Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 21, 2016	2016_303563_0020	019003-16	Resident Quality Inspection

Licensee/Titulaire de permis

CORPORATION OF THE COUNTY OF BRUCE
41 McGivern Street P.O. Box 1600 WALKERTON ON N0G 2V0

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

BRUCELEA HAVEN LONG TERM CARE HOME - CORPORATION OF THE COUNTY OF BRUCE
41 McGIVERN STREET WEST P.O. BOX 1600 WALKERTON ON N0G 2V0

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

MELANIE NORTHEY (563), ADAM CANN (634), INA REYNOLDS (524), NANCY JOHNSON (538)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 27-30, July 4-7, 2016

The following intakes were completed within the RQI:
024155-15: Follow Up to Order #001 related to the Infection Prevention and Control Program
029234-15: Critical Incident related to a fall and left humerous fracture (on-site

inquiry)
034517-15: Critical Incident related to a fall and left hip fracture (on-site inquiry)
035932-15: Critical Incident related to a fall and right hip fracture (on-site inquiry)
036406-15: Critical Incident related to a fall and right rib fracture (on-site inquiry)
013421-16: Critical Incident related to a fall and nasal fracture
013413-16: Critical Incident related to a fall and ankle sprain
001596-16: Critical Incident related to alleged incompetent treatment of a resident
018856-16: Critical Incident related to a fall and L1 & L3 fracture
018322-16: Critical Incident related to a fall and spinal compression fracture
004329-16: Critical Incident related to alleged staff to resident abuse
004363-16: Critical Incident related to alleged staff to resident neglect
018677-16: Critical Incident related to alleged staff to resident neglect
017186-16: Critical Incident related to a fall and left hip fracture
018835-16: Critical Incident related to a fall and orbital fracture
018838-16: Critical Incident related to a fall and left hip fracture
018848-16: Critical Incident related to a fall and femoral neck fracture
020122-16: Critical Incident related to fall and pelvic fracture

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Assistant Director of Care, the Administrative Assistant, the Dietary Services Supervisor, one Dietary Aide, the Environmental Supervisor, the Resident Council Representative, seven Registered Nurses, six Registered Practical Nurses, fourteen Personal Support Workers, three family members, and over forty residents.

The inspector(s) also conducted a tour of the home and made observations of residents, activities and care. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed. Inspector(s) observed meal and snack service, medication administration and drug storage areas, resident/staff interactions, infection prevention and control practices, the posting of Ministry information and inspection reports and the general maintenance, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 229. (4)	CO #001	2015_229213_0028	563

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

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

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every resident had the right to be treated with courtesy and respect and in a way that fully recognized the resident's individuality and respects the resident's dignity.

Record review of progress notes stated the resident voiced complaints to the Power of Attorney (POA). The POA then complained to a registered staff member that the resident was not treated with dignity and respect by a particular staff member.

Record review of the incident under the Risk Management tab in PointClickCare (PCC) documented that a staff member reported that he/she did not like the way a particular staff member spoke to the resident and felt it was neglect that the resident did not receive specific care as requested.

Record review of the home's investigation notes documented the first incident as reported by a family member to a registered staff member that the resident was not treated with respect and dignity and requested a different PSW to perform specific care. The notes also outlined that the same PSW was observed and heard to be disrespectful and rude to the same resident four days later during a specific care task. The PSW was not removed from the resident's care after the initial incident of suspected abuse. The resident was not treated with courtesy and respect, the POA and resident requested to have a different staff member provide a specific care task at the next scheduled time and this did not happen. [s. 3. (1) 1.]

2. The licensee has failed to ensure that every resident had the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.

Record review of the Critical Incident Report submitted to the Ministry of Health (MOH) stated the resident did not receive care or services for an extended period of time. The resident was in their room over night and did not receive care.

Record review of the incident under the "Risk Management" tab in PCC documented that the Registered Nurse (RN) was informed on report that the resident was absent from the home. Staff did a room check to find that the resident was not absent from the home. The RN stated that there was no documentation on the resident's chart indicating the resident was absent from the home.

Record review of the "72 Hours Summary" report from PCC stated that the resident was not absent from the home. The RN said that the Personal Support Workers (PSWs) did not check on the resident for an extended period of time. Record review of the home's investigation notes stated that PSWs did not check on the resident on their shift because they were told the resident was absent from the home.

The Director of Care (DOC) said PSWs did not check on the resident and had not provided the care as required in the plan of care. The resident was not cared for in a manner consistent with their needs. The home staff did not confirm the resident's presence in the home and therefore did not promote the resident's right to be cared for. [s. 3. (1) 4.]

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 resident has the right to be treated with courtesy and respect and in a way that fully recognized the resident's individuality and respects the resident's dignity, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 6. (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).

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 failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Record review of the Critical Incident (CI) Report submitted to the MOH where by the resident was transferred to acute care after sustaining an injury. PSW staff did not provide specific care required to keep the resident safe. The CI Report stated there was "failure to follow the plan of care."

Record review of the home's "Investigation Forms" where by PSWs left a particular device in place when it was to be removed once the resident was safely transferred. The resident was then involved in a critical incident and sustained an injury.

Record review of the incident under the "Risk Management" tab in PCC documented the resident had an unwitnessed fall where by the resident had sustained a significant injury that required transfer to acute care for medical assessment.

Record review of the progress notes documented that the resident returned from hospital with an injury that required a multidisciplinary response. The PSWs did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan related to the removal of a particular device. The resident then fell and sustained a significant injury requiring nursing and medical intervention for several weeks.

Record review of the current care plan stated the resident was to have the particular device removed once they were transferred safely.

The resident’s room was observed to have a logo posted on the wall at the head of the bed which stated the removal of this particular device.

The Director of Care (DOC) stated the expectation was for the PSW staff to remove the device post transfer and this did not happen.

2. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Record review of the Critical Incident (CI) Report submitted to the MOH where by the resident was discovered saturated in urine by the day shift Personal Support Workers (PSWs).

Record review of the current plan of care stated the resident required total care for most activities of daily living.

Record review of the home's investigation notes identified that PSWs did not provide routine continence care during a particular shift.

Record review of the Point of Care documentation stated there was only one documented entry completed for bladder continence, toileting, and bed mobility during that shift.

Record review of the "Night HCA Job Routine" stated at 2230 hours PSWs are to start first rounds, complete resident safety checks... turn/toilet/change all dependent residents & awake residents” and at 0300 hours a second light round and to turn high risk residents. At 0430 hours PSWs are to “answer call bells, toilet, resident safety checks, deliver towels, wash clothes and briefs." The resident did not have continence care again after the first round which started at 2230 hours.

The PSW said the resident required total assistance for bed mobility and would be at high risk requiring hourly checks, turning and repositioning every two hours with a brief change at approximately 0300 hours and 0500 hours if necessary.

The DOC said that there was confusion between the PSWs during rounds, one PSW answered a call bell and the other assumed the resident was seen and the brief was changed. The DOC also explained that the resident was checked, but the brief was not

changed and the resident was found saturated in urine by the day shift staff the following morning. The DOC said the continence care set out in the plan of care was not provided as planned and the night PSW staff did not follow the night shift routine as it related to continence care. [s. 6. (7)]

3. The licensee failed to ensure that the plan of care was being revised when care set out in the plan had not been effective, and that different approaches had been considered in the revision of the plan of care.

Record review of the current care plan in PointClickCare (PCC) stated the resident was at high risk for falls related to multiple cognitive and physical limitations.

Record review of the resident's fall history under the "Risk Management" tab in PCC documented multiple falls during various activities in the resident's room. The post fall assessments documented that the resident had increased difficulty with mobility and transfers. The resident was identified as high risk for falls on admission and this was documented as part of the "Falls Risk (MFS) Morse Fall Scale" Assessment completed in PCC.

Record review of the progress notes at the time of this incident documented an unwitnessed fall with a significant injury. A family member of the resident directed the home that she wanted specific interventions in place upon return from hospital to reduce the risk of falls and injuries. The care plan was updated to reflect the new interventions in place after the fall occurred with a significant injury .

Record review of the current care plan for interventions related to fall prevention and the "potential for injury" stated the specific interventions were created after multiple falls occurred in a short period of time.

The Director of Care (DOC) said when looking at the resident's contributing factors and history of falls, the care plan should have been updated to include the use of these specific interventions before the fall and significant injury occurred.

The plan of care related to fall prevention and the potential for injury was not revised when care set out in the plan had not been effective, and different approaches had not been considered in the revision of the plan of care related to the use of specific interventions prior to the fall and injury. [s. 6. (11) (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 care set out in the plan of care is provided to the resident as specified in the plan and to ensure that the plan of care is being revised when care set out in the plan had not been effective, and that different approaches have been considered in the revision of the plan of care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails were used, the resident had been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident.

a) On July 4, 2016 the resident's bed system was observed to have two bed rails in use. The logo beside the resident's bed indicated two bed rails were to be in use in the up position.

Record review of the resident's current care plan in PointClickCare (PCC) for device and restraint care stated the use of bed rails on both sides. A review of the resident clinical records indicated the absence of a documented resident assessment for the use of bed rails.

On June 29, 2016, Registered Nurse (RN) #114 said there was no bed rail assessment completed for resident #052. (634)

Interview with the Environmental Manager #119 and review of the "Record of Inspection Regarding Bed Entrapment" document indicated the audit was completed in March and April 2016 by maintenance staff members trained in the use of the entrapment tool. All bed systems were evaluated, however the Director of Care said that the home had not completed a bed assessment for any resident using bed rails and stated that there was no assessment tool in use in the home to assess a resident where bed rails were used. (524)

b) The resident was observed in bed with one bed rail in use.

Record review of the resident most recent care plan on PCC under the device and restraint care focus directed staff to apply one side rail when the resident was in bed. A review of the resident clinical records indicated the absence of a documented resident assessment for the use of bed rails. The Registered Nurse said there was no bed rail assessment completed for this resident. (524)

Where bed rails were used, residents had not been assessed to minimize risk to the resident. The home had not completed a bed assessment for any resident using bed rails and there was no assessment tool in use in the home to assess a resident where bed rails were used. [s. 15. (1) (a)]

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 failed to ensure that where bed rails were used, the resident have been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written policy that promoted zero tolerance of abuse and neglect of residents and that it was complied with.

Record review of the Critical Incident (CI) Report was submitted to the Ministry of Health and Long Term Care (MOHLTC). The CI was related to allegations of staff to resident abuse.

Record review of the Prevention of the Abuse and Neglect Policy last revised in April 2014 stated, "Listen to residents, families and their caregiver's suspicions." "Staff have the moral obligation to intervene and speak out when resident abuse is suspected…if abuse is witnessed, separate the parties involved." "The supervisor is expected to immediately send an employee away from the workplace until further notice, pending a thorough investigation and decision regarding disciplinary action and accusations of abuse." "Each employee that suspects abuse of a resident must immediately report such suspicions to their Supervisor, Charge Nurse, Director of Care, or the Administrator. Failure to advocate for the resident, results in a witness becoming involved in the abusive

act… External notification by Administration to the MOHLTC, cases of alleged / actual abuse shall be reported within specified time frames via afterhours contact and/or the Critical Incident System."

Record review of the progress notes written by registered staff stated the Power of Attorney (POA) complained that the resident was not treated with dignity and respect by a particular staff member. The POA and resident requested a different PSW to perform specific care as they felt the resident was a victim of elder abuse. Another progress note documented that the POA had ongoing concerns related to who was providing care to the resident. The registered staff member informed the POA that concerns were forwarded to the Assistant Director of Care (ADOC) who then discussed this with the Administrator. Four days later the same staff member performed this specific care task again regardless of the POA and resident requests for a different staff member.

Record review of the incident under the Risk Management tab in PointClickCare (PCC) documented that a staff member reported that they did not like the way a particular staff member spoke to the resident and felt it was neglect that the resident did not receive specific care as requested.

The Administrator and DOC discussed the incident where by the resident's POA reported suspected abuse and at that time the POA requested that this PSW not provide specific care to the resident. The Administrator acknowledged that the progress notes stated that the charge nurse and ADOC were aware of the allegations of abuse and said a CI should have been submitted to the MOHLTC as per their policy. The Administrator and the DOC said the plan of care was not changed until after the second incident of suspected abuse. Inspector reviewed the progress notes related to the incidents and reviewed the CI Report to the MOH where it does not mention the original allegation of abuse. Both the DOC and Administrator said the CI report should have been updated to reflect the accurate dates and information. The DOC explained it was the home's process that all staff were to follow the abuse policy and the obligation to report abuse as stated in the policy.

The home did not comply with the policy that promoted zero tolerance of abuse and neglect of residents and when abuse was reported; the PSW and the resident were not separated. The PSW performed care four days after the first reported incident of suspected abuse. The supervisor did not immediately send the employee away from the workplace until further notice, pending a thorough investigation. The PSW continued to work with residents for four days at which time the second reported incident of suspected

neglect was reported by a staff member. The plan of care was not revised so that the resident received care from a different PSW. External notification by Administration to the MOHLTC of cases of alleged / actual abuse were not reported within the specified timeframes via afterhours contact and/or the Critical Incident System related to the first incident of suspected abuse reported by the resident's POA. [s. 20. (1)]

Issued on this 26th day of July, 2016

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

Original report signed by the inspector.