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
Jan 20, 2020	2019_800532_0019	017886-19, 017887-19, 021624-19, 022741-19	Follow up

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

NUZHAT UDDIN (532), KATY HARRISON (766), TAWNIE URBANSKI (754)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): December 9-11, 13-20, 2019.

The following intakes were completed in this Follow-up (FU) inspection:
Log #017886-19, FU related to plan of care
Log #017887-19, FU related to pain management
Log #021624-19, Critical Incident (CI) #M581-000030-19 and Log #022741-19, CI #M581-000031-19 related to abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, acting Director of Care, Resident Care Coordinator (RCC), Physician, Receptionist, Minimum Data Set (MDS)-Resident Assessment Instrument (RAI) Coordinator, Abilities and Wellness Consultant, Registered Nurses, (RNs), Registered Practical Nurses (RPNs), Personal Support, Workers (PSWs) and residents.

The inspectors also toured resident home areas, observed resident care provision and resident staff interaction, reviewed relevant residents' clinical records, policies and procedures, and training records pertaining to the inspection.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **13 WN(s)**
- **8 VPC(s)**
- **2 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
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #002	2019_800532_0010	532

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. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the identified residents pain was not relieved by initial interventions, the residents were assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

This inspection was completed as a follow-up to compliance order #001 from inspection #2019_800532_0010 issued on September 4, 2019, with a compliance date of November 22, 2019.

Communication pain alerts located on Point of Care (POC) were documented for the identified residents by the PSW staff when the residents exhibited signs and symptoms of pain.

Review of Point Click Care (PCC) progress notes and the electronic medication administration record (EMAR) showed that there was no documentation to indicate that the residents' pain was assessed or treated in response to the pain alerts.

The MDS RAI Coordinator acknowledged that when the pain alerts were created by the PSW staff the registered staff were not responding to these alerts with either assessments or treatment of the pain. The RAI coordinator said that the registered staff should monitor and assess the pain and based on this information provide treatment to the residents. They acknowledged that this was not being done.

The licensee has failed to ensure that when the residents pain was not relieved by initial interventions, the residents were assessed using a clinically appropriate assessment instrument specifically designed for this purpose. [s. 52. (2)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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 has failed to ensure that staff used safe transferring and positioning techniques when assisting residents.

A Critical Incident (CI) was submitted to the MLTC on alleging physical abuse when an identified resident was injured during a transfer via mechanical lift.

The home's policy Minimal Lift Program, under policy section: Safety and Risk, stated that, procedures involving mechanical resident handling equipment were to be conducted by two trained direct care staff, where both were physically participating in the transfer from application of the sling to removal of the sling, and with one staff member being from the home.

The home's investigative briefing note stated that a Personal Support Worker (PSW) used the mechanical lift independently for part of the transfer for an identified resident.

A PSW said they observed another PSW using the lift independently, and the resident was crooked in the sling and appeared to be in distress.

The PSW confirmed that they applied the sling to the resident independently which was a regular practice for them.

The Administrator stated that the PSW used the lift independently which was not in keeping with the home's policy, resulting in injury and pain to the resident.

The licensee has failed to ensure that staff used safe transferring and positioning techniques when assisting the resident when they used the lift independently. [s. 36.]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that an identified resident's right to be treated with courtesy and respect were fully respected and promoted in a way that fully respected the resident's dignity.

A Critical Incident (CI) was submitted to the MLTC alleging physical abuse when an identified resident was injured during a transfer.

A staff member said that after the improper transfer a continence product was not applied to the resident and they were left sitting on a pad in their wheelchair.

Two identified PSW staff shared that the resident's right for respect and dignity was not met when the resident went without a continence product for several hours and the resident became incontinent.

The home's investigative briefing notes stated that the home failed to protect the dignity of the resident when staff chose to withhold the resident's incontinent product.

The licensee has failed to ensure that the resident rights were fully respected and promoted and that the resident was treated with courtesy and respect and in a way that fully respected the resident's dignity when staff withheld application of an incontinent product for the resident and with the resident's denture placement. [s. 3. (1) 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 every resident rights are fully respected and promoted and that every resident is treated with courtesy and respect and in a way that fully respected the resident's dignity, to be implemented voluntarily.

WN #4: 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that an identified resident was reassessed, and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed.

Progress notes indicated that a resident had an injury and infection in an identified area.

The plan of care for the resident under pain stated that the resident complained of pain, however, the identified area of pain and infection was not documented.

The resident stated that they had pain in the identified area.

An RPN stated that the resident had pain in the identified area and was on a regular analgesic for pain but there was nothing in the plan of care related to this area of pain.

The licensee has failed to ensure that when the resident was reassessed and the plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs changed. [s. 6. (10) (b)]

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 resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the identified resident was protected from neglect by the staff at the home.

As per O. Reg 79/10 s.5 defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A written complaint made by a family member was reviewed and it stated that there was an incident of alleged neglect involving a resident.

A progress note stated that the resident told a family member that there was an incident and they experienced some negative symptoms after the incident.

The resident recalled the incident and said they were frightened by it.

A staff member stated that at the time of the incident a second staff member was not monitoring the resident closely. The staff member said they thought they reported the incident of alleged neglect to a registered staff.

The registered staff did not recall the incident being reported to them.

The licensee also failed to ensure that the identified resident was protected from neglect by the staff when staff failed to report and document the incident, failed to physically monitor the resident during care provision and failed to assess the resident until two days later when the family raised concerns and the resident developed symptoms. [s. 19. (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 residents are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that appropriate action was taken in response to an incident of alleged physical abuse involving an identified resident.

A Critical Incident (CI) was submitted to the Ministry of Long Term Care (MLTC) related to allegations of physical abuse towards a resident in which the resident was injured.

A Personal Support Worker (PSW) shared that they reported the incident of alleged physical abuse involving the resident to a Registered Practical Nurse (RPN).

A review of the resident Point Click Care (PCC), electronic chart failed to show a pain assessment or progress note by registered staff in relation to the incident.

The RPN shared that they did not go see the resident at anytime that day or report the incident to the Registered Nurse on duty. They advised the PSW to write down what had occurred and they would email this to Administrator.

A staff member shared that it would be a nursing expectation to complete a pain assessment after a resident was involved in an incident that caused an injury. They said the RPN should have gone directly to management to report the incident and assess the resident, or if they could not leave their duties, report the incident to the Registered Nurse on duty to follow up.

The licensee failed to take appropriate action in response to an incident of alleged abuse where a resident was injured. The licensee also failed to ensure the incident was reported to the Registered Nurse on duty and reported immediately to the management at the home. [s. 23. (1) (b)]

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 appropriate action is taken in response to an incident of physical abuse for resident, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee failed to have a staffing plan in place to support the safety needs and requirements for residents, related to an identified Personal Support Worker (PSW) and their working requirements.

Record review showed that the Director of Resident Care sent a communication to all Registered Nurses indicating that an identified staff member had work restrictions. This plan was to continue until further notice.

A staff member stated that they observed the identified staff not working within their restrictions.

The Administrator and a staff member confirmed that the identified staff member was working outside their restrictions while providing unsafe resident care.

The licensee failed to have a staffing plan in place to support the safety needs and requirements for residents, related to a staff member working independently, and operating a mechanical lift independently which was associated with an injury for the resident. [s. 31. (3) (a)]

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 staffing plan must provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that staff were provided training as specified under the Long Term Care Home's Act s. 76 (2) 1-11, before performing their responsibilities.

During the course of the inspection, inspectors were made aware of concerns about education / training of agency staff related to abuse and neglect. Agency staff were listed on the annual abuse/neglect training records for 2018, however, the inspector could not find completion dates for their abuse/neglect training.

The Administrator said that it was the home's expectation that all staff of the home, agency staff included, complete the Orientation Checklists before performing their job duties. The Administrator also said that they only had four completed Orientation Checklist for agency staff while they had fourteen agency staff working at the home from the agency. They were unsure how many agency staff were working at the home from the other agency.

A review of the home's records showed that the Orientation training checklists, were completed by four agency staff members. The Administrator confirmed that those were all the records that the home had for agency staff members.

The licensee failed to ensure that staff were provided training as specified under the Long Term Care Home's Act s. 76 (2) 1-11, before performing their responsibilities [s. 76. (2)]

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 provide training as specified under the Long Term Care Home's Act s. 76 (2) 1-11, before performing their responsibilities, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee failed to ensure that at least once in every calendar year an evaluation was made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements were required to prevent further occurrences.

A review of the home's records failed to show an annual evaluation of the home's policy "Zero Tolerance of Abuse and Neglect, ADM F-10" with an effective date of April 2017.

The Administrator confirmed that the evaluation to determine the effectiveness of the home's policy for abuse and neglect was done at the county level. They said that there had been an evaluation of the abuse and neglect policy completed before, but it had not been completed annually.

The licensee failed to ensure that there was an annual evaluation to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements were required to prevent further occurrences. [s. 99. (b)]

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 at least once in every calendar year an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and what changes and improvements are required to prevent further occurrences, to be implemented voluntarily.

WN #10: 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 a written complaint made to a staff member concerning the care of an identified resident, where the complaint alleged risk of harm to the resident, was investigated immediately.

A progress note stated that a resident informed their substitute decision maker (SDM) about an incident where the resident may have been put at risk. A written complaint was submitted to the former Director of Resident Care (DRC) in relation to the incident.

Review of the resident/family concern or feedback form stated a follow up was scheduled with the staff member, however, there were no investigation notes attached to the complaint and concern form.

The Administrator said they thought the complaint was investigated as there was a screenshot for a meeting.

Record review and e-mails from former DRC stated that the interview with staff happened six days after the complaint was received.

The licensee has failed to ensure that a written complaint made to a staff member concerning the care of the resident was investigated immediately. [s. 101. (1) 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 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: 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, to be implemented voluntarily.

WN #11: 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 failed to ensure that the written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

The home's policy "Zero Tolerance of Abuse and Neglect, ADM F-10", effective date of April 2017, under Policy Section: Resident Safety and Abuse, stated that all staff, volunteers, contractors and affiliated personnel are required to immediately report to the Registered Nurse in the home on duty (or on call) at the time of a witnessed or alleged incident of abuse or neglect.

A Personal Support Worker (PSW) said they did not report an incident of alleged physical abuse involving a resident to the Registered Practical Nurse or Registered Nurse on duty that day. The PSW said they did report the incident to their PSW union representative who was on staff that day.

The PSW said they became aware of an allegation of physical abuse for a specified resident from another PSW but thought they did not have to report the allegation of abuse as they were not directly involved and did not witness the incident.

The Registered Practical Nurse (RPN) said they became aware of the alleged abuse from a PSW, however, the RPN did not ask additional questions of the PSW and instructed the PSW to write everything down in an email that they would send to management later. The RPN said they did not report the incident to the Registered Nurse on duty.

The Administrator confirmed that anyone that either witnesses or suspects abuse or neglect of a residents should directly report to the Registered Practical Nurse or Registered Nurse.

The licensee failed to ensure that the home's prevention of abuse and neglect policy was complied with when a number of identified PSW's, and an RPN were aware of an alleged incident of physical abuse and did not immediately report the allegation to the Registered Nurse on duty or on call in the home. [s. 20. (1)]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that they immediately forwarded any written complaints that have been received concerning the care of a resident or the operation of the home to the Director.

A written complaint was submitted to the former DRC on an identified date related to the care of an identified resident.

The Administrator acknowledged that the written complaint concerning the care of the resident was never forwarded to the Director.

The licensee has failed to ensure that they immediately forwarded any written complaints that have been received concerning the care of a resident or the operation of the home to the Director. [s. 22. (1)]

WN #13: 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):
4. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

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): Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident was taken to a hospital and that results in a significant change in the resident’s health condition.

Review of an identified resident's plan of care stated that the resident had number of falls over a three day period.

The resident was sent to hospital on an identified date and returned to the home having been diagnosed with several injuries.

The Physician looked up the discharge summary and confirmed the injuries. The physician said that the injuries were related to falls at the home.

There was no critical incident submitted by the home related to the resident's transfer to hospital and the significant change in the resident’s health condition resulting from the falls and injuries.

The Administrator acknowledged that there should have been a critical incident submitted for the resident related to a significant change in the resident’s health condition.

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): Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident was taken to a hospital and that results in a significant change in the resident’s health condition. [s. 107. (3) 4.]

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

Issued on this 31st day of January, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	NUZHAT UDDIN (532), KATY HARRISON (766), TAWNIE URBANSKI (754)
Inspection No. / No de l'inspection :	2019_800532_0019
Log No. / No de registre :	017886-19, 017887-19, 021624-19, 022741-19
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Jan 20, 2020
Licensee / Titulaire de permis :	Corporation of the County of Simcoe 1110 Highway 26, Midhurst, ON, L9X-1N6
LTC Home / Foyer de SLD :	Sunset Manor Home for Senior Citizens 49 Raglan Street, COLLINGWOOD, ON, L9Y-4X1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Martina Wynia

To Corporation of the County of Simcoe, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2019_800532_0010, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 52 (2).

Specifically, the licensee must:
a) ensure that when an identified resident's pain is not relieved by initial interventions, the residents are assessed using a clinically appropriate assessment instrument specifically designed for this purpose.
b) ensure that when communication alerts are created for the residents that pain is being assessed and appropriate actions are taken to address the pain in a timely manner.

Grounds / Motifs :

1. The licensee has failed to comply with the following compliance order #001 from inspection #2019_800532_0010 issued on September 4, 2019, with a compliance due date of November 22, 2019.

The licensee must be compliant with O. Reg. 79/10, s. 52 (2).

Specifically, the licensee must:
a) ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.
b) ensure that the communication alert located on Point of Care (POC) is used by the PSWs and the registered staff when verbal and non-verbal residents exhibit pain and responsive behaviours.

c) ensure that the physician-nurse communication tool that is currently in place is used by the registered staff to communicate to the physician, residents' verbal and non-verbal signs and symptoms of pain.
d) ensure training is provided to the registered staff of the home related to the home's pain policy, specifically recognizing, assessing, documenting and evaluating pain.
e) ensure that all staff sign off on the completed training and records are kept in the home.

The licensee completed steps c), d) and e) but failed to complete step a) and b) of CO #001.

a) This inspection was completed as a follow-up to compliance order #001 from inspection #2019_800532_0010 issued on September 4, 2019, with a compliance date of November 22, 2019.

Communication pain alerts located on Point of Care (POC) were documented for the identified residents by the PSW staff when the residents exhibited signs and symptoms of pain.

Review of Point Click Care (PCC) progress notes and the electronic medication administration record (EMAR) showed that there was no documentation to indicate that the residents' pain was assessed or treated in response to the pain alerts.

The MDS RAI Coordinator acknowledged that when the pain alerts were created by the PSW staff the registered staff were not responding to these alerts with either assessments or treatment of the pain. The RAI coordinator said that the registered staff should monitor and assess the pain and based on this information provide treatment to the residents. They acknowledged that this was not being done.

The licensee has failed to ensure that when the residents pain was not relieved by initial interventions, the residents were assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The scope of this issue was a level 3 widespread. The severity of the issue was

determined to be a level 2, minimal harm or minimal risk. The home has a level 5 history with a CO to the same subsection of the LTCHA that included:

compliance order (CO) #001 issued October 29, 2019, with a compliance due date of November 22, 2019 (2019_800532_0010). (532)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 03, 2020

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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.

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s. 36.

Specifically the licensee must:
a) ensure that staff use safe transferring and positioning techniques when transferring resident #001 and all other residents requiring assistance with transferring and positioning.
b) ensure that Personal Support Worker #107, as well as any other staff performing resident transfers, receive training on safe transferring and positioning techniques and devices. Training is to include transfers completed with and without mechanical lifts.
c) ensure that a written record is kept of the training including staff names, dates and training content, to ensure that all have nursing staff received the training.

Grounds / Motifs :

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

A Critical Incident (CI) was submitted to the MLTC on alleging physical abuse when an identified resident was injured during a transfer via mechanical lift.

The home's policy Minimal Lift Program, under policy section: Safety and Risk, stated that, procedures involving mechanical resident handling equipment were to be conducted by two trained direct care staff, where both were physically participating in the transfer from application of the sling to removal of the sling, and with one staff member being from the home.

The home's investigative briefing note stated that a Personal Support Worker

(PSW) used the mechanical lift independently for part of the transfer for an identified resident.

A PSW said they observed another PSW using the lift independently, and the resident was crooked in the sling and appeared to be in distress.

The PSW confirmed that they applied the sling to the resident independently which was a regular practice for them.

The Administrator stated that the PSW used the lift independently which was not in keeping with the home's policy, resulting in injury and pain to the resident.

The licensee has failed to ensure that staff used safe transferring and positioning techniques when assisting the resident when they used the lift independently.

The scope of this issue was a level 1 isolated. The severity of the issue was determined to be a level 2, minimal harm or minimal risk. The home has a level 3 history as previous NC to the same subsection that included:

Compliance order (CO) #001 issued May 30, 2019, with a compliance due date of August 31, 2019 (2019_605213_0019). (754)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 03, 2020

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Order(s) of the Inspector

Ordre(s) de l’inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
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
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 20th day of January, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Nuzhat Uddin

Service Area Office /
Bureau régional de services : Central West Service Area Office