Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 2, 2017	2017_395613_0006	003912-17	Resident Quality Inspection

Licensee/Titulaire de permis

584482 ONTARIO INC
689 YONGE STREET MIDLAND ON L4R 2E1

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

MANITOULIN LODGE
3 MAIN STREET P. O. BOX 648 GORE BAY ON P0P 1H0

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

LISA MOORE (613), CHAD CAMPS (609)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): March 20-24 and 27-31, 2017.

The following intakes were completed during this inspection:

One Follow up related to a compliance order #001 under s. 24. (1) of the LTCHA issued during inspection #2016_333577_0005 related to not immediately reporting certain matters to the Director;

One Complaint related to concerns regarding treatment by staff during the provisions of care;

Seven Critical Incidents (CIs) the home submitted to the Director regarding alleged staff to resident abuse.

Two CIs the home submitted to the Director related to resident falls resulting in injury.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Staff Educator (ED), Administrative Assistant (AA), Restorative Care Coordinator (RCC), Dietary Aides (DAs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), family members and residents.

The Inspector(s) also conducted a tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, and reviewed numerous licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
7 WN(s)
5 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 24. (1)	CO #001	2016_333577_0005	609

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, care set out in the plan had not been effective.

Inspector #609 reviewed two Critical Incident (CI) reports that were submitted to the Director in January 2016, and March 2016, which outlined two separate falls by resident #009, which resulted in the resident sustaining injuries.

A) A review of resident #009's current plan of care found that a safety device was to be applied to the resident when up in their wheelchair and that the resident was to be taken to a specified area to be monitored by available staff.

A review of resident #009's progress notes found in the post falls assessments that despite the safety device and the monitoring by staff at a specified area, the resident fell in February 2016. In March 2016, the resident again fell out of their mobility aid at a specified area, this time resulting in the resident sustaining an injury.

During an interview on March 28, 2017,with the Administrator, they verified that resident #009 was able to remove themselves from the safety device and that the safety device was ineffective in preventing the resident from falling. The Administrator further verified that monitoring of the resident at the specified area was also ineffective, as the resident continued to fall, despite this intervention.

B) A review of resident #009's plan of care found that in January 2016, a safety device was to be used when the resident was in bed.

A review of resident #009's progress notes found in the post falls assessments that despite the device, the resident fell out of bed on three occasions in February 2016, and as well on three occasions in March 2016.

During an interview on March 28, 2017, with the Administrator, they verified that the use of the device was ineffective, as the resident continued to fall.

C) A review of resident #009's progress notes found that in March 2016, resident fell out of bed.

The progress notes further indicated that the resident did not have an adaptive aid in use at the time of the fall.

During an interview on March 29, 2017 with PSW #108, they verified that they were present and working in the home in March 2016, when resident #009 had fallen and further verified that the resident did not have their adaptive aids on at the time of the fall. PSW #108 described how the resident would constantly remove the adaptive aids.

PSW #108 indicated that adaptive aid was not an effective fall prevention intervention as the resident would often refuse to have it applied. [s. 6. (10) (c)]

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 when residents are reassessed and the plan of care reviewed and revised at least every six months and at any other time when, care set out in the plan is not effective, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written policy that promoted zero tolerance of abuse and neglect of residents and was complied with.

Inspector #609 reviewed a Critical Incident (CI) report that was submitted to the Director in February 2017, which outlined allegations of abuse by RPN #106 towards resident #010 in February 2017.

A review of the home's internal investigation found that the allegations of abuse were written in a progress note by RN #105 in resident #010's health care record after the resident reported the allegations in February 2017. The allegations of abuse were not reported to the Director until 17 hours later in February 2017, when the Administrator was prompted after reading the progress note during the shift to shift report.

A review of the home's policy titled "Resident Rights, Care and Services- Abuse- Zero Tolerance- Staff Acknowledgement" last revised March 23, 2015, indicated that staff members who had reasonable grounds to suspect abuse or neglect of a resident must immediately report their suspicion to the most senior administrative personnel on site at the home.

During an interview on March 23, 2017, with RN #105, they verified to the Inspector that in February 2017, resident #010 made allegations of abuse by a staff member, which they wrote into a progress note. RN #105 indicated that they should have immediately reported the suspicion of abuse to the home's administration.

During an interview on March 22, 2017, with the Administrator, they verified that RN #105 should have immediately reported the allegations of abuse to the home's administration and that RN #105 did not comply with the home's zero tolerance of abuse and neglect policy. [s. 20. (1)]

2. Inspector #613 reviewed a CI report that was submitted to the Director in October 2016, which described an allegation of staff to resident abuse. The CI report stated that in October 2016, at a specific time, PSW #113 approached RN #110 in regards to allegations of inappropriate behaviour by a staff member during care, as reported by resident #011. The CI report indicated that resident #011 had reported their concerns to PSW #113 and RN #110.

The CI report indicated that RN #110 did not report the alleged abuse to management until the following day in October 2016, when RN #110 had emailed the details of the alleged incident to the Administrator in October 2016 at a specific time, six and half hours after the incident had occurred.

A review of the home's internal investigation identified that PSW#108 had provided care to resident #011 prior to the resident stating the accusation. The internal investigation identified that RN #110 had done the following;

-removed PSW #108 from caring for resident #011, and provided them with a different assignment.

-did not notify the Administrator or the Director of Care at the time the incident had occurred.

-did not notify resident #011's substitute decision-maker (SDM) of the alleged abuse that had resulted in distress to the resident.

-did not contact the police force.

The home's policy titled "Resident Rights, Care and Services - Abuse" last revised March 26, 2015, indicated that if the Administrator or Director of Care was not in the home, the Charge Nurse would conduct the following interventions;

-advise the abuser, staff member, that they would be placed off work with pay pending an investigation of the situation.

-notify the Administrator of the situation. If the Administrator was not available, notify the Director of Care.

-notify the resident's SDM, and any other person specified by the resident of the alleged, suspected or witnessed incident of abuse that had caused distress to the resident, if unable to reach either the Administrator or Director of Care.

-notify the appropriate police force, if unable to reach either the Administrator or Director of Care.

During an interview on March 27, 2017, with the Administrator and Director of Care (DOC), they verified that RN #110 had not followed the home's policy and should have brought forward the allegation of sexual abuse immediately to the manager on call to ensure that appropriate interventions were immediately completed. [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 by all staff, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident had fallen, the resident had been assessed and, where the condition or circumstances of the resident required, a post-fall assessment had been conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Inspector #609 reviewed two CI reports that were submitted to the Director in January 2016, and March 2016, which outlined two separate falls by resident #009 which resulted in the resident sustaining injuries.

Inspector #609 reviewed resident #009's progress notes which found that between January 2016, to March 2016, the resident had fallen nine times.

A review of the home's policy titled "Resident Rights, Care and Services- Required Programs- Falls Prevention and Management Program" last revised May 27, 2016, indicated that when a resident had fallen staff were to complete a post falls assessment, where the condition of circumstances of the resident was required.

A review of the nine post falls assessments resident #009 received between January 2016, to March 2016, found three of the nine or 33 per cent of the assessments were incomplete.

During an interview on March 28, 2017, with the Administrator, a review of resident #009's post falls assessments dated January 2016, March 2016, and March 2016, was conducted. In each of the three assessments areas of the post falls assessment were left blank or incomplete. The Administrator verified that the home's post falls assessments were to be completed in their entirety for every fall experienced by a resident and that for the three assessments reviewed this did not occur. [s. 49. (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 when a resident has fallen that the resident is assessed and, if required, a post-fall assessment has been conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 59. Therapy services
Every licensee of a long-term care home shall ensure that therapy services for residents of the home are arranged or provided under section 9 of the Act that include,
(a) on-site physiotherapy provided to residents on an individualized basis or in a group setting based on residents' assessed care needs; and
(b) occupational therapy and speech-language therapy. O. Reg. 79/10, s. 59.

Findings/Faits saillants :

1. The licensee has failed to ensure therapy services for residents of the home were provided that included on-site physiotherapy provided to residents on an individualized basis or in a group setting based on residents' assessed care needs.

Inspector #609 reviewed two CI reports that were submitted to the Director in January 2016, and March 2016, which outlined two separate falls by resident #009, which resulted in the resident sustaining injuries.

A review of the home's policy titled "Resident Rights, Care and Services-Required Programs-Falls Prevention and Management Program" last revised May 27, 2016, indicated that when a resident had fallen that they were to be assessed by physiotherapy in a timely manner via a post fall referral and that the outcomes of the physiotherapy assessment were documented in the resident's progress notes. The policy also indicated that an evaluation of the fall interventions was to be revised if found ineffective.

A review of resident #009's progress notes found that in January 2016, and February 2016, two post falls referrals to physiotherapy were made.

A review of resident #009's health care records found that despite the referrals to physiotherapy and nine falls, no physiotherapy assessments were performed for the resident from January to March 2016.

During an interview on March 29, 2017, with the Administrator, they outlined that there was no physiotherapist employed within the home between January 2016 and March 2016, and as a result, resident #009 was not provided physiotherapy services, they were assessed as requiring. [s. 59. (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 therapy services for residents in the home are provided that include on-site physiotherapy provided to residents on an individualized basis or group setting based on residents' assessed care needs, to be implemented voluntarily.

WN #5: 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. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

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 has failed to ensure that all medication incidents were documented, reviewed and analyzed, corrective action was taken as necessary and a written record was kept of everything required under clauses (a) and (b).

During an interview on March 23, 2017, with the DOC, they informed Inspector #613 that all medications incidents were reported on a form titled, "Medication Incident Form" that was completed by the registered staff and then provided to the DOC for follow up with the registered nurse who made the error. All medication incidents for the month were discussed at the registered staff monthly meetings to analyze the medication errors and at the quarterly Professional Advisory Committee (PAC) meetings.

During an interview with RN #114 and RPN #112, they stated that they could not recall the DOC following up with the registered staff member after a medication incident

occurred. They verified that medication incidents were reviewed at the monthly registered staff meetings, where the registered staff would discuss ways to prevent recurrence of medication incidents.

Inspector #613 reviewed a binder titled, "Medication Error Tracking", that contained all the medication error incident reports that had occurred for January 1, 2017 to March 23, 2017, which identified the following;

-January 2017 - 10 medication incidents occurred. Only two medication incident reports identified documented corrective actions for the medication errors. Eight incident reports were incomplete and did not identify any documentation that the medication incidents were reviewed and analyzed for corrective actions.

-February 2017 - 11 medication incidents occurred. Only four medication incident reports identified documented corrective actions for the medication errors. Seven incident reports were incomplete and did not identify any documentation that the medication incidents were reviewed and analyzed for corrective actions.

-March 2017 - 15 medication incidents occurred. Only five medication incident reports identified documented corrective actions for the medication errors. 10 incident reports were incomplete and did not identify any documentation that the medication incidents were reviewed and analyzed for corrective actions.

A review of the Registered Staff meeting minutes for January 2017 and February 2017 identified the medication errors were reviewed; however, there was no other information documented to identify that the medication errors had been analyzed or that corrective action had been taken to prevent recurrence.

A review of the home's policy titled, "Resident Rights, Care and Services – Medication Management – Medication Errors" last revised October 7, 2013, identified that the DOC would investigate all medication errors to determine the type and reason for the error, implement changes to correct system and process failure identified as root cause of the errors, implement changes to correct practice and or competency related to issues identified as root causes of the medication errors.

During an interview with the DOC, they confirmed that an analysis of each medication incident to identify corrective action had not been documented. [s. 135. (2)]

2. The licensee has failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that had occurred in the home, any changes and improvements identified in the review were implemented and a written record was kept of everything provided in clause (a) and (b).

On March 23, 2016, Inspector #613 interviewed the DOC, who stated that they did not have a record to show the Inspector that all medication incidents and adverse drug reactions were reviewed and analyzed quarterly in order to reduce and prevent medication incidents and adverse drug reactions but, that medication errors were discussed at the monthly registered staff meetings and at the quarterly Professional Advisory Committee (PAC) meetings.

A review of the Registered Staff minutes for January 2017 and February 2017 identified the medication errors were reviewed. No other information was documented. A review of the minutes of the PAC meeting for the month of January 2017, failed to reveal any mention of a discussion related to preventing and reducing medication incidents or any changes and improvements implemented in the review.

A review of the home's policy titled, "Resident Rights, Care and Services – Medication Management – Medication Errors" last revised October 7, 2013, did not identify that a quarterly review would be undertaken of all medication incidents and adverse drug reactions that had occurred in the home. The policy identified that an annual multi-disciplinary review and evaluation of all medication errors to demonstrate what improvements if any have been made to service.

During interviews with the Administrator and DOC, they both confirmed that quarterly reviews of all medication incidents and adverse drug reactions had not been done and there was no written documentation. [s. 135. (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 to ensure all medication incidents and adverse drug reactions are documented, reviewed and analyzed, corrective action is taken as necessary and a written record is kept of everything under clauses (a) and (b). Also, to ensure a quarterly review is undertaken of all medication incidents and adverse drug reactions that has occurred in the home since the time of the last review in order to reduce and prevent medication incident and adverse drug reactions, any changes and improvements identified in the review are implemented and a written record is kept of everything provided for in clauses (a) and (b), to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and of acquiring, in the case of new items.

During stage one of the inspection, Inspector #609 observed a used unlabelled tube of cream, used bottle of body wash, used bottle of skin lotion and a soiled unlabelled urinary device on the back of the toilet in the shared bathroom in a resident room. In another resident room, in the shared bathroom, two used bottles of unlabelled shaving cream were observed.

A review of the home's policy titled "Resident Rights, Care and Services- Nursing and Personal Support Services- Personal Aids" effective date September 16, 2013, indicated that all resident owned personal care items should be labelled with the resident's name within 48 hours.

During an interview on March 21, 2017, with PSW #104, they verified that the observed items were used and unlabelled and that they should have been labelled with the resident's name within 48 hours of the resident acquiring the item.

During an interview on March 21, 2017, with the DOC, they verified that all residents' personal care items were to be labelled within 48 hours of acquiring the item and that this did not occur. [s. 37. (1) (a)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident who was incontinent received an assessment using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence that included identification of the potential to restore function with specific interventions.

During the inspection, residents #001 and #003 were identified through a staff interview as requiring an urinary intervention.

Inspector #613 reviewed the continence care assessments for residents #001 and #003 completed in July 2016 and June 2013, which found that the assessments did not address the potential to restore function or provide any specific interventions.

A review of the home's policy titled "Resident Rights, Care and Services – Required Programs – Continence Care and Bowel Management - Program" last reviewed July 24, 2014, indicated that the continence care assessments included identification of potential to restore function with specific interventions.

During an interview on March 28, 2016, with the DOC, they reviewed the home's continence care assessment tool used by the home and verified that it did not address the potential to restore function with specific interventions. [s. 51. (2) (a)]

Issued on this 13th day of June, 2017

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

Original report signed by the inspector.