Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Oct 30, 2019	2019_792659_0022	017313-19, 017654-19, 018871-19	Complaint

Licensee/Titulaire de permis

AXR Operating (National) LP, by its general partners
c/o Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

Stirling Heights
200 Stirling Macgregor Drive CAMBRIDGE ON N1S 5B7

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

JANETM EVANS (659)

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): September 25, 26, 27, 30, October 1, 2, 3, 7 and 8, 2019.

The following intakes were included as part of this inspection:
Log #017654-19\IL-70159-CW Complaint related to care concerns for falls prevention and medication administration.
Log #017313-19\IL-69992-CW Complaint related to staffing.
Log #018871-19\AH IL-70702-AH/Critical Incident 2863-000025-19 related to alleged staff to resident abuse.

This inspection was completed concurrently with Critical Incident inspection 2019_792659_0023.

Inspector #753 attended and participated in this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Regional Manager (RM), Registered Nurses (RNs), Staff Educator, RAI Coordinator, Skin and Wound Nurse, Registered Practical Nurses (RPN), Personal Support Workers (PSW), and Physiotherapist.

Observations were completed for staff to resident interactions, medication administration and general care of residents. A review of relevant documentation was completed.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Sufficient Staffing

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

6 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	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. 6. Plan of care

Specifically failed to comply with the following:

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).

Findings/Faits saillants :

1. A complaint was submitted to the Ministry of Long Term Care (MLTC) related to inadequate interventions and interventions not being implemented related to falls for an identified resident. The complaint indicated that the home had implemented a check system for the resident, but that staff were not documenting the checks hourly and were not asking the questions of the resident as they were supposed to.

A Fall risk screen completed on a specified date, documented the identified resident as high risk for falls.

A RAI MDS assessment completed on a specified date, identified the resident's ambulatory status and and that they required extensive assistance from two persons for activities of daily living. A wheelchair was their primary mode of locomotion.

The plan of care for the identified resident, documented staff were to to complete and record hourly safety checks during certain periods. The plan of care stated a specific device was to be utilized daily when the resident was in their room. The plan of care said the resident was on a specific program to prevent the resident from self toileting.

A monitoring record titled High Fall Risk/Risk for Injury was observed to be kept in several locations and it documented hourly checks which included specific safety questions.

Observations completed on seven instances during the inspection showed that the items to be completed on the monitoring record were not completed when checked. The monitoring record was not completed at the required times and staff did not to ask the resident the specific questions, rather they just signed the document off.

A PSW acknowledged on two instances they had checked on the resident but they had not signed the monitoring record off at the time of check and they said they should have signed it off at the time of the check. A PSW acknowledged signing the monitoring record off early and stated it should not have been. Two PSWs acknowledged they checked the resident, but they had not asked the specific questions.

The licensee failed to ensure that care set out in the plan of care was provided to the identified resident as specified in the plan related to documentation of hourly checks and completion of safety questions.

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 care is provided to the identified resident as specified in the plan. Specifically, staff will document hourly checks at the time of the check and will ensure that the checks include: asking the resident about pain, voiding/elimination, positioning, and ensuring everything within reach, as well as asking if there was anything else they could do and tell the resident when someone would be back, to be implemented voluntarily.

WN #2: 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 :

1. The licensee has failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

A Critical Incident was reported to the Ministry Long Term Care (MLTC) on September 28, 2019, for an incident which occurred September 26, 2019. The allegation stated that staff were aggressive during the provision of care and the resident felt pain.

The home's policy: Resident Non Abuse Program, ADMIN1-P10-ENT, reviewed March 31, 2019, stated that any form of abuse or neglect by any persons interacting with residents, whether through deliberate acts or negligence, will not be tolerated. Anyone who becomes aware of or suspects abuse or neglect of a resident must immediately report that information to the ED, or if unavailable, to the most senior supervisor on shift. The home's policy, LTC-Investigation of Abuse or Neglect, ADMIN1-010.02, reviewed March 31, 2019, stated the priority was to ensure the safety and comfort of the abuse

victim(s) by taking steps to provide for their immediate safety and well being. Complete full assessments to determine the residents needs and document them on the resident's plan of care.

On a specified date, a progress note stated that an identified resident complained of pain and yelled at staff during care. The progress note entry stated the plan was to follow up; but no follow up was documented that shift. A progress note entry on the following day, documented the resident told the RPN one of the staff had not been properly assisting with their transfer and they were aggressive with care. The RPN said they would notify the ED and DOC and told the resident the next time something like that happened they should not hesitate to report to staff. An email was sent to the ED and DOC to advise them of the resident's concern.

There was no documented full assessment completed for the identified resident on either specified date.

An RPN stated they followed up with the identified resident the day after the resident had complained of pain. The RPN stated they notified the RN and management.

The DOC stated that in this situation, staff should have notified the manager on call and that notifications should be via telephone and not by email. A head to toe assessment was usually completed when an allegation of abuse or neglect was received and acknowledged that it had not been completed in this situation.

2. A complaint was received by the MLTC on a specified date, which stated an SDM had reported to an RPN that an identified resident verbalized fear of a staff member and requested the SDM not leave them alone as they could see the staff member.

An RPN stated that if a family member or resident came to them with an allegation of abuse they would report it to their supervisor and they would check the resident to ensure they were safe. The RPN acknowledged that the SDM for the identified resident had reported that the resident verbalized fear of an identified staff member and the SDM questioned if the staff member had been rough with the resident's care. The RPN acknowledged they had not reported the concerns about possible rough care towards the resident to anyone.

The licensee has failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with for two identified residents with

respect to immediate reporting of allegations of abuse and completing a full assessment to determine the residents needs.

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 comprehend and comply with the home's policy of zero tolerance to ensure that staff complete and document a full assessment of the resident to determine their needs and to immediately notify the manger/on call manager or most senior person staff on shift of an allegation of abuse or neglect, to be implemented voluntarily.

WN #3: 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 they immediately forwarded written complaints concerning the care of an identified resident , to the Director. Specifically, the licensee did not immediately forward a written complaint related to medication administration for the identified resident to the Director.

On a specified date the SDM for an identified resident submitted a written complaint via email to the DOC related to the resident's medication administration. The SDM reported that the identified resident's noon medication dose on a specified date had not been given as prescribed by the resident's consultant physician.

A review of critical incidents on longtermcarehomes.net, submitted by the licensee for a two month period did not show evidence of a submission to the MLTC related to this complaint.

A review of the home's Client Response Binder had not included documentation related to the resident or concerns with their medication administration.

The DOC stated that the process for dealing with a formal written complaint is to follow-up with the MLTC and family.

The licensee failed to ensure that a formal written complaint related to the medication administration for an identified resident was reported to the Director.

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 written complaints concerning the care of a resident are submitted to the Director, 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. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated: (i) Abuse of a resident by anyone.

A complaint was received by the MLTC on a specified date, which stated that an identified resident's SDM had reported to an RPN a situation of suspected abuse.

The RPN acknowledged that they received the report which indicated a suspician of abuse.

The DOC stated that they were aware of a recent allegation involving the identified resident. The DOC stated they had not completed a formal investigation for this incident and they were unable to produce any documentation related to their investigation.

The licensee failed to ensure that the alleged incident that the licensee knew of was immediately investigated: (i) Abuse of a resident by anyone.

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 home conducts an immediate investigation into allegations of abuse and documents the investigation, 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 has failed to ensure that drugs were administered to an identified resident in accordance with the directions for use specified by the prescriber.

A complaint was received by the MLTC which stated that an identified resident had been administered a specified medication in the wrong form.

Review of the clinical record for the resident showed a consultation letter from the resident's neurologist, which recommended in part, the change for the morning dose of the medication.

A review of the physician's order showed the specified morning dose of the medication was ordered to be given in a different form.

A typed document provided by the DOC stated it had been brought to their attention that the identified resident's medication was administered in the wrong form outside of the specified timeframe. There was no ill effect to the resident.

The ED and DOC stated they had spoken with the resident's attending physician who said that there was no ill effect of the medication being given in the wrong form.

An RN stated that it was not within their scope to determine what form a medication should be given in and they followed the order as it was written.

The DOC acknowledged that if staff administered medication in a different form than it was prescribed, then staff had not followed the physician's order.

The licensee failed to ensure that drugs were administered to an identified resident in accordance with the directions for used specified by the prescriber.

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 medications are administered in accordance with the directions for use specified by the prescriber, if orders appear confusing, clarification from the prescriber will be sought and documented, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction is:
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and
(b) reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

A complaint was received by the MLTC related to an identified resident's medication not being given in the correct form.

Ontario Regulation 79/19, defines a medication incident as "a preventable event associated with the prescribing, ordering, dispensing, storing, labelling, administering or distributing of a drug, or the transcribing of a a prescription and includes (a) an act of omission or commission, whether or not it results in harm, injury or death to a resident".

The licensee provided a paper with the name of the identified resident's SDM's on it. It reported a concern that on a specified date and time, the resident's medication was administered in the wrong form.

The DOC stated that failing to follow a physician's order constituted a medication incident. The DOC stated that they had started to complete a Medication Incident Reporting System (MIRS) for this incident but there was no appropriate category to enter for it so they had not completed a medication incident for this incident.

The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction is:
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and
(b) reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider

Issued on this 6th day of November, 2019

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

Original report signed by the inspector.