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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 5, 2018	2018_671684_0009	004480-18	Resident Quality Inspection

Licensee/Titulaire de permis

~~GREY-OWEN LODGE - H F A~~ CVH (No. 9) GP Inc. as general partner of CVH (No. 9) LP
~~206 TORONTO STREET MARKDALE ON N0C 1H0~~ 766 Hespeler Road, Suite 301
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Long-Term Care Home/Foyer de soins de longue durée

Southbridge Lakehead
135 South Vickers Street THUNDER BAY ON P7E 1J2

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

SHELLEY MURPHY (684), AMY GEAUVREAU (642), KATHERINE BARCA (625), LAUREN TENHUNEN (196), SHEILA CLARK (617)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): March 19-23, 2018 and March 26-28, 2018.

Additional intakes inspected during this Resident Quality Inspection (RQI) included:

One complaint, related to dealing with complaints, duty to protect, plan of care, bathing, menu planning and maintenance services;

One complaint, related to administration of drugs, and;

One complaint related to the prevention of abuse and neglect of residents;

Four Critical Incidents (CIs), related to prevention of abuse and neglect of residents;

Three CIs, related to falls prevention and management;

Five CIs, related to the medication management system; and

One critical incident, related to the home's emergency plans, policies and records.

An Other inspection #2018_671684_0010 was conducted concurrently with this RQI inspection.

The inspectors also conducted daily tours of the resident care areas, observed the provision of care and services to residents, reviewed relevant licensee policies, procedures, programs, internal investigation files, human resource files and resident health care records.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care (DOC), Associate Director of Care (ADOC), Environmental Service Manager, Pharmacy Manager, Pharmacist, Registered Dietitian (RD), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Resident Assessment Instrument (RAI) Coordinator, Restorative Care Aid (RCA), Personal Support Workers (PSWs), Housekeeper, Dietary Aides (DAs), residents and their families.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Critical Incident Response
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
6 WN(s)
2 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. 6. (1)	CO #001	2016_435621_0015	684

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 that, the home's written policy to promote zero tolerance of abuse and neglect of residents, was complied with.

A critical incident (CI) report was submitted to the Director related to abuse and neglect of resident #007 by PSW #113. The resident alleged the PSW attended the resident's room in response to their call bell for assistance. It was alleged that the PSW incorrectly provided a product to the resident and told the resident to change their incontinent product themselves. The report further outlined that, when the resident explained to the PSW why they were not able to manage, the PSW stated that the resident needed to learn how to do so.

A review of resident #007's care plan in place at the time of the incident identified that the resident required assistance of staff with the product.

Inspector #625 reviewed the home's policy, "Resident Non-Abuse – Resident Non-Abuse Program - ADMIN1-P10-ENT", last reviewed July 31, 2016. The policy identified that the licensee had zero tolerance for abuse and neglect, and that any form of abuse or neglect by any persons interacting with residents, whether through deliberate acts or negligence, would not be tolerated.

Inspector #625 reviewed the home's investigation file, including interview notes with resident #007, which were consistent with the details submitted in the CI report, and a letter to PSW #113 indicated they were no longer working at the home.

During an interview with the Associate Director of Care (ADOC) #116, they stated that they had been involved in the investigation into the incident involving resident #007 and PSW #113. The ADOC stated that the resident had been adamant about what had occurred, and acknowledged that abuse and neglect had occurred to resident #007 by PSW #113. [s. 20. (1)]

2. A CI report was submitted to the Director related to the abuse of resident #016 by PSW #121. The resident alleged the PSW attended their room in response to a call bell, and inappropriately addressed the resident. The report indicated the resident stated they were afraid of PSW #121 at the time of the incident.

Inspector #625 reviewed the home's investigation file, including interview notes with resident #016, which were consistent with the details submitted in the CI report, and a letter to PSW #121 detailing the type of discipline that was issued to the PSW for being in violation of the licensee's non-abuse policy as well as the Residents' Bill of Rights.

During an interview with resident #016, they stated that they recalled the incident that had occurred, and that PSW #121 had responded inappropriately to the resident.

During an interview with the ADOC #116, they stated that they had been involved in the investigation into the incident involving resident #016 and PSW #121. The ADOC stated that the investigation determined that abuse had occurred, that PSW #121 had made inappropriate remarks and the resident was frightened. [s. 20. (1)]

3. A CI report was submitted to the Director for the abuse of resident #015 by PSW #122. The resident alleged the PSW attended their room and made inappropriate comments to the resident about a previous incident which occurred between the PSW and the resident. The report identified that the resident stated they felt scared and intimidated by the PSW.

Inspector #625 reviewed the home's investigation file, including interview notes with resident #015, which were consistent with the details submitted in the CI report.

A review of PSW #122's employee file, found a letter, that identified that the PSW was issued discipline for violating the licensee's non abuse policy as well as the Residents' Bill of Rights.

During an interview with the Director of Care (DOC), they stated that they had been involved in the investigation of the incident involving resident #015 and PSW #122. The DOC stated that the investigation determined that the PSW had accused the resident of reporting them for a previous incident. The DOC stated that the PSW's actions were in retaliation to the resident's complaint. [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, without in any way restricting the generality of the duty provided for in section 19, that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and that the policy is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning
Specifically failed to comply with the following:

s. 71. (5) The licensee shall ensure that an individualized menu is developed for each resident whose needs cannot be met through the home's menu cycle. O. Reg. 79/10, s. 71 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that an individualized menu was developed for each resident whose needs cannot be met through the home's menu cycle.

A complaint was submitted to the Director, in which resident #004's family member reported that the resident's planned menu did not meet their needs.

In an interview with resident #004 they reported to Inspector #617 that they preferred a specific diet type and that they had spent time explaining their dislikes and likes to the Food Service Manager. Resident #004, reported that to meet their requests the staff in the dining room provided them with different menu options. Resident reported for one meal they were offered only three menu options. There was no specific diet options for them to choose. The resident reported that they were not happy with their meals and as a result would miss meals at times.

A review of resident #004's MDS from a specified date in 2018, indicated that resident #004 left a percentage of their food uneaten at most meals.

A review of resident #004's plan of care, indicated that the resident did not have any

interventions related to eating, they were identified as being a nutritional risk as they have specific food requests, and the dietary aide in the dining room was to provide the resident with an adjusted menu. A review of resident #004's diet order sheet located in the kitchen indicated that they were ordered a specific diet and texture, as well it indicated the resident; preferences and dislikes.

On a day in 2018, at a specified time, the inspector observed resident #004 not in attendance in the dining room for meal service.

On a day in 2018, in an interview with Dietary Aide (DA) #127, they confirmed to Inspector #617 that resident #004 did not have a meal as they did not provide them with food.

On a day in 2018, at a specified time, Inspector #617 observed resident #004 attend a meal service. The resident was shown the food options. Resident #004 refused both options and did not eat a meal at this service.

In an interview with DA #127, they reported that resident #004 refused many food options provided by the kitchen and they were to ask the resident which alternate food option they would prefer when the menu did not meet their needs.

A review of resident #004's meal consumption records, from a specified date range in 2018, indicated that they did not attend a meal service a quarter of the time. Meal consumption records for resident #004, from a second specified date range in 2018, indicated that they did not attend a meal service less than a quarter of the time.

In an interview with Registered Dietitian (RD) #126, they confirmed to the inspector that they had assessed resident #004 to be at a specified nutritional risk. The resident had a weight change, and they had specific dietary requests. The RD reported that the resident's diet requirements were not being met with the meals they had missed. RD #126, further reported that the kitchen should be offering more diet options and that they had a specific diet option which needed to be explored with the resident.

The licensee failed to ensure that resident #004 had an individualized menu developed for them as the home's menu cycle did not meet resident #004s needs. [s. 71. (5)]

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 an individualized menu is developed for each resident whose needs cannot be met through the home's menu cycle, to be implemented voluntarily.

WN #3: 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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A CI report was submitted to the Director related to the abuse and neglect of resident #007 by PSW #113. The resident alleged the PSW was responding to the resident who required assistance, when the PSW inappropriately provided the resident with an incorrect product and told the resident to change their product themselves.

Inspector #625 reviewed resident #007's care plan at the time of the incident and identified that the resident required a specific intervention. The care plan also included a specific intervention for staff to follow for all care with the resident as the resident may not respond appropriately.

During interviews with PSW #114 and RN #115, they stated that resident #007 required a specific intervention when staff provide care, as the resident may not respond appropriately.

A review of the home's investigation file, including interview notes with PSW #113, identified that the PSW did not follow the specified intervention for resident #007 at the time of the provision of care to the resident.

During an interview with the Associate Director of Care (ADOC), they stated that resident #007's care plan at the time of the incident identified a specific intervention that staff was to use while providing care to the resident. The ADOC acknowledged that PSW #113 had not used the intervention as specified in the plan of care, when they provided care to the resident. The ADOC acknowledged that PSW #113 failed to provide resident #007 with the care they required as specified in their plan of care. [s. 6. (7)]

2. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs changed or care set out in the plan was no longer necessary.

On a specified day in 2018, Inspector #684 observed that resident #001's care needs had not been met. During three more days in 2018, on nine separate occasions, Inspector #617 observed resident #001's care needs not being met.

On a specified day in 2018, in an interview with resident #001 they reported that they would like a specific care need be met but required the assistance from staff.

A review of resident #001's Resident Assessment Instrument Minimal Data Set (RAI MDS) from a specified date in 2018, indicated that the resident had independent cognitive abilities and did not exhibit behavioural symptoms. A review of resident #001's care plan from a specified date in 2018, indicated that the resident required staff assistance for care needs to be met.

A review of the unit's care schedule indicated that resident #001 was to have their care needs addressed on two specific days of the week each week.

On a specified day of 2018, Inspector #617 interviewed PSW #124, who confirmed that they were to provide care to resident #001 during their shift and that they did not provide

the care as the resident refused.

On a specified day of 2018, during an interview with PSW #118, they confirmed that resident #001 refused to have their care needs met.

A review of resident #001's documentation of care provision from the electronic documentation system, Point of Care (POC), indicated that during a specified period of time in 2018, a four week period, resident #001 refused care 87 per cent of the time. In a second period of specified time in 2018, a four week period, the resident refused care 50 percent of the time.

A review of resident #001's care plan from a specified date in 2018, did not indicate that the resident refused their care.

In an interview with PSW #125, they reported that resident #001 was known to refuse their care.

Both PSW #125 and Inspector #617 reviewed resident #001's care documentation together. PSW #125 confirmed to the inspector that during a specified time period in 2018, resident #001 had refused care, and that this was a new resident behaviour. PSW #125 and Inspector #617 also reviewed resident #001's care plan dated from a specified date in 2018, PSW #125 confirmed to the Inspector, that there were no interventions in place to promote receiving care as a result of the increase in their refusals.

In an interview with PSW #129, they reported to the inspector that resident #001 had specific requests during care and would react if they were not followed. PSW #129 explained that resident #001 had a concern regarding a specified care area and would use specific interventions related to this care area.

In an interview with ADOC #116, they confirmed that resident #001 required re-assessment of their care refusals. They further indicated that a review of the reasons for the refusals needed to be conducted; as well, the resident's care plan required revised interventions to promote care provision. [s. 6. (10) (c)]

WN #4: 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 were kept clean and sanitary.

During resident observations on a specified day in 2018, Inspector #196 noted dried debris on the mobility aid for resident #009 as well as dry food debris on the mobility aid for resident #011. On a day in 2018, Inspector #684 observed resident #009 and #011's mobility aids for cleanliness. The mobility aids for resident #011 and resident #009 were soiled with food debris and dirt.

Inspector #684 reviewed the mobility aid cleaning schedules on a specified day in 2018, at a specified time. Resident #009's mobility cleaning was scheduled for a specific day of the week, and resident #011's mobility aid cleaning was scheduled for another specified day of the week.

A review of a memo from a specified date in 2017, by DOC #102 indicated that night PSWs were to clean mobility aids and the RNs would co-sign that the mobility aids had been cleaned.

On a specified day in 2018, a review of the sign off for the weekly mobility aid cleaning schedule for resident #009 and #011 for a specified week in 2018, found resident #009 signed off as being completed, while resident #011 was blank upon review.

During an interview with ADOC #116, they indicated that the PSWs were to document weekly mobility aid cleaning on the weekly mobility aid cleaning schedule. After reviewing the weekly mobility aid cleaning documentation Inspector #684 asked ADOC #116 what does it mean when the box was blank on the cleaning schedule. They replied, it was not done. Inspector #684 and ADOC #116 both viewed the mobility aids of residents #009 and #011 on a specified day in 2018. Resident #009 was to have their mobility aid cleaned on a specified date in 2018 and resident #011 was to have their mobility aid cleaned on a specified date in 2018.

ADOC #116 confirmed that the mobility aid for resident #009 was not cleaned as scheduled and signed for on the weekly mobility aid cleaning schedule, and resident #011s mobility aid was not cleaned as indicated on the cleaning schedule. [s. 15. (2) (a)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area or a medication cart that was secure and locked.

Inspector #642 observed resident #007 on a specified date in 2018, during an interview, when the resident proceeded to withdraw a medication from a drawer and take the medication, they then placed it back in an unlocked drawer.

During an interview with RPN #106, they stated that the medication that resident #007 had in their drawer, should not have be there. After a review of the physician order, no order was found for resident #007 to have said medication in their drawer and they proceeded to remove the medication and lock it in the medication cart.

During an interview with RN #130, they stated that medication should be kept in a locked and secured area.

A review of the home's document titled, "Medication System, Medication Storage," last revised on January 17, 2017, indicated All medications were to be stored in a secured, locked location, accessible only to designated staff members.

In an interview with the DOC they stated that medication should not be stored in a resident's drawer, they should be stored in a secured and locked area. [s. 129. (1) (a) (ii)]

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 was, documented, and reported to the pharmacy service provider.

A review of the home's policy, "Medication Incidents – CAR13-030.01" last revised July 31, 2016, indicated that "for all Resident-related medication incidents there would be a brief factual description of the incident, treatment, and intervention documented in the interdisciplinary progress notes" and that the Medication Incident Reports would be analyzed by nursing administration, the Pharmacy Manger, and/or the consultant pharmacist to determine whether pharmacy and/or nursing procedures required modification.

Inspector #196 reviewed medication incident reports involving residents which included:
-resident #026, that identified, on a specified date in 2017, that a PSW found a medication cup with a medication in it on the resident's dresser in their room;
-resident #027, that identified, on a specified date in 2018, was administered an incorrect medication; and
-resident #028, that identified that the resident was administered an incorrect medication instead of the ordered medication.

A review of the progress notes for resident #026, #027, and #028, found no documentation in resident #026's or #027's progress notes to indicate the above medication incidents had occurred. In addition, the three medication incident reports did not indicate that the pharmacy was notified.

During an interview with the DOC, they confirmed that there was no documentation in resident #026's and #027's progress notes of the medication incidents. The DOC also reported that the home had not ensured that the pharmacy service provider had received a copy of the medication incident reports.

During a telephone interview with the Manager of the Pharmacy Service Provider, they reported that they had not received any Medication Incident reports or faxed copies of the medication incident reports, over the past six months. [s. 135. (1)]

Issued on this 5th day of April, 2018

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

Original report signed by the inspector.