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

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
Oct 29, 2018	2018_717531_0019	021518-18	Resident Quality Inspection

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

Hallowell House
13628 Loyalist Parkway PICTON ON K0K 2T0

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

SUSAN DONNAN (531), WENDY BROWN (602)

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): August 28, 29, 30, 31, September 4, 5, 6 and 7, 2018.

The following inspection logs were completed concurrently with this inspection::
Log #012088-18 (CIS # 0891-000005-18) related to fall prevention
Log #015331-18 (CIS # 0891-000006-18) related to alleged resident to resident sexual abuse

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), the Registered Dietitian (RD), the Program Manager (PM), the RAI Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), the Residents' Council President (RC), resident Substitute Decision Makers (SDM) and residents.
During the course of the inspection the inspection team, conducted a walking tour of the home, reviewed resident health care records, observed resident care and services, observed medication administration, reviewed the Residents' Council meeting minutes, reviewed the fall prevention policy and procedures, the skin and wound policy and procedures, the abuse policy and procedures and the minimizing of restraints policy and procedure.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

6 WN(s)
4 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

On a particular date resident #004 was found on the floor in the lounge. The resident had been restless and was resting in a recliner when they got up and walked independently, without a walker, for approximately 25 feet before the fall. Resident #004 was transferred to hospital for an injury requiring surgical intervention. The resident returned to the home on a particular date. The care plan was updated with fall interventions listed as follows:
Focus:
• Has been screened at MEDIUM risk for a fall as evidence by the Fall Risk SCREEN Medium risk - 14 Due to: Previous Fall, Impaired judgement, Confusion, Anxiety

Goal:
• Will experience reduced number of falls by 50% over the next quarter
Interventions:
• Reorient if confusion is evident
• Reminders are needed to use walker
• Verbal cues are required to use safety equipment during transfers- walker or bed rails
• Call bell is within reach
• Light cord is within reach
• Use of bedside commode at night

• Walker is within reach to allow safe independent transfers
• Appropriate footwear worn daily; ensure laces are tied
• Keep the bed at appropriate height so that feet can rest on the floor

At time of this inspection the actual fall interventions were as follows:

FOCUS:
• Has been screened at HIGH risk for a fall as evidence by the Fall Risk SCREEN 18. Due to: Previous Fall, Repeated Falls, Impaired judgement
GOALS:
• Will experience reduced number of falls by 50% over the next review
INTERVENTIONS
• Falling Star Logo applied to over bed.
• Review contributing factors to the fall, related to medication (new or change in meds, last dose given)
• Frequent reminders are needed to call for assistance
• Call bell is within reach
• Light cord is within reach
• Visual aides are cleaned and worn daily - eyeglasses
• Bed is kept at lowest level and in locked position when in bed

In an interview with the RAI Coordinator on September 4, 2018 the discrepancy specific to fall risk status, change in ability to use a walker and independently transfer were reviewed. Post interview the care plan was updated to include a high fall risk, removal of interventions specific to use of walker and clarification regarding transfers e.g. use of a mechanical lift. The plan of care failed to set our clear direction to staff an others who provide direct care for resident #004. [s. 6. (1) (c)]

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

On August 28, 2018 resident #008 was observed by inspector #602 to be sleeping in a tilt wheelchair. A review of the care plan indicated resident #008 requires the use of "a PASD tilt wheelchair with seatbelt & 1/4 bedrails due to: Leaning forward in chair, Need for comfort and positioning, for transfers and bed mobility". The seatbelt is to be applied "as per manufacturer's instructions" personal support staff are to check on resident #008 every two hours and repositioned.

On subsequent observations during the period of August 28 - September 6, 2018, the resident was noted to be in the tilt wheelchair, however, the magnetic lap belt was not in situ. PSW #109 indicated in an interview with inspector #604 on August 31, 2018, that the resident rarely wears the lap belt. PSW #109 indicated, after consulting with the Point of Care tablet, that two hour checks are not part of resident #008's plan of care. In interviews on September 5, 2018, PSW #120 and #122 confirmed that resident #008 is always in the tilt wheelchair, however, the lap belt is not applied. Use of the lap belt was discontinued as resident #008 would habitually pull at it, releasing the catch mechanism and set off the alarm. PSW #122 advised that the resident is not checked on specifically as part of the care however resident #008 is typically nearby and is observed regularly by staff.

The licensee failed to ensure the care set out in resident #008's plan of care was provided to the resident as specified in the plan. Resident #008 plan of care indicated the resident requires the use of a PASD tilt wheelchair with seatbelt; the belt is to be applied "as per manufacturer's instructions" and personal support staff are to check on resident #008 every two hours and repositioned. [s. 6. (7)]

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 plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident and that the care is provided as specified in the plan, 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 their Mandatory Reporting of Resident Abuse and Neglect of Residents policy ADMIN-010.01 was complied with, specifically the direction outlined under: Procedure Internal - Where any person has reasonable grounds to suspect that any of the following has occurred or may occur, such person must immediately verbally report the suspicion and information on which it is based to the person in charge i.e. the nurse on duty …. They will then together immediately report this to their legislative Authority as per legislation. Following this the Nurse will document the suspicion in the chart of each resident involved.

On an identified date resident #021 was found with their pants and product off standing beside their bed. Resident #022, was sitting on the bed. Resident #022 was taken back to their room and settled into bed. Resident #021 returned to bed and was monitored by staff 1:1.

The charge Nurse RN #124 noted the incident in resident #021's progress notes as follows:
Subjective: made an inappropriate sexual comment to the PSW
Objective: At an identified time was found with their pants and product off. A co resident was sitting on the bed. Resident #021's walker was out in the hallway between the residents rooms. Resident #021 has made inappropriate comments about co resident in the past. Whether Resident #021 went to find Resident #022 or they wandered into resident #022's room unknown. Resident #021 made the inappropriate comment when staff found them. Resident #021 was taken back to their own room and resettled into bed. Resident #021 had their product put back on and returned to bed as well.
Assessment: Poor decision making r/t disease process.
Plan: Monitor closely around co- residents.

There was no documentation of the incident in resident #022's chart.

The Director of Care was not available for an interview as they are no longer employed with the home, however, documentation indicated that management was notified of the incident the next morning.

Contrary to the policy: Mandatory Reporting of Resident Abuse and Neglect of Resident's policy ADMIN-010.01 the resident to resident abuse was not immediately reported internally and to the Director under the LTCHA, 2007. [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 the licensee written "Mandatory Reporting of Abuse and Neglect of Residents policy" to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the nutritional care and hydration program included a weight monitoring system to measure and record, with respect to each resident, their height annually.

A health care record review was completed on 20 residents. It was noted by the inspection team that not all residents had a documented annual height. The last dates that heights were documented for the following residents were:
Resident #004 - height 149 cm on June 1, 2017
Resident #005 – height 167 cm on March 8, 2017
Resident #009 – height 173 cm on April 4, 2017
Resident #012 – height 150 cm on August 18, 2016
Resident #013 - height 156 cm on December 8, 2016
Resident #011 – height 153 cm on June 1, 2017
Resident #008 – height 159 cm on June 4, 2017
Resident #017 – height 165 cm on June 6, 2017
Resident #019 – height 169 cm on June 1, 2017

During an interview with Inspector #531 on August 30, 2018, the Administrator indicated being aware that not all of the residents had an annual height documented.

The licensee failed to ensure that residents #004, 005, 008, 009, 011, 012, 013, 017 and 019 had a height obtained annually. [s. 68. (2) (e) (ii)]

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 nutrition care and hydration program includes resident height annually, to be implemented voluntarily.

WN #4: 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 resident #023 in accordance with the directions for use specified by the prescriber.

Inspector #531 reviewed resident #023's physician orders which indicated that resident #023 had been prescribed a specified medication to be administered twice daily at 0800 and 2000 hours. The licensee's medication incident report MIR-09279 completed by RPN #123 indicated that they were notified by the previous DOC, that resident #023's 2000 hour medication had been discovered in the resident's medication bin. RPN #123 notified the resident and the physician of the omission, the resident denied pain was monitored and there were no untoward effect as a result of the administration omission.
The DOC was not available for an interview as they are no longer employed with the home.

On Sept. 4, 2018 during an interview with RPN #123 and review of the medication incident report, the RPN told inspector #531 that they thought they administered the specified medication as directed; however the omission was discovered at the change of shift the next day. RPN #123 further indicated they notified the physician and the resident, the resident was monitored and there were no untoward effects to resident #023.

On September 4, 2018 during an interview with the Administrator and review of the medication incident report, the Administrator indicated the prescribed medication was not administered to resident #023 in accordance with the directions 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.

WN #5: 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 :

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

On a specified date resident #021 was found with their pants off, exposing themself, standing in front of resident #022, who was sitting on resident #021's bed. Resident #021 made an inappropriate sexual comment when the PSW entered the room. Resident #022 was taken back to their room and settled into bed. Resident #021 returned to bed and was monitored by staff.

The Director of Care was not available for an interview as they are no longer employed the home, however, documentation indicates that management was notified of the critical incident (CI) as part of morning report.

In a telephone interview on September 6, 2018, with inspector #602, RN #124 indicated they did not report the incident as they did not think it was abuse at the time as nothing physical had occurred. It was only when they received a telephone call from the DOC the following morning that they realized that the incident could have been considered sexual abuse and should have been reported as outlined in the Mandatory Reporting of Resident Abuse or Neglect policy.

In an interview on September 5, 2018, Administrator #100 indicated that they were not sure why RN#124 did not immediately report the incident to the manager on call, or why the Director of Care, once alerted that morning, did not immediately contact the Director. The Administrator was unable to locate the critical incident investigation file, and thus, the only available documentation for review was the CI report submitted to the Director, by the previous DOC, forty - two hours after the incident occurred.

The licensee had reasonable grounds to suspect that abuse of resident #022 by resident #021 that resulted in harm or risk of harm and failed to immediately report the incident to the Director. [s. 24. (1)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that they respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

The Residents' Council meeting minutes for August 2017 through August 2018 were reviewed. It was noted in the August 2, 2018 meeting minutes, concerns related to menu/dietary services and maintenance were brought forward as follows:

- menu being changed, snacks not labeled correctly, diet not followed, soup not matching posted menu, not always getting 2nd choice and 2nd sitting not always getting raisin bread and menu boards too high for residents in wheelchairs
- resident table tipping.

Written responses were provided specific to each concern at fourteen (14) and eleven (11) days respectively.
It has been PM #112's practice to review the responses with the president once received at approximately 10 days, however, the response time was exceeded with both of the above concerns. It is noted that PM #112 needed to ensure that the written response is physically given/or shown to the council president.

The licensee did not respond in writing within 10 days of receiving the concern related to menu/dietary services and maintenance [s. 57. (2)]

Issued on this 30th day of October, 2018

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

Original report signed by the inspector.