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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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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
Jan 6, 2016	2015_401616_0022	027914-15	Critical Incident System

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

LAKEHEAD MANOR
135 SOUTH VICKERS STREET THUNDER BAY ON P7E 1J2

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

JENNIFER KOSS (616), SHEILA CLARK (617)

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): November 25, 26, 27, December 1, 2, 3, 4, 2015

This inspection was conducted concurrently with Complaint inspection 2015_401616_0021 / 023709-15 and Follow Up inspection 2015_401616_0020 / 025740-15.

This Inspection includes intakes: 028736-15, 028600-15, 027296-15, 026497-15, 022576-15, 021402-15, 003890-14, 004696-15, 024698-15, 025671-15, 011508-15.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), interim Executive Director, Acting Director of Care (DOC), Associate Director of Care , Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Registered Dietitian (RD) , Food Service Manager (FSM), Environmental Service Manager (ESM), Resident Assessment Instrument (RAI) Coordinators, Life Enrichment, residents and family members.

Observations were made of the home areas, meal services, and the provision of care and services to residents during the inspection. The home's policies and procedures and resident health records were reviewed.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Snack Observation
Sufficient Staffing
Training and Orientation

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **1 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. 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 the home's written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

Inspector #617 reviewed Revera policy #LP-C-20-ON, titled "Resident Non-Abuse-Ontario" last updated on September 2014, which indicated that if a staff member of a Revera Home is alleged, suspected or witnessed to have abused and/or neglected a resident, that staff member will be immediately suspended from their duties with pay and required to leave the premises pending investigation.

A Critical Incident System report was submitted by the home to the Director regarding verbal abuse toward resident #005 by Personal Support Worker (PSW) #107. Inspector #617 reviewed the investigation notes regarding this incident which indicated two witnesses (PSW #104 and Registered Practical Nurse (RPN) #108) notified the home of allegations of verbal abuse in September 2015. The investigation into the incident was concluded 13 days later.

On December 3, 2015, Inspector #617 interviewed the Executive Director (ED) who confirmed that PSW #107 did verbally abuse resident #005. The ED stated that PSW #107 was not suspended with pay immediately after they were suspected of verbal abuse as per policy and continued to work prior to the conclusion of the investigation. [s. 20. (1)]

2. A Critical Incident System report was submitted by the home to the Director regarding neglect toward resident #005 by RPN #109. Inspector #617 reviewed the investigation notes regarding this incident which indicated Food Service Worker #110 reported allegations of witnessed resident neglect in October 2015. The investigation into the incident was concluded one day later.

On December 3, 2015, Inspector #617 interviewed the ED who confirmed that the home

determined that RPN #109 did not neglect resident #005. The ED stated that RPN #109 was not suspended with pay immediately after they were suspected of neglect as per policy and continued to work prior to the conclusion of the investigation. [s. 20. (1)]

3. A Critical incident System report was submitted to the Director regarding suspected abuse toward resident #007 by PSW #111 which occurred in September 2015. Inspector #617 reviewed the investigation notes regarding this incident which indicated the Resident Services Coordinator notified the home of allegations of resident abuse 3 days after the suspected abuse was witnessed. The investigation into the incident was concluded 16 days later.

On December 3, 2015, Inspector #617 interviewed the ED who confirmed that the home determined that PSW #111 did not abuse resident #007. The ED stated that PSW #111 was not suspended with pay immediately after they were suspected of abuse as per policy and continued to work prior to the conclusion of the investigation. [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 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, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.

Inspector #617 reviewed the home's staffing plan provided by the ED, which indicated that there was at least one Registered Nurse (RN) (not including the Director of Care (DOC)) on duty and present in the home at all times. The plan indicated if there was an unexpected absence or situation that prevented the home from meeting the 24 hours/7 days (24/7) a week RN coverage, the Alternate Staffing Plan was to be utilized.

Ontario Regulation 79/10 s. 45 (2) defines an emergency as an unforeseen situation of a serious nature that prevents a registered nurse from getting to the long-term care home.

The Alternate Staffing Plan directed the use of overtime pay or replacement with agency staff if there was a vacant RN position in the schedule. If unable to fill the vacancy, the plan further directed the RN replacement with an extra RPN with DOC consult via telephone. The RPN is responsible for modified RN duties as described in the staffing plan.

On December 4, 2015, at 1542hrs, the home's Staffing Scheduler stated to the Inspector that there was no RN scheduled from 1500-2300hrs this day. They added that RPN #112 was assigned as the extra RPN in the home to complete the modified RN duties with the acting DOC on call.

Inspector #617 interviewed the Manager of Clinical Services who confirmed that the home's staffing plan indicated in the absence of the RN, an extra RPN would be assigned to modified RN duties with the DOC on call. RPN #112 confirmed to the Inspector that they were the extra RPN responsible for modified RN duties. The Manager of Clinical Services reported to the Inspector that the vacancy for the RN evening shift on December 4, 2015, was the result of an unfilled shift in the planned rotational schedule. They stated that attempts to fill this vacancy with an RN were unsuccessful. Further, they stated the Alternate Staffing Plan was utilized on two other occasions when there was no RN in the home on day shift, November 17, 2015, and November 29, 2015, night shift.

The RN shift vacancies did not meet the definition of “emergency” as per O. Reg 79/10 s. 45 (2) therefore the home failed to ensure at least one registered nurse, an employee and a member of the regular nursing staff of the home, was on duty and present in the home at all times. [s. 8. (3)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

During inspection of the dining room on December 1, 2015, at 1320hrs, resident #014 voiced a complaint to Inspector #617 about the condition of a table. The Inspector observed that the table was not secured to the base and loosely moved up and down.

On December 2, 2015, at 1710hrs, Inspector #617 tested all of the tables in the dining room by applying light force to their corners and found an additional table top that was loosely fitted to the base. Resident #015 confirmed that it was loose and stated the table moved when they leaned on it.

On December 2, 2015, the Inspector interviewed the Food Services Manager (FSM), who confirmed that there were loose table tops on their bases in the dining room. The FSM stated that they had obtained a device that would secure the base to the table top which was not yet installed on those tables that were loose.

The home failed to ensure the tables in the dining room to be safe and in good repair. [s. 15. (2) (c)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home had a dining and snack service that included, at a minimum, the following elements: 6. Food and fluids being served at a temperature that is both safe and palatable to the residents.

On November 26, 2015, at 1855hrs, during the dinner meal service in the dining room, Inspector #617 asked resident #018 if they were satisfied with their meal. The resident stated that the meal was cold and they did not want to eat it. The Inspector confirmed that the rice with meat and vegetables on the plate were cold to touch.

As requested by the Inspector, Cook #113 reported the temperature of the rice in the steamer was above 160 degrees Fahrenheit. The Inspector requested to view the thermometer that Cook #113 used to measure the temperature of the vegetables which read 149.1 degrees Fahrenheit.

Inspector #617 reviewed the Meal Production Daily Temperature Record procedure which indicated that hot holding of cooked food is to be above 150 degrees Fahrenheit. On November 27, 2015, the day after the cold food was reported, the Inspector reviewed the recorded temperatures in a binder located in the kitchen. The temperatures for the dinner meal service on November 26, 2015, were not recorded.

On December 2, 2015, Inspector #617 interviewed the family members of residents #019 and #020 who sat together and waited for the lunch meal to be served. The family member of #019 stated that there was a long wait for the meal to be served at the table and that the food temperature for hot meals was at times, cold.

On December 2, 2015, the Inspector interviewed the FSM, who confirmed that the food temperature being cold was an issue brought up by Family Council over the past two months. They stated it was the expectation of the home for the dietary staff and cooks to measure and record food temperatures prior to service. The FSM confirmed that Cook #113 did not record several temperatures in the month of November 2015 as required. [s. 73. (1) 6.]

Issued on this 6th day of January, 2016

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

Original report signed by the inspector.