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 30, 2018	2018_740621_0022	019832-18	Resident Quality Inspection

Licensee/Titulaire de permis

North of Superior Healthcare Group (fka The McCausland Hospital)
20B Cartier Road TERRACE BAY ON P0T 2W0

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

Wilkes Terrace
20B Cartier Road TERRACE BAY ON P0T 2W0

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

JULIE KUORIKOSKI (621), RYAN GOODMURPHY (638), STEPHANIE DONI (681)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): August 13 - 16, 2018.

The following intakes were inspected during this Resident Quality Inspection:
Three intakes related to resident to resident sexual abuse; and
One intake related to staff to resident neglect.

During the course of the inspection, the inspector(s) spoke with the Chief Nursing Officer (CNO), Long-Term Care (LTC) Manager, Finance Officer, Food Service and Nutrition Manager, Resident Community Program Manager, Maintenance Lead, Registered Dietitian (RD), a Registered Nurse (RN), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) and a Housekeeping Aide.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident and resident to resident interactions, reviewed relevant health records, as well as licensee policies, procedures and programs.

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

During the course of this inspection, Non-Compliances were issued.
- **5 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the provision of care set out in the plan of care was documented.

Resident #001 was identified to have altered skin integrity, as identified through their April 2018, Minimum Data Set (MDS) assessment.

Inspector #638 further reviewed resident #001's health care records and identified the resident had altered skin integrity which required a specific treatment on particular days after a certain care activity was completed. The Inspector reviewed the resident's electronic medication administration record (eMAR) on particular dates in June and August 2018, which identified treatments as "s" (scheduled). However, on review of other required documentation for this resident, the Inspector was unable to identify if the dressing changes had been completed on the aforementioned dates.

In an interview with Inspector #638, RPN #105 stated that registered staff were in charge of completing residents' treatments for altered skin integrity. The RPN indicated that completed treatments were documented in the eMAR.

During an interview with Inspector #638, RPN #110 identified that treatments for altered skin integrity were managed as per physician orders and treatments were documented in the resident's progress notes and marked as complete in the eMAR. The Inspector reviewed resident #001's eMAR with the RPN, who indicated that "s" was not indicative of a completed treatment and they would not be able to identify if the care was completed or not.

The home's policy titled "Documentation – LTC CCC 022", last reviewed April 2016, indicated that care and services provided to each resident was to be documented in the resident's record, utilizing the resident's chart and care plan.

In an interview with Inspector #638, the LTC Manager indicated that a resident who had altered skin integrity would receive physician orders on how it was to be managed. The LTC Manager identified that when a resident required a treatment for altered skin integrity, staff were required to document the care, and identify whether the care was completed (or not) in the eMAR. Upon reviewing resident #001's health records with the LTC Manager, they stated that staff should have signed the eMAR to identify if the care had been provided or not, and they were unable to identify if the resident did indeed receive their treatments as it was indicated within their plan of care. [s. 6. (9) 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 the provision of care set out in the plan of care is documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,

i. kept closed and locked,

ii.equipped with a door access control system that is kept on at all times, and

iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,

A. is connected to the resident-staff communication and response system, or

B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by residents, and those doors were kept closed and locked when they were not being supervised by staff.

During a tour of the home, Inspector #621 observed in the residential home area the doors to specific non-residential rooms to be unlocked and unsupervised.

During an interview with the LTC Manager, they reported to Inspector #621 that all doors to non-residential home areas were to be locked. Together with the Inspector, the LTC Manager observed two specific non-residential areas to have doors that were unlocked and the respective areas unsupervised by staff. The LTC Manager confirmed to the Inspector that it presented a safety risk to residents when these doors were unlocked and the respective areas were unsupervised.

During an interview with the Maintenance Lead, they reported to Inspector #621 that one of their staff had been in one of the non-residential home area rooms earlier that day to complete their checks, and had forgotten to lock the door. The Maintenance Lead confirmed that only their staff maintained access to this room and that leaving it unlocked posed a risk to resident safety. [s. 9. (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 all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and those doors are kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #3: 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 the written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

Neglect is defined within O. Reg. 79/10 as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A CIS report was submitted to the Director on a day in May 2017, related to an incident where resident #012 was left alone by PSW #113 during a particular care activity, so the PSW could answer a call bell. The report identified that upon return, the staff member was unable to open the locked door to access the room where the resident #012 was located. Consequently, components of the door had to be broken to gain access, and upon entry the resident was found in the room without a specific safety device applied. The report alleged that upon investigation it was found that several steps to provide and maintain safety were negligent.

Inspector #638 reviewed resident #012's documentation and identified a note dated from May 2018, which outlined the resident was left unattended during a specific care activity while PSW #113 tended to another resident. The note identified that upon return to resident #012, the room door was found locked with staff having to break the door to get to the resident. The note also identified that staff actions in order to get access to resident #012 "took time".

The Inspector reviewed a letter of reprimand served to PSW #113 on a specific day in May 2017, which indicated that the PSW knowingly left a vulnerable resident unattended and that the PSW "exercised extreme poor judgment in leaving this patient unattended" and their "actions constituted negligence with the potential to cause harm".

During interviews with Inspector #638, PSW #101 and RPN #105 stated that PSW staff generally completed a specific care activity and were required to apply specific safety devices to ensure resident safety. Both PSW #101 and RPN #105 indicated that residents' were never to be left alone while providing this specific care activity.

The home's policy titled "Resident Safeguards & Advocacy – Abuse", last reviewed April 2018, defined neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well being and included inaction or a pattern of inaction that jeopardized the health safety or well being of one or more residents.

During an interview with Inspector #638, the Chief Nursing Officer (CNO) stated that that leaving a resident alone during a specific care activity was not tolerated; that there had been a few issues identified during investigation of the incident; and the staff member was reprimanded. The CNO also stated that they found PSW #113's actions in this incident negligent.

2. In an interview with Inspector #638, resident #003 identified that they felt belittled by a registered staff member a few weeks prior. The resident identified that the staff member had barged into their room and yelled at them.

Verbal abuse is defined in the O. Reg. 79/10 as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth that is made by anyone other than a resident.

Inspector #638 reviewed the home's internal investigation notes which identified that resident #003 attended an event that he was invited to, and RN #104 asked why the resident got to attend when other residents didn't. The notes identified that the resident expressed their anxiety to PSW #115, which was overheard by RPN #114, who then relayed this information to RN #104. The notes further identified that RN #104 confronted resident #003 for "talking behind their back", and that they were going to report them to the CEO and union. The report identified that the resident felt harassed, threatened and belittled by the RN and identified that RN #104's behaviour was inappropriate.

During an interview with Inspector #638, RPN #105 stated that any inappropriate verbal remark or put down directed towards a resident by staff could be considered abuse, and that incidents of this nature could also impinge on a resident's rights.

The home's policy titled "Abuse – Resident Safeguards & Advocacy", last reviewed April 2018, defined verbal abuse as the use of vexatious comments that are known, or that ought to be known, to be unwelcome, embarrassing, offensive, threatening or degrading to another person including swearing, insults or condescending language which causes the person to believe that their health, safety or well being is at risk. The home's policy identified that the LTC Home Operator shall: Neither abuse, nor allow the abuse of any resident in the Home by the staff or volunteers, nor condone the abuse of any resident by any other person or persons at the home.

In an interview with Inspector #638, the CNO stated that they were made aware of an incident between RN #104 and resident #003. The CNO reported that resident #003 felt belittled and threatened by RN #104 when they barged into the resident's room and raised their voice at them in an accusatory manner, and threatened to report the resident to the CEO. The CNO stated that RN #104 was reprimanded for their actions against resident #003. When the Inspector asked if they believed RN #104 complied with the home's policy to promote zero tolerance of abuse, they stated "No, the RN did not". [s. 20. (1)]

Additional Required Actions:

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

WN #4: 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 improper or incompetent care of a resident, which resulted in harm or a risk of harm to a resident, immediately reported the suspicion and the information upon which it was based to the Director.

A CIS report was submitted to the Director on a day in May 2017, related to an incident which occurred two days earlier, where resident #012 was left unattended during a particular care activity by PSW #113 so they attend to another resident. The report alleged that upon investigation it was found that several steps to provide and maintain safety were negligent. Please refer to WN #3.1 for further details.

The home's policy titled "Abuse and Neglect – Zero Tolerance of Abuse and Neglect", last reviewed April 2018, indicated that if the licensee or staff failed to provide a resident with treatment, care, services or assistance required for health, safety or well being, the licensee would immediately report the suspicion and information to the Director.

In an interview with Inspector #638, the CNO indicated that the incident in question occurred on a specific day in May 2017, and the Finance Officer, who was the Senior Manager on call, was notified at the time of the incident. Upon reviewing the incident and the "Licensee Reporting of Neglect" decision tree with the CNO, they stated that this incident should have been immediately reported by the Finance Officer to the Director,

and was not.

2. In an interview with Inspector #638, resident #003 identified that they felt belittled by a registered staff member a few weeks prior. The resident identified that a registered staff member had barged into their room and yelled at them, and that the home was aware. Please refer to WN #3.2 for further details.

The Inspector reviewed the Long-Term Care Homes.net reporting website and was unable to identify any critical incident report submitted by the home, regarding the incident of verbal abuse reported by resident #003.

The home's policy titled "Resident Safeguards & Advocacy – Abuse", last reviewed April 2018, indicated that zero tolerance meant that the LTC Home Operator was to report to the Ministry of Health and Long-Term Care (MOHLTC) every suspected or confirmed incident of abuse.

In an interview with Inspector #638, PSW #101 indicated that if they suspected an incident of abuse had occurred, they would immediately notify registered staff. The PSW also indicated that if the alleged incident involved a staff member, they would also notify the LTC Manager or CNO directly.

During an interview with Inspector #638, RPN #105 indicated that if an incident of abuse was suspected they would immediately obtain information regarding the incident, chart on the incident in the progress notes and notify management immediately.

In an interview with Inspector #638, the LTC Manager indicated that the incident of alleged verbal abuse between RN #104 and resident #003 was not reported immediately to the Director, and should have been.

3. A CIS report was submitted to the Director on a day in April 2017, related to an allegation of resident to resident sexual abuse.

Inspector #681 reviewed the progress notes in resident #009's and resident #010's electronic medical records, which included progress notes about the incident dated on a specific day in April 2017.

During an interview with RPN #111, they stated that they did not recall the actions they took following the incident. RPN #111 further stated that at the time of the incident, they

did not realize it was a critical incident that had to be reported.

Inspector #681 reviewed the home's policy titled "Zero Tolerance of Abuse and Neglect", last reviewed April 2018, which indicated that a staff member who received a report of alleged abuse or neglect should notify the CNO or senior manager on call immediately and complete all required documentation as per the critical incident reporting binder located at the nursing station.

During an interview with LTC Manager, they stated that nursing staff contacted the manager on call when the incident occurred, but that the manager on call did not report the incident to the Director immediately, but instead reported it three days later. [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 improper or incompetent care of a resident which results in harm or a risk of harm to a resident, immediately reports the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (2) The licensee shall ensure that each menu,
(b) provides for a variety of foods, including fresh seasonal foods, each day from all food groups in keeping with Canada's Food Guide as it exists from time to time. O. Reg. 79/10, s. 71 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the menu provided for a variety of foods, including fresh seasonal foods, each day from all food groups in keeping with Canada's Food Guide as it exists from time to time.

Canada's Food Guide recommends that males and females over the age of 51 consume a specified number of vegetables and fruit per day.

Residents #002 and #008 were identified as having experienced significant weight change through a record review. Resident #004 was also identified as having a certain body mass index (BMI), with no interventions to promote a certain outcome, following a staff interview conducted by Inspector #621.

During meal observations conducted on a day in August 2018, Inspector #681 observed that neither of the lunch meal options included a vegetable choice and that only one vegetable choice was offered at supper.

Inspector #681 reviewed the home's menu cycle and identified that vegetable choices were not included in any of the lunch meals, with the exception of two days. Inspector #681 also identified that on seven separate occasions an alternate vegetable choice was not offered at supper.

During an interview with the Food Service and Nutrition Manager, they acknowledged that vegetables were not being served at lunch. The Food Service and Nutrition Manager stated that the current menu had been reviewed by the home's Registered Dietitian (RD), and that they had not raised concerns about the lack of vegetables on the home's menu.

During an interview with the RD, they stated to Inspector #681 that they were aware that vegetables were not being offered at lunch and that there should be a first and second vegetable choice offered at both lunch and supper. The RD stated that the recommended number of vegetable and fruit servings for the residents in the home was a specified number of servings per day, and that residents were probably received less. The RD verified that the menu did not contain the recommended number of vegetable and fruit servings. [s. 71. (2) (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 the menu provides for a variety of foods, including fresh seasonal foods, each day from all food groups in keeping with Canada's Food Guide as it exists from time to time, to be implemented voluntarily.

Issued on this 30th day of August, 2018

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

Original report signed by the inspector.