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
Aug 25, 2017	2017_263524_0018	009011-16, 009645-16, 009653-16, 012334-16, 013731-16, 014475-16, 019258-16, 020728-16, 020918-16, 022164-16, 024218-16, 024670-16, 028249-16, 028395-16, 028429-16, 030365-16, 031101-16, 031850-16, 032648-16, 033440-16, 034026-16, 002125-17, 004625-17, 004769-17, 005492-17, 006595-17, 010124-17	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 GLENDALE CROSSING
3030 Singleton Avenue LONDON ON N6L 0B6

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

INA REYNOLDS (524), DEBRA CHURCHER (670), DONNA TIERNEY (569), DOROTHY GINTHER (568), NATALIE MORONEY (610)

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): June 19-23, 26-28, 2017.

The following critical incidents were conducted:
Related to prevention of abuse and neglect:
Log # 009011-16, CI 2979-000014-16
Log # 009645-16, CI 2979-000019-16
Log # 009653-16, CI 2979-000018-16
Log # 012334-16, CI 2979-000024-16
Log # 013731-16, CI 2979-000028-16
Log # 014475-16, CI 2979-000030-16
Log # 019258-16, CI 2979-000039-16
Log # 020918-16, CI 2979-000005-16
Log # 024218-16, CI 2979-000050-16
Log # 028249-16, CI 2979-000063-16
Log # 028395-16, CI 2979-000064-16
Log # 028429-16, CI 2979-000067-16
Log # 030365-16, CI 2979-000078-16
Log # 031101-16, CI 2979-000082-16
Log # 032648-16, CI 2979-000086-16
Log # 033440-16, CI 2979-000090-16
Log # 034026-16, CI 2979-000093-16
Log # 002125-17, CI 2979-000005-17
Log # 004625-17, CI 2979-000014-17
Log # 004769-17, CI 2979-000015-17
Log # 005492-17, CI 2979-000021-17
Log # 006595-17, CI 2979-000031-17
Related to transferring and positioning:
Log # 022164-16, CI 2979-000043-16
Related to medication administration:
Log # 010124-17, CI 2979-000044-17
Related to falls prevention:
Log # 020728-16, CI 2979-000069-15
Log # 031850-16, CI 2979-000076-16

During the course of the inspection, the inspector(s) spoke with the General Manager, the Director of Care, the Acting Director of Care, the Director of Food Services, the Assistant Director of Food Services, two Corporate Nursing Consultants, two Neighbourhood Coordinators, two Resident Assessment Instrument Coordinators, one Physician, two Kinesiologists, one Registered Dietitian, the Activity Director, three Registered Nurses, 12 Registered Practical Nurses, 27 Personal Support Workers, one Scheduling Clerk, one Housekeeping Aide, one Maintenance Staff, family members and residents.

During the course of the inspection, the inspector(s) also observed residents and the care provided to them, resident and staff interactions, meal and snack service, resident rooms, medication administration, infection prevention and control practices, reviewed medical records and plans of care for identified residents, postings of required information, minutes of meetings related to the inspection, staff training and education records, reviewed relevant policies and procedures of the home and internal investigation notes.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **10 WN(s)**
- **5 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone.

An identified Critical Incident System (CIS) report referred to an incident on a specific date, in which an identified resident was seen abusing another resident. Staff redirected the resident to another area while registered staff assessed the other resident.

An identified Critical Incident System (CIS) report referred to an incident on another specific date, in which the identified resident was witnessed abusing another resident.

During a review of the identified resident's plan of care it was noted that the resident exhibited numerous identified personal expressions and triggers were identified for these personal expressions.

Progress notes identified that the resident had a history of specific behaviours and altercations with other residents in the home.

During an interview with a Personal Support Worker (PSW) on a specific date, they shared that the resident's behaviours were triggered by a number of factors. The PSW said there had been other incidents where the resident had targeted a specific resident with their behaviours and this resident had been injured.

During an interview with another identified Personal Support Worker on a specific date, they shared that the resident had a lengthy history of behaviours with other residents. The PSW said that the resident's behaviours were sometimes triggered by a number of factors. The PSW stated that they were working when the resident abused an identified resident.

On a specific date, a Registered Nurse (RN) told the inspector that often the resident's response or reaction to something was to fight and a number of triggers had been identified. Because the resident was unpredictable it was very difficult to protect the other residents on the neighbourhood.

The licensee failed to ensure that residents were protected from abuse by anyone.

The scope of this area of non-compliance was isolated and the severity was determined to be minimal harm or risk. The home had related non-compliance in the last three years. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are protected from abuse by anyone, to be implemented voluntarily.

WN #2: 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 any of the following had occurred or may occur shall immediately report the suspicion and the information upon which it was 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.

a) An identified Critical Incident System (CIS) report was submitted to the Director for an incident that occurred on a specific date and time. The incident description stated that an identified resident had abused a co-resident.

During an interview with the home's General Manager (GM) on June 22, 2016, they said that once they became aware of the incident as documented in the CIS report they commenced their investigation. The GM acknowledged that the home had not immediately notified the Director of the incident of resident to resident abuse once they became aware.

b) An identified Critical Incident System (CIS) report stated that an identified resident had abused a co-resident on a specific date and time. The resident was identified as having a history of specific behaviours towards other residents. The CIS report stated that the Ministry of Health and Long Term Care after hours pager was not contacted about the incident. The incident was reported to the Director on a specific date and time.

During an interview with the General Manager on June 22, 2017, they told the inspector that they were aware that all incidents of alleged or witnessed abuse were to be reported to the Director immediately. The GM acknowledged that the incident identified in the CIS was not reported immediately.

c) A Critical Incident System (CIS) report was submitted by the home alleging resident to resident abuse.

Review of the resident's clinical record stated that the alleged reported incident was documented in the clinical record as occurring on a specific date. Review of the submitted, amended CIS stated that the critical incident date was on a specific date, and the date of submission was on a later date.

The home's policy titled "Investigation Process for Suspected Resident to Resident Abuse" Tab 04-06A, not dated, stated that "If Abuse Algorithm determines need to report to the Ministry of Health and Long Term Care, immediately initiate and submit the on-line Ciritical Incident System identifying as a mandatory report or if after hours or a statutory holiday, contact the after hours mandatory reporting line".

The Director of Care acknowledged that the report should have been submitted on the day of ocurance.

d) A Critical Incident System (CIS) report was submitted by the home alleging visitor to resident abuse.

Review of the resident's clinical record stated that the reported alleged incident was

documented in the clinical record on a specific date.

The home's policy titled "Investigation Process for Suspected Abuse of a Resident by a Team Member, Volunteer or Visitor" Tab 04-06B, not dated, stated that "A member of the leadership team, general manager or designate shall notify the Ministry of Health and Long Term Care immediately via Critical Incident Reporting System or if after hours or a statutory holiday contact the after-hours Mandatory Reporting line".

A Neighborhood Coordinator (NC) acknowledged that the alleged incident occurred on a specific date, and was not reported until two days later. The General Manager and NC stated that the incident should have been reported on the day it occurred.

The scope of this area of non-compliance was isolated and the severity was determined to be potential for risk. The home had related non-compliance in the last three years. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that 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, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident had fallen, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A CIS report submitted on a specific date, stated that an identified resident had caused another resident to fall to the ground on a specific date. The resident complained of pain as a result of the fall.

Review of resident's plan of care, including the electronic and paper chart, showed there was no evidence that a post-fall assessment had been conducted for the identified fall on that date.

During an interview with the General Manager on June 22, 2017, they told the inspector that it was the home's expectation that a post-fall assessment be completed for every fall. This would be documented in Risk Management and a part of the assessment would push to Point Click Care. On June 26, 2017, the General Manager acknowledged that there was no post-fall assessment for the resident's fall on the specific date.

The scope of this area of non-compliance was isolated and the severity was determined to be potential for risk. The home had related non-compliance in the last three years. [s. 49. (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 when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, 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 residents in accordance with the directions for use specified by the prescriber.

A Corporate Nurse Consultant (CNC) acknowledged that a resident received an identified amount of drugs on specific dates, and should have in fact received a lesser amount on these specific dates. The CNC acknowledged that the order was transcribed incorrectly into the electronic Medication Administration Record. The CNC acknowledged that the resident required medical attention on a specific date, due to the medication error.

The scope of this area of non-compliance was isolated and the severity was determined to be actual harm/risk. The home had related non-compliance in the last three years. [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 O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was, (a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and (b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the

pharmacy service provider.

Review of the home's medication incident reports and corresponding clinical records from March 21, 2017, through June 21, 2017, showed a total of 32 medication incident reports were reviewed.

The inspector was unable to locate any documentation related to notification of the resident or substitute decision maker for eight medication incidents or 25 per cent of the medication incidents. The inspector was unable to locate any documentation related to notification of the pharmacy for seven of the medication incidents or 22 per cent of the medication incidents. The inspector was unable to locate any documentation related to notification of the Director of Care for seven of the medication incidents or 22 per cent of the medication incidents. The inspector was unable to locate any documentation related to notification of the prescriber for 11 medication incidents or 34 per cent of the medication incidents.

The home's policy titled #4.15 "Medication Incidents" last revised March 1, 2016, under the procedure section stated that "all medication incidents or near misses must be reported, notify the prescriber, if appropriate of the incident, notify the resident or POA (family representative) for any incidents reaching the resident and any follow-up actions taken, fax the incident report to the pharmacy and forward report to Director of Care for investigation".

A Corporate Nurse Consultant (CNC) stated that if there was no documentation of notification related to medication incidents then the notification was not completed. The CNC acknowledged that it was the expectation of the home that the resident or substitute decision maker, pharmacy, Director of Care and the prescriber would be notified of all medication incidents. [s. 135. (1)]

2. The licensee has failed to ensure that, (a) all medication incidents and adverse drug reactions were documented, reviewed and analyzed; (b) corrective action was taken as necessary; and (c) a written record was kept of everything required under clauses (a) and (b).

Review of the home's medication incident reports and corresponding clinical records from March 21, 2017, through June 21, 2017, showed that a total of 32 medication incident reports were reviewed.

The inspector was unable to locate any documentation related to an analysis of medication incidents for 12 medication incidents or 36 per cent of the medication incident reports. The inspector was unable to locate any documentation related to corrective action taken for nine medication incidents or 28 per cent of the medication incidents.

The home's policy titled #4.15 "Medication Incidents" last revised March 1, 2016, under the procedure section stated that "the Director of Care or Pharmacy Manager, as appropriate, investigates the medication incident, identifying factors contributing to the incident and documents findings on the Medication Incident/Near Miss Report form, the Director of Care or Pharmacy Manager, as appropriate, determines corrective actions to be taken to reduce the risk of similar incident occurring in the future".

A Corporate Nurse Consultant (CNC) acknowledged that there was no documentation for analysis of 12 medication incidents and no documentation related to corrective action for nine medication incidents. The CNC stated that it was the expectation of the home that there would be an analysis of all medication incidents and corrective action would be taken. [s. 135. (2)]

3. The licensee has failed to ensure that, (a) a quarterly review was undertaken of all medication incidents and adverse drug reactions that had occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; (b) any changes and improvements identified in the review were implemented; and (c) a written record was kept of everything provided for in clauses (a) and (b).

Review of the home's most recent Professional Advisory Committee meeting minutes dated March 6, 2017, stated that the home had 53 medication incidents for the months of November 2016, December 2016 and January 2017, with the most common error being missed dose accounting for 35 of the medication incidents. The inspector was unable to locate any analysis of the data collected and was unable to locate any documentation related to any changes or improvements identified to reduce or prevent medication incidents.

The home's policy titled #4.15 "Medication Incidents" last revised March 1, 2016, under the procedure section stated that "all medication incidents/near misses are reported, compiled and analyzed and the results of this analysis presented to the Professional Advisory Committee. The evaluation of medication incidents is used to recommend changes to the medication management system to reduce and prevent future medication

incidents from occurring. Any changes implemented are monitored for effectiveness".

The General Manager acknowledged that the home had not been completing quarterly reviews and analysis of medication incidents and therefore had not identified any changes or improvements to reduce or prevent medication incidents. The GM stated that it was the expectation of the home that a quarterly review and analysis be completed and changes or improvements should be identified and implemented.

The scope of this area of non-compliance was isolated and the severity was determined to be potential for risk. The home had related non-compliance in the last three years. [s. 135. (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 every medication incident involving a resident and every adverse drug reaction is, (a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and (b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider; that; (a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; (b) corrective action is taken as necessary; and (c) a written record is kept of everything required under clauses (a) and (b); and, that (a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; (b) any changes and improvements identified in the review are implemented; and (c) a written record is kept of everything provided for in clauses (a) and (b), to be implemented voluntarily.

WN #6: 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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was reassessed and the plan of care was revised and different approaches had been considered when care set out in the plan had not been effective.

Review of an identified resident's clinical record identified that the resident had a history of responsive behaviours towards staff and other residents living in the home. Numerous incidents were identified and documented in the progress notes.

During a review of the resident's plan of care it was noted that the resident exhibited numerous personal expressions and triggers for these personal expressions were identified. Strategies/interventions to manage the resident's personal expressions were identified.

During interviews with three Personal Support Workers (PSW) on a specific date, they shared that the resident was abusive with staff and other residents. The Personal Expression Resource Team (PERT) together with other staff had identified a number of triggers for the resident's responsive behaviours, and had developed strategies to help staff to manage them. However, despite these interventions the incidents of responsive behaviours directed at other residents and staff continued.

On a specific date, a Registered Nurse (RN) told the inspector that while the home had developed strategies to address the identified triggers, it was impossible to eliminate them. Because the resident's responsive behaviours were unpredictable it was difficult to protect the other residents on the neighbourhood.

During an interview with two members of the PERT they told the inspector that the resident had a history of responsive behaviours and for this reason they were followed by

the home's Behaviour Support Ontario (BSO) team. One of the members was unsure if the home had initiated any one to one monitoring or specified time checks, but agreed that this type of intervention would have been helpful as it was impossible to eliminate the triggers.

On June 22, 2017, the General Manager told the inspector that they only started working in the home in October 2016. After reviewing the high intensity needs billings for the last year and speaking with the home's staffing coordinator they said that there was nothing to suggest that the resident had one to one monitoring for any specified period of time following the identified incidents. The General Manager acknowledged that one to one staffing and specified safety checks had not been included in the resident's plan of care and that they should have been explored given the resident's unpredictable behaviours.

The licensee failed to ensure that when care set out in the identified resident's responsive behaviour plan was not effective, that different approaches were considered in the revision of their plan of care.

The scope of this area of non-compliance was isolated and the severity was determined to be minimal harm/risk or potential for actual harm/risk. The home had related non-compliance in the last three years. [s. 6. (11) (b)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of the neglect investigation were reported to the Director.

An alleged neglect incident occurred on a specific date, as reported by the home on a Critical Incident System (CIS) report, involving a resident and a staff member. The home conducted an internal investigation and follow-up actions were initiated with the staff member involved. Review of the Long-Term Care Homes Critical Incident System portal used to report incidents to the Director, failed to identify an amended report of analysis and follow-up related to the identified critical incident.

Interview with a Neighbourhood Coordinator on a specific date, acknowledged that the results of the neglect investigation undertaken were not reported to the Director.

The licensee has failed to ensure that the results of the neglect investigation were reported to the Director.

The scope of this area of non-compliance was isolated and the severity was determined to be minimum risk. The home had unrelated non-compliance in the last three years. [s. 23. (2)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a plan of care was based on, at a minimum, an interdisciplinary assessment with respect to the resident sleep patterns and preferences.

Review of a Critical Incident System report (CIS) submitted by the home on a specific date and time, showed that an identified resident had concerns that their bed time preferences were not followed.

Review of the resident's clinical record indicated the resident was totally dependent on staff for all their care needs due to their medical diagnosis.

Interview with a Neighbourhood Coordinator stated that a team huddle was completed with staff and it was determined that staff were to check on the resident if the resident had fallen asleep and implement other bed time preferences. A followup memorandum stated that when "putting the resident to bed these were the resident's preferences and was a part of their care plan moving forward".

Record review of the plan of care for the resident showed there was no focus statement, goals or interventions related to the resident's sleep patterns or their bedtime preferences based on the assessment.

Interview with a Neighbourhood Coordinator acknowledged the absence of sleep patterns and preferences in the resident's plan of care.

The scope of this area of non-compliance was isolated and the severity was determined to be minimum risk. The home had related non-compliance in the last three years. [s. 26. (3) 21.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

A Critical Incident System (CIS) report was submitted by the home alleging visitor to resident abuse.

Review of the submitted CIS report stated that the police were not contacted.

The home's policy titled "Investigation Process for Suspected Abuse of a Resident by a Team Member, Volunteer or Visitor" Tab 04-06B, not dated, stated that "any alleged, suspected or witnessed incident of abuse or neglect of a resident that may constitute a criminal offence will be reported to the police by the charge nurse or designate immediately".

A Neighborhood Coordinator (NC) acknowledged that the home did not contact the police but should have notified them. The General Manager stated that they had no knowledge of the home contacting the police and acknowledged that the home should have notified the police.

The scope of this area of non-compliance was isolated and the severity was determined to be minimum risk. The home had related non-compliance in the last three years. [s. 98.]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director included a description of the individuals involved in the incident, including, ii. names of any staff members or other persons who were present at or discovered the incident.

Review of a Critical Incident System (CIS) report submitted to the Director by the home on a specific date, and amended on a specific date, showed that an identified resident had not been provided care during specific hours on an identified date.

The CIS report did not identify the two staff members that had not provided the resident with care.

On a specific date, a Neightbourhood Coordinator said that they had received training to complete the critical incidents reports to the director and identify the staff that were present at the time of the incident. The General Manager said that it was the home's expectation that when Critical Incident System reports were being completed the Director would be notified of all the staff involved in the incident and it would be part of the Critical Incident System report.

The scope of this area of non-compliance was isolated and the severity was determined to be minimum risk. The home had unrelated non-compliance in the last three years. [s. 104. (1) 2.]

Issued on this 12th day of September, 2017

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

Original report signed by the inspector.