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

Central West Service Area Office
500 Weber Street North
WATERLOO ON N2L 4E9
Telephone: (888) 432-7901
Facsimile: (519) 885-9454

Bureau régional de services du Centre-Ouest
500 rue Weber Nord
WATERLOO ON N2L 4E9
Téléphone: (888) 432-7901
Télécopieur: (519) 885-9454

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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
Jun 26, 2018	2018_723606_0012	027034-17, 001886-18, 006203-18, 008745-18	Complaint

Licensee/Titulaire de permis

Holland Christian Homes Inc.
7900 McLaughlin Road South BRAMPTON ON L6Y 5A7

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

Grace Manor
45 Kingknoll Drive BRAMPTON ON L6Y 5P2

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

JANET GROUX (606)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): May 23, 24, 25, 28, 29, and 30, 2018.

The following complaints intakes were inspected:
log # 008745-18 regarding resident to resident responsive behaviours;
log # 006203-18 regarding resident to resident responsive behaviours;
log #027034-17 regarding resident to resident responsive behaviours; resident abuse; and
log #001886-18 regarding an allegation of resident to resident responsive behaviours, maintenance services , medication management, food production, conduct of staff, infection control and prevention, safe and secure home, continuity of care, staffing, resident abuse and the Residents' Bill of Rights.

During the course of the inspection, the inspector(s) spoke with the inspector(s) spoke with the Administrator, Director of Resident Care (DRC), Resident Assessment Instrument Minimum Data Set (RAI-MDS) Coordinator, Behavioural Support of Ontario (BSO) Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Environmental Services Manager (EMS), Laundry Aide (LA), Residents and Substitute Decision Makers (SDM).

During the course of this inspection, the inspectors observed resident care, observed staff to resident interaction, reviewed resident health records, meeting minutes, schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Accommodation Services - Maintenance
Dignity, Choice and Privacy
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home
Sufficient Staffing

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

- **7 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 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 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 was complied with.

In accordance with O. Reg 79/10, s. 114(2) the licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.
(3) the written policies and protocols must be, (a) developed, implemented, evaluated and updated in accordance with evidence-based practices, and, if there are non, in accordance with prevailing practices, and
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. 0. Reg. 79/10, s. 114 (3).

Review of a complaint submitted to the Ministry of Health and Long Term Care (MOHLTC) alleged that an identified number of resident #002's medications were found that had supposedly been administered to the resident but instead the resident took them and hid them from the staff.

Review of an identified home policy directed registered staff to observe the resident taking all of the medications with water provided and never leave medication at side of bed, on table in the dining room, at resident's side and always ensure they take the medication.

Interview with Registered Nurses (RN) #108 and #110 indicated that resident #002 had an identified responsive behaviours that had made it difficult for staff to administer medications to the resident. RN #108 indicated that after the staff discovered that resident #002 was hiding their medications instead of taking them the home had ensured that when the resident was being administered their medication, the staff must always watch resident #002 take their medication before leaving them because of their responsive behaviours.

Interview with the Director of Resident Care (DRC) acknowledged that an investigation was completed of the above reported medication incident. The DRC indicated that after the home became aware of the resident's responsive behaviours that made it difficult for

staff to administer the medication to the resident, they had reminded the registered staff of the home's policy of Medication Administration and to ensure that they stay and observe the resident takes their medications before leaving them. [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 to ensure that 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 is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

The licensee has failed to ensure that residents with the following weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated: 2. A change of 7.5 per cent of body weight, or more, over three months.

Review of a complaint to the MOH reported concerns regarding resident #005's nutritional status.

Review of resident #005's progress notes indicated that between the time the resident was admitted to the home, the resident was identified with a significant weight variance. Review of the resident's progress notes did not show any evidence that an assessment was completed to address resident #005's significant weight variance.

Review of resident #005's written care plan identified the resident to be at nutrition risk with an identified goal weight range (GWR) to be maintained.

2. Review of an identified clinical record of resident #009, #010, and #002 identified the residents with a significant weight variance. Review of resident #009, #010, and #002's progress notes did not show evidence that an assessment to address resident #009, #010, and #002's significant weight variance were completed.

Review of resident #009's and #010's written care plan indicated the resident to be at nutrition risk with an identified GWR to be maintained.

Review of resident #002's written care plan indicated the resident to be at nutritional risk related to medical conditions and indicated an identified GWR to be maintained

Interview with RN #107 indicated that when residents had been identified with a significant weight variance such as a weight loss or gain, the registered staff must notify the dietician to assess the resident to address the identified weight variance.

Interview with the Dietitian (RD) acknowledged that when a resident has been identified with a significant weight loss or gain, they are informed by the registered staff and would then complete an assessment of the weight variance identified.

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 residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated: 1. A change of 5 per cent of body weight, or more, over one month. 2. A change of 7.5 per cent of body weight, or more, over three months. 3. A change of 10 per cent of body weight, or more, over 6 months. 4. Any other weight change that compromises the resident's health status, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that ensure that no person mentioned in subsection (1) performed their responsibilities before receiving training in the areas mentioned below: 1. The Residents' Bill of Rights. 2. The long-term care home's mission statement. 3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 4. The duty under section 24 to make mandatory reports. 5. The protections afforded by section 26. 6. The long-term care home's policy to minimize the restraining of residents. 7. Fire prevention and safety. 8. Emergency and evacuation procedures. 9. Infection prevention and control. 10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Review of a complaint submitted to the MOHLTC alleged that resident #006 was physically aggressive toward resident #005.

During the inspection, the inspector identified that the home used a staffing agency whom PSW #109 was employed with. During an interview with PSW #109 regarding the incident between resident #005 and resident #006, the PSW indicated that they had not received any training on the home's Resident Abuse and Neglect policy and procedure.

Review of the service contract between thee home and the staffing agency indicated that "The Services Provider Company is required to attend an annual training session at Client Institution on its policies and procedures. It is the responsibility of the Service Provider Company, to orient and train all Service Provider Company staff assigned to Client Institution on this material PRIOR to them being sent to work at the home".

Review of documents of the service provider indicated employees of the staffing agency to have received the home's training on Resident Abuse but did not include PSW #109's name and signature.

Interview with PSW #109 indicated that they have been employed with the staffing agency for less than a year and has not received orientation by the agency on the home's Resident Abuse and Neglect Policy nor had been directed to attended a home's mandatory training and education session by their agency or the home.

Interview with the DRC acknowledged that it is the staffing agency's responsibility to provide training and orientation for their staff regarding the home's policies and

procedures such as the policy on resident abuse and indicated that the agency is also responsible to ensure that their staff attend the home's mandatory training and education session when scheduled.

The licensee has failed to ensure no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below: 3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. [s. 76. (2) 3.]

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 ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below: 1. The Residents' Bill of Rights. 2. The long-term care home's mission statement. 3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 4. The duty under section 24 to make mandatory reports. 5. The protections afforded by section 26. 6. The long-term care home's policy to minimize the restraining of residents. 7. Fire prevention and safety. 8. Emergency and evacuation procedures. 9. Infection prevention and control. 10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 11. Any other areas provided for in the regulations, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that that all staff participate in the implementation of the program.

Review of a complaint submitted to the MOHLTC reported concerns related to the home's infection control practices during snack service.

During observations of a meal service the inspector observed several staff perform several identified care services without performing infection control practices such as hand hygiene.

Interviews with PSW #113, #114, and #111 indicated that the home's practice is to perform hand hygiene before and after resident care.

Interview with RN #107 indicated that the staff must perform hand hygiene before and after the meal service, when taking the resident's used plates and in between resident care.

Interview with the DRC indicated that the home's practice is for staff to perform hand hygiene before and after each resident care. [s. 229. (4)]

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 all staff participate in the implementation of the program, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe and secure environment for its residents.

Review of a complaint submitted to the MOHLTC alleged that there was no heat in resident #002's room and that the home provided the resident with a portable heater which was extremely hot and was unsafe.

Review of resident #002's written plan of care indicated the resident has medical conditions that affected the resident's decision making and mobility.

Interview with the complainant indicated that a portable heater was placed in resident #002's room as a temporary measure to heat the room and indicated that the portable was unsafe due to the resident's identified medical conditions. They indicated that the portable heater if touched could cause the resident to sustain a burn.

Interview with the Environmental Services Manager (ESM) acknowledged that the home's heating pumps in two rooms had failed and a portable heater was placed in the two rooms as a temporary measure to maintain heat until the heat pumps were replaced. They indicated the portable heater that was initially placed in resident #002's room was the type of heater that the outside surface heats up when the heater was running and could cause a person who come in contact with the outside surface of the heater to get scalded and burned. They indicated that they were notified by the MOHLTC regarding the safety issue of the portable heater and that they then replaced the portable heater with an oil ceramic radiator heater, which would not be hot when touched and safer for resident #002. They indicated the heat pumps were replaced and that the heating issue in two rooms were resolved.

The licensee has failed to ensure that the home was a safe and secure environment for its residents [s. 5.]

WN #6: 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 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: 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.

Review of a complaint submitted to the MOHLTC alleged that resident #006 was physically aggressive toward resident #005.

Review of a Critical Incident (CI) reported 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 and indicated the home did not report the incident immediately.

Interview with the DRC indicated that any allegation of abuse by anyone is reported to the Director immediately. [s. 24. (1)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure residents' personal items and clothing were labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing.

Review of a complaint reported that they had brought resident #005 new clothes and the home lost the clothes when they had taken the clothes to the laundry department to be labelled.

Interview with resident #005's Substitute Decision Maker (SDM) indicated they had brought the resident a number of clothing and that the clothes was sent to the laundry department to have the clothes labelled with the resident's name. They indicated that when they had asked the home what had happened to the clothes, the home told them that resident #005 clothes were labelled with resident #011's name and the clothes went to that resident.

Interview with Laundry staff #112 indicated that the family member of resident #002 had directly brought the clothes to the laundry department and indicated that the clothes were placed by mistake in a bag with resident #11's name on it and was labelled for resident #011. They indicated that they were able to located in resident #011's closet two of the clothing that belonged to resident #005 and a couple of day later while washing clothes for their other identified long term care home they then found the last identified clothing that was identified as missing. It was re-labelled and taken back to resident #005.

Interview with the DRC acknowledged that when a resident's clothes are brought in for labeling the staff must place the clothing in a bag and ensure that they include the resident's name and room number. [s. 89. (1) (a) (ii)]

Issued on this 5th day of July, 2018

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

Original report signed by the inspector.