Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 7, 2016	2016_280541_0016	015241-16/015442-16/015319-16/001851-16/012902-16/006916-16	Critical Incident System

Licensee/Titulaire de permis

COUNTY OF PRINCE EDWARD
603 Highway 49 R R 2 PICTON ON K0K 2T0

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

H.J. MCFARLAND MEMORIAL HOME
R.R. #2, 603 HIGHWAY 49 HALLOWELL TOWNSHIP PICTON ON K0K 2T0

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

AMBER MOASE (541)

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): June 17, 21-22, 24, 27-30, 2016

Six critical incidents logs were inspected during this inspection:
- Two unexpected deaths
- A written complaint regarding the administration of the Resident Satisfaction Survey
- Two incidents of alleged resident to resident physical abuse
- A fall that caused injury to a resident for which the resident was taken to hospital and resulted in a significant change in the resident's health status

During the course of the inspection, the inspector(s) spoke with the Administrator, the acting Director of Care (DOC), the Resident Services Manager, Registered Nurses, Registered Practical Nurses, a Programming staff member, Personal Support Workers and residents. In addition the inspector reviewed resident health care records and reviewed relevant polices.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Family Council
Hospitalization and Change in Condition
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
4 WN(s)
3 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care provided to the resident as specified in the plan.

Resident #010 was admitted to the home on a specified date and at that time was noted to have a history of falls. Resident #010's current plan of care identifies the resident as a high risk of falls due to multiple health conditions.

As of a specified date, resident #010's plan of care lists three specific interventions for fall prevention.

On a specified date resident #010 fell in his/her room in the middle of the night, sustained an injury and was sent to hospital. Following the fall on a specified date, another specified fall intervention was implemented to resident #010's plan of care.

Resident #010 sustained another fall on approximately two weeks later when the resident was witnessed coming out of the washroom by the kitchen without a walker or wheelchair. The resident lost his/her balance and fell; resident #010 did not sustain an injury.

Following the fall on the specified date, resident's plan of care was updated to include another specified fall intervention.

Approximately three weeks later resident #010 fell at 0016 hours in his/her bathroom. The fall was unwitnessed and the post-fall assessment indicates RPN staff became aware of the fall when notified by a co-resident.

PSW #105 was working on the specified date when resident #010 fell and when interviewed PSW #015 informed inspector that he/she responded to the fall. Upon entering resident #010's room, PSW #015 states the specified fall intervention was not in place. PSW #105 did state that the resident instead had another intervention in place that the resident had removed him/herself and therefore staff were not notified of the resident getting out of bed. PSW #105 could not recall if the specified fall intervention was supposed to be in place at that time.

Resident #010's plan of care effective on a specified date when the falls occurred, lists four specified interventions for fall prevention.

Resident #010 did not receive the care as specified in the resident's plan of care as the specified fall intervention was not in place when the resident fell on a specified date. [s. 6. (7)]

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 resident #010's fall prevention interventions are implemented as specified in the resident's plan of care, 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 that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director?
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

On a specified date, a critical incident was submitted notifying the Director that resident #007 slapped resident #008 causing an injury.

Upon review of resident #007's progress notes it was noted that again approximately a month later on a specified date, resident #007 struck out and this time hit resident #009 who sustained an injury as a result of the altercation.

As per O.Reg 79/10 s. 2(c) Physical abuse is defined as the use of physical force by a resident that causes physical injury to another resident.

Inspector #541 confirmed with the Critical Incident Reporting (CIR) system that as of a specified date, the Director was not notified of the resident to resident physical abuse that occurred eighteen days earlier.

RN #108 was the registered staff member who responded to the incident on the specified date. Inspector #541 interviewed RN #108 who stated that the home's process is for the Director of Care or the Administrator to complete the CIR, this is not a responsibility of the Registered Nurses. RN #108 further stated that he/she perhaps should have called the after-hours number.

The progress note entered on the specified date of the incident indicates the home's Administrator was notified of the incident. Inspector was unable to interview the Administrator as she is no longer an employee of the home.

During an interview with Inspector #541, the acting DOC indicated her expectation would be that registered staff notifies the Director via the after-hours number if an incident occurs in the evening or weekend. She further stated that herself or the Administrator would then complete the CIR form the following day.

Inspector #541 requested the home's policy for prevention of abuse, neglect and retaliation and was provided with policy #VII-G-10.00 titled "Prevention of Abuse & Neglect of a Resident".

Page 2 of the policy states the following:

The Charge Nurse will:
2. Provide support to the staff member reporting in immediately reporting any of the following to the MOHLTC (with ED/Administrator or designate, if available). Monday to Friday from 8am to 5 pm the staff member will take the action to immediately notify the MOHTLC by initiating the online Mandatory Critical Incident System form using the mandatory report section. If outside of normal business hours, call the MOHLTC toll-free

Action Line :
a. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

The licensee has failed to notify the Director on a specified date when resident #007 struck out and hit resident #009 causing injury to resident #009. [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 the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that strategies that were developed to manage resident #003's responsive behaviors were implemented.

A critical incident was submitted on a specified date for resident to resident physical

abuse. Resident #003 hit resident #004 multiple times. Resident #004 sustained an injury and was sent to the hospital for assessment.

The progress notes for resident #003 were reviewed and the following was noted:

- On a specified date resident #003 was found in a room with resident #006 who was lying on the floor. Resident #003 was hitting resident #006 multiple times by swinging the door back and forth. Resident #006 sustained injuries.

- On a specified date resident #003 physically abused resident #005. Resident #005 was found on the floor in a bathroom and resident #003 was kicking him/her. Resident #005 was assessed and did not sustain any injuries however was provided with an analgesic as needed as a precaution for pain.

Following the incidents on the three specified dates, the home contacted the Mobile Response Team (MRT) who immediately came into the home to assess resident #003.

On three separate specified dates over a five month period, MRT noted the same behaviors by resident #003 and suggested trialing the same specified interventions to manage resident #003's behaviors.

It is noted at the time of inspection, resident #003 was not in the home therefore no observations could be made.

During the inspection, this inspector interviewed PSW #100 who is full time on the unit where resident #003 resides. PSW #100 described resident #003's behaviors as unpredictable and confirmed the behaviors as noted by MRT. PSW #100 stated that the staff kept a close eye on the resident and would remove the resident from other residents if the resident became agitated. PSW #100 states the specified intervention recommended by MRT was not implemented.

PSW #102 works on an identified shift on the unit where resident #003 resides. PSW #102 confirmed that a trigger for resident #003's responsive behaviors is as noted by MRT . PSW #102 also stated the specified interventions suggested by MRT were not implemented.

RPN #101 was interviewed described resident #003 as generally keeping to him/herself however also confirmed the triggers for the resident's behavior as noted by MRT. RPN

#101 did list multiple interventions that had been trialed to manager resident #003's behaviors but did not they are not always effective. When asked if the specified intervention recommended by MRT was ever trialed for resident #003, RPN #101 confirmed it had not.

RN #103 was identified as the registered staff member who recently became the home's champion for responsive behaviors. RN #103 was interviewed by Inspector #541. When asked how the recommendations from MRT become implemented at the home, RN #103 states that once per week there would be a meeting with the staff member from MRT, the home's previous DOC, a Registered Nurse and the recommendations from MRT would be reviewed. RN #103 further stated that the home did not have a process to implement the interventions and once the meeting was over, no further action was taken. RN #103 states the home has since developed a better process.

The licensee failed to implement interventions to manage resident #003's physical responsive behaviors following three separate incidents where the resident physically abused residents #004, #005 and #006. [s. 53. (4) (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 any strategies developed to manage resident #003's responsive behaviors are implemented, to be implemented voluntarily.

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. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the advice of the Family Council is sought in developing and carrying out the satisfaction survey, and in acting on its results?

On a specified date, the home received a written complaint on behalf of the family council regarding the execution of the resident satisfaction survey in 2015.

The complaint letter indicates the survey was not reviewed by the family council and that no families were asked to complete the survey on behalf of residents who were unable to complete it.

On a specified date, a Family Council meeting was held and the minutes for this meeting were reviewed by Inspector #541. The minutes confirm that the satisfaction survey was completed December, 2015 with the help of kitchen staff who helped the residents complete the survey; the minutes further state 37 completed surveys were returned. The council asked why the Family Council was not invited to participate in the development of the satisfaction survey. The Administrator at the time informed the council that it was not a legislated requirement to involve Family Council and that the home is not required to consult with the Family Council in development of the satisfaction survey.

The home's Resident Services Manager confirmed with this inspector during the inspection, that the family council's advice had not been sought in the development of the resident satisfaction survey distributed in 2015.

It is noted the home was issued a written notification (WN) for LTCHA 2007 s. 85(3) during the RQI in October 2015. During an interview with the home's Resident Services Manager on a specified date, she confirmed that the satisfaction survey for 2015 was provided December, 2015.

It is noted, the home has since developed a working committee to seek out the advice of the family council in the development of the survey for 2016. [s. 85. (3)]

Issued on this 8th day of July, 2016

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

Original report signed by the inspector.