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 prévue 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**

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133


## Public Copy/Copie du public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Nov 23, 2018 | 2018_615609_0024 | 024948-17, 019997-18, 020482-18, 025575-18 | Complaint |

### Licensee/Titulaire de permis

584482 Ontario Inc.
c/o Jarlette Health Services 5 Beck Boulevard PENETANGUISHENE ON L9M 1C1

### 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

CHAD CAMPS (609)

## Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Complaint inspection.**

**This inspection was conducted on the following date(s): November 6, 8, 9, 2018.**

**Four intakes related to the care and safety of a resident were inspected upon during this Complaint inspection.**

**Critical Incident System (CIS) inspection #2018_615609_0025 was conducted concurrently with this Complaint inspection.**

**Non-compliance pursuant to the LTCHA, 2007, S. O. 2007, c. 8, s. 6. (7) and s. 6. (9) 1, identified from the concurrent CIS inspection will be issued in this Complaint inspection report.**

**During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (Administrator), Co-Director of Care (Co-DOC), Administrative Assistant (AA), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) and residents.**

**The Inspector(s) also conducted daily tours of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records as well as reviewed numerous licensee policies, procedure and programs.**

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

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

- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

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

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

**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. (9) The licensee shall ensure that the following are documented:**
**1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).**
**2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).**
**3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).**

**Findings/Faits saillants :**

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

a) Three complaints were submitted to the Director, alleging incidents of potential sexual abuse of resident #001 by male residents in the home.

As well, a Critical Incident (CI) report was submitted by the home to the Director, which outlined how on the same day the resident #001 was found in other residents' room being touched in a sexual manner.

Inspector #609 reviewed resident #001's plan of care which indicated that when the resident was in bed, a specific intervention was to be implemented to ensure the resident's safety.

On a particular day, resident #001 was observed in their room awake and lying in bed. The Inspector noted that the specified intervention was not implemented.

During an interview with PSW #107, they verified that resident #001's specified intervention was not implemented and should have been when the resident was in their room. The PSW then implemented the specified intervention.

A review of the home's policy titled "Resident Rights, Care and Services- Plan of Care- 24 Hour Plan of Care" last revised March 13, 2018, required the care set out in the care plan be provided to the resident as specified in the plan.

During an interview with the Administrator, they verified that care was not provided to

resident #001 as specified in their plan on the particular day when the specified intervention was not implemented.

b) A CI report was submitted by the home to the Director, which outlined how resident #002 was found on the floor, was subsequently taken to the hospital and diagnosed with an injury.

Inspector #609 reviewed resident #002's post fall assessment which indicated that the resident had fallen after attempting to self-transfer and that the resident's plan of care was updated to include two specified interventions be implemented.

On a particular day, resident #002 was observed with one of the two specific interventions implemented.

A review of resident #002's plan of care however, indicated that when the resident required two specific interventions to be implemented.

During an interview with PSW #101, they verified that resident #002 required two specific interventions be implemented, but that one was taken away to be used with another resident.

During an interview with the Co-DOC, a review of resident #002's plan of care was conducted. The Co-DOC verified that the resident was not provided with care as specified in their plan when one specific intervention instead of two was used to mitigate the resident's fall risk. [s. 6. (7)]

2. The licensee has failed to ensure that the provision of care set out in the plan of care was documented.

a) Two complaints were submitted to the Director which outlined concerns that resident #001 was being sexually abused by other residents in the home.

Inspector #609 reviewed resident #001's plan of care which required PSWs to perform a specified timed intervention for the resident.

A review of the Point of Care (POC) PSW documentation for resident #001 for a seven day time frame, found 28 per cent of the days had undocumented specific timed interventions.

A review of the home's policy titled "Personal Support Worker" last revised January 5, 2017, required PSWs to complete resident records accurately to reflect the resident care provided and to comply with legislative and home requirements.

During an interview with PSW #105, they verified that they were present and responsible for resident #001 on two specific shifts in a seven day review time frame. A review of the POC documentation for the two shifts were reviewed with PSW #105 who indicated that the specific timed interventions were done, but that they had forgotten to document them as completed.

During an interview with the Co-DOC a review of resident #001's seven day time frame of POC documentation was conducted. The Co-DOC acknowledged the missing PSW documentation and that it should have been completed.

b) Two CI reports were submitted by the home to the Director which outlined two potential sexual abuse incidents towards resident #001.

A review of the POC documentation for resident #001 on the two days cited in the CI reports found PSWs documented the resident's specific timed interventions up to two hours ahead of time.

During an interview with the Co-DOC, a review of the POC documentation was conducted. The Co-DOC verified that the PSWs should not have documented care as completed ahead of time. [s. 6. (9) 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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.***

**Issued on this 5th day of December, 2018**

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

**Original report signed by the inspector.**