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

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

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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
Dec 28, 2017	2017_680687_0010	022412-17	Resident Quality Inspection

Licensee/Titulaire de permis

THE ONTARIO-FINNISH RESTHOME ASSOCIATION
725 North Street Sault Ste Marie ON P6B 5Z3

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

MAUNO KAIHLA KOTI
723 North Street Sault Ste Marie ON P6B 6G8

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

LOVIRIZA CALUZA (687), SYLVIE BYRNES (627)

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): November 20-24, 2017.

An additional log was inspected during this RQI.

A critical incident related to staff to resident neglect was submitted by the home to the Director.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Food Services Manager, IPAC Lead, Registered Nurses (RNs), Registered Practical Nurses (RPNs) and Personal Support Workers (PSWs), Dietary Aids (DAs), and the unit clerk.

The Inspector(s) also conducted a daily walk through of resident care areas, observed the provision of care towards residents, observed staff to resident interactions, reviewed residents' health records, staffing schedules, internal investigations, policies, procedures, programs, and program evaluation records.

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
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 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. 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 written policy to promote zero tolerance of abuse and neglect of residents was complied with.

A critical incident (CI) report was submitted to the Director alleging neglect of resident #007 by RPN #114. It was alleged that RPN #114 transferred resident #007 to a specific chair and failed to provide the specified intervention to the resident that resulted in the resident being injured as a result of a fall.

Inspector #627 reviewed the home's investigation notes which indicated that on a particular day, RPN #114, with the assistance of RN #115, transferred resident #007 from their mobility assistive aid to a specified chair. The investigation notes further revealed that RPN #114 had stated that they sat with the resident as they were upset; however, a video of the common area revealed that RPN #114 had been using their cell phone while sitting next to the resident. At a specified time, the video revealed resident #007 sustained a fall.

Inspector #627 reviewed a video provided by the home and revealed that at a specific time, resident #007 was transferred to a specified chair from their mobility assistive aid by RPN #114 and RN #115. RPN #114 was observed sitting beside the resident, comforting them for a few seconds, turned their attention to their cell phone, and left the unit. RPN #114 returned and sat down beside the resident and was observed browsing on their cell phone for a specified time frame and again left the resident. Resident #007 was observed struggling to get up for a period of time and was observed falling while attempting to stand.

Inspector #627 reviewed the home's policy titled "Abuse of Residents, Preventing, Reporting and Eliminating", last revised June 2017, which indicated that "residents of the Ontario Finnish Resthome Association had the right to dignity, respect and freedom from abuse and neglect" as found in the Residents' Bill of Rights. The home's policy described neglect as "Failure to provide the care and assistance required for the health, safety or well-being of a resident; a pattern of inaction that jeopardized the health or safety of one or more residents and the failure to provide the ongoing care set out in a resident's plan of care".

Inspector #627 reviewed the home's policy titled "Code of Conduct and Behaviour", last revised July 2017, which indicated that "cellular telephones were to be turned off and not

utilized during work hours".

A review of the care plan in effect at the time of the incident indicated that resident #007 was at a high risk of falls. Interventions in the plan of care advised staff to ensure the resident was seated in a specified chair with a specific intervention in place.

Inspector #627 interviewed PSW #116 who stated that resident #007 was at an extreme risk of falls and required specific interventions while in bed or when they were using their mobility assistive aid.

During an interview with PSW #114 they stated that they were aware of resident #007's high risk of falls and required a specific intervention while sitting in a specified chair. The RPN acknowledged that they had not applied the specified intervention which caused the resident to fall and led to an injury.

During an interview with the DOC they stated that resident #007 was at a high risk of falls and had falls interventions in place. The DOC confirmed that the falls interventions were not initiated by RPN #114 for resident #007 which led to a fall incident. The DOC further stated that RPN #114 had utilized their cell phone during working hours, which contravened the home's policy and that constituted neglect. [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 there is in place a written policy to promote zero tolerance of abuse and neglect of residents and shall ensure that that the policy is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area or a medication cart that was used exclusively for drugs and drug-related supplies and that was secured and locked.

During an observation in the Lakka secure home unit, Inspector #627 observed two bottles of prescribed medicated product for resident #010 and #011.

Inspector #627 reviewed the home's policy titled "Medication Control, Safety and Security", last revised on June 2017, which indicated that drugs were to be stored in an area or a medication cart that was used exclusively for drugs and drug-related supplies and that was secure and locked.

During separate interviews with Inspector #627, RPN #109 and RPN #118 stated that it was the home's expectation that all prescribed medicated products were to be stored in the treatment cart. The registered staff would take the prescribed medicated product from the treatment cart during residents' scheduled shower days and staff were expected to return the prescribed medicated product to the treatment cart after use, to be locked in the medication room.

During an interviewed with the DOC, they stated that it was the home's expectation that the prescribed medicated product be taken out of the medication room and left in the treatment cart until they were used. They were to be returned to the treatment cart afterwards. The treatment cart was to be stored in the locked medication room when not in use. [s. 129. (1) (a)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participated in the implementation of the infection prevention and control program. O. Reg. 79/10, s. 229 (4).

Inspector #687 conducted an observation on a particular day and identified that resident #009's room had a personal protective equipment (PPE) supply bag but no precaution isolation signage, indicating what type of PPE was required for interacting with the isolated resident.

A review of the home's policy titled "Isolation Precautions, Contact Transmission" revised June 2, 2017, indicated the following under the heading Resident and Family Teaching:
- Residents and families should understand the nature of the infection and the precaution to be used, including the reason for using them. The home's policy further indicated that family members will be updated to ensure understanding of the nature and the limitations/restrictions as well as how to apply the precautions and all visitors were required to wear the appropriate personal protective equipment (PPE) as specified when visiting an isolated resident.

A review of the "Provincial Infectious Diseases Advisory Committee (PIDAC), Routine Practices and Additional Precautions, In All Health Care Settings, 3rd edition" a document that was developed by the Provincial Infectious Diseases Advisory Committee on Infection Prevention and Control (PIDACIPC). PIDAC-IPC is a multidisciplinary scientific advisory body that provides evidence-based advice to the Ontario Agency for Health Protection and Promotion (Public Health Ontario) regarding multiple aspects of infectious disease identification, prevention and control. PIDAC-IPC's work is guided by the best available evidence. On page 26/113 it indicates that signage specific to the type (s) of Additional Precautions should be posted:
-A sign that lists the required precautions should be posted at the entrance to the client/patient/resident's room or bed space.
-Signage should maintain privacy by indicating only the precautions that are required, not information regarding the patient's condition.

In an interview with Inspector #687, PSW #106 identified that resident #009 was on contact isolation and that staff were made aware of isolation precaution during their shift-to-shift report. PSW #106 stated that staff were required to wear a gown and gloves when performing personal care and hand hygiene before and after each encounter with any isolated resident.

During an interview with RPN #104, they indicated that resident #009 was placed on contact isolation at a specific date due to a possible infection.

In an interview with the Infection Control and Prevention (IPAC) lead, they validated that resident #009 was on contact isolation. The IPAC lead stated that resident #009 was placed on isolation at a specific date after confirmation of their diagnosis but was uncertain if the isolation signage was posted. [s. 229. (4)]

Issued on this 29th day of December, 2017

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

Original report signed by the inspector.