Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 17, 2019	2019_703625_0014	025328-18	Critical Incident System

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

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): July 2 to 4, 2019.

During this inspection, one intake was inspected, log #025328-18, related to Critical Incident System (CIS) report #3040-000003-18, submitted for the neglect of one resident.

During the course of the inspection, the inspector(s) spoke with residents, family members, Registered Practical Nurses (RPNs), a Registered Nurse (RN), a Psychogeriatric Resource Consultant (PRC), the Long-Term Care (LTC) Supervisor, the Chief Nursing Officer (CNO) and the Chief Executive Officer (CEO).

The Inspector also conducted observations of resident #001 and the care and services provided to resident #001, including a medication administration pass and the resident's bedroom. The Inspector reviewed records including resident #001's health care record, staff schedules, home's policies and procedures, complaint related documentation, medication packages, a medication incident report, a report on incidents, etc.

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

During the course of this inspection, Non-Compliances were issued.
- **5 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	Légende 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 Long-Term Care Homes Act (LTCHA) 2007, or Ontario Regulation (O. Reg.) 79/10 required the licensee of a long-term care home to have, institute or otherwise put in place any system, policy or protocol that the system, policy or protocol was complied with.

In accordance with O. Reg. 79/10, s. 114 (1) and in reference to O. Reg. 79/10, s. 114 (2), the licensee was required to develop an interdisciplinary medication management system to provide safe medication management, which included the development of written policies and protocols to ensure the accurate administration of all drugs used in the home.

Specifically, staff did not comply with the licensee's policies titled:
(a) "Medication Administration – PHA 034", last revised July 2016, which indicated that nursing staff were to observe a resident taking medications, and that poured drugs were not to be left at the resident's bedside"; and
(b) "Medication Incidents – PHA 035", last reviewed July 2016, which identified that an incident report was to be completed by a staff member when a medication incident occurred.

A CIS report was submitted for the neglect of resident #001 by staff, which the report indicated had occurred on a date in the summer of 2018. The report identified that the resident's family found the resident's medication in their bedroom on multiple occasions during a specified period of time.

(a) During interviews with resident #001's family members #104 and #105, it was identified that the family had found medications in the resident's room on more occasions

during the summer of 2018 than were listed in the CIS report.

During an interview with RPN #106, they stated that they knew they were not to leave medications with resident #001, they certainly would not leave medications with the resident, and that the resident's family member had given them medications that had been left in the resident's room.

During an interview with the LTC Supervisor, they stated that they were aware that medications had been left with resident #001 as they had been provided with multiple sets of pills that had been found in the resident's room.

During an interview with the CNO, they stated that they were aware that medications had been left with resident #001 on more than one occasion, as per discussion with resident #001's family members, who had provided the CNO with the medications found in the resident's room.

(b) A review of the progress notes identified an entry dated the summer of 2018, by RPN #106 that identified resident #001's family member had provided them with medications found in the resident's room.

During an interview with RPN #106, they stated that resident #001's family member brought pills found in resident #001's room to the RPN. The RPN stated they had documented the incident in the progress notes, they imagined they would have filled out a medication incident report, and multiple separate medication incident forms would be required if medications were found in the resident's room on multiple separate occasions.

During an interview with RN #103, they stated that resident #001's family member gave the RN medications resident #001 had not taken, which were found in the resident's room. The RN stated that they didn't remember much about it but, if pills were found in the resident's room multiple times, multiple separate incident reports should have been done for each incident as each one was an individual medication error.

During an interview with the LTC Supervisor, they stated that, if the resident's medications had been found in their room on multiple separate occasions, the resident's medications would not have been administered multiple times. They stated that they had not received medication incident reports for each of the medication incidents that occurred, where family found resident #001's medications in their room, only for the incident the CNO had learned of on a date in the summer of 2018.

During an interview with the CNO, they stated that they were aware of multiple occasions, based on what resident #001's family had said to them, when the resident's pills were found in the resident's room. The CNO stated they had not obtained the date of the first incident they were notified of from the family. The CNO stated that no medication incident reports had been completed other than the one they had generated but, if there were multiple separate incidents, there should have been multiple incident reports. [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 that, where the Act or Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any system, policy or protocol, that the system, policy or protocol is complied with, with specific focus on the licensee's interdisciplinary medication management system and the written policies and protocols to ensure the accurate administration of all drugs used in the home, to be implemented voluntarily.

WN #2: 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, regarding resident #001.

A CIS report was submitted for an incident, which the report identified occurred on a date

in the summer of 2018, involving the neglect of resident #001. The report identified that the resident's family had found medication in the resident's bedroom on multiple occasions during a specified period of time, registered staff had failed to monitor the resident when administering the medications, the resident had a specific diagnosis, there was the potential risk that the medications could have been ingested all at once and the medications were identified as medications administered at a particular time of day, but it was not clear which specific date they were from.

The home's policy titled "Zero Tolerance of Abuse and Neglect", revised April 2013, indicated that a staff member who received a report of alleged neglect was to notify the CNO or senior manager on call immediately upon the receipt of the report of the alleged neglect.

During an interview with resident #001's family members #104, they stated that they had found medications in the resident's room on multiple occasions, with a particular period of time in between the occurrences. The family member stated they had given the pills to nursing staff and told them the pills hadn't been taken on each occasion.

During an interview with resident #001's family member #105, they showed the Inspector a picture, dated a specific date in the summer of 2018, of a number of individual oral medications they found in resident #001's drawer. They stated they brought the CNO to the resident's room to address the medications found in the room. They stated they had been concerned about the resident's safety as they had missed taking medication and could have taken them on another day when they had already taken the same medication.

During an interview with RPN #106, they stated that resident #001's family member had brought medications in a cup, which looked like they had been sitting for days, to the RPN. The RPN stated that they did not recall having a conversation with the LTC Supervisor about the incident reported to them on a particular date in the summer of 2018, as being neglectful. They stated they themselves knew not to leave medications with the resident, they certainly wouldn't leave them with the resident. The RPN identified that, if neglect occurred, they were required to tell management or the RN in charge, who would tell management.

During an interview with RN #103, they stated that resident #001's family had given them medications the resident had not taken, which the family had found in the resident's room, but they could not recall the exact date. The RN identified that if neglect occurred,

they would notify senior management, that if a resident wasn't given their pills and they had been left at their bedside where they had the potential to ingest them all at once, or on a day with other medications, they would notify the senior manager.

During an interview with the LTC Supervisor, they stated that they had not been notified by staff that medications had been found in resident #001's room more than one time. They stated that staff should have communicated that to the LTC Supervisor and, if the supervisor was not available, staff should have told the CNO. The LTC Supervisor stated that staff did not follow the home's zero tolerance of abuse and neglect policy with respect to the process to follow for internal reporting within the home.

During an interview with the CNO, they stated that the home's zero tolerance of abuse and neglect policy had not been followed by staff with respect to internal reporting of neglect to management in the home. [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 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 is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person, who had reasonable grounds to suspect that neglect of resident #001 by the staff that resulted in a risk of harm to the resident had occurred, immediately reported the suspicion and the information upon which it was based to the Director.

A CIS report was submitted on a date in the summer of 2018, for the neglect of resident #001 by staff, which the report indicated occurred days prior. The report identified that the resident's family found medication in the resident's bedroom on multiple occasions during a specified period of time; that registered staff had failed to monitor the resident when administering the medications; that the resident had a specific medical diagnosis; and that there was the potential risk that the medications could have been ingested all at once.

O. Reg. 79/10 defines neglect 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 review of the home's policy "Abuse – A1.2" revised February 2014, identified the definition of neglect to be consistent with the legislation; indicated that abuse included, but was not limited to, neglect; and directed staff to "Report to the MOHLTC every

suspected or confirmed incident of abuse".

A review of the home's policy titled "Zero Tolerance of Abuse and Neglect" revised April 2013, identified that staff were to refer to the decision trees attached to the policy, and included the Licensee Reporting of Neglect decision tree, which directed staff to immediately report a suspicion of neglect and information to the Director.

During an interview with resident #001's family member #104, they stated that they had found the resident's medications left in their room on multiple occasions, and that their family member #105 had found medications left in the resident's room once. Family member #104 stated one time when they found the medication, they brought it to the nursing station and told the staff they were sitting in the resident's room and hadn't been taken. Another time, they found the medication in the resident's room, they did the same thing and made a point of talking to the LTC Supervisor about it. The family member stated they found the pills in the resident's room with a particular amount of time in between the occurrences.

During an interview with resident #001's family member #105, they showed the Inspector a picture of a number of individual oral medications in resident #001's drawer dated a particular date in the summer of 2018. They stated they brought the CNO to the room and showed them. They stated they had been concerned about the resident's safety as they had missed taking medication and could have taken them on another day when they had already taken the same medication.

A review of resident #001's progress notes identified an entry by RPN #106, dated a particular date in the summer of 2018, that identified resident #001's family member was upset that there were medications found in the resident's room, questioned why there were medications in the room when the nurses were supposed to be watching the resident take the medication, and was upset as they felt resident #001 was not getting needed medications.

During an interview with RPN #106, they stated that resident #001's family member had brought medications in a cup, which looked like they had been sitting for multiple days, to the RPN. The RPN identified that, if neglect of a resident had occurred, they would be required to notify management, or the RN in charge who would notify management, and that they would phone the number listed in a binder on the unit for mandatory reporting, but that no one had directed the RPN to call for the incident on which they had documented.

During an interview with RN #103, they stated that resident #001's family had given them medications the resident had not taken, which they found at the bedside. The RN stated they assumed they would have given the medications to the LTC Supervisor. If a resident wasn't given their pills and they were left at their bedside where they had the potential to ingest them all at once, or on a day with other medications, they would notify the senior manager about it who would handle the reporting to the MOHLTC.

During an interview with the LTC Supervisor, they stated they had not been aware that there was more than one time family brought staff pills found in resident #001's room. They stated they had thought that the pills provided to the LTC Supervisor from multiple separate medication passes, had been found at the same time. The LTC Supervisor stated they had not recognized the progress note dated a date in the summer of 2018, was a different incident than the incident reported to the CNO multiple days later. The LTC Supervisor stated that the Director had not been notified of the incidents of neglect immediately, but should have been immediately notified on each separate occasion. They also stated that the Director had not been notified of incident reported to the CNO until multiple days later.

During an interview with the CNO, they indicated that they had been notified of one incident of neglect on a date in the summer of 2018, that a CIS report had been submitted to the Director as an incident of neglect [multiple days later], and that the Director should have been notified immediately of the other incidents when they had been brought to the staff's attention. The CNO identified that the home had not immediately notified the Director of the multiple individual incidents of neglect which had occurred involving resident #001. [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 that ensures that a person who has reasonable grounds to suspect that neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident occurred or may occur, immediately reports the suspicion and the information upon which it is based to the Director, 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 resident #001 in accordance with the directions for use specified by the prescriber.

A CIS report was submitted during the summer of 2018. The report identified that the resident's family had found medication in the resident's bedroom on multiple occasions, with a particular period of time in between the occurrences; that registered staff had failed to monitor the resident when administering the medications; that the resident had a particular medical diagnosis; and that the medications were identified as medications administered at a particular time of day, but it was not clear which date they were from and that all medications had been signed as administered over a period of time.

During an interview with resident #001's family member #104, they stated that they had found the resident's medications left in their room on multiple occasions, during a specified period of time, and that their family member #105 had found medications left in the resident's room once.

During an interview with resident #001's family member #105, they showed the Inspector a picture dated a particular date in the summer of 2018, of a number of individual oral medications in resident #001's drawer. They stated they had been concerned about the resident's safety as they had missed taking medication.

A review of the home's policy titled "Medication Administration – PHA 034", reviewed July 2016, identified that medications should not be left at the bedside unless ordered by a physician for self-administration, that nursing staff were to observe the resident take the medications and that poured drugs were not to be left at the bedside.

Inspector #625 reviewed resident #001 physician's orders in place at the time of the incidents which did not indicate the resident self-administered medications.

During an interview with RPN #106, they stated that resident #001's family member had brought medications in a cup, which looked like they had been sitting for a period of time, to the RPN.

During an interview with RN #103, resident #001's family had given them medications the resident had not taken which they found at the bedside, but they could not recall the exact date.

During an interview with the LTC Supervisor, they stated that the prescriber's directions had not been followed when resident #001's medications had been found at their bedside, that the resident would not have received the medications multiple times. [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 that ensures 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. 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:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident. O. Reg. 79/10, s. 104 (1).

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:
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. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident 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. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that, in making a report to the Director under subsection 23 (2) of the Act, the following material was included in writing with respect to the alleged, suspected or witnessed incident of neglect of resident #001 by staff that led to the report: a description of the incident, including the date and time of the incident and the events leading up to the incident.

A CIS report was submitted for the neglect of resident #001 by staff, which the report identified occurred on a particular date in the summer of 2018. The report identified that the resident's family found medication in the resident's bedroom on multiple occasions during a specific period of time. The report did not identify (a) the date and time the medications were first found by the family and reported to the home's staff; (b) that this was one of a particular number of occasions where medications had been found in the

resident's room in a specific time period; or (c) which specific medications had been found.

(a) A review of resident #001's progress notes identified medications were found by the family in the resident's room and given to RPN #106 on a particular date, in the summer of 2018.

The CIS report had not identified that medications had been found in the resident's room on the date identified in the progress notes.

(b) During an interview with resident #001's family member #104, they stated that they had found medications in resident #001's room on multiple occasions, with a particular period of time in between the occurrences. The family member stated they had given the pills to nursing staff and told them the pills hadn't been taken on each occasion.

During an interview with resident #001's family member #105, they showed the Inspector a picture dated a particular date, in the summer of 2018, of a number of individual oral medications they had found in resident #001's drawer. They stated they brought the CNO to the resident's room to address the medications found in the room.

During interviews with RPN #106, RN #103, and the CNO, each stated that one of resident #001's family members had provided them with pills found in the resident's room. RPN #106 stated that they had documented the incident reported to them in the progress notes.

The CIS report had not identified multiple separate occasions where medications had been found in resident #001's room.

(c) Inspector #625 reviewed the medications in the photograph with RN #103 and compared them to resident #001's Medication Administration Record (MAR) for a particular month and current medication role. The medications were identified by the Inspector and RN as specific medications.

The CIS report had not identified the specific medications found in resident #001's room.

During an interview with the LTC Supervisor, they stated that they thought that the multiple sets of pills provided to them had been found at the same time by family, and that there was one incident to report. They stated that the had believed a family member

had told RPN #106 about the medications in the resident's room on the date documented in the progress notes in the summer of 2018, and that the family submitted a complaint to the CNO multiple days later. They stated they were able to identify the medications when reviewing the MAR as medications administered at a particular time of day on a specific day of the week because of the presence of a medication taken at a specific frequency, but that they had not written down what the medications were. [s. 104. (1) 1.]

2. The licensee has failed to ensure that, in making a report to the Director under subsection 23 (2) of the Act, the following material was included in writing with respect to the alleged, suspected or witnessed incident of neglect of resident #001 by staff that led to the report: actions taken in response to the incident, including the outcome or current status of resident #001.

A CIS report was submitted for the neglect of resident #001 by staff, which the report identified occurred on a date in the summer of 2018. The report identified that the resident's family had found medication in the resident's bedroom on multiple occasions during a particular period of time. The report indicated the resident had not taken the medication; there was no change in their current status; the resident was living with a specific medical diagnosis, was exhibiting specific symptoms and was taking a specific medication; and family was concerned that the symptoms would increase when the medication was not taken on a regular basis.

Inspector #625 reviewed a photograph of resident #001's medications dated a particular date in the summer of 2018, provided by family member #105. RN # 103 and the Inspector compared the pictured medications to resident #001's MAR for a period of time and current medication role and identified the medications. The MAR for that period of time did not list the specific type of medication identified in the CIS report was administered to resident #001 during the medication pass at a particular time of day, and no medications of that type were present in the pictured medications.

The CIS report had not identified the resident's outcome or current status related to missed prescribed medications such as the effect on the resident's health for which the medications had been prescribed.

During an interview with the LTC Supervisor, they stated that they had received medications they had identified as ordered for administration on a particular time of day and day of the week, as well as other medication in a cup that may have been spit out by the resident as they were partially dissolved and the specific pills could not be identified.

The LTC Supervisor stated they had determined the outcome of the resident to report to the Director by looking at progress notes to determine what one component of the resident's status had been going back one week before the incident was reported to the CNO, on a date in the summer of 2018. They stated they had believed the pills may have been from a particular day of the week in the month preceding the complaint to the CNO, but that they had not reviewed the resident's status that far back. They also stated that they had not reviewed any other health factors during the investigation for which the identifiable medications were prescribed, but had focused on one aspect of the resident's health. The LTC Supervisor acknowledged that the report to the Director had not been inclusive of the various aspects of the resident's health that could have been impacted. [s. 104. (1) 3. v.]

Issued on this 18th day of July, 2019

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

Original report signed by the inspector.