Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St 4th Floor
OTTAWA ON L1K 0E1
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston 4iém étage
OTTAWA ON L1K 0E1
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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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
Dec 12, 2014	2014_270531_0029	O-001138-14	Resident Quality Inspection

Licensee/Titulaire de permis

OMNI HEALTH CARE LIMITED PARTNERSHIP
1840 LANSDOWNE STREET WEST UNIT 12 PETERBOROUGH ON K9K 2M9

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

KENTWOOD PARK
2 ONTARIO STREET PICTON ON K0K 2T0

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

SUSAN DONNAN (531), BARBARA ROBINSON (572), KARYN WOOD (601), PAUL MILLER (143), SAMI JAROUR (570), WENDY BROWN (602)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): December 4,5,8, and 9, 2014

Log # O-001270-14 is included in this inspection.

During the course of the inspection, the inspector(s) spoke with Residents, residents family members, Personal Support Workers, Registered Practical Nurses, Registered Nurses, the Nutritional Care Manager, the Life Enrichment Coordinator, the Director of Care and the Administrator.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Family Council
Hospitalization and Change in Condition
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
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
7 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. 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).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home’s written policy "Zero Tolerance of Abuse and Neglect of Residents" (Policy #AM-6.9) is complied with.

On a specified date a Critical Incident (CI) (Log#O-001270-14) was submitted to the Ministry of Health and Long-Term Care by the home to report an incident of staff to resident abuse.

The Critical Incident (CI) report submitted described the incident as follows:
On a specified date PSW S110 and S111 heard S112 yelling at Resident#11 who came back into the dining room to "Get out of here, I'm sick of it go,go." Then while attempting to lower the foot rest of Resident #28's wheelchair, S112 was heard yelling at Resident

#28, "pick your feet up" several times. S110 and S111 then witnessed S112 roughly grab and lift Resident #28's legs into the air and place a pillow under them while Resident #28 was crying "stop you are hurting me" S112 then pointed his/her finger in Resident #28's face and yelled, "Now stay there."
S110 and S111 reported the incident to S113(RN) in charge of the building.

On December 8, 2014 review of OMNI Healthcare "Zero Tolerance of Abuse and Neglect of Residents" (Policy #AM-6.9) page 3-#4 states
"every incident of alleged suspected or witnessed neglect or abuse shall be immediately reported to OMNI Home Office and the Ministry of Health and Long-Term Care by the home upon learning of such an incident.

On December 8, 2014 during an interview with the Administrator and review of the Critical Incident confirmed that the incident was not immediately submitted to the Director. The Administrator confirmed that she was notified of the incident on a specified date by S113(RN) who left a written note under her door. The Administrator confirmed the incident was not immediately reported to OMNI Home Office and the Ministry of Health and Long-Term Director in accordance to the home's policy. [s. 20. (1)]

2. The licensee has failed to comply with the LTCH Act 2007, c. 8, s.20 (2) whereby the home's " Zero Tolerance of Abuse and Neglect of Residents" policy #AM-6.9 does not include an explanation of the duty under section 24 of the Act to make mandatory reports.

On an identified date a Critical Incident Report (Log#O-001270-14) was submitted to the Ministry of Health and Long-Term Care by the home to report an incident of staff to resident abuse.

On a December 9, 2014 the OMNI Health Care "Zero Tolerance of Abuse and Neglect of Residents" (Policy #AM-6.9) was reviewed and confirmed that it did not contain an explanation of the duty under section 24 of the Long Term Care Homes Act to make mandatory reports to the Director.

On December 9, 2014 the Administrator confirmed that the OMNI Health Care "Zero Tolerance of Abuse and Neglect of Residents" did not include an explanation of the duty under section 24 of the Long Term Care Homes Act to make mandatory reports to the Director. [s. 20. (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 all employees comply with the home's written policy to promote zero tolerance of abuse and neglect of residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance
Every licensee of a long-term care home shall ensure that the licensee’s written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;
(c) identifies measures and strategies to prevent abuse and neglect;
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents identifies the training and retraining requirements for all staff including:
i. training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
ii. situations that may lead to abuse and neglect and how to avoid such situations.

On a specified date a Critical Incident Report (Log#O-001270-14) was submitted to the Ministry of Health and Long-Term Care by the home to report an incident of staff to resident abuse.

The Critical Incident (CI) report submitted described the incident as follows:
On a identified date PSW S110 and S111 heard S112 yelling at Resident#11 who came back into the dining room to "Get out of here, I'm sick of it go,go." Then while attempting to lower the foot rest of Resident #28's wheelchair, S112 was heard yelling at him/her, "pick your feet up" several times. S110 and S111 then witnessed S112 roughly grab and lift Resident #28's legs into the air and place a pillow under them while Resident #28 was crying "stop you are hurting me" S112 then pointed her finger in Resident #28's face and yelled, "Now stay there."

On a December 9, 2014 review of OMNI Healthcare "Zero Tolerance of Abuse and Neglect of Residents" (Policy #AM-6.9) and the home's Training Manual (Human Resources Manual - Respect Always)confirm that the written policy did not contain or make any reference to training and retraining requirements for all staff that include:
i. power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
ii. situations that may lead to abuse and neglect and how to avoid such situations.

On a December 9, 2014 during an interview with the Administrator confirmed that the OMNI Health Care "Zero Tolerance of Abuse and Neglect of Residents" (Policy AM-6.9) did not include power imbalances between residents and staff, and situations that may lead to abuse and neglect and how to avoid such situations. [s. 96. (e)]

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 written policy to promote zero tolerance of abuse and neglect of residents identifies the training and retraining requirements include training on the relationship between power imbalances between staff and residents and situations that may lead to abuse and neglect and how to avoid such situations, to be implemented voluntarily.

WN #3: 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 comply with O. Reg. 79/10, s.8(1)(b) in that the medication management system policies and procedures, as required under O. Reg. 79/10, s.136(1) were not complied with.
O. Reg. 79/10, s.136(1)states that every licensee of a long-term care home shall ensure, as part of the medication management system, that a written policy is developed in the homes provides ongoing identification, destruction and disposal of,
a) all expired drugs

On December 9, 2014 observation of the homes drug storage for the medication cart and the drug stock cupboard in the Dispensary room confirmed the following medications as being expired:
- three sealed packages of expired Dimenhydrinate 50mg suppositories

- one bottle of expired Mylan Nitro
- two sealed bottles of expired Allenix was located in the stock cupboard, and one open bottle of expired Allernix was located in the medication cart.

On a December 8, 2014 review of the Pharmacy Policy and Procedures Manual Section 5 Handling of Medication Policy #5-4 "Drug Destruction and Disposal" states:
Procedure for Non-Monitored Medications (Non-Controlled Medication)
1.Nurse to identify on an ongoing basis (suggest weekly), any medication for disposal by:
a)completing scheduled checks for expired goods.

On December 8, 2014 S#106(RPN) was interviewed and confirmed that the night nurse was responsible to check the stock cupboards including drug storage in the medication cart on a weekly basis for expired medication. S#106 removed the expired drugs from the storage areas.

On December 9, 2014 S#109 (RN) who works the night shift confirmed the home has a form for weekly night duties and that every Thursday night the medication cart and the stock cupboard were checked for expired medication.
S#109 confirmed that the duties were not always completed as scheduled if the shift was busy.
On December 9, 2014 review of the homes 11-7 Night Duties form for an identified date confirm the task to check stock drugs for expiration date and make note of what needs re-ordering was not signed as completed.

On December 9, 2014 the Director of Care was interviewed and confirmed that the night nurse have a weekly routine to check medication storage areas and the homes expectation is to have weekly checks for expired medication. [s. 8. (1) (a)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10 s. 23 whereby the manufacture's instructions were not followed for resident bed system.

On December 5, 2014 observed Resident #2 had a Joerns Care 100 bed frame with mattress keepers.

The User-Service Manual for the Joerns Care 100 bed frame states the following under Important Precautions:
Warning: Possible Injury or Death. Use a mattress that is properly sized to fit mattress support platform, which will remain centered on mattress support platform relative to state and Federal guidelines. Length should match the mattress support platform. Use of an improperly fitted mattress could result in injury or death.

Resident #2's bed was observed with an eight inch gap between the mattress and top of the bed. The mattress was observed as 2 inches wider than the mattress keepers on the mattress support platform preventing the mattress to remain centered.

On December 5, 2014 the Administrator was interviewed and confirmed that the mattress did not match the mattress support system. The mattress was replaced by one that matched the mattress support platform. [s. 23.]

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 Ministry of Health and Long-Term Care was immediately notified of a staff to resident abuse.

On a specified date a Critical Incident Report (Log#O-001270-14) was submitted to the Ministry of Health and Long-Term Care by the home to report an incident of staff to resident abuse.

The Critical Incident (CI) report submitted described the incident as follows:
On a specified date PSW S110 and S111 heard S112 yelling at Resident#11 who came back into the dining room to "Get out of here, I'm sick of it go,go." Then while attempting to lower the foot rest of Resident #28's wheelchair, S112 was heard yelling at him/her, "pick your feet up" several times. S110 and S111 then witnessed S112 roughly grab and lift Resident #28's legs into the air and place a pillow under them while Resident #28 was crying "stop you are hurting me" S112 then pointed his/her finger in Resident #28's face and yelled, "Now stay there."
S110 and S111 reported the incident to S113(RN)who was in charge.

Review of the CI and the licensee's investigation into the incident indicate the alleged staff to resident abuse.

On December 8, 2014 the Administrator was interviewed and confirmed that she was notified of the incident by RN S#113 (RN) who left a written note under door. The Administrator confirmed the incident was not immediately reported to the Director. [s. 24. (1)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 101 (2) whereby a documented record was not kept in the home for each verbal or written complaint.

During the course of the inspection Resident # 17 and 34 indicated that they had reported to staff that they had some money go missing.

On December 9, 2014 Policy # AM-6.1 Complaints Procedure was reviewed and states: " the purpose of the procedure is to ensure each verbal or written complaint concerning the care of a resident or the operation of the home is appropriately investigated and responded to within the require time lines."

Review of the " concern/complaint reports" confirmed that neither Resident #17 or #34 verbal complaints were documented on the "Concerns/Complaint" report document.

On December 9, 2014 S104 and S109 were interviewed and confirmed that they were not aware of a concern/complaint report policy.
S104 and S109 confirmed that they document the missing money in the progress note and advise the charge nurse on the next shift.

On December 9, 2014 review of documented concerns and complaints report confirmed that the reports were not documented as per policy.

On December 9, 2014 during an interview with the Administrator confirmed that the concern/complaint report was not completed for the missing monies. [s. 101. (2)]

WN #7: 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. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

s. 131. (7) The licensee shall ensure that no resident who is permitted to administer a drug to himself or herself under subsection (5) keeps the drug on his or her person or in his or her room except,
(a) as authorized by a physician, registered nurse in the extended class or other prescriber who attends the resident; and O. Reg. 79/10, s. 131 (7).
(b) in accordance with any conditions that are imposed by the physician, the registered nurse in the extended class or other prescriber. O. Reg. 79/10, s. 131 (7).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 131(5) that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident.

On December 8, 2014 during an interview with S#106 (RPN) and observation of the medication management system confirmed that Resident #21 self-administers a prescribed treatment cream without a Physician's order.

On December 8, 2014 during an interview with the Director of Care and S#106(RPN) confirm that the home does have a self-administering policy and that there was no physician authorization in consultation with Resident #21 for self administration of the prescribed treatment ointment.

Review of the homes Policy 5-5 Self Administration of Medication states: Self-Administration of medication by a resident is permitted when specifically ordered by the physician who, with input from the nursing team, determines that the resident is capable of self-administering his/her own medications. These medications are stored in a secure area, inaccessible to other residents. [s. 131. (5)]

Issued on this 5th day of January, 2015

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

Original report signed by the inspector.