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 2, 2018	2018_657681_0001	014617-17, 015161-17, 018063-17, 021316-17, 021339-17, 021497-17, 022345-17, 022650-17, 022733-17, 023652-17, 024548-17, 025649-17, 025654-17, 025866-17, 026011-17, 026628-17, 026933-17, 027143-17, 027144-17, 027469-17, 028057-17, 028319-17, 028686-17, 029631-17, 001812-18, 001922-18	Critical Incident System

Licensee/Titulaire de permis

St. Joseph's Care Group
35 North Algoma Street P.O. Box 3251 THUNDER BAY ON P7B 5G7

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

Hogarth Riverview Manor
300 Lillie Street THUNDER BAY ON P7C 4Y7

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

STEPHANIE DONI (681), DEBBIE WARPULA (577), JULIE KUORIKOSKI (621), LISA MOORE (613), SHEILA CLARK (617), TIFFANY BOUCHER (543)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 22 - 26, 2018.

The following intakes were completed during this Critical Incident System (CIS) inspection:

- Four intakes related to missing residents.

- Thirteen intakes related to allegations of staff to resident abuse or neglect.

- Four intakes related to allegations of resident to resident abuse.

- Four intakes related to resident falls that resulted in injury and transfer to hospital.

- One intake related to missing or unaccounted for controlled substances.

A Complaint inspection #2018_657681_0002 was conducted concurrently with this CIS inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Clinical Managers, Resident-Assessment-Instrument (RAI) Coordinators, Manager of Building Services, Psychogeriatric Resource Consultant, Recreation Therapists, Physiotherapists (PTs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Physiotherapy Aids (PTAs), Therapeutic Recreation Aids, Security Guards, family members, and residents.

The Inspectors also conducted a tour of the resident care areas, reviewed relevant resident care records, home investigation notes, home policies, personnel files and observed resident rooms, resident common areas, and the delivery of resident care and services, including resident-staff interactions.

The following Inspection Protocols were used during this inspection:

Critical Incident Response
Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **10 WN(s)**
- **6 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:
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident's rights were fully respected and

promoted, specifically that every resident had the right not to be neglected by the licensee or staff.

A Critical Incident System (CIS) report was submitted to the Director related to an allegation of staff to resident neglect. The CIS report indicated that on a particular day, resident #018 had not been seen by staff a period of three hours and 45 minutes. The CIS report revealed that resident #018 had returned to their unit after attending an activity. PSW #149 noticed that resident #018 was not in attendance for a meal service and notified RPN #115. One hour and 45 minutes later, PSW #149 again notified RPN #115 that they were unable to locate resident #018 on the unit. RPN #115 telephoned the resident's substitute decision-maker (SDM) and was informed that they had not taken the resident out on a leave of absence (LOA). RPN #115 then directed staff to conduct a search of the unit. PSW #150, who was resident #018's assigned PSW, found resident #018 lying on the floor in another resident's room. Resident #018 was complaining of pain and was transferred to hospital.

Inspector #613 reviewed of the home's policy titled, "Code Yellow – Missing Resident" last revised September 2017, which identified that a code yellow was the designated code word to clearly communicate to all staff that a resident was wandering or missing. All staff were expected to be aware that a reportable incident of wandering/missing was when caregivers of a specific home area do not know the whereabouts of a resident and when there was no written communication to indicate that the resident may be elsewhere. Staff who discovered and confirmed that a resident was missing were responsible for initiating the search of the resident's room and all accessible areas of the home area and review the LOA binder to determine if the resident had been signed out by a family member.

A review of the home's investigation notes identified that RPN #115 thought resident #018 was off the unit with a family member. The home's investigation notes also indicated that PSW #150 failed to perform a round on their assigned residents at the start of their shift before they provided care to other residents.

During an interview with RPN #115, they stated that they had checked the sign out sheet and that resident #018's SDM had not signed the resident out. RPN #115 stated that they did not direct staff to do a unit search until after they had spoken with resident #018's SDM because they assumed that resident #018 had gone out with their SDM.

During an interview with Interim Clinical Manager #103, they verified that PSW #150 and

RPN #115 had neglected resident #018 by not following the LTC Home's policy and expectations. Interim Clinical Manager #103 stated that PSW #150, who was assigned to resident #018, should have completed an initial round on all assigned residents prior to commencing care to know the whereabouts of all of their assigned residents. Interim Clinical Manager #103 further stated that RPN #115 did not initiate a room check until after calling the resident's SDM and that RPN #115 should have initiated a unit search when they first suspected resident #018 was missing. [s. 3. (1) 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 every resident is not neglected by the licensee or staff, 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 licensee has failed to ensure that the home's Medication Administration Program was complied with.

The Ontario Regulation 79/10 describes a medication incident as a preventable event associated with the prescribing, ordering, dispensing, storing, labeling, administering or distributing of a drug, or the transcribing of a prescription, and includes:

(a) an act of omission or commission, whether or not it results in harm, injury or death to a resident;
(b) a near miss event where an incident does not reach a resident but had it done so, harm, injury or death could have resulted.

A CIS report was submitted to the Director, related to a missing transdermal patch. The report indicated that on a particular date, a transdermal patch was applied to resident #004 and eight hours later, RPN #147 was not able to find the transdermal patch during a patch check. The incident was reported to the RN the next day, at 1730 hours.

Inspector #577 conducted a review of the medication incident report, which indicated that, on a particular date, RPN #147 had performed a transdermal patch check and could not find the patch on the resident or in the resident's room. The Inspector further noted an additional medication incident report, which indicated that the incorrect dosage had been administered to resident #004.

Inspector #577 reviewed the home's policy titled "Narcotic and Controlled Drug Control – LTC 5-30" last approved February 2017, which indicated that, if a discrepancy was identified, the nurse was to complete the following two procedures immediately:
- Report any discrepancy to the Charge RN/Manager
- Initiate an investigation and complete the LTC Narcotic and Controlled Drugs Count-Discrepancy Report Form and submit this to the Manager.

During an interview with RPN #151, they reported that they would conduct a search for a missing transdermal patch, notify the RN and Manager, notify the family and initiate a safety report. Additionally, if the incorrect dosage of a transdermal patch was administered, they would treat it as a medication error, report it to the RN, call the family and document a safety report.

During an interview with the DOC, they reported to Inspector #577 that the RN was not made aware of the missing transdermal patch until the following day and there were no records to indicate that a LTC Narcotic and Controlled Drugs Count-Discrepancy Report Form had been completed. [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 all required plans and policies, including the Medication Administration Program, are complied with with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that, every alleged, suspected or witnessed incident of abuse or neglect of a resident was immediately investigated and that the requirements provided for in the regulations for investigating and responding were complied with.

Section 104 (1) of the Ontario Regulation 79/10, indicates that in making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:

2. A description of the individuals involved in the incident, including,
   i. names of all residents involved in the incident,
   ii. names of any staff members or other persons who were present at or discovered the incident,
   iii. names of staff members who responded or are responding to the incident.
4. Analysis and follow-up action, including,
   i. the immediate actions that have been taken to prevent recurrence, and
   ii. the long-term actions planned to correct the situation and prevent recurrence.

A CIS report was submitted to the Director, which indicated that, on a particular date, resident #024 was left in bed until 1450 hours. According to the CIS report, the resident was not provided breakfast, lunch or snacks.

Inspector #543 reviewed resident #024's progress notes, which identified that RN #152 was notified at 1500 hours on a specific date, that resident #024 had been left in bed all day and had not been up for breakfast, snack or lunch. The progress note identified that RPN #124 had asked a PSW why the resident had been left in bed, to which the PSW indicated that the resident had been asleep all day and was left in bed. The progress note also indicated that RN #152 had notified the Leadership on Call about the incident at 1550 hours.

During an interview with Inspector #543, the Administrator and DOC both verified that there was no investigation conducted related to the alleged incident of neglect. The DOC also verified that the CIS report was not amended to include the resident's name or long term interventions to prevent recurrence. [s. 23. (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 alleged, suspected or witnessed incident of resident abuse or neglect is immediately investigated by the licensee, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
18. Special treatments and interventions. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that with respect to every resident's plan of care, the plan of care must be based on, at a minimum, interdisciplinary assessment of special treatments and interventions.

A CIS report was received by the Director, regarding an allegation of staff to resident neglect. The CIS report indicated that resident #015's SDM had expressed frustration on two specific dates, about coming into the home every day and finding resident #015 in visibly soiled clothing.

Inspector #621 reviewed resident #015's care plan, which indicated that resident #015 had a specific device in place and that staff were to provide specific care to resident #015.

Inspector #621 reviewed resident #015's chart since their admission. The Inspector was unable to identify, as part of the plan of care, a written order from the physician outlining care requirements related to resident #015's particular device.

During an interview with RPN #107, they reported to Inspector #621 that resident #015 had a specific device and that RPN staff were involved in monitoring the device and providing specific care to resident #015. However, RPN #107 was unsure about how often some of this care needed to be completed. RPN #107 reported that they tracked the care provided using a particular assessment tool; however, on review of the tool, RPN #107 found entries on only three particular dates. RPN #107 was unable to find subsequent entries after a certain date to indicate that the specified care had been provided to resident #015. On review of resident #015's health care record, RPN #107 was unable to locate a physician's order for the plan of care for this resident's particular device.

During an interview with Clinical Manager #101, they reported to Inspector #621 that it was the expectation that there be a record of the physician's involvement in the assessment of resident #015, including written orders to direct staff on this resident's care requirements. Clinical Manager #101 reviewed resident #015's documentation and confirmed that there was no current order from the physician regarding resident #015's specific device, and that there should have been. [s. 26. (3) 18.]

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 resident's plan of care is based on a interdisciplinary assessment of the factors outlined in the Ontario Regulation 79/10 including, but not limited to, special treatments and interventions, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee has failed to ensure that, procedures and interventions developed were implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

A CIS report was submitted to the Director regarding resident to resident abuse resulting in injury. The CIS report indicated that resident #007 was hit by resident #008 while they were participating in a program. The CIS report identified that resident #008 began exhibiting responsive behaviours and resident #007 grabbed resident #008's arm requesting them to stop. Resident #008 responded by hitting resident #007, which resulted in injury.

Inspector #617 reviewed progress notes from resident #008's electronic medical record from a particular date, which indicated that resident #007 was taken back to their unit and registered staff on that unit were made aware of the incident. However, PSW #120 documented that resident #008 remained in the program and continued to exhibit responsive behaviours.

In an interview with PSW #120, they reported to the Inspector that resident #008 remained in the program after the altercation had occurred. PSW #120 further confirmed to the Inspector that they did not notify the registered staff on resident #008's unit that resident #008 had been involved in an altercation with another resident which resulted in injury.

On a particular date, Inspector #617 observed resident #008 being provided with heightened monitoring by Recreation Therapists #122 and #123 in an activity room. The Inspector observed resident #008 become agitated and exhibit responsive behaviours. The Inspector observed RPN #124 provide medication to resident #008 in response to the resident’s behaviour.

A review of resident #008’s health care record indicated a physician’s order for a medication to be administered when required for agitation.

A review of the home's procedure titled “Hogarth Riverview Manor Day Program Criteria” last updated in August 2017, indicated that Registered Staff on the units were responsible for all medications being administered to the residents who were attending a program off of the unit.

In an interview with RPN #124, they confirmed to the Inspector that resident #008 had an order for a medication, to be administered as needed for agitation. RPN #124 further clarified that when the incident occurred, program staff did not notify them that resident #008 was agitated and involved in an altercation. RPN #124 stated that if they had known about the altercation, they would have administered a medication to resident #008 to help with their agitation and responsive behaviours.

In an interview with the DOC, they confirmed that Social Worker #143 was the manager of the day program and that they were aware of the recent changes to resident #008’s medication. The DOC further explained that the day program staff would also be aware of the changes and communicate the resident’s agitation to allow the registered staff to

assess the resident's need for medication. [s. 55. (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents, to be implemented voluntarily.

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. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident and the resident's substitute decision-maker, if any, were notified of the results of the investigation required under 23 (1) of the Act, immediately upon the completion of the investigation.

A CIS report was submitted to the Director, related to an allegation of staff to resident physical abuse. The CIS report indicated that resident #038 reported to Recreation Therapist #113 that PSW #144 had slapped resident #019 on the wrist. On a later date, resident #038 stated they had made an error and that it was not PSW #144 who had slapped resident #019, but rather PSW #138.

A review of the home's investigation file revealed that the DOC was notified of the alleged witnessed abuse and the investigation was completed.

A review of the home's policy titled, "Zero tolerance of abuse and neglect of residents - Reporting and notifications about incidents of abuse or neglect" last revised February 2016, identified that the substitute decision-maker (SDM), if any, or any other person specified by the resident be notified immediately upon completion of the investigation to share the results of the investigation.

A review of the amended CI report and progress notes on MED e-care did not reveal documentation that the resident's SDM had been informed of the investigation completion nor outcome.

During an interview with Interim Clinical Manager #103, they were unsure if the SDM had been notified of the outcome of the investigation and confirmed that there was no documentation on the amended CI report to indicate that the results of the investigation had been shared with the SDM. [s. 97. (2)]

2. A CIS report was submitted to the Director that identified an allegation of staff neglect towards resident #020. The CIS report revealed that when waking the resident after breakfast, their bedding was soiled, suggesting the previous shift had failed to perform required care.

A review of the home's investigation file revealed that the home completed their investigation and determined that the allegation of neglect was unfounded.

A review of the amended CIS report and progress notes on MED e-care did not reveal documentation that the resident's SDM had been informed of the investigation completion nor outcome.

During an interview with Clinical Manager #102, they confirmed that they had not informed resident #020's SDM of the completion of the investigation nor shared the results of the investigation, as they were unaware this was required. [s. 97. (2)]

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 resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to, were kept closed and locked.

On January 22, 2018, at 0900 hours, Inspector #577 and #617 entered the home and observed the link door under repair by the electrician and two men from a Lock and Key company.

A review of the home's current Extendicare policy titled, "Safe and Secure Home" dated November 21, 2017, indicated that all doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

On January 22, 2018, at 0950hrs, the Inspector observed the link door propped open with a yellow 'Wet floor' sign and the doorway was not being monitored by any staff member. As Inspector #577 walked through link door, the Administrator was walking down hallway and observed the link door being propped open with a sign and told the Inspector that a registered nurse had just placed the sign there. They further indicated that the door was now fixed and a staff member should not have left the link door open and unlocked, and they removed the sign. [s. 9. (1)]

WN #8: 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 the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

A CIS report was submitted to the Director related to an allegation of physical abuse against resident #017 by PSW #145.

A review of the home's investigation file indicated that PSW #145 aggressively threw an object at resident #017, which struck resident #017 and caused injury.

Inspector #621 reviewed the home's policy titled "Zero Tolerance of Abuse and Neglect of Residents – LTC 5-50", last revised February 2016, which identified that residents living in the home had the right to be free from mental and physical abuse.

During an interview with Inspector #621, the DOC reported that during the home's investigation it was determined that the actions of PSW #145 towards resident #017 constituted physical abuse. Consequently, the home was not in compliance with their written policy on zero tolerance of abuse and neglect of residents. [s. 20. (1)]

2. A CIS report was submitted to the Director related to an incident of alleged physical abuse that caused injury to resident #014.

A review of the home's investigation notes indicated that resident #014 stated that, on a particular bath day, a PSW grabbed their arm and squeezed. It was reported that the resident then yelled, and the PSW responded by squeezing harder. The home identified that the PSW who provided resident #014 with their bath on that particular date was PSW #146.

During an interview with Inspector #621, RPN #117 reported that, on that particular date, they observed resident #014 come out of the spa room with PSW #146. RPN #117 stated that they observed that resident #014 had an injury. RPN #117 reported that the following day, resident #014's family member told them that resident #014 disclosed that during their bath on the previous day, the PSW was rough with their care and that was how the resident developed the injury.

During an interview with Inspector #621, Clinical Manager #104 reported that the results of the home's investigation determined that the actions of PSW #146 towards resident #014 constituted physical abuse. Consequently, the home was not in compliance with their written policy on zero tolerance of abuse and neglect of residents. [s. 20. (1)]

3. A CIS report was submitted to the Director, related to an allegation of staff to resident physical abuse. The CIS report indicated that a PSW allegedly grabbed the wrist of

resident #026 and caused injury to resident #026.

Inspector #543 reviewed the home's "Zero Tolerance of Abuse and Neglect of Residents - Reporting and notification about incidents of abuse or neglect" (LTC 5-51), revised February 2016. The policy indicated that all employees and affiliated personnel were required to fulfill their moral and/or legal obligation to report any incident or alleged incident of resident abuse immediately. The policy identified that the Director/designate and /or VP Seniors' Health must be notified immediately and they will notify the Ministry by phone. The policy described that the registered nurse would conduct a head to toe physical assessment on the alleged victim and document findings, and communicate the status of the resident's health condition.

Inspector #543 reviewed resident #026's progress notes and identified there was no documentation related to the injury.

The Inspector reviewed the home's investigation notes, which included an email that indicated that RN #128 and RPN #129 had not assessed or documented anything related to the resident's injury. The email indicated that documentation and reporting requirements would be reviewed with both of the employees.

Inspector #543 interviewed the DOC regarding the incident that occurred. The DOC verified that RN #128 and RPN #129 had not followed the home's "Zero Tolerance of Abuse and Neglect of Residents - Reporting and notification about incidents of abuse or neglect", with respect to reporting the incident, assessing the resident, and documenting the incident. [s. 20. (1)]

4. A CIS report was submitted to the Director related to an allegation of staff to resident physical abuse. The CIS report revealed that the alleged incident occurred on a specified date, when resident #038 reported to Recreation Therapist #113 that PSW #144 had slapped resident #019 on the wrist. On a later date, resident #038 stated they had made an error and that it was not PSW #144 who had slapped resident #019, but rather PSW #138.

During an interview with Recreation Therapist #113, they stated they reported the alleged physical abuse to RPN #114 as soon as it was reported to them by resident #038, but had not reported the occurrence to a manager/supervisor.

During an interview with RPN #114, they stated they were not made aware of the

incident on the date it occurred. RPN #114 stated that they only became aware of the incident when they were questioned by Interim Clinical Manger #103 and a previous Administrator at a later date.

During an interview with Interim Clinical Manager #103, they verified that staff had not reported the alleged abuse on the date it had occurred, rather Recreation Therapist #113 had informed the Interim Clinical Manger on a later date. Interim Clinical Manager #103 confirmed that staff had not followed the home’s abuse policy for immediately reporting to their manager/designate.

A Compliance Order (CO) was issued to the licensee on November 23, 2017, to address failure to comply with s. 19 (1) of the LTCHA, 2007 during CIS Inspection #2017_509617_0017. The CO required the licensee to review and revise the home's written policy to promote zero tolerance of abuse and neglect to ensure that it complied with with requirements of the LTCHA and O. Reg 79/10, and to ensure that this policy is complied with. The compliance due date of this CO was December 31, 2017. [s. 20. (1)]

WN #9: 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):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
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).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident 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: missing or unaccounted for controlled substance.

A CIS report was submitted to the Director, related to a missing transdermal patch. The CIS report indicated that on a particular date, a transdermal patch was applied to resident #004 and, during a patch check eight hours later, the patch was discovered to be missing. The RN was not made aware of the incident until the next day at 1730 hours.

During an interview with Inspector #577, the DOC stated that they thought that the CIS report was submitted to the Director on a particular date, but that the report had actually been 'saved' within the system, instead of it being submitted. The DOC further confirmed that the incident was not reported within one business day, as was required. [s. 107. (3)]

WN #10: 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 documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and 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.

Ontario Regulation 79/10 describes a medication incident as a preventable event associated with the prescribing, ordering, dispensing, storing, labeling, administering or distributing of a drug, or the transcribing of a prescription, and includes:

(a) an act of omission or commission, whether or not it results in harm, injury or death to a resident;
(b) a near miss event where an incident does not reach a resident but had it done so, harm, injury or death could have resulted.

A CIS report was submitted to the Director, related to a missing transdermal patch. The CIS report indicated that on a particular date, a transdermal patch was applied to resident #004 and, during a patch check eight hours later, the patch was discovered to

be missing. The RN was not made aware of the incident until the next day at 1730 hours.

Inspector #577 conducted a review of the medication incident report, which indicated that on a particular date, RPN #147 had performed a transdermal patch check and could not find the patch on the resident or in the resident's room. The Inspector further noted an additional incident report, which indicated that the incorrect medication dosage was administered to resident #004.

Additionally, the resident, the resident's SDM, the physician and the pharmacy service provider were not notified of the incident. Immediate actions taken to assess and maintain the residents' health were also not documented on the incident report or in the nursing notes.

Inspector #577 reviewed Janzen’s pharmacy policy titled "Administration of Medications" last revised January 2017, which indicated that medication administration errors were to be reported to the resident’s physician, RN, family, pharmacy provider and the Administrator.

During an interview with the DOC, they confirmed that the resident, the resident's SDM, the physician, the Medical Director and the pharmacy service provider had not been notified of two of the incidents, and immediate actions had not been documented for the incidents. [s. 135. (1)]

Issued on this 23rd day of February, 2018

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

Original report signed by the inspector.