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

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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
Jan 29, 2016	2016_347197_0002	001090-16	Resident Quality Inspection

Licensee/Titulaire de permis

THE CORPORATION OF THE COUNTY OF FRONTENAC
2069 Battersea Road Glenburnie ON K0H 1S0

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

FAIRMOUNT HOME FOR THE AGED
2069 Battersea Road R. R. #1 Glenburnie ON K0H 1S0

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

JESSICA PATTISON (197), AMBER MOASE (541), HEATH HEFFERNAN (622), WENDY BROWN (602)

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): January 18-22, 25, 26, 2016

Six critical incident and complaint inspections were also completed concurrently with the Resident Quality Inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Assistant Director of Care, the Environmental Manager, the Nurse Practitioner, the Food Service Manager, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Dietary Aides, Activation staff, the Resident Council President, residents and their family members.

Inspectors conducted a full tour of the home, observed resident care including dining service and medication pass and reviewed resident health care records and relevant policies and procedures related to fall prevention, prevention of abuse and neglect, medication administration and tray service.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

6 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	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. (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. 6(7) in that the care set out in the plan of care for a resident was not provided as specified in the plan.

It was noted during dining observation on January 18, 2016 that resident #060 received a tray to their room during the lunch meal. On January 22, 2016, the resident was observed during the lunch meal.

The resident's current care plan indicated certain methods of positioning the resident for meal times, the level of assistance required and that the resident should be monitored.

On January 22, 2016, the following was observed at the lunch meal for resident #060:

1229 hours - lunch tray delivered by PSW #111 who encouraged the resident to eat and asked if he/she needed help.
1230 hours - PSW #111 left the resident's room.
1241 hours - Inspector observed resident, no staff have checked on resident since delivering the tray. The resident was not in an upright position and had to reach out and up for the tray as it was not positioned at the proper level.
1300 hours - no staff have checked on the resident since the tray was delivered at 1229 hours. Inspector went into the nursing office and spoke to PSWs #111 and #110.

PSW #111 was asked to come to resident #060's room. She indicated that the head of the resident's bed does not come up any further but acknowledged that the resident should be propped up better for eating. She used the two pillows behind the resident to put the resident in a more comfortable position. She also elevated the bed so that the tray was at a more comfortable level for the resident.

Both PSW #110 and #111 were asked what the home's process is for monitoring

resident's who eat in their rooms. PSW #110 indicated that they really do not have a process, they just look in as they are going by.

RPN #116 was interviewed and stated that resident #060 receives a tray once the residents in the dining room have gotten their food. She said that staff deliver the tray and then look in on the resident when bringing other residents back to their rooms. She stated that staff should ensure that the resident is upright and positioned well for eating.

The DOC indicated in an interview that resident #060 does not need someone to sit with him/her constantly but that staff should be monitoring the resident regularly during the meal and positioning him/her properly to eat as comfortably as possible. [s. 6. (7)]

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 specific to eating and tray service is provided to residents as specified in the plan, to be implemented voluntarily.

WN #2: 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 following finding is related to log 026368-15:

The licensee has failed to comply with O. Reg. 79/10, s. 8(1)(b) in that the home's falls prevention and management policy related to a resident's fall was not complied with.

O. Reg. 79/10, s. 48 (1) states that every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The home's policy at the time of the incident titled "Resident Falls" last revised December 15, 2014, indicates that if a resident falls an RN or RPN must assess the resident before he/she is moved.

On a specified date, resident #051 was unsafely transferred in the shower room and as a result, the resident slipped and fell onto his/her right side. The resident was then transferred into a wheelchair by two staff immediately after the fall.

PSW's #114 and #115 both indicated when interviewed that they notified RPN #112 of the incident with resident #051, but not until after the resident was moved. . [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

O. Reg. 79/10, s. 131(6)(d)states that where a resident of the home is permitted to administer a drug to himself or herself under subsection (5), the licensee shall ensure that there are written policies to ensure that residents who do so understand the necessity for safekeeping of the drug by the resident where the resident is permitted to keep the drug on his or her person or in his or her room under subsection (7).

Review of the home's policy # MM11 Self Administration of Medication dated July 1. 2011 states:
The residents' competency will be considered and the safety of other residents that may be in close proximity.
The resident must also understand the necessity for safekeeping of the drug by the resident when they are permitted to keep the drug in their room.

On January 21 and 26, 2016, Inspector #622 observed that resident #058 had a bottle of a specified medication sitting on their over-bed table.

On January 22 and 26, 2016, Inspector #622 observed multiple medication dosettes on the bedside table immediately to the left side of resident #059's doorway.

On January 21, 2016, Inspector #622 interviewed resident #058 who revealed he/she keeps the bottle of medication on top of the over-bed table.

On January 22, 2016, Inspector #622 interviewed resident #059 who stated he/she could not remember why they keep the medication in their room but thinks it is because they really aren't medications. Resident #059 revealed not knowing how they would safeguard the medications.

During an interview on January 21, 2016, Inspector #622 asked the Registered Practical Nurse (RPN) #117 if any residents self-administer medications here in the home and she confirmed resident #058 administers a medication which is kept at the resident's bedside. The RPN #117 was not aware of the homes expectation for the safekeeping of medication in a resident's room or if a policy exists.

In an interview with the Assistant Director of Care (ADOC) on January 22, 2016 she revealed she went to the rooms of the two residents, #058 and #059, who were noted to self-administer medications. The ADOC agreed the medications of resident #059 were in close proximity to the doorway. There was a resident two doors down that wanders but that resident comes out to look for staff assistance only and neither she nor staff had concern for resident safety. This practice has been done since resident #059 was admitted and is how the resident handled medications at home. She agreed she could look at other ways for storage of the medications for resident #059 but stated it is resident #059's room. The ADOC was also aware that resident #058's medication was being kept on top of the over bed table. Further during the interview, the ADOC

confirmed the home's policy states that the resident is to understand the necessity for safekeeping of the drug by the resident when they are permitted to keep medications in their room.

Therefore, the medications being kept in resident #058 and #059's rooms, that self-administer their own medications, have not been safekept by the residents according to the home's policy. [s. 8. (1) (b)]

3. On January 21, 2016, Inspector #622 observed that resident #058 had a bottle of a specified medication sitting on the over-bed table in the resident's room. The medication was not labeled with the resident's name.

Interviews with the Assistant Director of Care (ADOC) on January 21, 2016 revealed the practice in the home, although not written in their policy, is to label medications with the resident's name when using emergency medications. The ADOC stated the medication was pulled from the emergency stock earlier in the week when the resident ran out of that particular medication and it should have been labeled with the resident's name when it was pulled.

On January 26, 2016, Inspector #622 observed that resident #058 continued to have the bottle of medication sitting on the over-bed table in the resident's room, which was not labeled with the resident's name.

Interview with the Director of Care (DOC) on January 26, 2016, confirmed the regular practice in the home when using medications from the emergency stock would be to label with the resident's name when the medication is put into use.

Therefore, the staff did not comply with the established protocol for labeling medications in the home. [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 to ensure that the home's policies and procedures related to falls prevention and the self-administration of medications are complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The following finding is related to log 026368-15:

The licensee has failed to comply with O. Reg. 79/10, s. 36 in that a resident was transferred using unsafe transferring techniques.

On a specified date, resident #051 had been showered and needed to be transferred out of the shower chair. The resident's care plan at the time indicated that the resident requires two staff side by side for this type of transfer. The Critical Incident Report submitted by the home indicates that PSW #114 and PSW #115 were planning to transfer the resident when PSW #115 went to get gloves on and in the interim, the resident was transferred by one staff. The resident then slipped and fell onto his/her right side. A bump and a forming bruise were apparent on the resident. The two PSWs then transferred the resident back into his/her chair.

An interview with the DOC and the investigation by the home confirmed that resident #051 was unsafely transferred by staff and sustained an injury as a result. [s. 36.]

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 safe transferring techniques are used when assisting residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that meals are served course by course unless otherwise indicated by the resident or the resident's assessed needs.

On January 18, 2016, Inspector #541 conducted an observation of the lunch meal service in a specific dining room.

Residents #056 and #057 were observed to be eating their soup while their entrée of sandwich and salad was placed on the table next to their soup. Resident #056 was observed trying to eat the entrée while it remained off to the side of the place setting.

On January 20, 2016, Inspector #541 was in the dining room during the lunch meal and noted resident #026 to be eating the soup while the entrée of baked beans was placed next to the resident.

On January 22, 2016, another observation of the lunch meal service was completed in the same dining room. Resident #054 had soup in front of him/her, PSW #104 approached resident with the entrée, asked if the resident was done eating the soup to which resident did not reply. PSW then moved the resident's soup to the side of the place setting and left the entrée in front of the resident. A few moments later resident #054 was observed trying to eat from the soup bowl but was having difficulty as it was not placed in front of the resident. Resident #055 was observed to be eating soup while an entrée of mashed potatoes and gravy and a sandwich was left beside the resident.

The care plans and diet roster was reviewed for residents #026, 054, 055, 056 and 057 and there is no indication the residents were assessed to require their meal courses served at the same time.

On January 22, 2016, the Food Service Manager #113 was interviewed. FSM #113 indicated the expectation is that all residents are to be served course by course unless their plan of care indicates otherwise. [s. 73. (1) 8.]

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 resident meals are served course by course, unless otherwise indicated by the resident or the resident's assessed needs, to be implemented voluntarily.

WN #5: 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. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The following finding is related to log 026368-15:

The licensee has failed to comply with LTCHA 2007, s. 20(2) in that their policy to promote zero tolerance of abuse and neglect of residents does not contain an explanation of the duty under section 24 of the Act to make mandatory reports.

The home's policy titled "Residents - Zero Tolerance for Resident Abuse and Neglect" last revised April 16, 2013 (reviewed November 2015) states the following:

Page 4 of 6 - "Any person may report witnessed or suspected abuse to any of the following:..."
Page 5 of 6 - "Section 24 of the Act requires reporting of the alleged, suspected or witnessed abuse or neglect. MOHLTC has provided homes with decision trees (Appendix 1) which are intended to guide homes to appropriate report. The Administrator and Director of Resident Care will review the decision tree and report as appropriate. In cases where reporting is deemed not to be necessary, documentation will be kept on file. For details on how to report refer Reporting of Critical Incidents and Mandatory Reports Policy (ADM-07)."

The policy does not indicate that immediate reporting is required when staff witness or suspect abuse or neglect.
The policy does not mention the other mandatory reports outlined in section 24:
- Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident
- Unlawful conduct that resulted in harm or a risk of harm to a resident
- Misuse or misappropriation of a resident's money
- Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. [s. 20. (2)]

WN #6: 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 following finding is related to log 026368-15:

The licensee has failed to comply with O. Reg. 97(1)(a) in that a resident's SDM (substitute decision-maker) was not immediately notified upon becoming aware of the alleged incident of neglect of a resident that resulted in a physical injury to the resident.

O.Reg. 79/10, s. 5 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.

On a specified date, when resident #051 was receiving a shower the resident was transferred by one staff, even though the resident's care plan at the time indicated that the resident should be a two person side by side transfer. The resident sustained an injury as a result of this transfer and this was reported to RPN #112.

During an interview with PSW #114 on January 25, 2016, she indicated that the resident's SDM was not notified of the incident immediately.

Review of the progress notes indicates that the resident's SDM was not notified of the incident until five days after it occurred.

The DOC stated in an interview that RPN #112 should have called the resident's SDM when the incident occurred but did not. She indicated that she called the resident's SDM as soon as she became aware of the incident. [s. 97. (1) (a)]

Issued on this 29th day of January, 2016

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

Original report signed by the inspector.