Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 26, 2019	2019_824765_0003	021417-19	Other

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

HILARY ROCK (765), LISA MOORE (613)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct an Other inspection.

This inspection was conducted on the following date(s): November 18-22, 2019.

This inspection was a Sudbury Service Area Office initiated inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Executive Director of Care (EDOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Dietary Aides (DAs), 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 health care records, internal investigation files and policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Dining Observation
Falls Prevention
Infection Prevention and Control
Medication
Reporting and Complaints
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 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	Légende 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. 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 has failed to ensure that a person who had reasonable grounds to suspect that the 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 had occurred or may occur shall immediately report the suspicion and the information upon which it was based to the Director.

Inspector #765 reviewed documentation provided by the home, which indicated that resident #008's Substitute Decision-Maker (SDM) made a verbal complaint to Registered Nurse (RN) #108 regarding allegations that Registered Practical Nurse (RPN) #103 had raised their voice and spoken inappropriately to resident #008. These allegations were reported to resident #008's SDM by resident #011's SDM who had heard RPN #108's interaction with resident #008. RN #108 informed the Executive Director of Care (EDOC) of the allegations immediately.

O. Reg. 79/10 defines verbal abuse as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminished a resident's sense of well-being, dignity or self-worth, that was made by anyone other than a resident.

A review of the home's investigation file indicated that the complaint was investigated as potential verbal abuse. Resident #011's SDM felt that this was inappropriate and a

misuse of power as RPN #103 had spoken in a very authoritative tone and their voice was very loud when speaking to resident #008. The documentation further indicated that resident #011's SDM felt they needed to advocate on behalf of resident #008. The documentation indicated that the EDOC had informed resident #011's SDM that the home cannot tolerate abuse in any way.

A review of the licensee's policy titled, "Abuse of Residents, Preventing, Reporting, & Eliminating," last revised July 2019, stated that verbal abuse was defined as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminished a resident's sense of well-being, dignity or self-worth, that was made by anyone other than a resident. The policy included examples of verbal abuse, which included inappropriate tone of voice and manner of speaking which was upsetting and/or frightening to the resident, shouting, belittling, degradation, infantilization and intimidation.

A review of the home's letter of response to resident #008's SDM, written by the EDOC, indicated that "an immediate investigation was initiated concerning the alleged verbal abuse."

During an interview with the EDOC, they stated that this complaint was inspected as verbal abuse, and that the allegations of verbal abuse were not reported to the Director. [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 to ensure that a person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that results in harm or a risk of harm to the resident will immediately report the suspicion and the information upon which it is based to the Director, 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 secure and locked.

Inspector #765 observed an unattended and unlocked treatment cart in a hallway. The Inspector opened the drawers of the treatment cart and observed scissors, labeled prescribed medication creams and other treatment supplies. Residents were nearby where the unattended and unlocked treatment cart was located. There were no registered staff in the hallway.

A review of the licensee's policy titled, "Medication Control, Safety & Security" last revised July 2019, stated that every licensee of a long-term care home shall ensure that, drugs were stored in an area or a medication cart, that was secure and locked. It also indicated to lock treatment cart when left unattended.

During an interview with RPN #109, they stated that there were prescribed medicated creams and other harmful items in the treatment cart and that they had forgot to lock the treatment cart. The RPN confirmed that the treatment cart should have been locked when it was unattended.

During an interview with the EDOC, they confirmed that unattended treatment carts were to be secured and locked. [s. 129. (1) (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 drugs are stored in an area or a medication cart that is secure and locked, to be implemented voluntarily.

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 staff participated in the implementation of the infection prevention and control program.

On November 19, 2019, during an observation of a medication administration pass for resident #008, Inspectors #765 and #613 observed RPN #107 fail to practice hand hygiene prior to and following the medication administration.

On November 20, 2019, Inspector #765 observed RPN #109 administer medications to residents in a dining room, during a specific meal. The RPN completed a medication pass to three different residents and failed to practice hand hygiene prior to and following the medication administration between each resident. RPN #109 was also observed using a cell phone, taking supplies out of the treatment cart, taking a resident's temperature and blood pressure, and touching a resident's silver wear and non-slip mat on the table to set them up for the specific meal, then proceed to complete paper and computer charting. RPN #109 failed to practice hand hygiene in between all observed tasks.

On November 20, 2019, Inspector #613 observed RPN #103 administer medications to three different residents in a dining room, during a specific meal. The RPN prepared medication and administered medication to three different residents and failed to practice hand hygiene prior to and following the medication administration between each resident.

Hand sanitizer was observed within reach, located on medication carts as well as outside resident rooms throughout the home.

A review of the licensee's policy titled "Hand Hygiene" last revised June 2019, recommended using alcohol-based hand rubs before and after administering medications.

During an interview with RPN #109, they confirmed to Inspector #765 that they were to complete hand hygiene in between residents during medication pass and that they did not practice hand hygiene when administrating the medications.

During an interview with EDOC, they confirmed that staff were expected to complete hand hygiene before and after administering medications. [s. 229. (4)]

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 staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #4: 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. (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 provision of the care set out in the plan of care were documented.

Resident #007 was identified as having an unwitnessed fall which resulted in an injury.

Inspector #765 reviewed the home's binder titled, "Incident Binder" and was unable to locate a post fall assessment, investigation report, Head Injury Routine (HIR) as well the fall was not indicated on the incident report monthly tracking form.

A review of the progress notes indicated that resident #007's post falls assessment was completed, head protocol was started, and incident report was filled out.

A review of the licensee's policy titled, "Falls, Management Quality Improvement Plan" last revised October 2019, stated to evaluate, monitor, investigate and record circumstances and complete an incident report and falls assessment.

A review of the licensee's policy titled, "Falls, Preventing" last revised July 2019, stated any resident fall included completing a resident incident report/post fall assessment.

A review of the licensee's policy titled "Falls, Managing" last revised July 2019, stated a resident incident report was to be completed for all resident falls.

A review of the licensee's policy titled "Head Injury Routine" last revised July 2019, stated that the RN was to initiate a HIR on a resident who suffered a fall and sustained an injury to their head, or if it was suspected that they had hit their head.

During interview with RPN #109, they indicated that they completed the investigation report, post falls assessment, HIR and left the paper documents on the desk and thought it may have been shredded.

During separate interviews with RPN #109, RPN #104, and RN #108, they all stated that they were unable to find the incident report, post falls assessment and HIR for resident #007's fall.

During an interview with RPN #104, they showed Inspector #765 resident #007's post fall care plan. The care plan had not been updated after their fall as it showed the last fall was from four months prior. RPN #104 indicated that RN #108 may have not received the post fall assessment as the care plan was not updated.

During an interview with the EDOC, they confirmed that staff were required to document the incident report, post falls assessment and HIR. They further stated that they were unable to find these documents for resident #007's fall. [s. 6. (9) 1.]

Issued on this 28th day of November, 2019

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

Original report signed by the inspector.