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 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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

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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
Nov 8, 2018	2018_729615_0039	006006-18, 023304-18	Complaint

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

Sumac Lodge
1464 Blackwell Road SARNIA ON N7S 5M4

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

HELENE DESABRAIS (615)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): October 30, 21 and November 1, 2018.

The following Complaints were inspected during this inspection:

Complaint IL-56189-LO/Log #006006-18 related to prevention of abuse and neglect and,
Complaint IL-59354-LO/Log #023304-18 related to physical altercations between residents.

During the course of the inspection, the inspector(s) spoke with the Acting Executive Director (Acting ED), a Regional Manager, the Director of Care (DOC), the Dietary Manager (DM), the Manager of Environment Services (MES) two Registered Nurses (RNs), the Registered Practical Nurse - Behavioural Support Ontario (RPN-BSO) and one Registered Practical Nurse (RPN).

The inspector also made observations of residents' care, reviewed clinical records and plans of care for identified residents, relevant policies and procedures, observed drug storage areas in the home, the infection prevention and control program and practices.

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

During the course of this inspection, Non-Compliances were issued.
- **5 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	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 O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rules were complied with: 1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that precluded exit by a resident, including balconies and terraces, or doors that residents did not have access to were kept closed and locked.

During a review of a resident's progress notes in Point Click Care (PCC), an entry on a specific date, stated that resident exited the home through an unlocked door in an area of the home.

On a specific date, the Inspector was able to open the exit door in an area of the home that lead to an outside unsecured area. At the time, residents of the home were in the home area and staff working stated that anyone could get out of these doors and would expect that they'd be locked.

A review of the home's policy #ADMIN10-O10.02 "LTC - Door Alarms" last reviewed March 31, 2018, stated in part "All doors leading to stairways and the outside of the Home must be kept closed and locked, and equipped with a door access control system that is kept on at all times".

During an interview, the Acting Executive Director (ED) stated that the fire Inspector had came to the home and had told them that the exit door could not be locked.

During an interview, the Manager of Environmental (MES) stated that the exit doors in that area prevented people from entering the home but did not prevent them from getting out the home. The MES said that the exit door had been that way since they came working in the home three years ago. The MES stated that they would expect these doors being locked.

During an interview, The Dietary Manager (DM) stated that the exit doors in that area have been unlocked for at least two years and there was a request to put magnets locks on the door and the Head Office did not approve and that the fire Inspector had said that they could put a magnet lock on the doors. The DM said they then requested again the head office for magnet locks and was not approved again and were told to have the doors locked but the company "Lock Smith" refused to lock the doors because there was an "exit" sign above the door. An email exchange, on a specific date, from the DM to a Regional Manager reported the fire inspector recommendations.

During an interview, the DM said that they would expect exit doors to be kept closed and locked as per the Legislation. [s. 9. (1) 1. i.]

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 following rules were complied with: 1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to be kept closed and locked, 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 a person who had reasonable grounds to suspect 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, had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director.

During a review of a resident's progress notes in Point Click Care (PCC), an entry on a specific date stated in part that the resident had an altercation with another resident and staff intervened, the resident then physically abused the other resident who became very upset.

There were no documented evidence of the home's investigation nor the completion of a Critical Incident report.

During interviews, the Acting ED , the DOC and the RPN-BSO all stated that the home's expectation was to report abuse immediately to the MOHLTC.

During interviews, the DM and a RN reviewed the above progress notes and stated it was physical abuse and the expectation was to report it immediately to the MOHLTC. The DM said that according to the Risk Management tab in PCC, the DOC at the time knew of the incident on the same day. [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 had reasonable grounds to suspect that any of the following had 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. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, (a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and (b) identifying and implementing interventions.

On a specific date, Complaint #IL59354-LO/Log #023304-18 was submitted to the MOHLTC where the complainant's concerns were regarding a physical altercation between two residents.

A review of a resident's progress notes for the last six months in PCC revealed the following:

June 14, 2018: resident altercation to other “Possible trigger for event staff talking to a resident;
July 2, 2018: resident physical and verbal abuse toward other residents;
July 17, 2018: resident to resident altercation;
July 18, 2018: resident physical abuse to a resident;
August 22, 2018: resident to residents altercations;
August 24, 2018: note stating pain was a possible trigger to responsive behaviours. Resident has been verbal and physically aggressive;
August 30, 2018: resident to resident altercation;
September 1, 2018: resident altercation with others;
September 2, 2018: resident to resident altercation;
September 3, 2018: resident to residents altercations;
September 4, 2018: resident to residents altercations;
September 22, 2018: resident to residents altercations;
September 26, 2018: note stating “Presenting issues: verbal and physical aggression towards co-residents, lack of insight into personal boundaries and irritability/agitation”;
October 16, 2018: resident to resident altercation.

A review of the home's policy #CARE3-O10.02 "Responsive Behaviour Procedure" stated in part "Responsive Behaviour - Resident Offender Initiate Behaviour Tracking Tool for Resident Offender (DOS or Sexually Responsive Behaviour Tracking Tool), Assess Resident Offender and determine if they have an unmet need, Collaborate with resident/SDM and Interdisciplinary team to determine interventions required to ensure safety of other residents, Update Plan of Care to reflect any new interventions to ensure safety of resident and others, If physical abuse is repeated or if interventions ineffective, initiate external referral and follow Responsive Behaviour Pathway".

A review of the home's "Responsive Behaviour ROADMAP" stated in part "STEP 1: Complete appropriate assessment tool (s), Update the plan of care according to changing resident's needs. STEP 2: BSO Internal Team: Gather all information about the resident, review the Behaviour Assessment Checklist, progress notes, lab work and DOS, etc. Provide more in-depth investigation; provide assessments and interventions. Add the resident's information to the white board/expression binder. Home area: Continue activities to find solutions, continue ongoing data collection, review white boards/expression binders and use interventions".

During an interview, the RPN-BSO stated that they had a white board for residents'

behaviours and interventions but not anymore and that now the staff used the expression binder with the "tip sheets" on each unit.

A review of the resident's care plan on a specific date, described general interventions for the resident.

During an interview, the DM stated that the resident had physical and verbal behaviours, the behaviours tracking was used and after assumed BSO would put interventions in place. The DM said that the resident's plan of care was not specific to the resident.

A review of the expression binder on the resident's had no "tip sheet" for their behaviours.

During an interview, a RN stated that the resident had responsive behaviours and would expect the resident to have a "tip sheet" with interventions specific for them and that the plan of care was more generalized.

During an interview, the RPN-BSO stated that the resident could be verbal and physical mostly related specific triggers. The RPN-BSO said that when they came back six months later the resident's tip sheet for BSO interventions was missing and noticed the resident's behaviours had increased. The RPN-BSO stated that they would have expected a BSO assessment and interventions in place for the resident, and that behaviours were tracked but nothing was completed. The RPN-BSO said that the resident's plan of care did not include the specific triggers, the interventions were not in the care plan because the care plan was more generalized.

During an interview, the Acting ED and the DOC stated that the home's expectation would be that residents' plan of care should be individualized for residents to minimize altercations between residents. [s. 54.]

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 steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, (a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and (b) identifying and implementing interventions, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was dealt with as follows: The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.

On a specific date, Complaint #IL-56189-LO/Log #006006-18 was submitted to the MOHLTC where the complainant's concerns were regarding the protection of a resident from abuse from another resident.

On a specific date, Complaint #IL59354-LO/Log #023304-18 was submitted to the MOHLTC where the complainant's concerns were regarding a physical altercation of between two residents.

A review of the resident's progress notes in PCC revealed the complainant's concerns were brought to the staff's attention on three different dates.

During a telephone interview on a specfic date, the complainant said that they were still concerned for the safety of the resident in relation to another resident and felt that the home was dismissing their concerns.

A review of the home's policy #ADMIN3-O10.01 "LTC - Management of Concerns, Complaints, Compliments and Requests" last reviewed March 31, 2018, stated in part "The following components form the protocols for addressing and resolving concerns or complaints that are received either verbally or in a formal, written matter. If concerns cannot be resolved immediately at point-of-service, the individual who is first aware of a concern will initiate the Client Service Response (CSR) Form. A copy of the initial form will be forwarded to the Executive Director. The original form will be forwarded to the member of the team who will be responsible for the resolution of the concern. The CSR form will be completed in full and all actions taken during the investigation will be documented. The CSR is then filed in the complaints management binder".

A review of the home's "Complaint Management" binder had no documented evidence of the complainant's concerns.

During a review of the "Complaints Management" Log with a RN said there were no documented evidence of the complainant's concerns. The RN stated that it was not completed, and would have expected the forms to be completed and that they were aware that it was still a concern for the complainant.

During interviews, the DM and a RPN said that they were aware of the complainant's ongoing concerns and that complaints/concerns should be documented with the Client Service Response forms and be dealt with.

During an interview, the Acting ED and the DOC stated that the home's expectation would be that the Client Service Response Form be completed and complaints/concerns be dealt with. [s. 101. (1) 1.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): 1. A resident who was missing for less than three hours and who returned to the home with no injury or adverse change in condition.

A review of a resident's progress notes in PCC revealed that on a specific date the resident was exit seeking. At a later date, the resident was found outside the home without their alert system on. The resident exited the home two days later through an unlocked door of the home.

A review of the resident's care plan did not include that the resident was "exit seeking".

A review of the home's policy #EMP2-O20.06 "Code Yellow" last reviewed October 31, 2018, stated in part "Yellow Code will be used each time a Resident is discovered missing. When the resident is found, the Charge Nurse will notify: the Executive Director, the DOC, The attending physician, family. The Executive Director/designate will notify the regulatory agency and the Regional Director of Operations.

During an interview, the DM stated that the resident was found outside the home and thought that the DOC at the time would be taking care of that. The DM said they did not know they had to report to the MOHLTC a resident who was missing for less than three hours and who returned to the home with no injury or adverse change in condition. [s. 107. (3) 1.]

Issued on this 13th day of November, 2018

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

Original report signed by the inspector.