Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 21, 2019	2019_664602_0043	015491-19, 016327-19, 016418-19, 016853-19, 016988-19, 017082-19, 017455-19, 017613-19, 018438-19, 019773-19	Critical Incident System

Licensee/Titulaire de permis

County of Prince Edward
603 Highway 49 R.R. #2, Hallowell Township PICTON ON K0K 2T0

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

H.J. McFarland Memorial Home
603 Highway 49, R.R. #2, Hallowell Township PICTON ON K0K 2T0

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

WENDY BROWN (602)

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): September 27, 30, October 1 - 4, 9 - 11 and 15 - 17, 2019

Log # 015491-19/ CIS M556-000029-19 - regarding a fall with injury and transfer to hospital.
Log # 016327-19/ CIS M556-000031-19 - regarding alleged resident to resident abuse.
Log # 016418-19/ CIS M556-000030-19 - regarding alleged staff to resident abuse/neglect.
Log # 016853-19/ CIS M556-000033-19 - regarding a fall with injury and transfer to hospital.
Log # 016988-19/ CIS M556-000035-19 - regarding alleged resident to resident abuse.
Log # 017082-19/ CIS M556-000036-19 - regarding alleged resident to resident abuse.
Log # 017455-19/ CIS M556-000039-19 - regarding a fall with injury and transfer to hospital.
Log # 017613-19/ CIS M556-000040-19 - regarding alleged resident to resident abuse.
Log # 018438-19/ CIS M556-000042-19 - regarding alleged staff to resident abuse/neglect.
Log # 019773-19/ CIS M556-000045-19 - regarding alleged staff to resident abuse/neglect.

During the course of the inspection, the inspector(s) spoke with the acting Administrator, the acting Director of Care (DOC), a physician, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), the acting Nutritional Services Supervisor, the acting Activities Director, Activities staff, Dietary Aids, Staffing /Reception staff, residents and family members.

In addition, observations of resident care service delivery and reviews of electronic and hard copy health care records, investigation documents, and relevant policies/procedures were completed.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **1 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	Légende 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 was provided to the resident as specified in the plan.

On two (2) specified dates, at a specified time, residents #011 and #012 were found by staff having gone with out specified care. Both residents were assessed by the Registered Nurse (RN) and cared for by the attending PSWs. Neither resident expressed concern and no injury was noted on assessment(s). The Director of Care (DOC) #101 was alerted to the incident(s) on a specified date.

The plan(s) of care for resident #011 and #012 indicated that both residents required specified care.

The licensee's subsequent investigation found that PSW #115 had not provided the specified care, nor did they alert another PSW staff that residents #011 and #012 required care.

The licensee failed to ensure that the care set out in the residents' plan(s) of care was provided for residents # 011 and #012 as specified in their plan(s). [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 in ensuring that the care set out in the plan(s) of care are provided to the resident(s) as specified in the plan(s) of care, to be implemented voluntarily.

WN #2: 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:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure a resident's right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.

On a specified date, resident #007 was assisted by PSW #115 who did not ensure the resident's call bell was in reach. Resident #007 is dependent on staff for assistance. At a specified time PSW #115 did not complete pre meal rounds and, as a result, did not realize that resident #007 had not been assisted to the dining room for their meal. Resident #007 called out repeatedly for assistance, but there was no response from staff. PSW #115 heard the resident calling out for assistance. Resident #007 was provided a late meal in their room and provided support by nursing and another PSW staff.

Interviews with the Administrator #100, the DOC #101, the Acting Nutrition Services Supervisor, PSW and Dietary staff indicated that there is no current specific system to ensure all residents attend, or are taken, to the dining room(s) for meals. The DOC explained that there has been direction to nursing and PSW staff to complete rounds at each meal time to ensure all residents are in the dining room / receiving their meals, however, this has not been consistently completed.

Resident #007's right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs was not fully respected. [s. 3. (1) 4.]

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 ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, that the policy was complied with.

In accordance with O. Reg. 79/10, s. 48, the licensee is required to ensure that a falls prevention and management program that reduces the incidence of falls and the risk of injury is developed and implemented in the home: Specifically, staff did not comply with the licensee's "Falls Prevention" Policy # VII-G-30.00 - Revision: May 2019", which is part of the Falls Prevention and Management Program and notes on page two (2) of three (3) in the procedure that as part of the "Post Falls Assessment, Registered staff will initiate a head injury routine if a head injury is suspected or if the resident fall is un-witnessed".

On a specified date at a specified time resident #010 had an un-witnessed fall. The resident was assessed by RN #132 for injury; localized swelling and pain was noted. A specified period of time later resident # 010 was sent to hospital given ongoing discomfort where they were treated for a specified injury.

Registered Practical Nurses (RPN) #131 and #130 indicated in interviews that the head injury routine (HIR)/protocol was followed if there was any sign that a resident may have hit their head after a fall. When asked specifically if the HIR was completed with every un-witnessed fall the staff advised that the HIR was completed if there was "any sign of head injury", but not necessarily with every un-witnessed fall. RN #132 noted that typically the HIR was followed for un-witnessed falls, however, they were unable to state that it was completed in every case.

The Administrator #100 and the DOC#101, advised that if a resident sustained an injury to the head following a fall, and/or after un-witnessed fall, the “neurological vital signs post head injury monitoring record” should be completed as part of the post fall assessment/HIR. Inspector #602 completed an electronic and hard copy health record review for resident #010 and found no indication that the HIR was completed and no neurological monitoring record.

The licensee did not comply with their "Falls Prevention" policy which is part of the Falls Prevention and Management program. [s. 8. (1) (a),s. 8. (1) (b)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident-staff communication response system can be easily seen, accessed, and used by residents, staff and visitors at all times.

On a specified date, at a specified time, resident #007 was assisted with care, however, their call bell was not placed within reach. At a specified time later, resident #007 called out verbally for assistance but there was no response from staff until PSW #115 walked by resident #007's room. Resident #007 had missed a meal and was provided a late meal in their room a specified period of time later. [s. 17. (1) (a)]

2. On a specified date, at a specified time, staff found resident #006 uncomfortable and upset after having been missed for specified care. Resident #006's family was alerted to the incident a specified period of time later. Resident #006 told their family that they had waited for their care; no one came and that their call bell was out of reach. The resident indicated that they eventually managed to reach the call bell and staff responded to their need for assistance.

Resident(s) #006 and #007 were unable to access the licensee's resident - staff communication system [s. 17. (1) (a)]

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 failed to ensure that the person who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm, was immediately reported to the Director.

On a specified date, at a specified time, staff found resident having not received specified care. PSWs #117 and #116 provided the care and RN #118 provided resident #006 analgesic for pain. The resident remained uncomfortable and anxious about the missed care for a specified period of time. In an interview, DOC #101 indicated that the incident was not reported by registered or PSW staff, rather it was reported by the resident's family member a specified period of time later.

Resident #006's family/POA was notified of the incident a specified period of time after the incident occurred. The family//POA immediately reported the incident to the DOC #101 who then alerted the Director [s. 24. (1)]

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. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's Substitute Decision Maker (SDM) was immediately notified upon becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of a resident that resulted in a physical injury or pain to the resident, or caused distress to the resident that could potentially be detrimental to the resident' s health or well-being.

On a specified date, at a specified time, staff found resident #006 uncomfortable and upset; the resident had not been provided care. Resident #006 was uncomfortable and anxious for a specified period of time after the incident. Resident #006's family was alerted to the incident a specified period of time after the incident occurred. Resident #006 told their family that they had waited for their care but no one came and their call bell was not within reach. In an interview, DOC #101 advised that the incident was not immediately reported to the family//POA. The incident was reported to the DOC by the resident's POA who was alerted to the incident a specified period of time after the incident. [s. 97. (1) (a)]

Issued on this 21st day of October, 2019

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

Original report signed by the inspector.