Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 28, 2018	2018_572627_0004	001857-18	Resident Quality Inspection

Licensee/Titulaire de permis

Finlandia Nursing Home Limited
c/o Sudbury Finnish Rest Home 233 Fourth Avenue SUDBURY ON P3B 4C3

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

Finlandia Hoivakoti Nursing Home
233 Fourth Avenue SUDBURY ON P3B 4C3

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

SYLVIE BYRNES (627), AMY GEAUVREAU (642), JULIE KUORIKOSKI (621), RYAN GOODMURPHY (638)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 12-16 and February 20-23, 2018.

The following additional intakes submitted to the Director were inspected during this Resident Quality Inspection:

- Follow-Up related to compliance order #001 issued during inspection #2017_616542_0007 regarding s.6 (7), care not being provided as specified in in the plan of care;
- Follow-Up related to compliance order #002 issued during inspection #2017_616542_0007 regarding s.20 (1), the home's policy to promote zero tolerance of abuse and neglect of residents not being complied with;
- Follow-Up related to compliance order #003 issued during inspection #2017_616542_0007 regarding s.129 (1) (a) (b), safe storage of medications;
- Two complaints related to falls;
- Two critical incidents related to prevention and management of falls;
- Two CIs related to alleged staff to resident abuse;
- Two CIs related to alleged resident to resident abuse, and
- One CI related to reporting certain matters to the Director.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), the temporary Assistant Director of Care (TADOC), Maintenance Manager, Food Service Manager, Volunteer Coordinator and Family Council Liaison, Resident Assessment Instrument/Minimum Data Set (RAI-MDS) Coordinator, Registered Dietitian (RD), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Dietary Aides (DAs), family members and residents.

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

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Trust Accounts

During the course of this inspection, Non-Compliances were issued.
- **8 WN(s)**
- **2 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. 129. (1)	CO #003	2017_616542_0007	627
LTCHA, 2007 S.O. 2007, c.8 s. 20. (1)	CO #002	2017_616542_0007	627
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2017_616542_0007	627

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 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 the home's policy titled "Wheelchairs, Geri-chairs, Commodes, Walkers – Cleaning – Policy No. 61" last reviewed November 2014, was complied with.

Section 87, subsection 2 of the O. Reg. 79/10 indicated; as part of the organized program of housekeeping under clause 15 (1) (a) of the Long Term Care Homes Act (LTCHA), 2007, the licensee shall ensure that procedures were developed and implemented for, cleaning and disinfection of supplies and devices, including personal assistance services devices, assistive aids and positioning aids, in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant.

Resident #001's wheelchair was observed by Inspector #621 on a specified date and time with debris and stains to the seat and dried white debris present. Inspector #638 observed resident #001's wheelchair seven days later with a moderate amount of dried white stains to the seat of their chair.

Inspector #621 reviewed the home's policy titled "Wheelchairs, Geri-chairs, Commodes, Walkers – Cleaning – Policy No. 61" last reviewed November 2014, which indicated that resident's equipment was to be cleaned at minimum monthly and as needed and according to the schedule on each unit during night shift. The policy further indicated to document completion of each wheelchair that was cleaned on the wheelchair cleaning form in the wheelchair cleaning binder.

Inspector #638 reviewed the wheelchair cleaning schedule for resident #001, which indicated that they were to have their wheelchair cleaned at an earlier date. The Inspector reviewed the wheelchair cleaning form and was unable to identify any documentation indicating that the resident's wheelchair had been cleaned since the previous month.

Inspector #638 interviewed PSW #106 who indicated that night shift routinely cleaned resident mobility devices. The PSW indicated that there was an assignment to follow in the night shift binder and a note would be left on resident equipment requiring cleaning between scheduled cleaning dates.

Inspector #638 interviewed PSW #119 who stated that the night shift PSWs routinely cleaned the residents ambulation equipment based on a monthly schedule. The PSW

indicated that if a resident's device became soiled in the interim, it should be immediately cleaned by staff and communicated to night shift to complete a thorough cleaning again. The Inspector reviewed the cleaning form with the PSW who indicated that if the cleaning had been completed, it was not documented as being complete. The Inspector observed resident #001's wheelchair with the PSW, who indicated that the stains should have been cleaned immediately by staff and reported to night shift for additional cleaning. The PSW stated that the wheelchair should not have been left this way.

Inspector #638 interviewed RPN #104 who indicated that night shift staff were assigned cleaning routines for residents' ambulation equipment. The RPN indicated that if a resident's wheelchair became soiled between scheduled cleaning dates, they would clean the stains immediately and communicate to the night shift staff that an additional cleaning would have been required.

Inspector #628 interviewed the DOC who indicated that the home's policy titled "Wheelchairs, Geri-chairs, Commodes, Walkers – Cleaning – Policy No. 61" last reviewed November 2014, was an active home policy. The DOC indicated that staff were required to clean resident equipment based on the schedule or more often if required and sign the equipment cleaning record once completed. The Inspector reviewed resident #001's scheduled cleaning date and equipment cleaning record with the DOC, who indicated that the cleaning of the resident's equipment should have been documented when and if it was completed.

As resident #001's wheelchair was noted to be soiled and the wheelchair cleaning record was not completed, the licensee had failed to ensure that the home's policy titled "Wheelchairs, Geri-chairs, Commodes, Walkers – Cleaning – Policy No. 61" last reviewed November 2014, was complied with. [s. 8. (1) (b)]

2. The licensee has failed to ensure that the home's policy titled "Narcotics and Controlled Substances", effective January 2007, was complied with.

Section 114, subsection 2 of the O. Reg 79/10, indicated that the licensee was to ensure that written policies and protocols were developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

On a specified day, during a tour of the medication room of one of the home's units, Inspector #627 noted that the medication cart was stored in the locked medication room,

however the cart was noted to be unlocked.

The following day, during a tour of another of the home's untis, Inspector #627 noted that the medication cart was stored in the locked medication room, however, the cart was noted to be unlocked.

Inspector #627 reviewed the home's policy titled "Narcotics and Controlled Substances", effective January 2007, which indicated that "all controlled substances were to be stored in the separate locked narcotic bin in the medication cart in the appropriate home area. When unattended the medication cart was also locked".

Inspector #627 interviewed RPN #109 who said that they were not aware that the medication cart was to be locked when it was stored in the locked medication room.

Inspector #627 interviewed RPN #108 who said that they were aware that the medication cart was to be locked while in the medication room and that this was an oversight on their part.

Inspector #627 interviewed RN #110 and RPN #112, who told the Inspector that it was the home’s policy that the medication cart was to be locked and stored in the locked medication room while not in use.

Inspector #627 interviewed the DOC who stated that the medication cart was to be locked when stored in the medication room as stated in the home’s policy titled “Narcotics and Controlled Substances”.

As the medication cart was noted to have been left unlocked and stored in the medication room while not in use, on two separate occasions, the licensee has failed to ensure that the home’s policy titled “Narcotics and Controlled Substances”, dated January 2007, was complied with. [s. 8. (1) (b)]

3. The licensee has failed to ensure that the home's policy titled " Resident Nutritional Referrals - SS-D-DC-02", effective January 2011, was complied with.

Section 69, subsection 2 (b) of the O. Reg. 79/10 indicated that the licensee was to ensure that the Nutrition Care and Hydration programs, required under clause 11 (1) (a) of the LTCHA, included the development and implementation, in consultation with a Registered Dietitian who was a member of the staff of the home, of policies and

procedures relating to nutrition care and dietary services and hydration.

Resident #002 was identified as having had a significant weight change from their previous to most recent MDS assessment.

Inspector #621 reviewed the weight records for resident #002 and identified a specified weight change within an 11 day period. Additionally, the Inspector reviewed resident #002's health record and was unable to find documentation identifying that a referral to the Registered Dietitian (RD) had been made for the weight change.

Inspector #621 reviewed the home's policy titled "Resident Nutritional Referrals - SS-D-DC-02", effective January 2011, which indicated that referrals to the RD were to be reported and addressed as soon as possible for situations including unplanned weight loss or gain, and RD referrals were made by filling in a Progress Note in PCC with the nature of the change.

Inspector #621 interviewed RPN #109 who reported that residents were weighed by PSW staff on admission and within the first week of every month. RPN #109 identified that weights were transferred from a paper record to the resident's electronic weight record on Point Click Care (PCC) by RPN staff, and RPNs were responsible for checking weights for accuracy to the previous months recorded weight, and request PSW staff re-weigh any resident when there was a weight discrepancy of at 2.5 kg or more. Additionally, RPN #109 indicated that when there was a significant weight change of 2.5 kg or more, RPNs were to make a referral to the RD in the Progress Notes section in PCC, which generated a referral report for the RD to follow up on their next visit. Upon review of resident #002's electronic weight record on PCC, RPN #109 identified that there had been a documented weight change identified on a specified date. Additionally RPN #109 reviewed the PCC and found no RD referral generated on or after the specified date, documented weight change.

Inspector #621 interviewed RD #117 who verified that resident #002 had a significant weight change as recorded in their electronic health record during an 11 day period, and that they had not received a referral from the registered nursing staff to assess the weight change any time after the specified date.

Inspector #621 interviewed the DOC who indicated that it was their expectation that weight changes were assessed using a team approach; PSW staff measured resident weights monthly; RPN staff entered monthly weights into the electronic health record;

and when here was a significant weight change, RPN staff verified the weight accuracy through re-weigh, with confirmed weight changes of significance referred immediately to the RD using the RD referral as was indicated in the home's policy "Resident Nutritional Referrals - SS-D-DC-02".

As resident #002's weight loss over an 11 days period, was not assessed using an interdisciplinary approach, actions were not taken and outcomes were not evaluated, the licensee has failed to ensure that the home's policy titled "Resident Nutritional Referrals - SS-D-DC-02" was complied with. [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 titled " Wheelchairs, Geri-chairs, Commodes, Walkers – Cleaning – Policy No. 61" last reviewed November 2014, Narcotics and Controlled Substances", effective January 2007, and "Resident Nutritional Referrals - SS-D-DC-02", effective January 2011, be complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident and the resident's substitute decision maker (SDM), if any.

Inspector #627 reviewed two medication incident reports which indicated that resident #025 and #026 had not received a prescribed medication as ordered. The medication incident reports had not indicated if the residents and the residents' SDM, if any, had been notified of the incident.

Inspector #627 reviewed resident #025 and #026's electronic progress notes which failed to reveal any documentation indicating that residents #025 and #026 or the residents' SDM had been notified of the medication incidents.

Inspector #627 reviewed the home's policy titled "Medication-General-Miscellaneous", effective February 2011, which indicated that "all medication errors and adverse drug reactions had to be documented and reported to the resident and the SDM, if any".

Inspector #627 interviewed RPN #112 who indicated that when and medication incident was discovered, the resident was assessed and monitored for safety. It was then reported to the RN and an online incident report would be filled out. The RPN further stated that the person who had committed the error was to notify the resident and the resident's SDM, if any. RPN #112 stated that they had not made the resident aware of the incident nor had they called resident #025's SDM in regards to the incident, as they had been made aware of the occurrence days later and were unsure who was to call the SDM at that time.

Inspector #627 interviewed RN #114 who indicated that every medication incident was reported to the RN and that the RN completed the online medication incident report. The staff member who had committed the error would inform the resident and the SDM, if any, of the occurrence.

Inspector #627 interviewed RN #128 who indicated that when they were made aware of a medication incident, they immediately assessed the resident to ensure the safety of the resident. An online medication incident report was filled out, the Physician and the DOC were notified. The staff member responsible for the medication incident notified the SDM. RN #128 further stated that they had no recollection of the resident or the SDM being notified of the incident that occurred on a specified date, for which they had completed a medication incident report. They should have been notified as this was their

policy.

Inspector #627 interviewed the DOC who indicated that the residents and their SDMs should have been notified of the medication incidents by the staff members who had made the error. They further stated that they could not find any documentation indicating that resident #025 and #026 and their SDMs had been made aware of the medication incident.

As residents #025 and #026's and their SDMs were not made aware of the medication incidents, the licensee failed to comply with O. Reg. 79/10, r. 135. (1). [s. 135. (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 every medication incident involving a resident and every adverse drug reaction was reported to the resident and the resident's substitute decision maker (SDM), if any, to be implemented voluntarily.

WN #3: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

Resident #002 was identified as having had a significant weight change from their previous to most recent MDS assessment.

Inspector #621 reviewed resident #002's plan of care which identified as part of this resident's nutrition supplement orders that they were to receive a supplement at specified times of the day.

Inspector #621 interviewed the Dietary Aide (DA) #131 who reported that Dietary staff during a meal service provided the PSW staff with the nutritional supplements that were required for each resident, and the PSW staff documented whether a supplement was consumed or not in the blue folder titled " Meal Supplement Nourishment List". DA #131 indicated to the Inspector that they provided the PSW staff with one bottle of Nutritional supplement as prescribed.

Inspector #621 reviewed the "Meal Supplement Nourishment List" found in the blue folder and found that resident #002 was had two conflicting orders as to when they were

to receive a nutritional supplement.

Inspector #621 had further interviews with DA #131, and PSWs #122 and #132 who stated that when there was no volume listed for a nutrition supplement, that they would assume that one bottle was to be offered. Upon review of the "Meal Supplement Nourishment List" for resident #002, DA #131 and PSWs #122 and #132 reported to the Inspector that they made "their own educated guess" as to what volume might be required for the nutritional supplement, and the documentation for this resident was unclear as to when they should offer the nutritional supplement to the resident.

Inspector #621 interviewed RPN #109 who reported that resident #002's orders for the nutritional supplement was changed on a specified date, by the RD. RPN #109 confirmed that when transcribing an order to another area of the resident's plan of care that the entire order was to be transcribed verbatim.

Inspector #621 interviewed the Food Services Supervisor who reported that when a nutrition supplement was ordered for meal or nourishment times, they were responsible for adding this information to the meal or nourishment tracking sheets used by the PSW and Dietary staff at meal and nourishment service.

Inspector #621 interviewed the DOC who indicated that it was their expectation that when nutrition supplement orders were prescribed in the physician's order section of a resident's chart by the physician or RD, that these orders included details on the type of product, the dosage and the timing of delivery of the product. Additionally, the DOC confirmed that it was their expectation that if orders were being documented in other places of a resident's plan of care, that they were transcribed verbatim to as to provide clear direction to staff and others who were to follow the order.

As resident #002 was listed as requiring a nutritional supplement at two conflicting times, the licensee failed to ensure that the written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the resident was reassessed and the plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

During a record review, Inspector #638 noted that resident #006 was identified as having impaired skin integrity.

Inspector #638 reviewed resident #006's health care records and identified in the progress notes that the resident was assessed as having impaired skin integrity for a period of 21 days. Upon reviewing the resident's care plan the Inspector identified that the resident's care plan for the foci of impaired skin integrity, was updated to "Resolved" on a specified date, 35 days after the impaired skin integrity issue had resolved.

Inspector #638 reviewed the home's policy titled "Plan of Care and Resident Care Plan – NM-A-4" effective December 2006, which indicated that the care set out in the plan of care was to be continually reviewed, evaluated and revised. The policy identified that revisions may be required when interventions were no longer effective as the resident's condition changed or as the targeted dates for goal statements came due.

Inspector #638 interviewed RPN #104 who indicated that when a resident's care needs changed, the care plan should be updated. The Inspector reviewed resident #006's care plan which should have indicated that the skin integrity issue had been resolved sooner, when their care needs changed.

Inspector #638 interviewed the DOC who indicated that registered staff were required to ensure that the resident's care plan was kept up to date whenever their care needs changed. The Inspector reviewed resident #006's care plan with the DOC who indicated that the care plan should have been updated when the resident's impaired skin integrity issue had resolved.

As resident #006's care plan identified the resident as having impaired skin integrity after the issue had resolved, the licensee had failed to ensure that the resident's plan of care was reviewed and revised when the resident's care set out in the plan was no longer necessary. [s. 6. (10) (b)]

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 has failed to ensure that there was a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy was complied with.

Physical abuse was defined within O. Reg. 79/10 as the use of physical force by anyone other than a resident that caused physical injury or pain.

A Critical Incident System (CIS) report was submitted to the Director related to an incident of witnessed staff to resident physical abuse.

Inspector #638 reviewed the internal investigation notes and identified a statement written by PSW #111 . The statement indicated that PSW #111 witnessed the alleged abuse by PSW #113 to resident #019. A second written statement by RPN #112 indicated that they witnessed PSW #113 abusing resident #019.

Inspector #628 reviewed the home's policy titled "Resident Abuse and Neglect – Zero Tolerance – ID-20", last updated September 2017, which indicated that residents will be free from abuse and neglect by staff.

Inspector #638 interviewed PSW #111 who indicated that they witnessed an interaction between PSW #113 and resident #019. The PSW indicated that PSW #113's actions towards resident #019 were "not acceptable".

Inspector #638 interviewed RPN #112 who indicated that they also witnessed the interaction between PSW #113 and resident #019. The RPN stated that this was not the appropriate approach for a staff member.

Inspector #628 reviewed resident #019's care plan in effect at the time of the incident, which indicated that the resident's interventions for responsive behaviours which

indicated specific interventions when the resident exhibited a certain type of responsive behaviour.

Inspector #628 interviewed the DOC who indicated that the PSW had not followed the home's policy of zero tolerance of abuse at the time of the incident.

As resident #019 was witnessed to have been abused by direct care staff, the licensee had failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents was complied with by PSW #113.

A previous compliance order for section 20, subsection 1, of the O. Reg 79/10 was issued, with a compliance date of June 30, 2017, therefore a WN will be issued for this non-compliance. [s. 20. (1)]

WN #5: 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 the abuse of a resident, by anyone, that resulted in harm or risk of harm to the resident has occurred, shall immediately report the suspicious and the information

upon which it was based to the Director.

A CIS report was submitted to the Director related to an incident of witnessed staff to resident abuse. Please refer to WN #5 for details.

Inspector #638 reviewed the internal investigation notes which indicated that PSW #111 and RPN #112 reported the incident to the charge RN at the time of the incident. The notes identified charge RN notified the DOC at the time of the incident. The Inspector was unable to identify any indication that the Director had been notified on the date of the alleged incident.

Inspector #628 reviewed the home's policy titled "Resident Abuse and Neglect – Zero Tolerance – ID-20" last updated September 2017, which indicated that upon witnessing abuse the staff member will immediately report it to either the ADOC, DOC or Administrator and if it is after hours, the RN in charge. The policy identified if the incident occurred after normal business hours, the RN in charge and the person who became aware of, or witnessed the abuse was to call the Ministry of Health and Long-Term Care (MOHLTC) emergency after hours pager and report the incident.

Inspector #638 interviewed PSW #111 who indicated that they witnessed an interaction between PSW #113 and resident #019 and that they immediately informed the charge RN at the time of the incident.

Inspector #638 interviewed RPN #112 who indicated that they also witnessed the interaction between PSW #113 and resident #019 and that they notified the charge RN at the time of the incident.

Inspector #638 interviewed the RN in charge on the date of the incident. They indicated that PSW #111 and RPN #112 made them aware of an incident of staff to resident abuse. The charge RN indicated that they had not immediately reported the incident to the Director as they believed that there had to be adequate evidence prior to reporting an incident of abuse. The charge RN stated that they had not submitted an after hours report, but should have in hindsight.

Inspector #628 interviewed the DOC who indicated that if an incident of abuse was suspected, it should have been reported immediately to the MOHLTC. The DOC stated that management would be made aware of incidents during business hours and the charge RN assumed the role after hours and completed the immediate reporting

requirements. Upon reviewing the incident with the DOC, they indicated that the Director should have been notified immediately via the after hours line.

As resident #019 was witnessed to have been physically abused by direct care staff, the licensee had failed to ensure that the person who had reasonable grounds to suspect that the abuse of a resident occurred, immediately reported the suspicion and information upon which it was based to the Director. [s. 24. (1)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to respond in writing to the Family Council's concerns or recommendations under either paragraph 8 or 9 of subsection (1), within 10 days of receiving the advice.

Inspector #621 interviewed the Family Council (FC) President-Chairman who stated that the home responded to the FC inquires or concerns through voice messages or direct contact and that the FC had not received responses in writing.

Inspector #642 reviewed the meeting minutes for the FC, and identified three written concerns from the Secretary of the FC.

Inspector #642 interviewed the Volunteer Co-coordinator-Resident and Family Council Liaison who stated the FC concerns documented in the meeting minutes had verbal responses only and that there was no documentation of the responses.

Inspector #642 interviewed the DOC who stated that the home had provided verbal responses only to address the FC concerns. They had not been responding to the FC in writing within 10 days to address the concerns.

As the home provided verbal responses only to the FC's concerns, the licensee failed to respond in writing to the Family Council's concerns or recommendations under either paragraph 8 or 9 of subsection (1), within 10 days of receiving the advice. [s. 60. (2)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents that had a weight change of five per cent body weight, or more, over one month, a change of seven and one-half per cent body weight, or more over three months, or a change of ten per cent of body weight, or more, over six months, were assessed using an interdisciplinary approach, and that actions were taken and outcomes evaluated.

Resident #001 was identified as having had a significant weight change for their previous to most recent minimal data set (MDS) assessment.

Inspector #621 reviewed the weight records for resident #001, which identified a greater than five percent weight change over a one month period. Additionally, the Inspector reviewed resident #001's health record and was unable to find documentation identifying that a referral to the Registered Dietitian (RD) had been made for the weight change.

Inspector #621 reviewed the home's policy titled "Resident Nutritional Referrals - SS-D-DC-02", effective January 2011, which indicated that referrals to the RD were to be reported and addressed as soon as possible for situations including unplanned weight loss or gain, and RD referrals were made by filling in a Progress Note in PCC with the nature of the change. Additionally, a review of the home's policy titled "Unplanned Weight Change – SS-D-NC-04", effective June 2004, identified that nursing was to communicate to the RD any unplanned weight changes of five per cent or more over one month, seven and a half per cent or more over three months or ten per cent or more over six months.

During an interview with Inspector #621, RPN #104 reported that residents were weighed by PSW staff within the first week of every month. RPN #104 identified that weights were transferred from a paper record to the resident's electronic weight record on Point Click Care (PCC) by RPN staff, and RPNs were responsible for checking weights for accuracy to the previous months recorded weight, and to request PSW staff to re-weigh any resident when there was a weight discrepancy of at least 4.5 kg. Additionally, RPN #104 indicated that when there was a significant weight change of more the 4.5 kg, RPNs were to make a referral to the RD in the Progress Notes section in PCC, which generated a referral report for the RD to follow up on their next visit. Upon review of resident #001's electronic weight record on PCC, RPN #104 identified that there had been a greater than five percent weight change during a one month period. Additionally, RPN #104 reviewed PCC and found no RD referral generated on or after the date of the documented weight change.

Inspector #621 interviewed RD #130 who verified that resident #001 had a greater than five percent weight change recorded in their electronic health record over one month period, and that they had not received a referral from the registered nursing staff to assess the weight change any time after the specified date of the significant weight change.

Inspector #621 interviewed the Director of Care (DOC) who indicated that it was their expectation that weight changes were assessed using a team approach; PSW staff measured resident weights monthly; RPN staff entered monthly weights into the electronic health record; and when there was a significant weight change, RPN staff verified the weight accuracy through re-weigh, with confirmed weight changes of significance referred immediately to the RD using the RD referral linked within the progress notes section of PCC.

As resident #001's had a greater than five percent weight change during a one month period, was not assessed using an interdisciplinary approach, actions were not taken and outcomes were not evaluated, the licensee failed to comply with Ontario Regulation (O. Reg.) 79/10, s 69 (1). [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed no later than one business day after the occurrence of the incident of an environmental hazard that affected the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including:
ii. a breakdown of major equipment or a system in the home.

A CIS report was submitted to the Director regarding a heating issue in one of the home's areas. The CI report revealed that a valve in the in-floor heating system in the specified home area had malfunctioned. The heat had to be turned off and the residents had to be moved to other areas of the home for safety and comfort.

Inspector #627 interviewed the Maintenance Manager who said that they had been called early in the morning (unsure of time) on a specified date and informed of the heat issue in home. They stated that they had directed the maintenance worker on site to isolate the valve and shut the water off for the in floor heating system. They further stated as the building was insulated concrete form (ICF), it had taken a few days for the building

to cool down. The Maintenance Manager called the repair company at this time.

Inspector #627 interviewed PSW #123 who said that the heat issue had begun on the day prior and had gotten worse throughout the night. They stated that it was "stifling" when they arrived for their shift on a specified date. They further stated that it had remained so throughout the day and that the residents had to be moved to other areas of the home for the duration of their shift.

Inspector #627 interviewed RN #114 who said that they had been made aware of the heat issue during report. They stated that they had been told that the previous shift had noticed an increase in the temperature and that the home area became very hot during the shift. The RN stated that it had remained hot throughout the following shift and that residents had been moved to other areas throughout the home. The RN stated that they had reported the issue to the administration at approximately 0700 hours on a specified date, but had not reported the incident to the Director as reporting had to be completed within one business day.

Inspector #627 interviewed the DOC who acknowledged that the incident should have been reported on the following business day, one day after the incident, however due to some miscommunication, it had been reported three days later.

As the home submitted a CI report on the third business day of the incident, the licensee failed to ensure that the Director was informed no later than one business day after the occurrence of the incident of a breakdown of major equipment or a system in the home that affected the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours. [s. 107. (3) 2.]

2. The licensee has failed to ensure that the Director was informed of an incident that caused an injury to a resident for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition, no later than one business day after the occurrence of the incident, subject to subsection (3.1) and followed by the report required under subsection (4).

The Ontario Regulation (O. Reg.) 79/10 defined a "significant change" as a major change in the resident's health condition that, will not resolve itself without further intervention, impacts on more than one aspect of the resident's health condition, and required an assessment by the interdisciplinary team or a revision to the resident's plan of care.

A complaint was submitted to the Director which indicated that resident #023 sustained an incident which caused an injury that resulted in a significant change in their health status.

Inspector #638 reviewed resident #023's health care records and identified an assessment which indicated that resident #023 was involved in an incident which caused an injury that resulted in a significant change in their health status.

Inspector #638 reviewed the home's policy titled "Mandatory Reporting to MOHLTC" effective September 2006, which indicated that an incident that causes an injury to a resident for which the resident was taken to hospital and that resulted in a significant change in the resident's health condition, was to be reported within one business day of the incident or within three calendar days if unable to determine whether the injury caused a significant change.

The Inspector reviewed the Ministry of Health and Long Term Care (MOHLTC) online reporting site and was unable to identify any CIS reports submitted to the Director related to resident #023's incident during this period.

Inspector #638 interviewed RPN #124 who indicated that whenever a resident was involved an incident which caused an injury which resulted in a significant change, the Director was made aware via an incident report. The RPN indicated that registered staff completed the report once the resident's status was determined.

Inspector #638 interviewed the DOC who indicated that if a resident was involved in an incident which caused an injury resulting in a significant change in their status, the incident was to be reported to the Director. The Inspector reviewed resident #023's incident with the DOC who indicated that the injury would be considered a significant change in the resident's status.

As resident #023 was involved in an incident which resulted in an injury that caused a significant change in their health status, the licensee had failed to ensure that the Director was informed of the incident that caused an injury to the resident, which resulted in a significant change in their health condition. [s. 107. (3) 4.]

Issued on this 1st day of March, 2018

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

Original report signed by the inspector.