and had not reported the alleged abuse to the police. The DOC/ADM further indicated that RPN #108 should have reported the abuse incident immediately to the police.

The Police were notified a day later after the incident occurred. [s. 98.]

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 ensuring that the appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that documentation included all assessments, reassessment and monitoring, including the resident's response.

The licensee's policy, Restraints Implementation Protocols (#VII-F-10.08) (effect date of January 2017), directs that registered nursing staff will, reassess the resident's condition, and the effectiveness of the restraining device at least every eight hours; and that such will be documented and signed on the Electronic Medication Administration Record (eMAR).

Related to resident #016:

Resident #016 has a medical diagnosis which included Cognitive Impairment, and was dependent on staff for activities of daily living (ADL), and was identified as being at high risk for falls.

Resident #016 was observed, by Inspector #554, using a mobility aid with a restraint device in place and was unable to remove the device.

Personal Support Worker (PSW) #102 indicated, to the Inspector, that resident #016 is at high risk for falls, had a restraint device in place while using the mobility aid. PSW #102 also indicated that resident #016 uses the mobility aid throughout most of the day.

The clinical health record, for resident #016, was reviewed for a two month time period and had three identified interventions in place related to the application of a restraint

device and falls.

During an interview, RPN #100 indicated, to Inspector #554, that resident #016 used a restraint device while using the mobility aid. Registered Practical Nurse #100 indicated that the PSWs sign for restraints hourly on an Electronic Restraint Monitoring Record, and that the registered nursing staff sign every eight hours on the Electronic Medication Administration Record (eMAR).

The eMAR, specific to resident #016, was reviewed, by Inspector #554, for a one month period. There was no signage documented by registered nursing staff that the condition of resident #016 was reassessed or the effectiveness of the restraint device was evaluated at a minimum of every eight hours by registered nursing staff.

During interviews, Registered Practical Nurse #101 and the Resident Care Manager, both indicated, to Inspector #554, that it is an expectation that registered nursing staff sign on the eMAR, resident's condition and the effectiveness of the restraining device every eight hours. Registered Practical Nurse #101 indicated, that there was no signage documented by registered nursing staff on the eMAR, specific to resident #016, for an identified one month period.

The licensee has failed to ensure that when resident #016's condition had been reassessed related to a restraining device being used for the resident, as there was no documented signage of the restraint by a registered nursing staff member, at least every eight hours as required. [s. 110. (7) 6.]

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 there is a process in place and monitored, ensuring that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented, all assessment, reassessment and monitoring, including the resident's response, specifically related to resident #016 restraint device, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee failed to ensure that all areas where drugs are stored are restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator.

During an interview, RPN #100, who was the designated Charge Nurse indicated to Inspector #554, that he/she carries a set of keys, which included a keys to three identified areas including the medication room, that were restricted to registered staff and the Administrator. Registered Practical Nurse #100 indicated that a spare set of keys, for the identified restricted areas, were also kept inside an unlocked drawer in an identified area. Registered Practical Nurse #100 indicated, the identified area where the keys were being kept, was not locked and was accessible to staff and others in the long-term care home. Registered Practical Nurse #100 indicated, that the spare set of keys, which include keys to the three identified restricted designated areas were always stored in the unlocked drawer, in an identified area, in case someone needs them.

During an interview, the DOC/ADM indicated to Inspector #554, being aware that a spare set of keys for the three identified restricted designated areas including the medication room, were being stored in the unlocked drawer in the identified area. The DOC/ADM indicated that the spare keys were in the unlocked drawer in case registered nursing staff locked their keys in the restricted designated area.

2. On an identified date, Inspector #554 observed Housekeeping Aid (HSK) #104 exiting the medication room that was restricted to registered staff and the Administrator only. The door to the identified area was locked before HSK #104 exited. The HSK #104 indicated having keys in his/her possession for the area that was restricted to registered staff and the Administrator only. House keeping Aid #104 indicated he/she enters the restricted area daily to clean and empty garbage. The HSK #104 indicated that he/she was not being supervised by anyone when inside the restricted area and uses the spare set of keys, which were stored in an unlocked drawer in an identified area, to access the registered staff restricted identified area.

During an interview, RPN #100 indicated, to Inspector #554, that the keys HSK #104 had in his/her possession was to enter the area that is restricted to registered staff only, contained keys to the three identified restricted areas which included the medication room. Registered Practical Nurse #100 indicated being aware that housekeeping staff enter this restricted area unsupervised on a daily basis.

The DOC/ADM indicated to Inspector #554, that he/she was aware that housekeeping staff do access the area that was restricted to registered staff and the Administrator only. [s. 130. 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 ensuring that all areas where drugs are stored are restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator, to be implemented voluntarily.

WN #11: 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).

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Related to resident #023:

Registered Practical Nurse (RPN) #100 was observed, by Inspector #554 on an identified date, preparing to administer a physician ordered medication to resident #023. Registered Practical Nurse #100 completed a treatment as part of the physician's order prior to administering a subcutaneous medication. The RPN did not administered the subcutaneous medication as per the physician's order after completing the specified treatment on resident #023.

During an interview, RPN #100 indicated, to Inspector #554, that he/she was not administering the physician ordered subcutaneous medication to the resident due to the treatment range. Registered Practical Nurse #100 indicated, to Inspector #554, that the decision to not administer the physician ordered medication was based on his/her nursing judgement, and was not an order from the Physician.

The clinical health record, for resident #023, was reviewed by Inspector #554 for a two month period.

The Physician's Order Form indicated the following: Medication to be administered, subcutaneously at three identified times daily, may increase medication as per physician instructions, a specified treatment to be completed at two identified time periods.

The Electronic Medication Administration Record (eMAR) was reviewed, by Inspector #554, for two identified dates and time, and there were documented evidence to indicate that the ordered subcutaneous medication was held and not given for both times.

The clinical health record, including physician's orders, did not contain directions specific to the prescribed medication being held or not administered for resident #023.

During an interview the DOC/ADM indicated, to Inspector #554, that physician's orders are to be followed as written. The DOC/ADM indicated that Registered Practical Nurse #100 should have contacted resident #023's Physician to discuss his/her concerns, regarding the specified treatments for resident #023, and should not have just held or not given the subcutaneous medication without the Physician's direction, and/or specific physician's orders to do so.

Registered Practical Nurse #100 failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, specifically related to the physician ordered medication not administered on two identified dates and times. [s. 131. (2)]

2. The licensee failed to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident.

Related to resident #001 and #002:

Personal Support Worker (PSW) #102 and RPN #100 indicated, to Inspector #554 on an identified date, that resident's #001 and #002 are cognitively well and self-administer either topical and oral medications.

Registered Practical Nurse #100 indicated that the identified topical medication are considered prescribed medication. Registered Practical Nurse #100 indicated that any resident self-administering medications must have a physician's order to do so.

During interviews, resident #001 and #002 both indicated to Inspector #554, that they self-administers medications, specifically, physician prescribed topical and mineral oral medications. Inspector #554 observed resident #001 and #002 with identified medications stored in identified areas of their personal space.

The clinical health record for resident #001 and #002 were reviewed, for four month period indicated that both resident #001 and #002 had no physician orders to self-administer the identified medications.

During an interview, the RCM indicated, to Inspector #554, that the identified topicals were considered to be prescribed medications, and that any resident self-administering medications must have a physician's order. The RCM reviewed resident #001 and #002's physician's orders, with Inspector #554, and indicated that the resident #001 and #002 did not have orders to self-administer the above identified medications. [s. 131. (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 ensuring that drugs are administered to residents in accordance with the directions for use specified by the prescriber, specifically Physician ordered medication not administered to resident #023, and to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident, specifically related to resident #001 and #002, to be implemented voluntarily.

WN #12: 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 respond in writing within 10 days of receiving Family Council advice related to concerns or recommendations.

A review of the Family Council Minutes with an identified date, indicated that a concern was brought forward related to the licensee's emergency telephone system and further indicated that the DOC/ADM was aware of the above identified concern.

During an interview, the Family Council Representative indicated to Inspector #607, the concerns related to licensee's telephone system had been an ongoing concern and indicated that the DOC/ADM was aware of the concern. The Family Council Representative further indicated a response to the concern was not received in writing within 10 days, but was communicated at the next Family Council meeting, 30 days later.

During interviews with the DOC/ADM indicated to Inspector #607, being aware of the above identified concern related to the licensee's emergency phone line and further indicated that a response was not provided in writing to the Family Council within 10 days. [s. 60. (2)]

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 67. A licensee has a duty to consult regularly with the Residents' Council, and with the Family Council, if any, and in any case shall consult with them at least every three months. 2007, c. 8, s. 67.

Findings/Faits saillants :

1. The licensee has failed to ensure that the Residents' Council, is consulted with regularly, in any case, at least every three months.

During an interview, the Resident Council Assistant indicated to Inspector #607, that he/she had been assisting the Council for a specified time period, and further indicated that licensee had not consulted with the Council at any time during a one year period.

During an interview, the DOC/ADM indicated to Inspector #607, the licensee do not consult with Resident Council.

The licensee failed to ensure that Resident Council is consulted at least every three months. [s. 67.]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(f) is reviewed by the Residents' Council for the home; and O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that menu cycle was reviewed by the Residents' Council.

During an interview, by Inspector #607, the assistant to Resident Council indicated, that the menu cycle was not being reviewed at the Resident Council meetings. The assistant to Resident Council further indicated that concerns related to meals were being discussed with the Food and Services Manager (FSM) at the Diners Club Committee meetings, which was a separate committee from Resident Council.

During an interview, by Inspector #607, the FSM indicated that a review of the menu cycle was not being reviewed by the Resident Council, but was being reviewed at Diners Club Committee, a separate committee from Resident Council.

The licensee failed to ensure that menu cycle was reviewed by the Residents' Council. [s. 71. (1) (f)]

Issued on this 26th day of October, 2017

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

Original report signed by the inspector.