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

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Inspection de soins 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
Feb 6, 2017	2017_544527_0001	000965-17	Resident Quality Inspection

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF PEEL
10 PEEL CENTRE DRIVE BRAMPTON ON L6T 4B9

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

PEEL MANOR
525 MAIN STREET NORTH BRAMPTON ON L6X 1N9

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

KATHLEEN MILLAR (527), HEATHER PRESTON (640), SAMANTHA DIPIERO (619)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): January 12, 13, 16, 17, 18, 19 and 20, 2017

During the inspection the following Critical Incidents (CIS) were inspected:

Log #025150-15, related to unknown bruising
Log #030379-15, related to alleged staff to resident abuse
Log #031395-15, related to a fall

Log #032966-15, related to resident to resident abuse
Log #011742-16, related to unknown injury
Log #018501-16, related to alleged staff to resident abuse
Log #024999-16, related to a fall
Log #026600-16, related to missing/unaccounted for controlled substances
Log #027495-16, related to medications
Log #030767-16, related to a fall
Log #031991-16, related to resident to resident abuse
Log #032043-16, related to resident to resident abuse
Log #032110-16,related to alleged staff to resident abuse
Log #033833-16, related to an unexpected death
Log #033881-16, related to missing/unaccounted controlled substance
Log #001128-17, related to alleged staff to resident abuse

During the course of this inspection, the inspectors toured the home, observed residents and staff, reviewed clinical records, policies and procedures, training documents, meeting minutes, annual program evaluations, complaint and critical incident logs.

During the course of the inspection, the inspector(s) spoke with the residents, family members, the President and Vice President of the Residents' Council, the President of the Family Council, the Administrator, the Director of Care (DOC), the Supervisors of Care, the Supervisor of Activation and Volunteers, the physiotherapist (PT), the Behavioural Support Organization (BSO), the registered nurses (RNs), the registered practical nurses (RPNs), and the Personal Support Workers (PSWs)

The following Inspection Protocols were used during this inspection:

Critical Incident Response
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours

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

- **8 WN(s)**
- **5 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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system was complied with

1) Resident #007 ingested medications that were intended for another resident. RPN #116 left unsecured medication on top of the medication cart that the resident had access to. There was no harm to resident #007.
A review of the home's policy titled, "Medication – Errors", # LTC 09-05.12.10, stated that in the event of a medication error registered staff must "monitor vital signs, mental status, physical status and any behavioural changes as per center's policy", and that registered staff were to "document a description of the medication error and any adverse effect on the resident's file". Interview with DOC confirmed that this monitoring was to be completed and documented as a head to toe assessment.
Interview with RPN #118 indicated that they monitored the resident until they were transferred to hospital; however, the LTCH Inspector #619 was unable to locate documentation of this. In addition, upon further review of the resident's health record, there was no head to toe assessment completed until the resident's return from hospital.
Under regulation 141(3)(a) of the Ontario Regulation 79/10, it was a requirement that the home had written policies and protocols developed for medication management and that those written policies and protocols must be implemented and adhered to.
Interview with DOC indicated that when a medication error occurs, staff must document an assessment in the resident's health record, which included at minimum vital signs, and a description of the incident. The DOC confirmed that the home had policies in place pertaining to medication management, and that RPN #118 did not comply with the home's policy as it related to the medication error.

2) Resident #009 had returned to the home from a leave of absence. When the family designate returned the resident to the home they were greeted by PSW #120 who accepted the resident and the medication from the family member. Registered staff found the medication in the resident`s mobility device later that evening and found one of the medications unaccounted for.
Interview with PSW #120 indicated that they accepted the resident and the medication from the family member. They returned the resident to their room and left the medication in the resident`s mobility device.
Under regulation 114 of the Ontario Regulation 79/10, the home was required to have policies related to medications, including the management and storage of narcotic

medications.
According to the home`s leave of absence (LOA) policy, titled "Casual/Vacation Leave of Absence", policy #LTC9-05.10.07, on the resident`s return staff must "direct the resident/responsible party to return the resident back to the unit, to sign-in in Leave of Absence binder, and notify nursing staff of resident`s return", and registered staff must "determine if medications were given/taken as directed and record amount of medication returned in Leave of Absence Medication Record Form (NF-082), and resident/responsible party to sign off".
Interview with the DOC confirmed that when a resident returned from an LOA, unregistered staff must direct the resident and their responsible party to registered staff so that the resident and their accompanying medication could be accounted for. The DOC confirmed that PSW #120 failed to follow the home`s policy when they did not ensure that the family designate returned the medication directly to the registered staff.

3) Resident #026 displayed new onset behaviours in November 2016. A review of the resident’s health record indicated that Dementia Observation Screening (DOS) monitoring was not initiated until two days later.
A second incident of inappropriate behaviours by resident #026 occurred in January 2016. A review of the resident’s health record indicated that DOS monitoring was not initiated until two days later.

Under regulation 53 of the Ontario Regulations 79/10, it was a requirement that the home had a Responsive Behaviour program. A review of the home's policy titled, “Prevention and Management of Responsive Behaviour Program”, and last revised May 2014, stated that, “The RN/RPN will screen residents where there is a change of status that affects their behaviour”, and will, “initiate Dementia Observation Screening (DOS) monitoring on the electronic health record for seven (7) days if any questions on the screening tool are answered yes and if two (2) or more episodes occur within seven (7) days”.
Interview with RPN #111 stated that registered staff were responsible for implementing DOS monitoring for residents when there was a new onset behaviour or an increase in responsive behaviours. Interview with Supervisor of Care (SOC) #104 confirmed that registered staff were expected to initiate the electronic DOS monitoring record in Point of Care (POC) immediately when there was an incident involving a resident with responsive behaviours so that staff can assess and subsequently intervene upon those behaviours. SOC #104 confirmed that the registered staff did not comply with the home’s policy for DOS monitoring for residents displaying responsive behaviours due to the delay in initiating the observation tool.

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 where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, (b) is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident’s plan of care only if all of the following are satisfied: 4. The use of the PASD had been consented to by the resident or, if the resident was incapable, a substitute decision-maker of the resident with authority to give that consent.

Resident #011 was assessed for a special wheelchair to assist with positioning and safety. The resident was cognitively impaired and they had a designated power of attorney for personal care.
The physician ordered the special wheelchair in May 2016, and identified on the order that it was a personal assistance services device (PASD).
The resident's clinical record was reviewed and there was no verbal or written consent for the PASD.
The home's policy called "Minimizing Restraint use and the use of Personal Assistance Services Devices (PASD) Program", last revised April 2013, directed staff to obtain consent from the resident or substitute decision maker (SDM) if the resident was not capable, documenting the discussion on "IDF-38 Restraint Assessment and Consent Form" and ensure the consent form was signed and dated. The policy also indicated that "if required, the nurse could document on the consent form that verbal consent was obtained including the name of the person giving consent, the date and time that verbal consent was obtained and signs and dates the consent form."
Interviewed RN #113 and the Supervisor of Care (SOC) #115 who indicated that a consent form was required for a PASD and they were unable to find the written or verbal consent from the SDM for the PASD. SOC #115 also indicated that it was the home's practice to obtain consent for PASDs during the annual care conference; however they were unable to locate the documentation to support that this occurred.
Interviewed the DOC and Administrator who confirmed that consent was required from the SDM for the special wheelchair (PASD), and their policy identified it could be written consent, or if the staff obtained verbal consent they would document it on the form. The DOC and Administrator confirmed that they did not follow their policy related to obtaining consent for the use of the PASD.

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 use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives a skin assessment by a member of the registered nursing staff.

In November 2016, resident #008 reported to staff that there was an altercation with resident #029.
A review of the resident's health care record indicated that registered staff documented in the progress notes that the resident had altered skin integrity.
Interview with RPN #111 indicated that when the condition of a resident's skin became altered that registered staff must initiate a skin and wound assessment as well as follow up with a weekly skin and wound assessment until the issue was resolved.
A review of the home's "Skin and Wound Care Program", last revised June 2016, stated, "The RN/RPN will upon identification of altered skin integrity (pressure ulcer, skin tear, wound, burn, rash, abrasion, surgical wound, laceration, bruise etc.), initiate a baseline assessment using the Skin and Wound Assessment on Point Click Care (PCC)", and to, "complete the weekly Skin and Wound Assessment on PCC for each area of altered skin integrity identified". A review of the resident's health record did not indicate that any skin and wound assessment was initiated for resident #008 in relation to the altered skin integrity on their left arm.
Interview with SOC #104 confirmed that registered staff did not complete a skin and wound assessment for resident #008 with the use of a clinically appropriate assessment tool after the altered skin integrity was identified.

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, (b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #4: 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 failed to ensure that drugs were stored in an area or a medication cart that is secure and locked.

Resident #007 had a history of dementia and responsive behaviours. In September 2016, the resident approached RPN #116 in the hall during medication pass. According to the internal investigation notes, RPN #116 had left medication for another resident on top of the medication cart while they were performing other duties.
Interview with RPN #116 indicated that when they turned around and resident #007 took the cup of medications that was left sitting on top of the medication cart and ingested them. The resident was asked to spit out the medications immediately and complied. There was no harm to the resident.
A review of the home's policy titled "Medication - Administration General", policy # LTC9-05.12.01 stated that registered staff were to "never leave unlocked medication cart unattended or medications/e-mars information unattended."
Interview with the DOC confirmed that RPN #117 should have secured the poured medications for one resident prior to assisting resident #007 and confirmed that the medication was not properly secured when left unattended.

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) 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 (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., to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a drug was administered to a resident in accordance with the direction for use specified by the prescriber.

Resident #034 required narcotic medication as part of their pain management regimen. In August 2016, while completing the end of shift narcotic count, RPN #117 and RPN #121 discovered that the narcotic count for this resident was incorrect by one pill.
Interview with RPN #121 indicated that the resident should have had ten (10) tablets of narcotics remaining in the blister pack of medication, but that there were only nine (9) tablets remaining. RPN's #117 and #121 re-counted the medications and searched the medication cart for the missing narcotic but were unable to locate it.
On review of the resident's blister pack it was noted that the following days evening dose was missing, RPN #117 determined that they must have administered an extra dose to resident #034. The physician was notified and the resident was monitored overnight in the home with no adverse effects noted.
In an interview, RPN #117 accepted responsibility for the medication error and indicated that they must have administered an extra dose of narcotic to resident #034 while distracted.
Interview with the DOC confirmed that RPN #117 did not administer the narcotic medication in accordance with the direction for use specified by the prescriber. [s. 131. (2)]

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 administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's response to interventions were documented.

Resident #026 displayed inappropriate behaviour towards resident #027. A review of resident #026's health record indicated that Dementia Observation Screening (DOS) monitoring was initiated two days post incident and for a period of seven (7) days until completed. A review of the DOS monitoring record for the month of November 2016, indicated that on two specific dates in November 2016, there were no observations documented for a period of six hours and on another date for seven hours.
Interview with PSW #122 indicated that when a resident required DOS monitoring that staff were to check the resident in specified time increments and to document the observation in Point of Care electronically.
Interview with RPN #111 indicated that PSW staff were responsible for completing DOS monitoring tasks and should report to the registered staff if any changes in the resident's behaviour occur.
Interview with SOC #115 confirmed that staff did not complete all required documentation for the resident's DOS monitoring during a specific time period in November 2016.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee failed to ensure that upon receiving advice of concern or recommendations from Residents' Council, a response to the Residents' Council was done in writing within 10 days of receipt of the advice.

The President and Vice-President of Residents' Council, indicated during interview with the LTCH Inspector #640, there was no written response to Residents' Council advice of concern or recommendations from the licensee within 10 days.
Review of the minutes of Residents' Council for the year 2016, revealed there were no written responses within 10 days, to Residents' Council concerns raised at the April, June, July, September, October, November and December 2016 Residents' Council meetings.
Interview with the Supervisor of Activation and Volunteers confirmed the home did not have any evidence of written responses to the Residents' Council within 10 days of receiving the advice for April, June, July, September, October, November and December 2016.
The Administrator was interviewed and confirmed the home did not have any evidence of written response to concerns or recommendations received from Residents' Council, within 10 days for the months noted above.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee failed to ensure advice was sought from the Residents' Council in developing and carrying out the satisfaction survey.

The President and Vice-President of Residents' Council, indicated during interview with the LTCH Inspector #640, the licensee did not seek advice of the Residents' Council in developing and carrying out the 2016 satisfaction survey.
Review of the minutes of Residents' Council for the year 2016, revealed that the licensee did not seek advice from the Residents' Council in developing and carrying out the satisfaction survey.
Interview with the Supervisor of Activation and Volunteers confirmed there was no evidence that the licensee sought advice from the Residents' Council in developing and carrying out the 2016 satisfaction survey.
Interview with the Administrator confirmed there was no evidence that the licensee sought advice from the Residents' Council in developing and carrying out the 2016 satisfaction survey. [s. 85. (3)]

Issued on this 16th day of February, 2017

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

Original report signed by the inspector.