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 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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

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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 15, 2018	2018_606563_0016	021543-17, 024447-17, 000349-18, 001570-18, 005466-18, 005641-18, 005812-18, 008829-18, 015318-18, 016758-18, 021402-18	Critical Incident System

Licensee/Titulaire de permis

The Corporations of the City of Stratford, The County of Perth and The Town of St. Mary's
643 West Gore Street STRATFORD ON N5A 1L4

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

Spruce Lodge Home for the Aged
643 West Gore Street STRATFORD ON N5A 1L4

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

MELANIE NORTHEY (563), RHONDA KUKOLY (213)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): October 29, 30, 31, and November 1 and 2, 2018

The following Critical Incident (CI) intakes were completed as part of this inspection:

Related to the Prevention of Abuse and Neglect:
Log #001570-18 / CI #M575-000002-18
Log #005466-18 / CI #M575-000006-18
Log #008829-18 / CI #M575-000008-18

Related to Fall Prevention:
Log #015318-18 / CI #M575-000010-18
Log #005641-18 / CI #M575-000004-18
Log #008829-18 / CI #M575-000008-18

Related to Medication Administration:
Log#016758-18 / CI #M575-000011-18

The following Onsite Inquiry intakes were completed as part of this inspection:
Log #024923-17 / CI #M575-000009-17
Log #009614-18 / CI #M575-000009-18
Log #017153-18 / CI #M575-000012-18
Log #017000-18 / CI #M575-000013-18

The following Critical Incident (CI) intakes were reviewed/closed as part of this inspection:
Log #021543-17 / CI #M575-000007-17
Log #024447-17 / CI #M575-000008-17
Log #005812-18 / CI #M575-000005-18
Log #000349-18 / CI #M575-000001-18
Log #021402-18 / CI #M575-000016-18

During the course of the inspection, the inspector(s) spoke with the Director of Care, the Resident Assessment Instrument Coordinator, the Behavioural Supports Ontario Registered Practical Nurse, Registered Nurses, Registered Practical Nurses, Personal Support Workers, an Environmental Services Housekeeper, a Kitchen Resident Assistant, and residents.

The inspector(s) also made observations of residents and care provided. Inspector

(s) observed medication administration. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were also reviewed.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **3 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. 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 :

The licensee has failed to ensure that there was a written policy that promoted zero tolerance of abuse and neglect of residents and that it was complied with.

The Critical Incident System (CIS) Report documented an incident of resident to resident suspected abuse. The CIS documented that the residents involved were cognitively impaired. The first documented incident occurred nine days prior to the submission to the Ministry of Health and long Term care (MOHLTC) and the second incident involving these residents occurred two days before the report was submitted to the MOHLTC.

A) The Health Status Note in PCC documented that the Director of Care (DOC) was notified of the incident five days after it happened.

The Director of Care (DOC) #101 stated they were the building Registered Nurse at the time of the incident. DOC #101 verified that at the time of the incident involving one of the residents, it was not reported to the DOC until five days later. DOC #101 stated there was some confusion amongst the senior staff related to inappropriate physical contact where some staff believed that if there was no harm and no distress to the resident, it would not be considered abuse. DOC #101 verified both residents could not have provided consent due to dementia and cognitive decline and the incident should have been reported immediately to leadership staff and a Critical Incident Report submitted to the MOHLTC.

The Spruce Lodge Zero Tolerance of Abuse and Neglect policy index #RCM I-36 last revised June 2018 stated that immediate staff interventions included reporting any witnessed, suspected or alleged abuse to a Supervisor/Manager, the Director of Resident Services, or the Administrator. "The Registered Practical Nurse (RPN) is to notify the Registered Nurse (RN) on duty immediately." "All employees of Spruce Lodge are required to immediately report alleged abusive acts that are alleged, suspected or witnessed to the most senior supervisor in Resident Care Department at the time of the incident."

2. The Critical Incident System (CIS) Report documented an incident of resident to resident suspected abuse. The CIS documented that a Personal Support Worker (PSW) witnessed a resident in another resident's room on two occasions on the same day. An Incident Note in Point Click Care (PCC) documented two separate incidents involving the two residents during the same day. The incidents occurred approximately two hours apart and were discussed with both registered staff working. The DOC #101 explained the expectation related to reporting of suspected abuse between residents and the PSW

should have reported the first incident to the RPN when it happened and it was not reported until the next incident approximately two hours later.

Another Incident Note in PCC documented that another incident occurred the next day between the two residents. The incident was only reported when the RPN went back to the unit asking the unit staff regarding the resident's behaviour. The RPN discussed this situation with the Registered Nurse (RN) right away, and the RN called the DOC to inform them of the incident.

The Director of Care (DOC) #101 stated that it was the same PSW on both days and the PSW should have reported the incident immediately at the time. The DOC stated that the CIS should have been amended to include the second incident the next day. The first incident involving the two residents was reported to the MOHLTC action line, but the Director was not notified of the second incident that occurred the next day.

The licensee failed to ensure the written policy that promoted zero tolerance of abuse and neglect of residents and that it was complied with regarding immediate reporting of witnessed suspected abuse. [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 a written policy that promotes zero tolerance of abuse and neglect of residents and that it is complied with., 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 :

The licensee failed to ensure that the person who had reasonable grounds to suspect that any of the following had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director; abuse of a resident by anyone that resulted in harm or risk of harm.

The Critical Incident System (CIS) Report documented an incident of resident to resident suspected abuse. The CIS documented that the residents involved were cognitively impaired. The first documented incident occurred nine days prior to the submission to the Ministry of Health and long Term care (MOHLTC) and the second incident involving these residents occurred two days before the report was submitted to the MOHLTC.

The Behaviour Observed note in Point Click Care (PCC) documented that PSW #108 observed the resident to resident suspected abuse.

The General Note in PCC dated documented that the resident's spouse was informed of the incident and stated that the resident was not able to consent to the relationship.

The Health Status Note in PCC documented that the Director of Care (DOC) was not notified of the incident until five days later.

The Incident Note-Near Miss in PCC documented that the registered staff received a call

stating that an environmental staff member had witnessed the resident to resident suspected abuse.

The Director of Care (DOC) #101 stated they were the Director of Care as of November 1, 2018 and was the building Registered Nurse at the time of the incident. DOC #101 verified that at the time of the incident involving one of the residents, it was not reported to the DOC until five days later and was not submitted to the MOHLTC until nine days later. DOC #101 also verified that the second incident involving two residents was related to suspected resident to resident abuse and was not immediately reported to the MOHLTC.

PSW #108 stated they recalled the incident involving the resident to resident suspected abuse. PSW #108 stated that they told the Registered Nurse (RN) right away because any suspected abuse of any kind needed to be reported immediately. PSW #108 stated that the RN at the time of the incident was now the Director of Care.
Environmental Service Housekeeper (ESH) #109 stated they recalled the incident between resident the two residents where they observed suspected resident to resident abuse. ESH #109 verified they reported the incident right away to the charge nurse.

The Spruce Lodge Critical Incident/Mandatory Reporting policy index # RCM 3-3 last revised June 2018 stated, "Immediate reporting using after hours phone and CIS completion: abuse of a resident by anyone or neglect of a resident by the licensee or staff that results in harm or risk of harm to a resident."

The Spruce Lodge Zero Tolerance of Abuse and Neglect policy index #RCM I-36 last revised June 2018 stated, "All employees of Spruce lodge are required to immediately report alleged abusive acts that are alleged, suspected or witnessed to the most senior supervisor in Resident Care Department at the time of the incident. This supervisor is then responsible for completing the report to the Ministry using the Critical Incident System (CIS)." "The immediacy in reporting is not only intended to ensure that the victim is not subjected to further abuse and neglect, however is also intended to ensure compliance with legislated standards for reporting as well as result in improved, and more timely investigations."

The licensee failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or risk of harm, immediately reported the suspicion and the information upon which it was based to the Director.

2. The Critical Incident System (CIS) Report documented an incident of resident to resident suspected abuse. The CIS documented that a Personal Support Worker (PSW) witnessed a resident in another resident's room on two occasions on the same day.

Director of Care (DOC) #101 stated there was an incident involving the two residents and that it was reported to the MOHLTC action line, however the DOC also stated that the incident that occurred the next day was not reported to the Director and the CIS should have been amended to include the second incident.

The licensee failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or risk of harm, immediately reported the suspicion and the information upon which it was based 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 the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director; abuse of a resident by anyone that resulted in harm or risk of harm, to be implemented voluntarily.

WN #3: 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 :

The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A) The Critical Incident (CI) System report was submitted to the Ministry of Health and Long Term Care (MOHLTC). The CI documented that a medication incident/adverse drug reaction occurred involving a resident. The report stated that the resident was administered a dose of medication that was higher than the dose ordered by the prescriber.

A Health Status progress note in Point Click Care (PCC) documented that the resident received an overdose of a medication.

The Remedy's Rx Medication Incident/Near Miss Report documented an incident where there was a medication administration dose error.
Director of Care (DOC) #101 stated RPN #116 miscalculated the dose of medication.

The licensee failed to ensure that the medication administered to the resident was in accordance with the directions for use specified by the prescriber.
B) Inspector #563 observed the administration of a medication for a resident. RPN #117 stated that the morning dose of medication was held for a specific reason. The RPN also stated that it was their clinical judgement to hold the dose because the resident was still in bed in the morning. Inspector #563 asked if the resident ate breakfast and the RPN replied, "I don't know". Inspector #563 asked if there was a physician's order to hold the medication if specific parameters were not met and RPN #117 replied, "no". RPN #117 then asked Personal Support Worker (PSW) #110 if the resident had breakfast and the PSW stated that the resident was up and attended the dining room for breakfast and ate the morning meal.

The Physician Order in Point Click Care (PCC) documented a specific medication order to be administered at a specific time.

The Medication Administration progress note in PCC documented that RPN #117 held the resident's medication. The Medication Administration Notes in PCC were then reviewed for similar entries. The Medication Administration Note on another date documented that the resident's medication was held by RPN #117.

DOC #101 was made aware of the medication that was held for administration. The DOC was asked when it would be clinically indicated to hold an order for a medication for any resident, and the DOC stated that if the resident had a specific order or range it should be followed to the protocol, or if the resident was symptomatic. DOC #101 verified that

the resident did not have specific instructions to hold the order for the medication administration. The DOC stated that the expectation whenever a registered staff member held an administration of a specific medication was the completion of documentation in the progress notes as to why the medication was held and verified that RPN #117 did not include enough detail as to why the medication was held for the resident. DOC #101 verified that the resident was not administered the medication on two separate dates in accordance with the directions for use specified by the prescriber.

The licensee failed to ensure that the medication was administered to the resident in accordance with the directions 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.

Issued on this 20th day of November, 2018

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

Original report signed by the inspector.