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**

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## Public Copy/Copie du public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jan 28, 2019 | 2019_760527_0001 | 005159-18, 009799-18, 019938-18, 022470-18 | Critical Incident System |

### Licensee/Titulaire de permis

Corporation of the County of Simcoe
1110 Highway 26 Midhurst ON L9X 1N6

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

Sunset Manor Home for Senior Citizens
49 Raglan Street COLLINGWOOD ON L9Y 4X1

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

KATHLEEN MILLAR (527)

### 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): January 10, 11, 14, 16, 18, 21, 22 and 23, 2019.**

**The following Critical Incident System (CIS) inspections were conducted:**

**Log #005159-18, related to transferring and positioning;**
**Log #009799-18, related to alleged staff to resident abuse; and**
**Log #022470-18, related to a medication incident.**

**The Follow-Up Inspection was conducted and complied:**

**Log #019938-18**

**The Critical Incident System (CIS) Inspection was conducted concurrently with the Complaints and Follow-Up Inspections, Inspection Report #2019_760527_0002.**

**Rhonda Ridgeway, LTCH Inspector #737 attended this inspection.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Associate Director of Care (ADOC), registered nurses (RNs), registered practical nurses (RPNs), Personal Support Workers (PSWs), Activation Aides, Responsive Behaviour Nurse, Program Support Services Manager, the Professional Standards Supervisor, residents and families.**

**During the course of the inspection, the inspectors toured the home, reviewed the licensee's compliance plan, reviewed clinical records, reviewed investigation notes, reviewed the licensee's information and policies and procedures, interviewed staff, residents and families, and observed the provision of care.**

**The following Inspection Protocols were used during this inspection:**
**Critical Incident Response**
**Medication**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Responsive Behaviours**

**During the course of this inspection, Non-Compliances were issued.**

- **3 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

**The following previously issued Order(s) were found to be in compliance at the time of this inspection:**
**Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:**

| REQUIREMENT/ EXIGENCE | TYPE OF ACTION/ GENRE DE MESURE | INSPECTION # / NO DE L'INSPECTION | INSPECTOR ID #/ NO DE L'INSPECTEUR |
|---|---|---|---|
| O.Reg 79/10 s. 53. (4) | CO #001 | 2018_742527_0009 | 527 |

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.**

**Findings/Faits saillants :**

1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

Resident #009 was being transported from an activity on a specific date in 2018, in their mobility device. According to the Critical Incident System (CIS), the resident refused a specific aide be applied to their mobility device and as a result the resident was injured.

The clinical record review was completed and there was no documentation or interventions related to the specific aide being applied or not to resident #009's mobility device.

Staff member #122 was interviewed and acknowledged that the resident was positioned in their mobility device for transportation to an activity and the resident refused to have their aide applied to their mobility device.

PSW #123 was interviewed and acknowledged that they were expected to position the resident's aide on their mobility device, if the staff were the one's that would be transporting the resident off the unit and this was for resident safety.

The physiotherapist (PT) #132 said that they recommended that resident's have their aide applied to their mobility device when the staff were transporting resident off the unit, in order to support the resident and prevent any kind of injury.

The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting resident #009.

***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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements**

**Specifically failed to comply with the following:**

**s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including interventions were documented.

Resident #009 was prescribed a medication every two days. On a specific date in 2018, resident #009's medication went missing and was not found.

The clinical record was reviewed, which identified the home had implemented checks to ensure the medication was in place and the registered staff were to document their checks in the electronic medication record (eMAR). As a result of the medication incident, the staff reviewed and revised the resident's written plan of care and to ensure it included the verification checks required each shift of the medication's position and presence. Review of the eMAR revealed that staff were inconsistently documenting their verification checks before and after the medication incident.

On specific dates in July, August and September 2018, there was no documentation of the medication verification checks by the registered staff.

The DOC and RPN #119 were interviewed individually and acknowledged that the registered staff were expected to document the position and presence of the medication for resident #009 on every shift and they were to document that the verification checks in the eMAR.

The licensee failed to ensure that any actions taken with respect to resident #009, under a program, including interventions and the resident's responses to interventions were documented.

**WN #3: 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 failed to ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident, were notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that had resulted in a physical injury or pain to the resident or that caused distress to the resident that could potentially be detrimental to the resident's health or well-being.

On a specific date in 2018, residents #004, #010, #011 and #012, were allegedly abused by a staff member.

The clinical record was reviewed, which revealed that there was no documentation that the substitute decision-makers (SDM) for each of the residents were notified of the alleged abuse by a staff member.

The DOC was interviewed and acknowledged that the SDM for each of the residents should have been notified immediately after the alleged abuse occurred and this did not happen according to their abuse policies and procedures and the legislation.

**Issued on this 28th day of January, 2019**

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

**Original report signed by the inspector.**