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 sions 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
Apr 18, 2016	2016_236622_0010	004913-16, 006606-16, 008384-16	Complaint

Licensee/Titulaire de permis

COUNTY OF PRINCE EDWARD
603 Highway 49 R R 2 PICTON ON K0K 2T0

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

H.J. MCFARLAND MEMORIAL HOME
R.R. #2, 603 HIGHWAY 49 HALLOWELL TOWNSHIP PICTON ON K0K 2T0

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

HEATH HEFFERNAN (622), JESSICA PATTISON (197)

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): March 21, 22, 23, 24, 29, 2016.

The following complaint inspections were completed during inspection# 2016_236622_0010;

004913-16 - complaint related to care of a resident
006606-16 – complaint related to management qualifications
008384-16 – complaint related to care of a resident and staffing

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, Resident Assessment Instrument (RAI) Coordinator, Dietary/Environmental Manager, Dietary Aide, County Representative and County Human Resources Manager, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Resident Power of Attorneys, residents.
Inspectors also reviewed resident health care record, Policies and procedures and other documents provided by the Administrator, Director of Care and Registered staff.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Hospitalization and Change in Condition
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **7 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	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. (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 comply with LTCHA 2007, s. 6(1)(c) in that the plan of care did not set out clear directions to staff who provide direct care to the resident.

The following finding is related to log 004913-16:

Resident #001 was admitted to the hospital on a specified date after he or she sustained a fall and returned to the home on a specified later date. RN #101 stated in an interview on March 23, 2016, that resident #001 had to be fed his or her meals once they came back from the hospital admission. On the date of return from hospital, a progress note indicated that the resident ate 100% of supper being fed by staff.

The day following resident #001's return from hospital, a note on the facility bulletin board in Point Click Care by RN #101 indicated that resident #001 was doing better than anticipated and that staff should encourage the resident to feed his or her self. The note further stated that the resident could hold his or her sippy cup to drink and could manage finger foods.

Two days after resident #001 returned from hospital, a progress note by RPN #106 indicated that resident #001 fed his or her self 100% at both meals.

On the third day post return from hospital for resident #001, RPN #115 wrote a progress note indicating that she found resident #001 in his or her room and that the resident had a mouth full of their hs snack. The note stated resident #001 was very congested and not able to follow direction to swallow food. The RPN wrote that she removed the food from the resident's mouth and the resident began to cough. She then wrote that the POA was notified that the resident's diet was changed to minced texture for a 7 day trial and would then be reassessed. The note stated that a dietary referral would be filled out.
RPN #115 made a note on the facility bulletin board in Point Click Care on this specified date that resident #001 was now on a trialed minced diet and that staff were not to leave any food with the resident unattended for safety reasons.

Four days after resident #001 returned from hospital, RPN #115 wrote in a progress note that the resident ate well with minced texture diet, no pocketing reported during meal.

During an interview with RPN #115 on March 23, 2016, she indicated that when she found resident #001 with food in the resident's mouth on a specified date, the PSW was in the bathroom. She informed the PSW that she needed to stay with the resident while he or she was eating.

The Dietary/Environmental Manager was interviewed on March 22, 2016 and indicated that she was not working in the home when the resident's diet would have changed, but she stated that the process would be for a Dietary Requisition Form to be filled out to change the resident's diet to minced. She stated that these forms are filled out and filed in her office. She could not find a copy of this form for resident #001's diet to be changed to minced. She stated that she did speak to one of their cooks and he indicated that he recalled a nurse coming in one day and asking for a minced meal for the resident but he was unsure of the date and the specific nurse that asked.

PSW # 103, and Dietary Aide #117 both indicated when interviewed that they were unaware of any changes to resident # 001's diet order before he or she passed away. Dietary Aide #117 stated that she remembered hearing something about it but never saw anything in writing. She further stated that she checked with RN #101 on one particular day because the family asked for mashed potatoes and she said she wasn't sure what the resident could have.

PSW #122 who worked with the resident stated that she had to provide assistance to the resident with his or her snacks after their fall. When asked how she knew the resident

needed assistance, she stated because the resident would tell her they needed help.

The care plan in place at the time of the resident's death,indicated the following:

- provide modified diabetic diet, regular texture with chopped texture meats, and monitor closely during meal times.
- provide supervision with minimal set up or assistance

The physician's orders were reviewed in the paper and electronic chart and there was nothing to indicate a change had occurred in resident #001's diet order.

Therefore, the plan of care did not set out clear directions to staff and others who provide direct care with respect to the resident's diet order and the type of monitoring required when the resident was eating in her room.

After a specified date, the progress notes indicated that the resident continued to decline and passed away on a specified date four days later. [s. 6. (1) (c)]

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

The following finding is related to log # 008384-16

Orders were received for treatment of resident #002 from the physician on a specified date. The orders had not been processed, resident #002 had not received the treatment on five specified dates.

During an interview with inspector #622, resident #002 stated they had not been given a reason for the delay in the treatment. Resident #002 stated that staff had applied the treatment as prescribed by the physician only once. Resident #002 indicated treatment was provided on the fist day and not continued for a two day period. On a second occasion treatment was provided and not continued for three days following. Resident #002 reported experiencing pain when the treatment was not provided.

On March 23, 2016 inspector #622 reviewed the Care Plan which did not include interventions as per physicians orders.

A review of the electronic Treatment Administration Records (eTAR) revealed the orders

were not processed on to the eTAR until a specified date six days after the initial order.

During an interview March 23, 2016 with inspector #622, Registered Nurse (RN) #101 stated she had “dropped" the ball, regarding the new orders for this resident. [s. 6. (7)]

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

Reference to log # 004913-16 for resident #001

The complainant reported they were visiting and observed on a specified date from 1000 hours until 1600 hours, resident #001 had not been repositioned by staff.

The care plan revealed two staff was to provide repositioning for comfort as needed.

On March 29, 2016 at 1426 hours inspector #622 interviewed the Administrator regarding the homes expectation for care and positioning of the resident.

On March 24, 2016 at 1320 hours, inspector #622 interviewed Personal Support worker (PSW)#103 who indicated on the date the complainant alleged resident #001 was not repositioned from 1000 hours to 1600 hours, she worked the day shift and repositioned resident #001 with PSW #105. PSW #103 confirmed resident #001 would have been repositioned every few hours; they informed family that if they needed anything or needed staff assistance at any time to let them know. No complaints were voiced by family.

On March 29, 2016 at 1440 hours inspector #622 interviewed Personal Support Worker (PSW)#102 who stated staff would follow the Kardex for direction of care for a resident and would document on point of care the repositioning and care given.

On March 23, 2016 at 1504 hours inspector #622 interviewed Personal Support Worker (PSW)#105 who stated they worked the day shift on the date the complainant alleged resident #001 was not repositioned from 1000 hours to 1600 hours. PSW #105 stated they had given resident #001 care that morning and made them comfortable. PSW #105 stated they had repositioned resident #001 when family requested. PSW #105 confirmed they had been in the room several times that shift to look in on resident #001 and repositioned resident #001 but had not documented the times they had performed the care.

Review of the Point of Care on the date the complainant alleged resident #001 was not repositioned from 1000 hours to 1600 hours confirmed there was no documentation related to repositioning of resident #001 from 1000 hours to 1600 hours. [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 the resident plans of care set out clear direction to staff related to current diet order and level of monitoring required; care set out in the plan of care is provided to the resident as specified in the plan and the provision of care set out in the plan of care is documented., to be implemented voluntarily.

WN #2: 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 comply with LTCHA 2007, s. 24(1) in that the person who had reasonable grounds to suspect that abuse or neglect of a resident had occurred, did not immediately report the suspicion and the information upon which it is based to the Director.

The following findings are related to log 004913-16:

1. The home submitted a Critical Incident Report on a specified date indicating that on a specified date seven days earlier, a staff member reported to the RN in charge that another staff member (PSW #118) yelled at a resident while the resident's POA was on the phone.

There was no evidence that the home informed the Director of this allegation prior to the specified date. Investigation notes indicate that the Director of Care and the Administrator in place at the time were made aware of the incident on the date of incident. They were not available for interview as they no longer work in the home.

2. The investigation notes for the above incident on the specified date, included an email that referenced another incident that occurred on a later date twelve days later, involving the same staff member (PSW #118) and another resident. The email was from the Director of Care at the time, #119, and stated that the incident was reported as suspected abuse/neglect through the Critical Incident System. The investigation notes were provided by Human Resources and indicated that the Director of Care was notified of the alleged/suspected neglect on the specified date of incident via email.

The Critical Incident System was checked and a report was not submitted to the Director. There is no evidence that the Director was ever notified of this alleged/suspected neglect. [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 the person who had reasonable grounds to suspect that abuse or neglect of a resident had occurred, immediately reports the suspicion and the information upon which it is based to the Director., to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, s. 76(4) in that the home did not ensure that a staff member had received annual retraining related to the Residents' Bill of Rights, the home's policy to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under section 24 and whistle-blowing protection.

The following finding is related to log #004913-16:

On a specified date, PSW #118 was alleged to have verbally abused a resident. Twelve days later, the same PSW was alleged to have neglected another resident.

During an interview with the Administrator, she indicated that the home uses an online program called Surge Learning for staff education. The Administrator indicated that staff complete this education on their own and there are due dates for each course. She further stated that staff were given two hours of paid time to complete all of their online courses.

A review of PSW #118's User Education Status for 2015, indicated that she had not completed any education for 2015 related to the Residents' Bill of Rights, prevention of abuse and neglect, mandatory reports or whistle-blowing protection.

The Administrator further indicated that documentation within the home indicated that PSW #118 had not received training on these topics since 2013. [s. 76. (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 receive annual retraining related to the Residents' Bill of Rights, the home's policy to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under section 24 and whistle-blowing protection., to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with LTHCA 2007, s. 23 (2) in that the home did not report the results of an abuse investigation to the director.

The following finding is related to log 004913-16:

On a specified date, the home submitted a Critical Incident Report about an alleged case of staff to resident abuse that occurred on a specified date seven days earlier. The last update on the report was by the Director of Care at the time (#119) eight days post incident indicating that the accused PSW was re-assigned to a different home area pending full investigation.

The results of the abuse investigation were not shared with the Director until inspectors entered the home to conduct an inspection on March 21, 2016. [s. 23. (2)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 33(1) in that a resident was not bathed, at a minimum, twice in a week by the method of their choice.

The following finding is related log 008384-16:

According to Resident #002's current care plan the resident required two persons and was totally dependent on staff for bathing. The plan of care also indicated that the resident preferred a tub bath, twice weekly.

The POA for resident #002 indicated that the resident did not receive a tub bath on a specified date. On this date, PSW #114 charted that the resident's bath was completed by floor staff. During an interview with this staff member, she indicated that the resident had been given a bed bath.

On March 24, 2016, resident #002 was interviewed by Inspector #622 and stated that he or she did receive a bed bath on the specified date, but that he or she was not pleased with this. Resident #002 indicated they would have wanted to have their tub bath. He or she stated that they were told the reason for not having a tub bath was that no bath person was working.

Resident #002 was not offered a tub bath until his or her next scheduled bath day and had not had a tub bath for seven days. [s. 33. (1)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 101(1)3 in that no response was provided to a person who submitted a letter of concern regarding the care of a resident.

The following finding is related to log 008384-16:

The POA (Power of Attorney) for resident #002 indicated that he or she had provided a letter of concern to the licensee on a specified date nine months earlier and indicated that to date, on March 23, 2016, had still not received a response.

During an interview with the current Administrator, she indicated that she had been given a letter by resident #002's POA that was dated a specified date. She stated that she was not working in the home at the time the letter was written and so provided a copy to the Commissioner of Corporate Services and Finance.

During an interview with the Commissioner of Corporate Services and Finance on March 23, 2016, she indicated that she did receive this letter on a specified date nine months earlier and had passed it along to the Administrator to respond at that time. She said she assumed a response was provided but did not provide one herself.

The current Administrator indicated that the home had no record of any response ever being provided to the POA of resident #002 and the letter of concern. [s. 101. (1) 3.]

WN #7: 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. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff monitor symptoms of infection in residents on every shift in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Reference to complaint log # 004913-16 for resident #001

During an interview March 21, 2016 at 1320 hours with the Power of Attorney (POA) #003 who indicated resident #001 had a decline in condition post falls. According to the POA #003; resident #001 had been noted to have declining cognition, was congested with an elevated temperature and passed away on a specified date.

A review of the progress notes revealed on a specified date and time, resident #001 was noted to be congested, coughing and elevated temperature. No documentation was noted regarding assessment of resident #001's respiratory status on the following night or day shift.

A Review of the 72 hour Summary from Point Click Care for a specified date revealed resident #001 was ill, showing signs of infection. No documentation was noted on the 72 hour summary for the following night and day shift regarding resident #001's infection.

On March 24, 2016 at 1110 hours during an interview with inspector #622; RN #101 indicated there would be no other place registered staff would chart the assessment of a resident's condition besides the progress notes.

On March 24, 2016 at 1125 hours inspector #622 interviewed RN #107 regarding the day shift they worked on a specified date. RN #107 was unable to recall that she worked nor how resident #001 was during the day shift that date. RN #107 confirmed that the progress notes would be the only place she would have documented the assessment of the resident condition for that date if an assessment was completed.

On March 24, 2016 at 0948 hours, Inspector #622 interviewed the Administrator who revealed she spoke with a registered nurse March 24, 2016 regarding the homes expectation for assessment and follow up for residents who are showing signs of infection. The Administrator stated that the registered nurse revealed information is passed on in report on the 72 hour summary regarding residents who are ill and from that information; the registered staff will follow up with residents if there is a need. The Administrator confirmed if resident #001 was ill with symptoms of an infection, the onset of the infection and that documentation should have occurred indicating that the resident

was being monitored for an infection. [s. 229. (5) (a)]

Issued on this 18th day of April, 2016

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

Original report signed by the inspector.