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
Aug 1, 2018	2018_758613_0015	016320-18	Resident Quality Inspection

Licensee/Titulaire de permis

584482 Ontario Inc.
c/o Jarlette Health Services 5 Beck Boulevard PENETANGUISHENE ON L9M 1C1

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

Manitoulin Lodge
3 Main Street P.O. Box 648 GORE BAY ON P0P 1H0

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

LISA MOORE (613), SYLVIE BYRNES (627)

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): July 23-27, 2018.

The following intakes were were inspected during this Resident Quality Inspection:

Five Critical Incident (CI) reports the home submitted to the Director regarding resident to resident abuse;

One CI report the home submitted to the Director regarding a fall resulting in an injury.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (ADM/DOC), Co-Director of Care (CO-DOC), Life Enrichment Coordinator, Registered Dietitian (RD), 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, the home's internal investigation files and resident council meeting minutes.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours

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

5 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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that 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, immediately reported the suspicion and the information upon which it was based to the Director.

Ontario Regulations (O. Reg) 79/10 defines sexual abuse as (a) any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member, or (b) any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

During a family interview, resident #013's family member brought forth concerns to Inspector #627, regarding the resident not being safe in the home due to potential abuse from another resident. The family member stated that monitoring of resident #013 had been initiated; however, they felt that it may not have been maintained by staff.

A review of resident #013's progress notes identified multiple entries of interactions between resident #013 and resident #016. A progress note dated October 2017,

described that resident #013 was found in an area of the home with resident #016. Resident #013 was brought to their room, where it was noted that resident #013 appeared upset and refused to have their clothes removed. A later progress note, on the same date, indicated that the registered staff had been made aware that an article of resident #013's clothing was on backwards when found in an area of the home with resident #016. In two subsequent notes, it was indicated that the Co-Director of Care (CO-DOC) and the previous Director Of Care (DOC), who was no longer an employee, had been made aware of the incident and that monitoring of resident #013 had been initiated to ensure their safety and whereabouts.

A progress note dated November 2017, indicated that resident #016 was observed, making physical contact with resident #013's and was stopped and redirected by staff. A subsequent progress note indicated that management was contacted regarding the physical contact that was made between the two residents. It was documented that management had replied that resident #013 was not negatively affected; therefore, it was consensual. A progress note dated November 2017, indicated that a PSW had reported to a RN that resident #016 was making physical contact with resident #013, and that resident #013 was verbally refusing the physical contact.

Inspector #627 searched the Ontario Long Term Care Home online reporting site and could not locate a critical incident report submitted by the home for the aforementioned incidents. An anonymous complaint was submitted to the Director alleging abuse to resident #013 from resident #014.

A review of the home's policy titled "Resident Rights, Care and Services- Abuse-Zero Tolerance for Resident Abuse and Neglect," last revised June 2, 2017, indicated that upon being notified of abuse or neglect of a resident, the Administrator or Director of Care would follow the investigation procedures using the Resident rights, care and services, administration investigation checklist.

During an interview with the CO-DOC, they acknowledged that the incident which occurred in October 2017, was reported to them. They stated that since the resident had not verbally responded, they had assumed that it was consensual. The CO-DOC stated that interventions had been put in place after the interaction to protect resident #013 from resident #016. The CO-DOC further acknowledged that "looking at it now and the progression, it, should have been reported to the Director; however, when management had looked at it, one by one, it was decided that it would be handled internally."

During an interview with the ADM/DOC, they stated that they were aware of the aforementioned incidents. For two of the incidents, it was felt that since resident #013 had not verbally responded, the interactions had been consensual. The incident whereby resident #013 was verbally refusing the physical contact from resident #016, was impossible to substantiate that the physical contact had been abuse. For those reasons, the incidents had not been reported 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 a 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 results in harm or a risk of harm, immediately reports the suspicion and the information upon which it is based to the Director., to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident, 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.

Inspector #627 reviewed a medication incident form, dated for a specific date in March 2018, regarding a medication dose omission. The medication incident form indicated that resident #014 was to receive a medication tablet at a specific time and the tablet was found in the medication cup the following morning. The form had not indicated that the resident's substitute decision-maker, (SDM) had been called and informed of the medication incident.

A review of resident #014's electronic progress notes did not identify any documentation that the resident's SDM had been made aware of the medication incident.

A review of the home's policy titled "Medication Management System, Medication Incident," last revised July 20, 2017, indicated that upon identification of a medication error, the individual identifying the error was to notify the resident's SDM of the medication incident.

During an interview with RN #103, they stated that the incident had been discussed with them. They stated that the nurse discovering the incident would have been responsible to call the substitute decision maker and inform them of the medication incident.

During an interview with RN #102, they stated that they had discovered the medication error at the beginning of their shift and had completed the medication incident form. The RN indicated that they would have been the one responsible for calling the SDM and would have documented the call on the form and in the progress notes under the focus of family interaction. They further stated that they may not have called as no harm had come to the resident.

During an interview with the Administrator/DOC (ADM/DOC), they stated that the SDM was to be called for every medication incident and documented on the medication incident form and in the progress notes. [s. 135. (1)]

2. The licensee has failed to ensure that all medication incidents were documented, reviewed and analyzed, corrective action was taken as necessary and a written record was kept of everything required under clauses (a) and (b).

Inspector #627 reviewed a medication incident form, dated for a specific date in March 2018, regarding a medication dose omission. The incident report indicated that resident #015 had not received their scheduled medication at a specific time. The medication incident report had no documentation in regards to the actions taken, comments, recommendation and improvement strategy.

A review of the home's policy titled "Medication Management, Medication Incident," last revised July 20, 2017, indicated that upon identification of a medication error, the individual identifying the error was to initiate and complete the internal medication incident report and to document in the progress notes the status of the resident, actions taken and further follow up action to be taken.

During an interview with RN #101, who was the RN on duty for the date in March 2018, and would have been responsible for giving the medications to the resident, they stated

that they did not recall the incident and stated that it was not discussed with them.

During an interview with the ADM/DOC, they stated that the previous DOC had failed to follow up with medication incidents numerous times and that they were no longer employed in the home. The DOC acknowledged that the medication incident should have been discussed with the RN to identify the cause of the error, and that the findings should have been documented on the medication incident report. [s. 135. (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 (a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed, (b) corrective action is taken as necessary, and (c) a written record was kept of everything required under clauses (a) and (b)., 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 of a resident by anyone reported to the licensee was immediately investigated.

During a family interview, resident #013 reported allegations of abuse from another resident in the home to resident #013. An anonymous complaint was also submitted to the Director alleging abuse to resident #013 from resident #014. Please see WN #1 for further specific details.

During an interview with the CO-DOC, they acknowledged that the incident which occurred in October 2017, was reported to them. The CO-DOC stated that they had spoken to the RN regarding the incident; however, they could not recall if they had interviewed any of the PSW's who had reported the incident. The CO-DOC stated that they had no written documents and all of the interactions with staff had been verbal.

During an interview with the ADM/DOC, they stated that they were aware of the aforementioned incidents and that it was felt that since resident #013 had not verbally responded to the physical contact that the interactions had been consensual and therefore, no further investigations had been completed. [s. 23. (1) (a)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee has failed to document and make available to the Residents' Council the results of the satisfaction survey in order to seek the advice of the Council about the survey.

Inspector #613 interviewed the President of the Residents' Council, who stated they had not been provided with the results of the satisfaction survey. They stated they did not remember hearing about the satisfaction survey results at a meeting.

A review of the Residents' Council meeting minutes from January to June 2018, did not identify that the results of the satisfaction survey were made available to the Residents' Council in order to seek the advise of the Council about the satisfaction survey.

During an interview with the Administrator/Director of Care, they provided the Inspector with the "Abaqis Resident Satisfaction Customer Satisfaction Report," which did not identify it had been provided to the Residents' Council. The ADM/DOC stated they were not aware that they were required to review the results with the Residents' Council and confirmed that the results were not reviewed with the Residents' Council. [s. 85. (4) (a)]

WN #5: 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. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

Inspector #627 reviewed a medication incident form, dated for a specific date in March 2018, which indicated that resident #014 was to receive a scheduled medication at a specific time. A day later, the medication tablet was found at the bedside in a medication cup.

A review of the home's policy titled "Medication Management System-Administration of Medications," last revised July 20, 2017, indicated that at the time of the administration, the Registrant was to remain in attendance until the mediation was taken.

During an interview with RN #103, they acknowledged that they had given the resident their scheduled medication at a specific time and that they had left resident #014's medication at the bedside. The RN stated that they had forgotten on that specific date to return to the resident and ensure they had taken their medication.

During an interview with the ADM/DOC, they acknowledged that RN #103 should have remained with the resident to ensure that all their medication was taken. [s. 131. (2)]

Issued on this 2nd day of August, 2018

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

Original report signed by the inspector.