Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Feb 21, 2020	2020_771609_0003	015811-19, 023433-19, 024117-19	Critical Incident System

Licensee/Titulaire de permis

Canadian Reformed Society for a Home for the Aged Inc.
c/o Mount Nemo Christian Nursing Home 4486 Guelph Line BURLINGTON ON L7P 0N2

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

Mount Nemo Christian Nursing Home
4486 Guelph Line BURLINGTON ON L7P 0N2

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

CHAD CAMPS (609)

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): February 10-14, 2020.

The following intakes were inspected during this Critical Incident System (CIS) Inspection:

One intake related to alleged staff-to-resident abuse;
One intake related to missing controlled substances; and
One intake related to a fall of a resident.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Resident Care (DRC), Pharmacist, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) and residents.

The Inspector(s) also conducted a daily tour of the home, observed staff-to-resident and resident-to-resident interactions as well as reviewed relevant health care records, training records, internal investigations, policies, programs and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **4 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	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 provided to resident #001 was as specified in the plan.

A Critical Incident (CI) report was submitted by the home to the Director, which outlined how on a particular day, resident #001 fell resulting in an injury. The CI report indicated that the resident required a specific intervention.

On a particular day and time, Inspector #609 observed resident #001 without the specified intervention.

A review of resident #001's current plan of care directed staff to ensure that the resident had the specified intervention.

During an interview with Personal Support Worker (PSW) #106, they verified the Inspector's observation that resident #001 did not have the specified intervention.

During an interview with Registered Nurse (RN) #104, they verified that resident #001 was supposed to have the specified intervention and that staff had probably forgotten.

During an interview with the DRC, they indicated that staff were expected to provide care to residents as specified in their plans of care and that this did not occur when resident #001 was observed without the specified intervention. [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 the care set out in the plan of care is provided to resident #001 as specified in the plan, to be implemented voluntarily.

WN #2: 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 home's written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

Physical abuse is defined in Ontario Regulation 79/10, section 2, as the use of physical force by anyone other than a resident that causes physical injury or pain.

A CI report was submitted by the home to the Director on a particular day, which described how resident #006 alleged that PSW #108 injured them when providing care.

During an interview with resident #006, they recalled the incident. The resident described how PSW #108 was harsh during care and injured them during care.

A review of resident #006's health care records found in a progress note at the time of the allegations, that the resident had sustained an injury.

A review of the home's policy titled "Abuse and Neglect of Residents: Preventing, Reporting and Eliminating" last reviewed October 31, 2019, indicated that residents were always to live free from any form of abuse or neglect.

During an interview with the DRC, they outlined that at the completion of the investigation, there was no reason to disbelieve resident #006's allegations.

A review of PSW #108's letter of reprimand found that upon completing the home's investigation, there was evidence to support the allegations of physical abuse of resident #006. [s. 20. (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 home's written policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #3: 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 abuse of resident #006, immediately reported the suspicion and the information upon which it was based to the Director.

A Memorandum titled "Clarification of Mandatory and Critical Incident Reporting Requirements", dated July 05, 2018, was sent to all Long-Term Care Home Licensees. This memorandum identified that "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: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident".

A CI report was submitted by the home to the Director on a particular day which described how six days prior, resident #006 alleged that PSW #108 injured them during care. The CI report further indicated that the allegations of abuse were not reported to the DRC by the Charge RN until the next day.

A review of the home's policy titled "Abuse and Neglect of Residents: Preventing, Reporting and Eliminating" last reviewed October 31, 2019, required a person to immediately report abuse of a resident by anyone to the Charge RN, DRC or Administrator who in turn would ensure that the Ministry of Long-Term Care was notified by entering a CI report.

A review of an email sent to the DRC by Charge RN #104 described allegations that a staff member had been rough to resident #006 during care. The email also indicated that the resident had felt threatened.

During an interview with the DRC, the email from Charge RN #104 was reviewed. The DRC indicated that they became aware of the email outlining the allegations of abuse hours after it was sent. They acknowledged that they should have immediately reported the allegations of abuse of resident #006 to the Director, which did not occur until five days after they became aware of the information. [s. 24. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area.

A CI report was submitted by the home to the Director, which outlined how on a particular day, during routine destruction of discontinued controlled substances, the DRC along with the Pharmacist found 19 ampules of two milligram (mg) per millimetre (ml) Hydromorphone, 10 tablets of one mg Hydromorphone and 10 capsules of six mg Hydromorph Contin were missing.

A review of the home's internal investigation found that the 39 missing controlled substances were placed in the controlled substances destruction box on two particular days. Registered staff noted that the controlled substances destruction box was so full that the lid was blocked from closing.

During an interview with Registered Practical Nurse (RPN) #103, they verified that they had placed the 19 ampules of Hydromorphone into the controlled substances destruction box. The RPN described how the box was "really, really full" and that the cover to the box would not close. When asked if controlled substances were accessible from the box, they replied "yes, some, if you stick your hand in you can take stuff out".

During an interview with RPN #105, they verified that they had placed the 10 tablets of one mg Hydromorphone and 10 capsules of six mg Hydromorph Contin into the controlled substances destruction box. The RPN described the box as full where medication cards could be seen when the drawer to the box was opened.

A review of the home's policy titled "Drug Storage and Destruction" last reviewed December 31, 2019, indicated that controlled substances that were discontinued or required disposal were to be retained in a double locked bin in the medication room.

During an interview with the DRC, they outlined how the controlled substances destruction box at the time of the incident was filled with controlled substances, with some accessible from outside the box. This was due to a one-month delay in the routinely scheduled controlled substances destruction between the Pharmacist and the DRC. [s. 129. (1) (b)]

Issued on this 21st day of February, 2020

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

Original report signed by the inspector.