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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 20, 2014	2013_140158_0037	S-0274-13	Critical Incident System

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

KELLY-JEAN SCHIENBEIN (158)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): October 23 and 24, 2013

Logs S-000927-12, S-000016-13, S-000085-13, S-000101-13, S-000170-13, S-000199-13, S-000204-13, S-000235-13, S-000274-13, S-000295-13 and S-000429-13 were reviewed.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, Registered Staff, Personal Support Workers (PSW), the Food Service Supervisor, maintenance staff, residents and family.

During the course of the inspection, the inspector(s) conducted a walk through of resident care areas, observed staff to resident interactions, reviewed residents' health care records, monitored water temperature values and reviewed policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

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. (5) The licensee shall ensure that the resident, the resident’s substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident’s plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. Resident # 08 quarterly assessment identified that the resident has mild cognition loss and becomes upset when others enter their room or take their things. Resident # 08 will confront residents when they do and be physically aggressive. In June 2013, resident # 03 was wandering the halls carrying resident # 08 pants. Resident # 08 recognized their pants and confronted resident # 03. Resident # 03, who has severe cognitive impairment, pushed resident # 08, who sustained bruising when they fell after being pushed.
Resident # 08 plan of care was reviewed and failed to address the resident`s confrontational behaviour. Clear direction regarding aggressive behaviour was not provided to staff and others who provide care to resident # 08 [s. 6. (1) (c)]

2. On October 22, 2013 at 16:30h, the inspector observed that staff # S-104 and S-105 entered resident # 01 room, to provide toileting assistance. Resident # 01 had been placed in a sling, which was suspended over a bedpan on the bed by staff # S-104 and S-105. The staff then vacated the room. In the course of being toileted, the resident slid out of the sling and fell on the bed sideways without injury. The PSWs were alerted to this incident when cries for help from resident # 01 were heard.
The inspector reviewed resident # 01 health care record on October 23, 2013. Resident # 01 has a history of fractures and the progress notes identified that the resident is impatient and demanding with care delivery.
On October 23/13, staff # S-104 and S-105 stated to the Inspector stated that although the resident is to be toileted using a commode (confirmed in the recent continence care assessment and in resident # 01 plan of care), that the toileting with

the sling suspended over the bed pan on the bed is used when resident # 01 becomes demanding and anxious and cannot wait.
The Inspector reviewed resident # 01 plan of care, which identified that a sling is used with transferring resident # 01 and that a commode is used with toileting the resident. There was no indication of the above toileting process, the resident's request to use a bed pan or of the resident's anxiety /impatience with care delivery.
The licensee did not ensure that there is a written plan of care that sets out clear directions to staff and others who provide direct care to resident # 01. [s. 6. (1) (c)]

3. In March 2013, resident # 01 pushed resident # 02 and threatened to kill them. The Inspector reviewed resident # 01 health care record on October 22, 2013. The assessment records identified that resident # 01 was anxious and agitated. It was documented in resident # 01 progress notes that resident # 01 had several episodes of anxiety and agitation and that resident # 01 was physically aggressive toward resident # 02. The progress notes also identified that a pharmaceutical intervention had been ordered. Resident # 01 plan of care, however, did not identify interventions to manage resident # 01 anxiety or physical or verbal aggression towards any resident, especially resident # 02.
The licensee did not ensure that there was a written plan of care for resident # 01 that set out clear directions to staff and others who provide direct care to the resident to manage resident # 01 anxiety and physical or verbal aggression towards any resident, especially resident # 02. [s. 6. (1) (c)]

4. In March 2013, resident # 01 pushed resident # 02 and threatened to kill them. A resident to resident abuse critical incident was reported to the Director. The Inspector reviewed resident # 02 progress notes and noted that in June 2013, staff # S-101 documented that resident # 02 was wandering in and out of resident's rooms when resident # 11 threw a cup of water at resident # 02 and that resident # 14 struck resident # 02.
Behaviours such as wandering, agitation, sadness, anxiety, resistive to care were identified on resident # 02 plan of care, however, interventions such as "modify environment to prevent situations that trigger inappropriate behaviour" and "redirect undesirable behaviour" are vague and do not provide clear direction to manage resident # 02 behaviour. [s. 6. (1) (c)]

5. There were two incidents of resident to resident altercations in May and June 2013, which were reported to the Director and involved resident # 03, who had been wandering at the time of the incidents.

On October 23 and 24, 2013, the Inspector observed throughout the day, that resident # 03 was quietly sitting in her wheelchair and did not display any behaviours.
The Inspector reviewed resident # 03 health care record, which identified that resident # 03 has cognition impairment.
Documentation in the progress notes in October 2013 indicated that resident # 03 now displays behaviours, such as crawling out of bed and out of the wheel chair.
Staff # S-108 confirmed in an interview with the Inspector (October 24/13) that the above behaviours are current and that resident # 03 behaviours of wandering in halls, entering other resident rooms and exit seeking no longer occur.
On October 21, 2013, the Inspector reviewed resident # 03 plan of care which contained interventions to manage resident # 03 behaviours of wandering in halls, entering other resident rooms and exit seeking. Interventions to manage resident # 03 climbing out of bed and chair were not identified.
The licensee did not ensure that there is a written plan of care that sets out clear directions to staff and others who provide direct care in managing resident # 03 current behaviours. [s. 6. (1) (c)]

6. In December 2012, staff # S-110 documented in resident # 09 progress notes to change the texture of the diet to a liquid consistency as resident # 03 refused to eat from the spoon.
In January 2013, it was identified in the nutritional assessment by Staff # 109 that resident # 09 weight was stable. There was no change to resident # 09 diet, however, staff # S-109 documented that the resident was eating their diet poorly and left a request for the doctor to change resident # 09 diet to a liquid consistency.
The physician orders were reviewed by the Inspector and a diet with a liquid consistency was not ordered.
Staff # S-111 identified to the Inspector on October 22, 2013 that a liquid consistency diet was given to resident # 09.
There was no indication in the MDS assessment or in the progress notes that the Substitute Decision Maker was notified of the use of the liquid consistency diet. It was noted at the annual multi-discipline meeting (2 months later), that the SDM was informed and the SDM clearly identified that a liquid consistency diet was not to be used.
The licensee did not ensure that resident # 09's substitute decision-maker,was given an opportunity to participate fully in the development and implementation of the resident # 09's plan of care. [s. 6. (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 clear direction regarding the management of resident # 08 aggressive behaviour, the management of resident # 01 anxiety and aggression and the management of resident # 02 wandering, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. According to a Critical Incident submitted to the Director, Staff # S-100 used a prohibited device to restrain resident # 10 and left the resident in this position until the next shift started. This was confirmed by the Administrator on October 23, 2013.
The Inspector reviewed Staff # S-100 employee record and found that 12 days after the above incident, two residents complained to the Administrator that Staff # S-100 was verbally and emotionally abusive to them.
In October 2013, Staff # S-100 was involved in a third staff to resident abuse incident. It was reported by resident # 11 that staff # S-100 caused him, an injury during care delivery. The Inspector reviewed resident # 11 health care record, particularly the progress notes and there was no documentation that the injury was present prior to staff # S-100 delivery of care. It was also identified that Staff # S-100 indicated that the resident sustained the injury when they went to use the call bell. The RN who assessed the resident, checked the head board, bed linen and call bell and found no blood.
The licensee did not ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home. [s. 19. (1)]

2. As identified in resident # 05 MDS assessment (2013), their decision making ability was moderately impaired. The Inspector spoke with Staff # 107 who identified that resident # 05 has a sexual attraction to the opposite sex.
The Inspector reviewed resident # 05 plan of care and it did not identify resident # 05 sexual behaviours and/or vulnerability.
In March 2013, it was documented in resident # 05 progress notes that a visitor who was visiting their spouse, was observed by staff, sitting on resident # 05 bed, urging resident # 05 to kiss them on the lips. Resident # 05 and the visitor were later observed by staff to be kissing on the lips. Four days later, this same visitor was observed by staff to lead resident # 05 into a room (which could not be easily viewed) and embrace and kiss resident # 05 on the lips. Staff # S-113 documented in the progress notes that resident # 05 felt uncomfortable and afraid after the incident. [s. 19. (1)]

3. Resident # 07 plan of care was reviewed and their wandering behaviour was identified but their physical aggressive behaviour and interventions to manage the aggression were not in the plan of care. In May 2013, resident # 06 sustained a laceration after being pushed to the ground by resident # 07. This was the second reported altercation involving resident # 07 and other residents within two days. [s. 19. (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 all residents are protected from abuse by anyone, specifically staff # S-100, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. On October 22, 2013 at 16:30h, the inspector observed that staff # S-104 and S-105 entered resident # 01 room to provide toileting assistance. Resident # 01 had been placed in a sling, which was suspended over a bedpan on the bed by staff # S-104 and S-105. The staff then vacated the room. In the course of being toileted, the resident slid out of the sling and fell on the bed sideways without injury. The PSWs were alerted to this incident when cries for help from resident # 01 were heard.
The inspector reviewed resident # 01 health care record on October 23, 2013. Resident # 01 has a history of fractures and the progress notes identified that the resident is impatient and demanding with care delivery.
On October 23, 2013, staff # S-104 and S-105 stated to the Inspector that although the resident is to be toileted using a commode (confirmed in the recent continence care assessment and in resident # 01 plan of care), that the toileting with the sling suspended over the bed pan on the bed is used when resident # 01 becomes demanding and anxious and cannot wait.
The Inspector reviewed resident # 01 plan of care, which identified that a sling is used with transferring resident # 01 and that a commode is used with toileting the resident. There was no indication of the above toileting process, the resident's request to use a bed pan or of the resident's anxiety /impatience with care delivery.
The licensee did not ensure that there is a written plan of care that sets out clear directions to staff and others who provide direct care to resident # 01. [s. 36.]

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 residents, specifically resident # 01 are transferred safely at all times, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature; O. Reg. 79/10, s. 90 (2).

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. A review of the home's temperature log for October 2013 showed that the water temperature in various resident rooms ranged from 51.0 C to 58.7 C. Staff S-112 identified to the Inspector that the water temperature valve was recently replaced (this past month) and that hot as well as cold water temperatures occur, as it is a supply and demand system.
The licensee did not ensure that the temperature of the water serving bathtubs, showers and hand basins used by residents is 49 degrees Celsius or less. [s. 90. (2) (g)]

2. On October 23, 2013, Staff # S-107 stated to the Inspector that there was no hot water for the residents' shower or baths. Staff # S-10 stated "no wonder residents hit me during the bath".
The water temperatures in both tubs were taken by the Inspector and showed a fluctuation of water temperatures from 45.1 C to 33.1 C within 5 minutes of water temperature monitoring. Staff S-112 identified to the Inspector that the water temperature valve was recently replaced (this past month) and that cold temperatures occur as it is a supply and demand system.
The licensee did not ensure that the hot water temperature serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius. [s. 90. (2) (i)]

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 temperature of the water serving bathtubs, showers and hand basins used by residents is 49 degrees Celsius or less and that the hot water temperature serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius., to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 112. Prohibited devices that limit movement
For the purposes of section 35 of the Act, every licensee of a long-term care home shall ensure that the following devices are not used in the home:
1. Roller bars on wheelchairs and commodes or toilets.
2. Vest or jacket restraints.
3. Any device with locks that can only be released by a separate device, such as a key or magnet.
4. Four point extremity restraints.
5. Any device used to restrain a resident to a commode or toilet.
6. Any device that cannot be immediately released by staff.
7. Sheets, wraps, tensors or other types of strips or bandages used other than for a therapeutic purpose. O. Reg. 79/10, s. 112.

Findings/Faits saillants :

1. Resident # 10 progress notes identified that their condition changed and that the resident was unsteady and required the use of a wheel chair. A critical incident was submitted to the Director identifying that Staff # S-100 used a prohibited device to restrain resident # 10 to a wheelchair after resident # 10 attempted to stand several times. The resident remained restrained in this way until the next shift came on. The licensee failed to ensure that prohibited devices are not used in the home as a restraint. [s. 112.]

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 prohibited devices are not used in the home as a restraint, to be implemented voluntarily.

WN #6: 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. In December 2012, a critical incident was submitted to the Director, identifying that staff # 100, used a prohibited device to restrain resident # 10 in their wheelchair after the resident repeatedly tried to stand. The resident remained restrained until the next shift came on and reported the incident to their Charge nurse.
The Administrator identified in the October 23, 2013 interview with the Inspector that staff # 100 did not follow the home's policy related to restraint use and that staff # S-101, staff # S-102 and staff # S-103 did not follow the home's abuse policy regarding reporting.
The licensee failed to ensure that its written policy that promotes zero tolerance of abuse and neglect of residents was complied with. [s. 20. (1)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. On October 22, 2013, Inspector observed staff shift change (14:30-22:30) and report. There were 4 out of the 6 scheduled PSW staff present. (2 full time PSW and 2 part time PSWs). The PSWs were observed to attempt to distribute the resident assignments. The evening charge RN stated that she usually lets the staff figure out the assignments as they know the residents better. A "plan B" back up plan was found in the assignment book, however, this plan is put in use when there is 1 staff member missing. There was no back up plan for nursing and personal support staffing that addresses situations when more than one staff cannot come into work. [s. 31. (3) (d)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Resident # 03 cognition is impaired. On October 24, 2013, the Inspector reviewed resident # 03 health care record. It was documented in the progress notes by staff # S-106 in October 2013 that resident # 03 family member approached them to identify a trigger of resident # 03 agitation. The Inspector reviewed the resident's plan of care, which showed that this trigger was not incorporated into the plan of care.
The licensee did not ensure that the behavioural trigger for resident # 03 who demonstrates responsive behaviours was identified. [s. 53. (4) (a)]

Issued on this 20th day of January, 2014

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