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 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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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 25, 2018	2018_563670_0013	010106-18	Resident Quality Inspection

Licensee/Titulaire de permis

S & R Nursing Homes Ltd.
265 North Front Street Suite 200 SARNIA ON N7T 7X1

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

Twin Lakes Terrace Long Term Care Community
1310 Murphy Road SARNIA ON N7S 6K5

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

DEBRA CHURCHER (670), ALICIA MARLATT (590), CASSANDRA TAYLOR (725), ORALDEEN BROWN (698), PRAVEENA SITTAMPALAM (699)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): June 11, 12, 13, 14, 15, 18, 19, 20, 21, and 22, 2018.

Inspector Terri Daly #115 was present during this inspection.

The following Critical Incident System Reports (CIS) were inspected during this RQI:
Log #013701-18 CIS #2889-000005-18 related to alleged abuse.
Log #013704-18 CIS #2889-000006-18 related to alleged abuse.
Log #013706-18 CIS #2889-000007-18 related to alleged abuse.
Log #013352-18 CIS #2889-000004-18 related to a fall with injury.
Log #005546-17 CIS #2889-000003-17 related to a fall with injury.

During the course of the inspection, the inspector(s) spoke with the Residents' Council representative, the Administrator, the Manager of Resident Care, the Manager of Food Services, one Resident Assessment Instrument Coordinator, the Environment Services Supervisor, two Life Enrichment Aides, the Registered Dietitian, three Registered Nurses, six Registered Practical Nurses, 19 Personal Support Workers, three Dietary Aides, three Environmental Service Workers, Family Members and over forty Residents.

The inspectors also observed resident rooms and common areas, observed medication storage areas, observed medication administration, observed meal and snack service, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, observed recreational activities, observed infection control practices, observed the overall cleanliness and maintenance of the home, reviewed policies and procedures of the home, reviewed various meeting minutes and also reviewed written records of program evaluations.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

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

- **7 WN(s)**
- **5 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	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents shall comply with the regulations regarding mandatory reporting requirements.

During stage one of the Resident Quality Inspection (RQI), three specific residents indicated to a Inspector in an interview, that staff had behaved in a certain manner during care. Two Inspectors informed the Administrator immediately.

The three Critical Incident System reports (CIS) were submitted with information on the investigation of alleged abuse, with no definitive findings of abuse. The CIS reports were submitted the day after the Inspectors had reported to the Administrator.

The homes policy ADMIN 08-05 Resident Abuse and Neglect – Last Revision Date: May 19, 2017 states, "Notification of the MOHLTC Compliance Inspector – the inspector will be notified by Administration immediately (same day) upon determining that there are reasonable grounds to suspect a situation has occurred which is outlines in LTCA 24(1) Mandatory Reporting. Notification can be done the same day by completion of a Critical Incident Report.".

During an interview with the Manager of Resident Care (MRC), they stated that in the event of reported abuse an investigation would be conducted first, then a Critical Incident System report (CIS) would be completed if required.

During an interview with the Administrator, it was stated that in the event of reported abuse an investigation would be conducted first and if so required then a CIS report would be completed. The Administrator did confirm the policy states to complete an investigation and then notify the inspector upon determining that there are reasonable grounds to suspect a situation has occurred. The Administrator acknowledged that the homes policy does not support the legislation in regards to making mandatory reports.

The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents shall comply with the regulations regarding mandatory reporting requirements. [s. 20. (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 at a minimum, the policy to promote zero tolerance of abuse and neglect of residents, shall provide for a program, that complies with the regulations, for preventing abuse and neglect, 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 has reasonable grounds to suspect that the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

During stage one of the RQI, a specific resident, indicated to an Inspector in an interview that a specific type of staff member behaved in a certain manner during a specific aspect

of care. Two Inspectors informed the Administrator immediately.

The Critical Incident System (CIS)report was submitted for the specific resident with information on the investigation of alleged abuse, with no definitive findings of abuse. The CIS report was submitted the day after the Inspector reported to the Administrator.

The Administrator confirmed during an interview that the legislation requires an immediate report and that a report was not submitted immediately as the homes policy was followed and states to complete an investigation and then report. [s. 24. (1)]

2. During stage one of the RQI, a specific resident, indicated to a Inspector in an interview that, sometimes staff behave in a certain way during care. Two Inspectors informed the Administrator immediately.

The Critical Incident System (CIS) report was submitted for the specific resident with information on the investigation of alleged abuse, with no definitive findings of abuse. The CIS report was submitted the day after the Inspectors reported to the Administrator.

3. During stage one of the RQI, a specific resident, indicated to a Inspector in an interview that, specific staff behave in a certain manner when providing care. Two Inspectors informed the Administrator immediately.

The Critical Incident System (CIS) report was submitted for the specific resident, with information on the investigation of alleged abuse, with no definitive findings of abuse. The CIS was submitted the day after the Inspectors reported to the Administrator.

The Administrator confirmed during an interview that the legislation requires an immediate report and that a report was not submitted immediately for three specific residents, and should have been.

The licensee has failed to ensure that a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. [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 has reasonable grounds to suspect that the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

During stage one of the Resident Quality Inspection (RQI) a specific resident was identified through a census review as having a specific condition.

Record review of the specific resident's clinical records revealed that they had been admitted to the home on a specific date with a specific condition.

The specific resident's eTAR for a specific date, revealed that monitoring of a specific condition was initiated on a specific date which was ten days after admission.

Progress notes on a specific date, showed a specific assessment that showed a deterioration of a specific condition.

In an interview with a Registered Practical Nurse (RPN), they stated that if a resident was admitted with a specific condition, specific weekly assessments were required to be initiated. The RPN indicated that the specific resident was admitted with a specific condition on a specific date and the required specific weekly assessments were not initiated until 10 days after admission.

Review of the Skin and Wound Program policy RCM 10-06-01, last revised August 11, 2017, included direction for registered staff to assess residents with altered skin integrity at least weekly. The program also indicates that “the skin and wound treatment regimen will be recorded in the eTAR system with each dressing change”.

In an interview with the Manager of Resident Care (MRC), they indicated that residents with altered skin integrity require weekly skin assessments. MRC confirmed that specific, required weekly assessments were not initiated for the specific resident when a specific condition was identified at admission.

The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated. [s. 50. (2) (b) (iv)]

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 ensure that, a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

A review of medication incidents that occurred for a specific time frame, indicated that a specific resident was administered a medication that was discontinued by the physician on a specific date.

Review of the analysis section of the medication incident report dated for a specific date, showed that the physician ordered that a specific medication be discontinued on a specific date. A Registered Practical Nurse (RPN) had discontinued a specific resident's medication incorrectly. This error was indicated in the incident report.

Review of the specific resident's Electronic Medication Administration Record (eMAR) by

an Inspector showed that the incorrect medication was discontinued and the error was recognized at the resident's quarterly review on a specific date.

In an interview with the Manager of Resident Care (MRC), the March eMAR was reviewed with two Inspectors. The MRC confirmed a specific medication had been given to a specific resident, and was not administered as prescribed.

The licensee failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. [s. 131. (1)]

2. The licensee failed to ensure that drugs are administered to residents in accordance with the direction for use specified by the prescriber.

A review of medication incidents that occurred from a specific time frame indicated that two specific residents did not receive medication although it was ordered by the physician.

a) Review of the analysis section of the medication incident report for a specific date showed that a specific resident was given a specific medication on a specific date however staff did not stay with the resident to ensure the medication was taken and the resident did not take the medication.

b) Review of the incident report dated on a specific date, a specific resident did not receive their scheduled medication however it was signed off in the eMAR noted at 2300 hours.

In an interview with Manager of Resident Care (MRC), they stated that the missed medications were considered as dose omissions as two specific resident's did not receive their prescribed medications. The MRC acknowledged that the two specific residents were not administered medications in accordance with the direction for use as specified by the prescriber.

The licensee failed to ensure that drugs are administered to residents in accordance with the direction for use specified by the prescriber. [s. 131. (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 no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident was analyzed with corrective actions taken as necessary and that a written quarterly record was kept of these requirements.

The Medication Incident Analysis for a specific time frame, was reviewed and did not have any evidence of quarterly reviews for medication incidents.

The home provided the PAC miniutes for the quarter and the Classic Care Pharmacy quarterly report for a specific time frame. Neither documents contained information related to the analysis with the corrective actions taken as necessary related to the medication incidents in that quarter.

The home’s policy titled RCM 09-19 Medication Incidents last reveiwd November 6, 2017, stated that "A quarterly review is undertaken of all medication incidents. The review will be reported to the Professional Advisory Committee (PAC) for further analysis quarterly".

An interview was conducted with the Manager of Resident Care (MRC) who stated that the analysis was not recorded in the Professional Advisory Committed (PAC) minutes nor was there documentation of a medication incident summary. The MRC stated that all investigation notes for medication incidents were documented on the medication incident report. The MRC said that the process to identify ways to reduce and prevent medication incidents and preventative measures to be implemented were done quarterly at the home ’s PAC meeting. MRC stated there was no analysis documented in the PAC minutes and that the home did not document the analysis.

The licensee has failed to ensure that a written record was kept of a quarterly review of all medication incidents and adverse drug reactions, that have occurred in the home in order to reduce and prevent medication incidents and adverse drug reactions and any changes and improvements identified in the review were implemented and a written record is kept of everything. [s. 135. (3)]

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 quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; any changes and improvements identified in the review are implemented; and a written record is kept of everything, to be implemented voluntarily.

WN #6: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident.

Review of a specific resident's Minimum Data Set assessment (MDS) completed on a specific date, showed that the resident had a specific condition that had deteriorated.

Review of the specific resident's care plan documentation for a specific date, stated that the resident did not have the specific condition identified in the MDS assessment.

The home's policy titled RCM 08-04 Resident Plan of care last reviewed on October 23, 2015, stated "A care plan is an important tool that communicates the resident's care needs/preferences to the multidisciplinary team. The care plan is a dynamic document that should be changed as the residents care needs change. Homes are responsible for addressing all needs and strengths of the residents".

A Registered Nurse stated that if they did not know the resident they would look in the care plan.

The Manager of Resident Care reviewed the specific resident's MDS assessment and care plan and acknowledged that the resident did have a specific condition that had deteriorated and that the care plan did not reflect the resident's current condition and did not provide clear direction to staff.

The licensee has failed to ensure that there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
8. Continence, including bladder and bowel elimination. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure the resident’s plan of care was based on an interdisciplinary assessment of the resident’s continence, including bladder and bowel elimination.

During stage one of the Resident Quality Inspection (RQI) a specific resident was identified as having a specific condition that had declined.

Record review of a specific resident's clinical records revealed they had been admitted to the home on a specific date with a specific condition.

The specific resident's Minimum Data Set (MDS) admission assessment dated for a specific date, indicated that the resident’s specific condition had deteriorated.

The specific resident's current care plan initiated on a specific date, did not reflect the decline in the resident's specific condition.

In an interview with a Personal Support Worker (PSW) they stated that staff would access a resident’s chart to access information regarding the resident’s specific condition. The PSW said that the specific resident had a specific condition.

In an interview with the Resident Assessment Instrument (RAI) Coordinator, they said that a specific assessment would be completed at admission or if there was a decline in the specific condition. The RAI Coordinator stated that a resident's specific condition would be communicated to staff through the care plan. The RAI Coordinator stated that the specific resident did have a decline in a specific condition and that the resident’s current care plan was not based on an interdisciplinary assessment of the resident’s specific condition.

The licensee has failed to ensure the resident’s plan of care was based on an interdisciplinary assessment of the resident’s continence, including bladder and bowel elimination. [s. 26. (3) 8.]

Issued on this 27th day of June, 2018

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

Original report signed by the inspector.