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
May 12, 2017	2017_658178_0004	006066-17	Complaint

Licensee/Titulaire de permis

DEEP RIVER AND DISTRICT HOSPITAL
117 BANTING DRIVE DEEP RIVER ON K0J 1P0

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

THE FOUR SEASONS LODGE
117 BANTING DRIVE DEEP RIVER ON K0J 1P0

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

SUSAN LUI (178)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): Onsite: April 11, 12, 13, 2017. Offsite: April 21, 28, May 4, 2017.

This inspection involved a complaint regarding resident care.

During the course of the inspection, the inspector(s) spoke with Interim Chief Nursing Officer/Administrator, Registered Dietitian, Registered nursing staff, personal support workers, family of a resident.

The following Inspection Protocols were used during this inspection:

Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

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

- **4 WN(s)**
- **2 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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the provision of the care set out in resident #001's plan of care was documented.

Review of resident #001's current plan of care indicated that the resident has an identified medical intervention which requires daily care which is provided by registered staff.

The electronic Medication Administration Record (eMAR) and medication progress notes for resident #001 were reviewed for three identified months in 2016. The eMARs direct staff to provide an identified treatment to resident #001 three times daily at specified times if needed. The eMARs contain entries which indicate that the resident did not receive the treatment at the specified times on 52 separate occasions during the three month period. The medication notes accompanying the entries when the treatment was not provided state simply "not needed" or "sleeping" as the reason the treatment was not administered. No documentation is present documenting an assessment of the resident to indicate why the resident did not require the treatment. No documentation is present to indicate that the treatment was provided later in the day, or that it was provided by someone other than the home staff, such as the resident's family.

On April 13, 2017, inspector #178 interviewed RPN #104, who worked regularly on resident #001's unit and was responsible for providing the identified treatment for resident #001's medical intervention when he/she worked. RPN #104 indicated that when the identified treatment was due, he/she would assess the resident to determine whether or not the resident required the treatment. If the resident was sleeping and was assessed to not require the treatment, RPN #104 would not provide the treatment at that

time. RPN #104 indicated that if he/she did not provide the treatment at the specified time, he/she would provide it later in the shift. RPN #104 indicated that he/she consistently provided the identified treatment to resident #001 at least twice during the shift, unless the resident's family was present and provided the identified treatment. RPN #104 indicated that he/she would document on the eMAR when he/she provided the identified treatment, or document that the family provided the treatment if applicable.

Review of the eMARs for three identified months showed multiple entries indicating that the identified treatment was not provided when RPN #104 was working, with no documentation indicating why it was not required. No documentation was present on those dates stating that the identified treatment was provided later in the shift. Review of the eMARs for the three identified months showed 14 dates when RPN #104 was working and there was no documentation of the identified treatment for resident #001 during RPN #104's shift.

In an interview with inspector #178 on April 11, 2017, the interim Chief Nursing Officer/Administrator indicated that it is the home's expectation that the identified treatment for resident #001's medical intervention be documented on the eMAR, and that if the identified treatment is not required, the assessment of the resident should be documented, stating why the treatment was not required. The interim Chief Nursing Officer/Administrator indicated that RPN #104 failed to document care and assessment of resident #001 related to the resident's identified treatment needs. [s. 6. (9) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the provision of the care set out in resident #001's plan of care is documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff have received retraining annually relating to the following:
-The Residents' Bill of Rights
-The home's policy to promote zero tolerance of abuse and neglect of residents
-The duty to make mandatory reports under section 24
-The whistle-blowing protections.

In accordance with LTCHA 2007, section 76 (1), (2) and (4) and O.Reg. 79/10 section 219 (1), all staff are to be provided training on the long term care home's policy to promote zero tolerance of abuse and neglect of residents, prior to performing their responsibilities and annually thereafter.

On April 13, 2017, RPN #104 indicated to inspector #178 that he/she does not receive training in the prevention of abuse and neglect every year.

On April 28, 2017, the home's interim Chief Nursing Officer/Administrator indicated to inspector #178 via email that RPN #104 did not receive annual training in the following in 2016:
-The Residents' Bill of Rights
-The home's policy to promote zero tolerance of abuse and neglect of residents
-The duty to make mandatory reports under section 24
-The whistle-blowing protections.
The home's interim Chief Nursing Officer/Administrator indicated to inspector #178 via email that due to turnover in leadership in the home in 2016, annual training in the prevention of abuse and neglect of residents in 2016 was not completed by any of the staff of the home. The interim Chief Nursing Officer/Administrator indicated that the home will be providing this training to all staff in June 2017. [s. 76. (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 all staff have receive retraining annually relating to the Residents' Bill of Rights, the home's policy to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under section 24, and the whistle-blowing protections, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that suspicion of improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm was immediately reported to the Director under the Long Term Care Homes Act (LTCHA).

During an interview with the home's interim Chief Nursing Officer/Administrator on April 12, 2017, she indicated to inspector #178 that the family of resident #001 brought it to her attention on a number of occasions prior to an identified date, that they felt that an identified RPN was not providing competent care to the resident. The family reported various concerns regarding care and medication safety with regards to the RPN. The family's concerns were investigated by the home, and actions were taken to correct the issues, but the allegations were not reported to the Director under the LTCHA as required by the Act. The interim Chief Nursing Officer/Administrator indicated that in looking back, she should have reported the allegations of incompetent care to the Director under the LTCHA. [s. 24. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee has failed to ensure that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences.

During email correspondence on May 5, 2017, the Interim Chief Nursing Officer / Administrator indicated to inspector #178 that she has no knowledge of an evaluation of the effectiveness of the Licensee's policy to promote zero tolerance of abuse and neglect being conducted in 2016, and has found no records to indicate that an evaluation of the policy took place in 2016. [s. 99. (b)]

Issued on this 12th day of May, 2017

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

Original report signed by the inspector.