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
Feb 13, 2018	2018_687607_0003	017509-17, 022140-17, 028003-17	Critical Incident System

Licensee/Titulaire de permis

Schlegel Villages Inc.
325 Max Becker Drive Suite. 201 KITCHENER ON N2E 4H5

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

The Village of Taunton Mills
3800 Brock Street North WHITBY ON L1R 3A5

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

JULIET MANDERSON-GRAY (607)

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 26, 29 and 30, 2018

A Follow up to a Compliance Order inspection (#2018_687607_0002) (Log #s #: 027276-17, 027542-17) was also completed concurrently during this Critical Incident inspection and non-compliance was identified for the Follow up inspection and is being issued under inspection #2018_687607_0003 related to plan of care.

In addition, the following Logs were reviewed and inspected during this Critical Incident inspection:

Log #017509-17- Critical Incident Report (CIR), regarding a witnessed resident to resident abuse

Log # 022140-17- CIR, regarding an alleged resident to resident abuse.

Log # 028003-17- CIR, regarding and alleged resident to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Assistant General Manager, Director of Nursing Care (DON), Neighbourhood Coordinators (NC), a Social Worker, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Care Attendants (PCA), and residents.

During the course of this inspection, the Inspector reviewed clinical health records, observed staff to resident interactions, reviewed the homes investigations notes, reviewed home specific policies related Resident Abuse Prevention and Responsive Behaviours.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Skin and Wound Care

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

3 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. 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

Related to Log # 022140-17, involving residents #006 and #009:

A Critical Incident Report (CIR) was submitted to the Director for an incident of alleged resident to resident abuse. The CIR indicated that resident #006 had a one to one nursing staff observations in place, the staff stepped away to go to the nursing station when the staff heard a noise and had observed resident #009 outside resident #006's room, with a noted injury.

Resident #006 had diagnoses which included Cognitive impairment.

Resident #009 had diagnoses which included Cognitive impairment, and had an identified responsive behaviour.

A review of the current written plan of care for resident #009 indicated the resident had several interventions in place to manage the resident responsive behaviours, including one to one nursing supervision.

The staff member whom was providing one to one nursing supervision at the time of the

incident was not interviewed, as the staff was on a leave of absence from the home.

During an interview with the Director of Nursing (DON), the DON indicated the staff member who provided one to one nursing supervision to resident #006 on the above identified date walked away to go by the nursing station, when resident #009 wandered into resident #006's room, and sustained an injury by resident #006. The Director of Nursing indicated the staff member who provided one to one nursing observation to resident #006 should not have left the resident alone.

The care set out in the plan of care was not provided to resident #006 as specified in the plan, as the staff member who provided one to one nursing supervision to resident #006 on an identified date, left the resident, and went to the nursing station, resulting in resident #009 sustaining an injury by resident #006. [s. 6. (7)]

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

Related to Log # 028003-17 involving resident #008:

A Critical Incident Report (CIR) was submitted to the Director for an incident of alleged resident to resident abuse. The CIR indicated that resident #008 sustained an injury on an identified date, which was assessed by RPN #105. The CIR further indicated that the Assistant General Manager (AGM) received an email from resident #008's family member, seven days after the incident, alleging abuse to resident #008 by resident #006 which resulted in the injury.

A review of resident #008's current written plan of care indicated the resident had several interventions in place related to skin integrity.

On an identified date and time, the Inspector observed resident #008's identified intervention in place related to the resident's use of an assistive device.

Further review of resident #008's written care plan did not have interventions related to the use of the assistive device, nor were there any indication of what the identified interventions were used for.

During an interview, the Neighbourhood Coordinator (NC) #121, indicated learning of the

above identified incident involving resident #008 a day after the incident occurred, and conducted an investigation which determined that the injury might have been caused by the resident’s assistive device. Following this incident, NC #121 ordered and implemented an identified interventions related to an assistive device for resident #008. Neighbourhood Coordinator #121 indicated that the interventions implemented were not included in the written plan of care for resident #008.

During an interview, the AGM indicated that all registered staff were responsible for updating the residents written plan of care and the expectation was that if a resident had an assistive device in place, the interventions related to the assistive device were to be included within the written plan of care.

When resident #008 was reassessed, the written plan of care was reviewed, but was not revised when the resident's care needs changed, specifically, to include interventions related to an identified intervention related to the assistive device in the written plan of care for the resident. [s. 6. (10) (b)]

3. Related to Log #027542-17, involving resident #001 and #007:

A review of resident #001’s progress notes for a five month period, indicated there were three incidents of an identified responsive behaviours, involving resident #001 and #007 that were directed towards each other.

A review of the plan for care for resident #001 indicated the resident had several interventions in place related to responsive behaviours.

During interviews, PCA #115 and #102, both indicated, resident #001 would often be found in an identified area belonging to resident #007, getting undressed. PCA #115 indicated that resident #007 was aware of the residents' actions, and the possible consequences, whereas resident #001 was not always aware. PCA #115 and #102 further indicated that when resident #001 and #007 were found in the identified area, the resident were separated.

During an interview, RPN #105 indicated that if residents #007 and #001 were found in an identified area belonging to resident #007 undressed, staff should be redirecting them.

There was no documented evidence in the written plan of care for resident #001 related to responsive behaviours, to direct staff of what they should be doing when resident #001

was found in an identified area belonging to resident #007.

During an interview, the AGM indicated that if resident #001 was found in an identified area belonging another resident undressed, the resident should be redirected and the expectation was that the resident care plan be updated with this intervention.

When resident #001 was reassessed, and the plan of care was reviewed, the plan of care was not revised when the resident's care needs changed, as evidenced by resident #001 and #007 had three separate incidents of identified responsive behaviours. The plan of care failed to identify interventions of how staff should be managing the responsive behaviours. [s. 6. (10) (b)]

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 Ensure that the care set out in the plan of care was provided to the resident as specified in the plan,specifically related to resident #006. Ensuring that when the resident was reassessed, the plan of care was reviewed and revised at any other time when the resident's care needs change, specifically related to resident #003, #001 and #008, related to responsive behaviours, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that its policy related to the Skin and Wound Program, was complied with.

Under O. Regulation 79/10, s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

Under O. Reg 79/10, s. 50 Skin and Wound Program.

A review of the licensee policy # Tab 04-78 - Skin and Wound Care Management Program directs:

Nursing (Registered Nurse (RN) and Registered Practical Nurse (RPN))
Refers to the Dietitian, using the Dietitian referral form- altered skin integrity including skin breakdown, pressure injuries, skin tears and wounds.

Related to Log # 028003-17 involving resident #008:

A Critical Incident Report (CIR) was submitted to the Director for an incident of alleged resident to resident abuse. The CIR indicated that resident #008 sustained an injury on an identified date, which was assessed by RPN #105. The CIR further noted that, the Assistant General Manager (AGM) indicated receiving an email from resident #008's family member seven days after the incident had occurred, alleging abuse of resident #008 by resident #006, which resulted in the injury.

A review of the progress notes for resident #008 indicated that resident #008's family member voiced concerns nine days after the incident had occurred, indicating that a staff member had contacted the family member, and had indicated that the injured area to resident #008's was necrotic.

Further review of resident #008's clinical health records revealed no documentation, to

support that resident #008 had been referred to the Dietitian, related to the injury.

During an interview, RPN #105 indicated that when the injury had occurred to resident #008 was discovered, a referral was not completed to the Dietitian.The RPN indicated not being aware of what the licensee policy indicated related to when a referral was to be completed to the Dietitian.

The Dietitian was not available for an interview during the inspection.

During an interview, the Assistant General Manager (AGM) indicated that the expectation, related to the Skin and Wound Program was that if a resident sustained an identified injury, a referral to the Dietitian would be completed.

The licensee failed to ensure that its Skin and Wound Care Management Program, policy #Tab 04-78, was complied with, specifically related to resident #008, who obtained an injury on an identified date, there was documentation to support that the injury to an identified area of resident #008 had worsened and the resident had not been referred to a Dietitian at the time the incident occurred or after. [s. 8. (1) (a),s. 8. (1) (b)]

2. The Licensee has failed to ensure its procedure related complaints was complied with.

Under LTCHA, s. 21. Every licensee of a long-term care home shall ensure that there are written procedures which comply with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints.

A review was completed of the licensee's "Resident/Family Concerns" procedure, Tab #11-21 directs:
If a family member or Resident expresses a concern to a Team Member, the Team Member will notify the Neighbourhood Co-ordinator (NC) or designate in writing by way of an incident Report Form, providing as much detail about the nature of the complaint as possible.

Related to Log # 028003-17, involving resident #008:

A Critical Incident Report (CIR) was submitted to the Director for an incident of alleged resident to resident abuse. The CIR indicated that resident #008 sustained an injury on an identified date, which was assessed by Registered Practical Nurse (RPN) #105. The CIR further indicated the Assistant General Manager (AGM) indicated receiving an email

from resident #008's family member seven days after the incident, which alleged abuse to resident #008 by resident #006, and resulted in an injury to the resident's body part.

A review of resident #008's progress notes for a five month period, indicated the following:

On an identified date and time, resident #008's family member approached RPN #122 and asked about the injury to resident #008's body part. RPN #122 indicated that a few days prior, resident #008 was found with the injury, and the cause was unknown. The family member then reported to the RPN that the family member had spoken to resident #008, and the resident had indicated having an altercation with an unidentified person. RPN #122 responded to the family member that there were no reports from anyone earlier that shift of another resident being in resident #008's room, other than the roommate.

During an interview, RPN #122, indicated that learning of the incident on an identified date, when resident #008 indicated that someone had hurt him. RPN #122 further indicated that resident #008's family member approached the RPN, and wanted to look at the injury to the resident's body part, as the family member was concerned about the injury. RPN #122 indicated reporting the concern to a Registered Nurse (RN), but could not identify which RN it was reported to. RPN #122 indicated that the RPN documented the family concern in the progress notes but did not fill out an Incident or Family Concern Form, as the RPN was not aware of the procedures.

During an interview, the AGM indicated that the licensee's expectation was that staff complete a Family Concern Form whenever there was a concern brought forward by a family member. The AGM further indicated that all staff were trained on the use of this form.

The licensee failed to ensure the procedure related Resident/Family Concerns procedure # Tab 11-21 was complied with. When resident #008's family member brought forward concerns related to an allegation of resident to resident abuse, and a Family Concern Form was not completed. [s. 8. (1) (b)]

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 ensuring that its policy #Tab 04-78 - Skin and Wound Care Management Program was complied with, to be implemented voluntarily.

WN #3: 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 the person who had reasonable grounds to suspect abuse of a resident by anyone had occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

A Critical Incident Report (CIR) was submitted to the Director for an incident of alleged resident to resident abuse. The CIR indicated that resident #008 sustained an injury on an identified date, which was assessed by RPN #105. The CIR further indicated the Assistant General Manager (AGM) indicated receiving an email from resident #008's family member seven days after the incident occurred, alleging abuse to resident #008 by resident #006, which resulted in an injury

During an interview, Neighbourhood Coordinator (NC) #121 indicated learning of the above identified incident on an identified date. The NC #121 indicated that an investigation was completed. The NC indicated speaking with resident #008, who indicated that an unidentified person had caused the injury to the resident. The Neighbourhood Coordinator further indicated that at the time of the incident was not aware of the legislative requirement around reporting of an alleged resident to resident abuse that resulted in an injury. NC #121 indicated that they realized that the incident should have been reported to the Director after an email was received by the AGM from resident #008’s family member.

During an interview, the AGM indicated receiving an email five days after the incident, from resident #008's family member, alleging resident to resident abuse, but did not open the email until two days later.

During another interview, the AGM indicated that Neighbourhood Coordinator #121 should have notified a member of the management team of the above identified incident when it was discovered.

When Neighbourhood Coordinator (NC) #121 who had reasonable grounds to suspect that a resident to resident abuse had occurred on an identified date, that resulted in harm to resident #008, the NC #121 failed to immediately report the suspicion and the information upon which it was based to the Director. [s. 24. (1)]

Issued on this 20th day of February, 2018

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

Original report signed by the inspector.