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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 23, 2014	2014_284545_0015	000247-14,000517-13,000796-13	Critical Incident System

Licensee/Titulaire de permis

Chartwell Master Care LP
100 Milverton Drive, Suite 700, MISSISSAUGA, ON, L5R-4H1

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

BON AIR RESIDENCE
131 Laidlaw Street South, Cannington, ON, L0E-1E0

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

ANGELE ALBERT-RITCHIE (545)

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 16, 17, 18, 19 and 20, 2014

Two Complaint Inspections (Log#:O-000681-13 and O-001185-13) and three Critical Incident Inspections (Log #: O-000247-14, O-000517-13, O-000796-13) were conducted concurrently.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (DOC), Resident Care and Services Consultant-Nursing, Assistant Director of Care (ADOC), one Maintenance Staff, several Registered Nurses (RN), several Registered Practical Nurses (RPN), a Physiotherapy Assistant and several Personal Care Workers (PSW).

During the course of the inspection, the inspector(s) reviewed health records for several residents, reviewed several policies used in the home: Resident Abuse Policy No. LTCE-RCA-E-002 NUR-II-02 (REGS 96,97,98,99) revised July 2010, Resident Abuse/Whistle-Blowing Protection Policy No. RRCS-G-05/LTCE-RCA-E-002, revised September 2013, Skin and Wound Policy NO: LTCE-CNS-I-1, revised January 2013, reviewed a bed entrapment assessment completed June 9, 2013, reviewed staff education records, observed a mechanical lift transfer, and observed care provision and interaction between staff and residents.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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. 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 comply with LTCHA 2007, S.O. 2007, c.8, s. 24 (1) in that the licensee did not ensure that the person who had reasonable grounds to suspect that an abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm that has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

During an interview with the ADOC on June 18, 2014 she indicated that an alleged verbal abuse between staff member #S211 and Resident #005 was reported on a specific date in April 2013 to the Management Team. The ADOC indicated that an investigation was conducted by the Administrator/DOC who no longer is an employee at this home. It was documented in the investigation report that staff member #S211 told Resident #005 "to shut up and mind your own business" while providing care to another resident in the same room. The Administrator/DOC who had reasonable grounds to suspect a verbal abuse suspended staff member #211 from work for a specific amount of time and directed this staff member to read and sign the Abuse Policy.

Resident #005 scored "1" (borderline intact cognition) on the Cognitive Performance Scale score which was generated from the RAI-MDS 2.0 assessment completed on a specific date in April 2014. During an interview on June 18, 2014, Resident #005 indicated she/he recalled the incident that occurred in April 2013. Resident #005

indicated that a staff had been verbally abusive to her/him while providing care to another resident in the room. Resident #005 indicated she/he could not remember the name of the staff and stated she/he did not want to talk more about the incident.

During an interview with the ADOC and the Resident Care and Services Consultant—Nursing on June 18, 2014, they indicated that the verbal abuse by staff member #S211 towards Resident #005 should have been reported immediately to the Director, as per legislation, but was not.

On June 19, 2014 the Resident Care & Services Consultant-Nursing provided a document titled: "Quality Huddle Record" dated June 6, 2014. It was documented that on June 6, 2014, the Resident Care & Services Consultant—Nursing, the Administrator/DOC and the ADOC met, completed the Abuse Inspection Protocol and outlined the following issue at hand: Resident incidences of suspected abuse were not all reported to the MOHLTC as per the regulations. [s. 24. (1)]

2. Staff member #S209 stated that on November 06, 2014 she/he reported to the Administrator an incident of Staff to Resident Verbal and Emotional Abuse that had occurred at the home. A written complaint was submitted by staff member #S209 to the home on November 11, 2014 detailing the incident. The complaint states that a family member requested that the staff member go to the Residents' Council meeting, as the family member felt the "resident was being brow beaten and verbally abused by the Program Support Services Manager". Staff member #S209 states that when she/he questioned the resident, she/he indicated that she/he felt "verbally attacked, emotionally abused and that attempts were made to intimidate her/him"

The Administrator at the time of the incident is no longer at the home. The current Administrator and Resident Care & Services Consultant-Nursing have confirmed that the abuse incident of November 06, 2014 was not reported to the Director.(194) [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 the person who has reasonable grounds to suspect that an abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm that has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 6 (7) in that the licensee did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan of care.

In a review of the Critical Incident Report dated a specific date in August 2013 it was indicated that a long-term action plan to prevent recurrence of skin tears to Resident #002's fragile skin on her/her arms, protective sleeves would be applied to resident's arms.

Resident #002's care plan dated on a specific date in March 2014 indicated that the resident had altered skin integrity and potential for alteration as her/his skin was very fragile. Care strategies to minimize risk of skin tear included assistance from staff with all transfers, and to apply protective sleeves to resident's limbs.

During an observation on June 17, 2014, Inspector #545 noted Resident #002 lying in bed with no protective sleeves on both her arms and legs. Resident #002's limbs were observed to have very dry paper-thin skin with patchy dried spots.

A Skin & Wound Assessment completed on a specific date in June 2014 indicated that

Resident #002 had altered skin integrity. On another specific date in June 2014, a ONT-Pressure Sore Risk Assessment was completed indicating a moderate risk score of 13. On a specific date in June 2014 a Head to Toe Assessment was completed, it indicated that Resident #002 had a healed skin tear and bruising on one of her/his limb. On a specific date in June 2014 another ONT-Skin & Wound Assessment was completed, it was indicated that Resident #002 had altered skin integrity on one of her/his limb and that a dressing was applied.

During an interview with PSW #S207, it was indicated that protective sleeves should be applied to Resident's legs because her/his skin was very frail and fragile, but today they had not been put on. PSW #S207 pulled one worn protective sleeve containing two holes from Resident #002's drawer and applied it to only one of the Resident's limb, then re-applied resident's white sock. PSW #S207 indicated that the protective sleeves were not applied to Resident #002's all four limbs as per plan of care.

In an interview with staff member #S209, it was indicated that staff were expected to apply the protective sleeves on Resident #002's upper and lower limbs but was aware that this was not always being done. Staff member #S209 indicated that the supply of protective sleeves was an issue and that Resident #002 did not have enough supply.

In an interview with the ADOC on July 19, 2014 she indicated that one pair of protective sleeves was ordered for Resident #002 on two occasions: July 9, 2013 and January 24, 2014. The ADOC indicated that protective sleeves would be ordered for Resident #002's upper and lower limbs today to ensure staff can provide care to Resident #002's as specified in the plan of care. [s. 6. (7)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10 s. 97 (1) (b) in that the licensee did not ensure that the resident's Substitute Decision Maker (SDM) and any other person specified by the resident were notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

On July 17, 2014 during an interview with the ADOC, she indicated that PSW staff member #S211 grabbed Resident #002's limb at a specific time on a specific date in August 2013 while providing care that resulted in a skin tear.

In a review of a progress note dated a specific date in August 2013 at a specific time it was documented that: "Message left on answering machine for Resident's #002's POA regarding skin laceration to a specific area. To call home if any concerns."

In an interview with staff member #S209 on July 18, 2014, it was indicated that after the message was left, she/he reported to the management team the incident that was reported to her/him in report. Staff member #S209 indicated that in this home, it is the responsibility of the management team to report allegations of abuse to the SDM.

In a review of the investigation report completed by the ADOC, it was documented that the ADOC had spoken to Resident #002's family member on a specific date in August 2013 at a specific time. During an interview with the ADOC on July 17, 2014, she indicated that she had not contacted Resident #002's SDM within 12 hours upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of Resident #002 that resulted in a physical injury to the resident. [s. 97. (1) (b)]

Issued on this 24th day of June, 2014

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