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 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 19, 2016	2016_195166_0009	002311-16	Resident Quality Inspection

Licensee/Titulaire de permis

Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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

PLEASANT MEADOW MANOR
99 Alma Street P. O. Box 426 Norwood ON K0L 2V0

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

CAROLINE TOMPKINS (166), JULIET MANDERSON-GRAY (607), SARAH GILLIS (623)

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): April 4, 5, 6, 7, 8, 11,12, 13, 14, 2016

Critical incidents(CIR), log 006491-15, 007192-15 and 012045-15, related to allegations of staff to resident abuse, log 020502-15 related to falls , log 010916-15 ,010917-15, related to follow up to orders and complaint log 030613-15 related to resident care, were inspected concurrently with this Resident Quality Inspection

During the course of the inspection, the inspector(s) spoke with Residents, Family members, Substitute Decision Makers(SDM), Representative of the Residents' Council, the Administrator/Director of Care, Environmental Manager, Maintenance personnel, Nutritional Care Manager, Cook, Office Manager, Clinical Care/RAI Coordinator, Personal Support Workers(PSW), Registered Nurses(RN) and Registered Practical Nurses(RPN).
During the course of this inspection, the inspectors toured the home, observed staff to resident interactions, observed a resident meal service, resident social programs, medication administration and infection control practices.
The inspectors reviewed clinical health records, staff education records, Resident Council minutes, the licensee's investigation documentation and the licensee's policies related zero tolerance of abuse and neglect of residents, skin and wound management, falls prevention, management of complaints, continence management and infection control

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **7 WN(s)**
- **5 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 15. (2)	CO #001	2015_365194_0005	166
O.Reg 79/10 s. 17. (1)	CO #002	2015_365194_0005	166

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. 13. Every licensee of a long-term care home shall ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy. O. Reg. 79/10, s. 13.

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy.

The privacy curtains in six identified residents' rooms, between residents' beds are short in length and when the beds are at the lowest level do not provide total privacy to the residents.(166) [s. 13.]

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 every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy, 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 ensure that the person who had reasonable grounds to suspect that neglect of a resident by the licensee or staff that resulted in harm or risk of

harm has occurred , immediately report the suspicion and the information upon which it was based to the Director.

Related to Log 007192-15

A Critical Incident (CIR) was received reporting two alleged incidents of staff to resident neglect which occurred on the same identified date.

Review of the CIR documentation and the licensee's investigation indicated that PSW #127 exited resident #042's room and indicated to RN #119,that the "room was done." Resident #042 indicated to RN #119 ,he/she required assistance.RN #119 assessed the resident and found the continence product to be quite full and heavy enough to be falling away from the resident. The resident's bed linen was also wet.

In a second incident, resident #041 indicated to to RN #119, that the resident was not wearing a continence product and stated that PSW #127, indicated there were no continence products available. The licensee's investigation indicated continence products were visible on the the resident's bedside table. Resident #041 had used toilet tissue as a continence protection. Resident #041 bed linen was also wet.
Both resident #041 and #042 immediately received continence care after RN#119 became aware of these incidents.

Review of the licensee's investigation and interview with Manager #126, indicated that RN#119, who was the charge nurse on the date of the incident did not immediately report the allegations of staff to resident neglect to the Director.

Related to log#006491-15

A critical incident report was received for an allegation of staff to resident verbal abuse.

Review of the licensee's investigation notes as well as an interview with the manager on call #126 indicated that on an identified date while providing care to resident #024, PSW#123 reported to have witnessed PSW#124 speaking in a disrespectful and belittling manner when the resident requested assistance after an episode of incontinence.

Resident #024 was apologetic and tearful after the incident.

Interview of Manager #126 indicated that the incident was immediately reported to the Charge Nurse and the Manager on call but the incident was not reported to the Director until two days post incident.(623) [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 any person who had reasonable grounds to suspect that neglect of a resident by the licensee or staff that resulted in harm or risk of harm has occurred, immediately report the suspicion and the information upon which it was 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. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee has failed to document and make available to the Residents' Council the results of the satisfaction survey in order to seek the advice of the Council about the survey.
Interview with the President of the Residents' Council, the Program Manager, who is the Residents' Council liaison, the Administrator and review of the Residents' Council minutes indicated that the results of the 2015 Resident Satisfaction survey have not been documented and made available to the Resident's Council. [s. 85. (4) (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 the results of the survey are documented and made available to the Residents' Council if any and to seek their advice about the results of the survey, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

**s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).**

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident, are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that causes distress to the resident that could potentially be detrimental to the resident's health or well-being.

Related to log 006491-15

Review of the homes internal investigation for the reported alleged verbal abuse of resident #024 by staff.
RN#125 notified Manager #126 of the allegations of verbal abuse. A written statement from Manager #126 indicated that she immediately attended the home to review the written statement and began the investigation. Manager #126 contacted the SDM for resident #024 two days post incident to advise of the investigation into the alleged verbal abuse.(623)

Related to log 007192-15

Review of the CIR documentation, the licensee's investigation and interview with Manager #126 indicated the SDMs' for both resident #041 and #042 were not notified of the alleged staff to resident neglect until six days post incident.(166)

Therefore the licensee failed to ensure that the SDMs for residents #024, #041 and #042 were immediately notified of the allegations abuse and neglect. [s. 97. (1) (a)]

2. The licensee has failed to ensure that the resident and the resident's SDM were notified of the results of the alleged abuse or neglect investigation immediately upon completion.

Related to log 006491-15

Review of the licensee's investigation notes as well as an interview with Manager #126 indicated the licensee did not notify the SDM of resident #024 of the results of the alleged abuse or neglect investigation immediately upon completion.

Related to log 007192-15

Review of the licensee's investigation notes as well as an interview with Manager #126 indicated that resident #041 and #042's, SDMs were not notified of the results of alleged neglect investigation immediately upon completion. [s. 97. (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 residents substitute decision-makers, if any, and any other persons specified by the resident are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that causes distress to the resident that could potentially be detrimental to the resident's health or well-being, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of the alleged verbal abuse of resident.

Related to log#006491-15

Review of the homes internal investigation for the reported alleged verbal abuse of resident #024 revealed that the home first became aware of the alleged verbal abuse when they received a written witness report from PSW#123. Internal investigation notes written by Manager #126 reveal that the police were not contacted until two days following the incident. (623)

Related to log 007192-15

Review of the licensee's investigation and interview with Manager #126, did not provide evidence that charge nurse, RN #119, immediately notified the police concerning the allegations of neglect of residents #041 and #042. [s. 98.]

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 appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director is immediately notified of any written complaint received concerning the care of a resident.

Related to log # 030613-15

A family member of Resident #044, submitted written complaints to the DOC/Adm. identifying concerns related to provision of care of resident #044 by staff. A copy of the responses to the written complaints were submitted to the Director, but the written complaint letters by the family member of resident #044 were not submitted. [s. 22. (1)]

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,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff on every shift record symptoms of infection in residents and take immediate action as required.

A review of the clinical records revealed that resident #009 was receiving a prescribed medication three times daily times for ten days. A review of the clinical records and interview with RPN #110 confirmed that records could not be located verifying that staff had been recording resident #009 symptoms every shift. [s. 229. (5) (b)]

Issued on this 20th day of April, 2016

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

Original report signed by the inspector.