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
Dec 21, 2017	2017_395613_0021	026443-17	Resident Quality Inspection

Licensee/Titulaire de permis

CLURELEA LTD.
481 Victoria Street East Alliston ON L9R 1J8

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

GOOD SAMARITAN NURSING HOME
481 Victoria Street East Alliston ON L9R 1J8

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

LISA MOORE (613), JENNIFER LAURICELLA (542), JULIE KUORIKOSKI (621)

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): December 11-15, 2017.

The following intakes were completed during this inspection:

One Complaint related to concerns regarding the outbreak management at the LTC Home and residents rights.

Two Critical Incidents (CIs) the home submitted to the Director regarding resident falls resulting in injury.

One Critical Incident the home submitted to the Director regarding the failure/break down of the door access control system.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Nursing (ADM/DON), Director of Care (DOC), Environmental Service Supervisor (ESS), Activity Coordinator (AC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), family members and residents.

The Inspector(s) also conducted a tour of resident care areas, observed the provision of care and services to residents, staff to resident interactions, reviewed relevant health care records, various licensee policies, procedures and programs, staff training records, the home's internal investigation files and resident council meeting minutes.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Safe and Secure Home

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. 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:
6. Every resident has the right to exercise the rights of a citizen. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rights of residents were fully respected and promoted: every resident had the right to exercise their rights as a citizen.

Inspector #621 reviewed a complaint that was submitted to the Director in October 2016, which indicated that the home had notified resident #006's family in October 2016, of a respiratory outbreak at the home, and that no visitors would be allowed into the building, and residents would not be allowed out during that time.

During an interview with the complainant in December 2017, they reported that the home had called them on a specific date in October 2016, and notified them and resident #006's family member, who was their substitute decision-maker (SDM), of a respiratory outbreak in the home, and that no visitors were allowed into the building and residents were not allowed out, until further notice. The complainant reported that resident #006's SDM went to the home later on the same specific date in October 2016, and was refused entry into the home. Additionally, the complainant identified that both they and the SDM went to the home on another date in October 2017, and again were refused entry by RN #111, as per the home's directive. The complainant indicated that resident #006 was upset that their family could not come to visit them and that the resident would not be able to leave the home for a planned event on a specific date in October 2017. The complainant reported that although the home later allowed the resident to leave with the family at a pre-determined time on a specific date in October 2017, they and the resident's SDM continued to not be allowed to enter the building.

During an interview with resident #006, they remembered that during October 2016, in the previous year, there had been a cold going around in the home and there were restrictions for residents and family coming into and out of the building. The resident identified that their family members were prevented from coming into the home at that

time, and that they were concerned that they were not going to be allowed to leave the home, which had been upsetting for them. Additionally, resident #006 indicated that to their knowledge, there had been no further incidents of the home preventing a family member from entering or a resident from leaving the home.

A review of resident #006's health care record identified a late entry documented in October 2016, which indicated that the resident's family member had been very upset that they were unable to come inside the building to visit.

During an interview with Activity Coordinator #110, they reported that there had been one facility outbreak in 2016 which had occurred over the month of October. The Activity Coordinator identified that as part of outbreak management in the home, the former Administrator #114 had refused residents from leaving, as well as entry of visitors into the home. The Activity Coordinator indicated that they were surprised that such strict entry and exit restrictions were being enforced, as they had worked in another facility in the past where visitor restrictions had been much more flexible.

During an interview with the Director Of Care (DOC) #101, they reported that the previous Administrator #114 had restricted in and out access to the home during facility outbreaks. The DOC identified that during the respiratory outbreak and over a weekend in October 2016, they had been made aware by the Simcoe Muskoka District Health Unit (SMDHU), that SMDHU had received a call from a family member regarding visitors being restricted from entering the Good Samaritan home during the outbreak; that there were Ministry of Health guidelines for outbreak management; and that closure of a long-term care home to visitation was not permitted unless there was an order issued by the Medical Officer of Health, as it could cause residents and visitors emotional hardship. The DOC indicated to the Inspector that the home did not have an order from the Medical Officer of Health to close the home to visitors during this outbreak; that they had informed the former Administrator #114 of the conversation with the SMDHU; that the former Administrator #114 continued to refuse visitor access into the home; and that in spite of the former Administrator's decision, the DOC took it upon themselves to allow resident #006, who was asymptomatic during the outbreak, to leave with their family on a specific date in October 2017.

During an interview with the current Administrator/Director of Nursing (ADM/DON), they reported that it was their expectation that during an outbreak, that the home respected residents rights as a citizen to have visitors during an outbreak, to leave the home if that was the resident's and/or SDM's wishes, and to not prevent visitors of the home from

entering the building. The ADM/DON indicated that home's policies were updated after this incident had occurred, to reflect the current Ministry of Health guidelines during outbreaks and staff, residents and visitors were informed of the easing of former restrictions. [s. 3. (1) 6.]

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 exercise their rights as a citizen and specifically during an outbreak that visitors of the resident's choice may enter the home and residents may leave the home, to be implemented voluntarily.

WN #2: 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 the person who had reasonable grounds to suspect 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, was immediately reporting the suspicion to the Director.

Resident #002 was identified as having a fall in the last 30 days through a staff interview.

Inspector #542 reviewed resident #002's progress notes that identified an entry documented on a specific date in October 2017, describing an incident where resident #002 was injured by resident #008. Another entry on the same date, revealed documentation indicating that resident #002 sustained a bruise to a specific area of their body, as a result of the incident.

A review of a document titled, "Resident Incident Report" dated on a specific date in October 2017, revealed that PSW #104 heard resident #002 yelling and found resident #008's exhibiting a specific responsive behaviour towards resident #002. Resident #002's was noted to have bruising to a specific area on their body.

A review of another "Resident Incident Report" dated on specific date in September 2017, identified that resident #002 had exhibited a specific responsive behaviour with co-resident #009. Resident #009 indicated that resident #002 had approached them and exhibited a specific responsive behaviour. Resident #009 stated that resident #002 had caused injury to a specific area on their body.

Inspector #542 reviewed resident #009's progress notes and located an entry indicating that resident #009 had complaints about discomfort to a specific area of their body as a result of the incident.

A review of the home's policy, titled, "Resident Abuse and Neglect" last revised on August 2017, defined physical abuse as, the use of a physical force by a resident that caused physical injury to another resident, such as, but not limited to, hitting, scratching, pushing and scratching. The policy verified that the Administrator or Designate, was to report abuse of a resident to the Director.

During an interview with the Administrator, they verified that they should have reported both of these incidents immediately to the Director. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any person who has reasonable grounds to suspect that 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, immediately reports the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (4) A member of the registered nursing staff may permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical, if,
(a) the staff member has been trained by a member of the registered nursing staff in the administration of topicals; O. Reg. 79/10, s. 131 (4).
(b) the member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and O. Reg. 79/10, s. 131 (4).
(c) the staff member who administers the topical does so under the supervision of the member of the registered nursing staff. O. Reg. 79/10, s. 131 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that a member of the registered nursing staff permitted a staff who was not otherwise permitted to administer a drug to a resident to administer a topical, only if, (a) the staff member had been trained by a member of the registered nursing staff in the administration of topicals.

On December 13, 2017, Inspector #542 completed an observation of a medication administration.

During an interview with RPN #107, they revealed that the home's Personal Support Workers (PSWs) administered topical medications to the residents, but they were unsure if the PSW staff were trained to perform this duty.

During an interview with the DOC, they indicated that they thought the PSW staff were trained in the administration of topical medications.

During an interview with the ADM/DON, they provided some of the PSW training records regarding the administration of topical medications. The ADM/DON verified that not all of the PSW staff had received training in the administration of topical medications.

A review of the training records that were provided, revealed that only 18 out of 38 (47%) PSW staff were trained on the application of topical medications. [s. 131. (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 a member of the registered nursing staff permits a staff who is otherwise permitted to administer a drug to a resident to administer a topical, only if (a) the staff member is trained by a member of the registered nursing staff in the administration of topicals, to be implemented voluntarily.

WN #4: 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. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug interactions.

During an interview with the ADM/DON, they indicated that the home had quarterly meetings to discuss the medication incidents; however, they had not completed a quarterly review of all medication incidents and adverse drug reactions in order to reduce and prevent medication incidents and adverse drug reactions. [s. 135. (3)]

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 a quarterly review is undertaken of all medication incidents and adverse drug reactions that has occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug interactions, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the home received a written complaint concerning the care of a resident or the operation of the long-term care home, that they immediately forwarded it to the Director.

A complaint was submitted to the Director in October 2016, which indicated that the home notified resident #006's family on a specific date in October 2016, concerning a respiratory outbreak at the home, and that no visitors would be allowed into the building, and residents would not be allowed out during that time.

Inspector #621 reviewed documentation received from the home which included:
-a letter of complaint, dated on a specific date in October 2016, which the home acknowledged receipt of one day later in October 2016;
-a letter of response from the home to the Director on a specific date in October 2016; and
-a letter of response from the home to the complainant, dated on a specific date in October 2016.

During an interview with the complainant, they stated that they had written a letter of complaint to the home on a specific date in October 2016, and dropped it off to the home on a specific date in October 2016.

During an interview with the ADM/DON, they revealed that the previous Administrator #114 had addressed the complaint in question; that the home's records indicated receipt of the letter of complaint from resident #006's family on a specific date in October 2016, and that the home had forwarded the written letter of complaint to the Director seven days later, in October 2016. Additionally, the ADM/DON verified that written letters of complaint concerning the care of a resident or the operation of the long-term care home, were to be immediately forwarded to the Director, as per legislative requirements. [s. 22. (1)]

WN #6: 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. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report made in writing to the Director set out the names of any resident involved in the incident.

Inspector #542 reviewed a Critical Incident (CI) Report that was submitted to the Director in November 2016, which indicated an incident that caused an injury to resident #007, for which the resident was taken to the hospital and resulted in a significant change in the resident's health status.

A review of the CI report did not identify the name of the resident involved in the incident.

A review of the amended CI report that was submitted in December 2016, still did not identify the resident's name.

During an interview with the ADM/DON, they verified that the resident's name was not included on the CI report and informed the Inspector of the resident's name. [s. 107. (4) 2. i.]

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Issued on this 21st day of December, 2017

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

Original report signed by the inspector.