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
Feb 22, 2016	2016_333577_0002	000599-16	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

DEBBIE WARPULA (577)

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): January 28, 29, 2016 and February 1, 2, 2016

The purpose of this inspection was to conduct a Critical Incident inspection, for logs: 035582-15, 000599-16, 035709-15, 000233-16. This inspection was conducted concurrently with Complaint inspection #2016_333577_0003 and Follow up inspection #2016_333577_0004.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Assistant Director of Care (ADOC), Registered Nurse (RN), Registered Practical Nurses (RPN), RAI Coordinator, Personal Support Worker and residents.

Observations were made of home areas, staff and resident interactions, provision of care and services to residents, reviewed health care records, internal investigation reports, an employee file and the home's policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that all residents were protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

A Critical Incident report was submitted to the Director in November 2015, regarding resident #003 and resident #004 having a consensual relationship. Resident #003 was moved to another floor due to their responsive behaviours.

A Critical Incident report was submitted to the Director in relation to reported abuse by resident #003 towards resident #005 in January 2016. It was reported that resident #003 abused resident #005.

Under O. Reg. 79/10, sexual abuse is defined as "any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed to a Resident by a person other than a licensee or staff member".

A review of resident #003's progress notes dated in December 2015, documented that resident stated that they were aware specific behaviours were not acceptable and the "1/2 hourly safety checklist" was completed for six days with no incidences or inappropriate behaviours noted and then it was discontinued. Another progress note dated in December 2015, identified that resident #003 was displaying responsive behaviours towards a co-resident and a staff member intervened. A progress note dated January 2016, indicated that resident #003 was witnessed to approach resident #005 and abuse them. The progress note also identified that staff implemented increased monitoring for resident #003.

A review of resident #003's chart found "1/2 hourly safety checklist" forms were implemented from November 2015-December 2015. A review of the resident's health care record found Dementia Observation System/DOS documentation was implemented from January 2016-February 2016, and another behaviour tracking tool was implemented for two weeks in January 2016.

A review of resident #003's care plan, prior to incident, dated January 2016, found that resident had specific responsive behaviours. Interventions in the care plan included: all incidents of specific responsive behaviours are to be documented and reported to Registered Nurse. The care plan did not indicate interventions in place to ensure that co-residents were safe from resident #003's specific responsive behaviours.

A review of the home Policy: Resident non-abuse- Ontario Index- LP-C-20, revision date September 2014, revealed that sexual abuse was defined as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed to a

resident by a person other than a licensee or staff member.

During an interview with the Executive Director they confirmed that it was the expectation of the home that all residents be protected from abuse and the home failed to protect resident #005 from abuse by resident #003. They further confirmed that the home failed to have any specific interventions in place for resident #003 at the time of the incident. [s. 19. (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 all residents are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff, specifically in regards to resident #005, to be implemented voluntarily.

WN #2: 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 had failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A Critical Incident Report was submitted to the Ministry in November 2015, which indicated that resident #002 had requested two medications to be given for pain on two mornings in November 2015, and RPN #102 refused to administer one of the medications. Resident #002 indicated that they begged for their medication, was in terrible pain and did not receive pain medication as ordered for two consecutive days while RPN #102 was working.

A review of the physician's orders revealed that on a day in November 2015, an order was received for resident #002 to be given a pain medication every six hours when needed (prn), may give both pain medications together.

A review of the Medication Administration Records (MARS) revealed that resident #002 did not receive their pain medication as requested on two days in November 2015.

During an interview by Inspector #617 with resident #002 on November 26, 2015, they stated that they had requested two medications be given together and had not received it for two consecutive days.

During an interview with resident #002 they stated that they were aware that the physician had ordered another pain medication when needed/prn in November 2015, as it was to be given with another pain medication and that RPN #102 had refused to administer the medication.

During an interview with the Executive Director they confirmed that it was the home's expectation to ensure that residents receive pain medication as ordered, and that resident #002 should have received pain medication when requested. [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, specifically in regards to resident #002, to be implemented voluntarily.

Issued on this 29th day of February, 2016

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

Original report signed by the inspector.