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 # / Registre no	Type of Inspection / Genre d'inspection
Oct 31, 2016	2016_512196_0014	032529-15, 000949-16, 004902-16, 008466-16, 008488-16, 008494-16, 012294-16, 012836-16, 013880-16, 019570-16, 022314-16	Critical Incident System

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

PINEWOOD COURT
2625 WALSH STREET EAST THUNDER BAY ON P7E 2E5

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

LAUREN TENHUNEN (196), KATHERINE BARCA (625)

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): August 15, 16, 17, 18, 19 and 22, 2016.

The following intakes were inspected: eight intakes related to staff to resident abuse; one related to a resident fall; one related to missing controlled substances; and one related to a disease outbreak.

During the course of the inspection, the Inspector(s) conducted a walk through of resident care areas, observed staff to resident interactions, observed the provision of care and services to residents, reviewed various home policies and procedures, and reviewed several resident health care records.

This Critical Incident System inspection was conducted concurrently with Complaint inspection #2016_512196_0013 and Follow Up inspection #2016_512196_0012.

For details and additional findings of non-compliance related to LTCHA 2007, s.19, found during this inspection, refer to the Follow Up inspection #2016_512196_0012.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Resident Assessment Instrument (RAI) Coordinator, Pharmacist, residents and family members.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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 LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the rights of residents were fully respected and promoted, including the right to be treated with courtesy and respect and in a way that fully recognized the resident's individuality and respected the resident's dignity.

A review by Inspector #625 of a Critical Incident System (CIS) report identified that the Food Services Manager (FSM) #104 and current Assistant Director of Care (ADOC) #105 were present and witnessed an incident of alleged staff to resident abuse that occurred on a specific day in the Spring of 2016. The report indicated that PSW #106 was observed by FSM #104 to very quickly push resident #020 in a wheelchair. The report also indicated that ADOC #105 observed PSW #106 push the resident roughly and use an angry and frustrated tone of voice when speaking to a nurse and also angrily walk away from the resident. The report was amended on a further date to identify that PSW #106 was disciplined regarding potentially unsafe portering of the resident.

A review of PSW #106's employee file identified that the employee had been issued discipline regarding inappropriate language and resident care, on three separate occasions, over the previous two years.

During an interview with Inspector #625, the Executive Director (ED) stated that they were notified of further details of the incident the day after the occurrence, when speaking with the ADOC #105 who had witnessed what had occurred. The ED confirmed that PSW #106 had a history of swearing in front of residents, had been issued disciplines involving suspensions for using inappropriate language while providing care to a resident and for using inappropriate language in front of residents; and for using inappropriate language to a supervisor, and unsafe use of a wheelchair when portering a resident, all within the previous two years. [s. 3. (1) 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 that ensures the rights of residents are fully respected and promoted, including the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, to be implemented voluntarily.

WN #2: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident.

A Critical Incident System (CIS) report was submitted to the Director on a specific day in the winter of 2015. The report identified that resident #011 sustained an injury from a fall on a specific day which required transfer to hospital a week later and resulted in a significant change to the resident's health status.

The health care records for resident #011 were reviewed by Inspector #196. The SALT (Safe Ambulation Lifts and Transfers) assessment identified the resident to be a two person assist with a transfer device. The progress notes on this same day, identified that the resident was unable to transfer safely without the aid of two staff with a transfer device. The Point of Care (POC) charting, prior to the fall, as completed by PSW #121, noted the resident required assistance of two or more person physical assist with transferring. The written care plan, current, at the time of the fall indicated that the resident required support for transfers, and that the resident was independent with transfers once the mobility aid was close at hand.

During the inspection, Inspector #196 conducted an interview with the DOC. They reported that resident #011 was improperly transferred on the day of the fall as they had been assisted by only one staff member as in the written care plan. The resident should have been transferred with two staff and the use of a transfer device as in the most recent SALT assessment. [s. 6. (1) (c)]

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 that ensures the written plan of care for each resident sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #3: 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 Regulation required 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 was required to ensure that the plan, policy, protocol, procedure, strategy or system was complied with.

Ontario Regulation 79/10 s. 114 (2) required the licensee to ensure that written policies and protocols were 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.

A review of the home's policy "Management of Narcotic and Controlled Drugs – LTC-F-80" revised November 2015, identified that narcotic and controlled drug discrepancies would be immediately communicated to the Director of Care, followed by the completion

of a "Medication Incident Report".

Inspector #625 reviewed a Critical Incident System (CIS) report which was submitted on a specific day in Winter 2016. The report indicated that a controlled substance was missing or unaccounted for, on three dates within a one month time period for resident #010.

A review of a "Medication Incident Report" completed by RN #103, listed the three dates, within a one month time period, where the controlled substance was unaccounted for. The report also identified that the discovery of the missing controlled substances occurred during one of the evenings of one of these dates.

Inspector #625 identified additional incidents of missing controlled substances, recorded in resident #010’s progress notes. They were recorded on two days in one particular month in the Fall of 2015, once in the following month, four times in the month after that, and three times in the following month. Inspector #625 reviewed the tracking sheets that contained notations that the controlled substances could not be located for resident #010 on six specific dates in Fall 2015 and three specific dates in early 2016.

During an interviews with Inspector #625, the Director of Care (DOC) confirmed that all of resident #010’s missing controlled substances in the four consecutive months in winter 2015/2016 had not been reported by the home’s staff to the DOC, and "Medication Incident Reports" had not been completed at the time that the occurrences were noted, for any of the missing controlled substances. The DOC stated that staff should have completed "Medication Incident Reports" each time a controlled substance went missing from resident #010 as indicated the home’s policy, but had not done so. [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 that ensures where the Act or 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 is complied with, specifically the home's policy "Management of Narcotic and Controlled Drugs – LTC-F-80", to be implemented voluntarily.

WN #4: 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, without in any way restricting the generality of the duty provided for in section 19, the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

The licensee's policy titled "Resident Non-abuse - Ontario - LP-C-20-ON", revised September 2014, identified that the internal mandatory reporting was "any staff member or person, who becomes aware of and /or has reasonable grounds to suspect abuse or neglect of a Resident must immediately report that suspicion and the information on which it is based to the Executive Director (ED) of the Home or, if unavailable, to the most senior Supervisor on shift at that time. The person reporting the suspected abuse or neglect must follow the Home's reporting requirements to ensure that the information is provided to the ED immediately". In addition, the policy reads that a staff member that is alleged to have abused a resident would be immediately suspended from their duties pending an investigation. The policy also indicated that external mandatory reporting

under the Long-Term Care Homes Act, section 24(1) required a person to make an immediate report to the Director where there was a reasonable suspicion that abuse of a resident by anyone, or neglect of a resident by the licensee or staff, that resulted in harm or risk of harm to the resident occurred or may occur.

A review by Inspector #625 of a particular Critical Incident System (CIS) report, identified that the Food Services Manager (FSM) #104 and current Assistant Director of Care (ADOC) #105 were present and witnessed an incident of alleged staff to resident abuse that occurred on a specific day in the Spring of 2016. The report indicated that PSW #106 was observed by FSM #104 to very quickly push resident #020 in a wheelchair. The report also indicated that ADOC #105 observed PSW #106 push the resident roughly and use an angry and frustrated tone of voice when speaking to a nurse and also angrily walk away from the resident. The report was amended on a further date to identify that PSW #106 was disciplined regarding potentially unsafe portering of the resident.

During an interview with Inspector #625, the Executive Director (ED) stated that they were notified of further details of the incident the day after the occurrence, when speaking with the ADOC #105 who had witnessed what had occurred. The ED stated that the FSM had informed the ED of "horseplay" but that the FSM had not witnessed all of the details and therefore, only relayed part of what had occurred. The ED stated that they interpreted the incident as one of suspected abuse on the following day when the ADOC #105 spoke to the ED about it further. The ED stated that the home's resident non-abuse policy indicated that the incident should have been reported to the ED immediately on the day of the incident and the ADOC #105 did not report the incident to the ED until the following day. [s. 20. (1)]

2. A Critical Incident System (CIS) report was submitted to the Director on a specific day in Spring 2016, for an incident of staff to resident verbal abuse which had occurred eight days previous. According to the report, PSW #123 overheard PSW #124 yelling at resident #001 and made an infantalizing statement. In addition, the report indicated that resident #001 was observed to be upset with what had been told to them.

An interview was conducted with the DOC regarding the incident of verbal abuse. The DOC reported that they became aware of the incident after PSW #123 had provided a written account eight days after the occurrence. In addition, the DOC reported that the investigation determined that PSW #123 had not informed the charge RN nor the ED on the day of the incident. It was reported by the DOC that the alleged abuser, PSW #124,

continued to work from the date of the incident and continued to work over the following seven days. According to the DOC, they did not return once the investigation commenced eight days after the incident. [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 that ensures, without in any way restricting the generality of the duty provided for in section 19, the written policy to promote zero tolerance of abuse and neglect of residents is complied with, 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 the person who had reasonable grounds to suspect that abuse of a resident by anyone, or neglect of a resident by the licensee or staff, that resulted in harm or risk of harm had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director.

The home's policy "Resident Non-Abuse - Ontario - LP-C-20-ON" revised September 2014, indicated that external mandatory reporting under the Long-Term Care Homes Act, section 24(1) required a person to make an immediate report to the Director where there was a reasonable suspicion that abuse of a resident by anyone, or neglect of a resident by the licensee or staff, that resulted in harm or risk of harm to the resident occurred or may occur.

Inspector #625 reviewed a Critical Incident System (CIS) which was submitted on a specific date in the autumn of 2015, regarding alleged staff to resident physical abuse. The report indicated that the allegation of abuse was made verbally to the Executive Director on a specific date in the autumn of 2015.

A review of an email written by the Executive Director (ED) to a member of the Thunder Bay Police Service on a later date, identified that the ED was aware that the CIS report was submitted late.

During an interview with Inspector #625, the ED stated that they had received the verbal allegation of staff to resident abuse on a specific date in autumn 2015, but did not report the allegation to the Director until 15 days after becoming aware of the allegation. The ED stated that they did not immediately report the allegation to the Director. [s. 24. (1)]

2. Inspector #625 reviewed a Critical Incident System (CIS) report which indicated that alleged staff to resident abuse involving resident #019 occurred on a specific date in winter of 2016, at 0630hrs. The report was submitted the following day, at 1057hrs, greater than 28 hours after the incident occurred.

A review of resident #019's health care record included progress notes from the date of the incident. The notes at 0748hrs, had identified that RPN #107 had been made aware of an incident in which PSW #108 had told the resident that they were being argumentative and unreasonable. A second progress note that same day at 0945hrs, was written by RN #103 and identified that resident #019's family member had received a call from the resident at 0630hrs, that the resident was upset and agitated about the PSW who had performed care, and that the PSW had lectured resident #019 about not cooperating. The second progress note indicated that the Acting DOC had called the DOC to inform them of the occurrence. There was no documentation in the progress notes to indicate that the Director had been notified of the allegation.

During an interview with Inspector #625, the Executive Director (ED) stated that they had

been at a work-related conference with DOC #102 on the date of the alleged abuse incident. The ED stated that RN #103 had been the Acting DOC at the time of the incident and had responded to the incident.

During an interview with RN #103, they stated that they had spoken to a family member of resident #019 between 0900-1000hrs on the date of the incident. The RN stated they followed the home's procedure from their CIS reporting table and was aware of the required reporting and stated that they had called the after hours reporting phone number, but had not been provided with a reference number for the call or the name of the person with whom they spoke.

Inspector #625 confirmed through the Central Intake Assessment and Triage Team that the home had not contacted the after hours pager on the date of the incident. [s. 24. (1)]

3. A Critical Incident System (CIS) report was submitted to the Director on a specific day in spring of 2016, for an incident of staff to resident verbal abuse which had occurred two days prior. According to the report, resident #013 rang the call bell for assistance and PSW #124 responded by belittling the resident.

An interview was conducted with the DOC regarding the incident of verbal abuse. The DOC reported that they became aware of the incident two days after the occurrence after RN #125 had sent them an email of a "family/resident complaint" which had occurred. The email indicated that RN #125 had received a phone call from a family member of resident #013 and they were upset about what had happened on the night shift. In addition, the email identified that the RN spoke with the resident and the resident told them that they felt belittled and like a small child after the incident had occurred. According to the DOC, RN #125 did not report the incident to the ED or to the Director at the time of becoming aware of the incident on the day of the occurrence.

An interview was conducted with the ED of the home and they reported that RN #125 was the charge RN and was required to notify the ED at the time of the incident. The ED then stated they would have ensured a report was made to the Director immediately, as the RN also did not report to the Director, but was required to do so. [s. 24. (1)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that a licensee who was required to inform the Director of an incident under subsection (1), (3) or (3.1), within 10 days of becoming aware of the incident, or sooner if required by the Director, made a report in writing to the Director setting out the following with respect to the incident: the outcome or current status of the individual or individuals who were involved in the incident.

In the spring of 2016, a Critical Incident System (CIS) report was submitted by the Executive Director (ED) to the Director outlining a disease outbreak within the home. Inspector #196 reviewed the online CIS and it was determined that an update which identified the outcome of the outbreak, had not been completed by the home.

An interview was conducted with the ED, during the inspection, regarding the submitted CIS report. They reported, after reviewing their records, that the CIS report for the disease outbreak in spring of 2016 had not been updated with information regarding the outcome or status of residents affected. [s. 107. (4) 3.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 215. Criminal reference check

Specifically failed to comply with the following:

s. 215. (2) The criminal reference check must be,
(a) conducted by a police force; and O. Reg. 79/10, s. 215 (2).
(b) conducted within six months before the staff member is hired or the volunteer is accepted by the licensee. O. Reg. 79/10, s. 215 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that, where a criminal reference check was required before a licensee hired a staff member as set out in subsection 75 (2) of the Act, the criminal reference check was conducted within six months before the staff member was hired.

A review by Inspector #625 of PSW #106's employee file identified that the criminal reference check was conducted over seven months prior to PSW #106's date of hire.

During an interview with Inspector #625, the Executive Director (ED) confirmed the date of PSW #106's acceptance of the home's offer of employment was a specific date in the winter of 2013 and the date on the criminal reference check was a specific date in spring of 2013. The ED stated that they were aware that criminal record checks could be no older than six months at the time of the employee's hire, and acknowledged that PSW #106's reference check was obtained more than six months prior to the employee being hired by the home. [s. 215. (2) (b)]

Issued on this 2nd day of November, 2016

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

Original report signed by the inspector.