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
Mar 18, 2022	2022_974670_0006	019829-21, 020871-21	Critical Incident System

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)

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): March 9, 10, 14, 15 and 16, 2022.

The purpose of this inspection was to inspect the following:
Log #010829-21 CIS #2889-000030-21 related to a fall with fracture.
Log #020871-21 CIS #2889-000032-21 related to alleged staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Manager of Resident Care, one Registered Practical Nurse Infection Prevention and Control Lead, one Registered Practical Nurse Resident Assessment Instrument Coordinator, one Registered Nurse, two Registered Practical Nurses, 10 Personal Support Workers and residents.

During the course of this inspection the Inspector observed infection prevention and control practices in the home, observed the overall cleanliness and maintenance in the home, observed the provision of care, observed staff to resident interactions, reviewed relevant clinical records, reviewed relevant internal documentation and reviewed relevant policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **4 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 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 :

The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to resident #003.

Observation of resident #003's room showed the presence of specific equipment.

Review of resident #003's plan of care showed that the specific equipment was not included in the plan of care.

During an interview with Registered Practical Nurse Resident Assessment Coordinator (RPNRAI) #113 they stated that the specific equipment was an intervention for resident #003 and should have been part of the plan of care.

The homes failure to ensure the plan of care was up to date and accurate placed the resident at risk as staff did not have clear direction related to falls prevention interventions.

Sources: Record review of resident #003's plan of care, observation of resident #003's room and interview with RPNRAI #113.

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 plan of care sets out clear directions to staff and others who provide direct care to the residents, to be implemented voluntarily.

WN #2: 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 :

The licensee has failed to ensure that residents #001, #003, #004 and #006 were protected from abuse by anyone.

Review of the homes internal investigative notes showed that on a specific date, the Manager of Resident Care (MRC) #100 had received a report from employee #104 and #106 that PSW #108 had been physically and verbally abusive to residents. On the following day the MRC #100 received a additional report from employee #105 that they had witnessed PSW #108 being physically and verbally abusive to residents.

Review of employee #104's written statement showed that they reported that PSW #108 had been physically and verbally abusive to resident #003 on a specific date and had been verbally abusive to resident #001 and #003 on a subsequent date.

Review of employee #106's written statement showed that they reported that PSW #108 had been physically abusive to resident #004 on a specific date and on a subsequent date, had been verbally abusive to multiple residents by calling them names and stating they were going to rage, had been verbally abusive to resident #001 and had been physically and verbally abusive to resident #003.

Review of employee #105's written statement showed that PSW #108 had been physically abusive to resident #006 on a specific date and that over a two week period had been verbally abusive to resident #001.

Interview with resident #004 was conducted and resident #004 confirmed that PSW #108 had been verbally abusive and physically abusive with them.

This Inspector interviewed employee #104, #105 and #106. The employees confirmed the dates and content from their written statements was correct.

Administrator #101 stated that during the interview with PSW #108 they admitted to the

items that had been reported and had subsequently been terminated. Administrator #101 acknowledged that PSW #108 had verbally and physically abused residents.

The homes failure to protect residents from PSW #108 placed them at risk for harm.

Sources: Internal investigation notes, interviews with resident #004, employee #104, #105, #106 and Administrator #101.

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 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 #3: 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 :

The licensee has failed to ensure that a person who has reasonable grounds to suspect that 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 was immediately reported.

Review of the homes internal investigative notes showed that on a specific date, the Manager of Resident Care (MRC) #100 had received a report from employee #104 and #106 that PSW #108 had been physically and verbally abusive to residents. On the following day the MRC #100 received a additional report from employee #105 that they had witnessed PSW #108 being physically and verbally abusive to residents.

Review of employee #104's written statement showed that they reported that PSW #108 had been physically and verbally abusive to resident #003 six days prior to reporting to the MRC #100 and had been verbally abusive to resident #001 and #003 one day prior to reporting to the MRC #100.

Review of employee #106's written statement showed that they reported that PSW #108 had been physically abusive to resident #004 two days prior to reporting to the MRC #100 and one day prior to reporting to the MRC #100, had been verbally abusive to multiple residents by calling them names and stating they were going to rage, had been verbally abusive to resident #001 and had been physically and verbally abusive to resident #003.

Review of employee #105's written statement showed that PSW #108 had been physically abusive to resident #006 either eleven or twelve days prior to reporting to the MRC #100 and that over a two week period prior to reporting to the MRC #100 had been verbally abusive to resident #001.

This Inspector interviewed employee #104, #105 and #106. The employees confirmed the dates and statements from their written statements. All employees interviewed acknowledged that they did not report abuse immediately and should have.

Administrator #101 acknowledged that the expectation would be that any witnessed or suspected abuse would be immediately reported and it was not.

Failure of employee #104, #105 and #106 immediately reporting staff to resident abuse placed the residents at risk of experiencing additional abuse.

Sources: Internal investigation notes, interview with employee #104, #105, #106 and Administrator, infoline, and Critical Incident System report.

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 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. 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. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, to be implemented voluntarily.

WN #4: 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 :

The licensee has failed to ensure that, when resident #003 and #010 were 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.

A) Review of resident #003's clinical record showed that the resident had altered skin integrity. No record of weekly wound assessments could be located by this Inspector.

B) Review of resident #010's clinical record showed that the resident had altered skin integrity. This Inspector was unable to locate weekly wound assessments for two specific dates.

During an interview with RPNRAI #113 they were unable to locate any weekly wound assessments for resident #003 or weekly wound assessments for two specific dates for resident #010 and stated that the wound assessments should have been completed.

The home's policy titled Skin and Wound Program RCM 10-06-01 stated "Residents Exhibiting Altered Skin Integrity: The Registered Team Member will re-assess at a minimum, weekly thereafter, using the Altered Skin Integrity Assessment until the area is resolved.

The homes failure to ensure that weekly wound assessments were completed put resident #003 and #010 at risk for wound deterioration.

Sources: Resident #003's and resident #010's clinical records, interview with RPNRAI #113 and the homes policy titled Skin and Wound Program RCM 10-06-01 last updated March 4, 2019.

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 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.

Issued on this 18th day of March, 2022

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

Original report signed by the inspector.