Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: August 23, 2024
Inspection Number: 2024-1583-0003
Inspection Type: Critical Incident
Licensee: The Corporations of the City of Stratford, The County of Perth and The Town of St. Mary's
Long Term Care Home and City: Spruce Lodge Home for the Aged, Stratford

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 14, 15, 16, 2024
The inspection occurred offsite on the following date(s): August 19, 2024
The following Critical Incident (CI) intake was inspected:

- Intake: #00120619 [CI #M575-000018-24] related to a resident elopement

The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control
Safe and Secure Home

INSPECTION RESULTS

WRITTEN NOTIFICATION: Medication Management System

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)

Medication management system
s. 123 (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The licensee failed to ensure the written policies and protocols for the medication management system were implemented.

Rationale and Summary
The CareRx Medication Pass policy documented medications were to be administered on the date and hour of administration to ensure accuracy. The failure to administer or take a medication within the acceptable 'window' of the scheduled administration time would be considered a medication incident. "Administer all scheduled medications within the standard timeframe of the medication pass established by the home. Prevailing practice is to administer medications within 1 hour before or after the scheduled time."

The CareRx Medication Administration Times policy documented that standardized medication administration times were utilized in the home to provide consistent, appropriate administration of medications while minimizing the number of medication passes per day. "The standard hours of administration (HOA) are established by the home and Pharmacy when initiating the Pharmacy service for the home." "Medications are to be given within an acceptable 'window' of time around the scheduled time as defined by the Home (e.g., within 1 hour before or after the scheduled administration time for medications prescribed more frequently than daily but no more frequently than every 4 hours)."

The electronic Medication Administration Record (eMAR) for a resident was reviewed against the Medication Admin Audit Report generated in Point Click Care

(PCC). There were multiple prescribed medications due for administration at 0800 hours that were coded as "7=Sleeping" by a Registered Practical Nurse (RPN) and administered approximately four hours later on multiple dates with no adjustment of the timing of the next dose.

The Director of Care (DOC) and the Inspector reviewed the medication administration documentation and multiple medications were administered four hours late for those medications to be administered at 0800 hours with a code of "7=sleeping" that were given for multiple dates with no staggered timing for the next dose due. The DOC verified the doses were too close together for the dates discussed. The DOC verified there could be adverse consequences for the resident if they were administered their antipsychotic and/or pain medications without the scheduled amount of time in between doses, and residents should be wakened to receive the medications at those scheduled times.

Medications taken at times that were not then staggered may contribute to side effects or complications. The resident did not receive the medication at the right time for optimal effectiveness and medication potency.

Sources: resident clinical record review, policy review, and staff interviews.

COMPLIANCE ORDER CO #001 Doors in a Home

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 12 (2)

Doors in a home

s. 12 (2) The licensee shall ensure that there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The Licensee has failed to comply with O. Reg. 246/22, s. 12 (2)

Specifically, the licensee must:
a) Ensure the written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents is reviewed and/or revised as needed. A documented record of the review and/or revision as required, the date of the review, the changes made if any, and who participated must be maintained.
b) Staff members are provided education related to the policy for door security, ensuring the written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents is complied with. A documented record must be maintained of this training, including the date the training was provided, content covered as part of the training, who provided the training, and who attended the training.
c) Ensure the care plan for a resident specifically identifies strategies related to exit seeking and risk of elopement.
d) Ensure the care plan for a resident identifies the potential risk to the resident and other residents when the resident is in the secured outdoor courtyard. Develop and implement interventions for the resident to ensure a safe and secure environment for all residents using the courtyard.

Grounds

The licensee failed to ensure that the written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents was complied with.

Ontario Regulation 246/22, s. 11 (1) (b) 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, program, procedure, strategy, initiative or system, the licensee

is required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system, is complied with.

Rationale and Summary

The Door Security policy documented security and safety measures carried out to ensure the safety and well-being of the residents, staff and visitors to minimize the potential for personal injury to all persons within Spruce Lodge. "Doors to secure courtyard areas are equipped with a keypad that will open doors for staff to enable residents to enjoy the courtyards. (eg. Center courtyard, Cottage B/C courtyard, West Courtyard, Cottage A courtyard). Staff are then expected to monitor the courtyards if the keypad has been unlocked or green-lighted."

A Critical Incident Report was submitted to the Ministry of Long-Term Care documenting an incident where a resident was missing from the secured neighborhood courtyard. The courtyard had a fence and gate replaced and the gate was closed but unlocked after the completion of the work for a period of one day at which time the resident exited the secured area. The Registered Nurse arrived on scene where the resident was at risk for a negative health outcome, the RN sent resident to hospital for further assessment. Maintenance was contacted and the gate was locked.

The Director of Care verified residents were to be supervised while in the courtyard either going outside with them or sitting at the door monitoring them, but the resident was unsupervised and left the courtyard. A Personal Support Worker (PSW) was working the evening of the elopement and verified the resident exited the courtyard through an unlocked gate. The RN stated upon reaching the gate it was closed, but it was not locked, and the latch was easily opened because the pad lock was not applied after renovations were completed the day prior. The courtyard was not a secured outdoor area at the time of the incident.

There was high risk to the safety and security of the resident and any other residents in the courtyard. The resident eloped from the courtyard, made their way to another residential area and was missing for 90 minutes and a short term change in their health status. It was the responsibility of the licensee to ensure the home was a safe and secure environment for its residents by applying a lock to the gate to restrict access, and the staff were to monitor the resident while in the courtyard. The home did not provide access to a secured courtyard area by the resident.

Sources: Critical Incident, resident clinical record review, policy review, observations, and staff interviews.

This order must be complied with by October 11, 2024

COMPLIANCE ORDER CO #002 Responsive Behaviours

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The Licensee has failed to comply with O. Reg. 246/22, s. 58 (4) (b)
Specifically, the licensee must:
a) Ensure at least one member of the nursing management team, one member of the registered nursing staff and one member of the Personal Support Workers

participate in the care plan review for the resident. A documented record of the review and/or revision as required, the date of the review, the changes made if any, and who participated must be maintained.
b) Ensure the care plan related to responsive behaviour management for the resident identifies potentially harmful interactions between and among residents, including identifying factors based on an interdisciplinary assessment or through observation that could potentially trigger such altercations, and identifying and documenting interventions to prevent potential harmful interaction with residents and staff.
c) Ensure the care plan for the resident related to responsive behaviour management identifies the specific socially inappropriate behaviours and strategies developed to manage the behaviours and any other identified socially inappropriate behaviour. Review the resident's toileting routine and the triggers and physical expressions for continence care.

Grounds
The licensee failed to ensure for a resident demonstrating responsive behaviours, strategies were developed and implemented to respond to those behaviours, where possible.

Rationale and Summary
"Behavioural Supports Ontario (BSO) Program Interventions" was posted in the bathroom for the resident with an initiation and review date in three months ago. The plan did not identify that the resident had multiple responsive behaviours and no interventions or strategies were developed to address these identified areas of concern. The care plan created in Point Click Care (PCC) documented other types of behaviour but was not inclusive of all behaviours identified.

There were multiple progress notes for the resident since admission. The admission

Minimum Data Set (MDS) assessment was compared to the quarterly assessment dated and there was continued or increased frequency in multiple behavioural symptoms. A PIECES (Physical, Intellectual, Emotional, Capabilities, Environment, Social) assessment was completed and identified the same behaviours.

The responsive behaviour care plan for the resident was updated during the inspection with no interventions to address the resident's multiple responsive behaviours.

The Director of Care (DOC) verified the resident had multiple behaviours that did not have individualized strategies developed and implemented to respond to those behaviours. The DOC verified the resident's care plan was update during the inspection, and many of those behaviours were documented as part of the progress notes since admission. Progress notes identified interventions staff were implementing in the moment and those strategies identified were not a part of the care plan for easy access to those strategies for all staff to ensure continuity of care and implementation of strategies that were proven effective.

The BSO Personal Support Worker (PSW) acknowledged the BSO care plan for the resident was last update three months ago, and since that time the resident's behaviours had escalated putting staff, other residents, and the resident at risk for harm and injury. The BSO PSW verified the care plan was updated to include the strategies implemented to respond to those behaviours and noted that the behaviours were exhibited for months prior. The interventions added were statements of information or were not individualized for the resident.

A new staff member would not have the information required to respond and interventions were not developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of the resident's

behaviours. Care plan focus statements were added months after the responsive behaviour was identified and interventions were not resident specific in minimizing behaviours and risk to others.

Sources: resident clinical record review, policy review, observations, and staff interviews.

This order must be complied with by October 11, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the

Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.

(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director

c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.