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
Jan 7, 2018	2017_580568_0026	025548-17	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON 000 000

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

SUMMIT PLACE
850-4TH STREET EAST OWEN SOUND ON N4K 6A3

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

DOROTHY GINTHER (568), APRIL TOLENTINO (218)

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): November 20, 21, 22, 23, and 24, 2017.

Critical Incident system (CIS) report #2624-000019-17 log #020661-17, #2624-000014-16 log #031722-16, and #2624-000017-16 log #032738-16 related to falls where there was injury and a change in health status;
CIS #2624-000012-16 log #028111-16, #2624-000015-16 log #029934-16 and complaint IL-46870-LO log #028184-16 related to resident to resident altercations; were completed in conjunction with the Resident Quality Inspection (RQI).

During the course of the inspection, the inspector(s) spoke with the Interim Executive Director, Director of Care, Programs Manager, Resident Care Manager, Environmental Manager, Pharmacist, Physiotherapist, two Registered Nurses, five Registered Practical Nurses, ten Personal Support Workers, Residents' Council representative, residents and their families.

The inspectors also toured the home, observed medication administration, medication storage, reviewed relevant clinical records, policies and procedures, meeting minutes, schedules, posting of required information, medication incidents; observed the provision of resident care, resident-staff interactions, and observed the general maintenance, cleanliness, safety and condition of the home.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours

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

7 WN(s)
5 VPC(s)
3 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. 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 residents were protected from abuse by anyone.

A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long Term Care (MOHLTC) in relation to an incident identified on the CIS report as "unlawful conduct that resulted in harm/risk of harm to resident". The incident description stated that there was an altercation between resident #033 and resident #008 resulting in harm to resident #008.

A second CIS report submitted to the MOHLTC involved an altercation between the same two residents,which resulted in harm to resident #008.

During a review of resident #008's clinical record, the Resident Assessment Protocol (RAP) for cognition identified that the resident had severe cognitive impairment.

The plan of care for resident #033 stated that the resident exhibited responsive behaviours. Progress notes showed that resident #033's history of responsive behaviours and altercations with resident #008 commenced several months before the two reported incidents.

During an interview with a Personal Support Worker (PSW) they told the Inspector that they recalled an incident involving resident #033 and resident #008 in which there was an altercation that resulted in injury to resident #008. The PSW said they had to intervene to prevent escalation of the incident.

In interviews with a Registered Practical Nurse (RPN) and PSW they shared that resident #033 had a history of responsive behaviours directed towards resident #008.

During an interview with the Director of Care (DOC) they acknowledged that resident #033's behaviours towards resident #008 had escalated over time and that the home had not been able to protect resident #008 from abuse by resident #033. [s. 19. (1)]

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. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident involving a resident was: (a) documented together with a record of the immediate actions taken to assess and maintain the resident's health, and (b) reported to the resident and their substitute decision maker (SDM), if any.

A medication incident report documented that a resident did not receive their scheduled medications the previous night which consisted of seven different drugs. A clinical record review was conducted and there was no documentation to support that any immediate actions were taken to assess and maintain the resident's health. The home was unable to provide documented evidence to demonstrate that any actions were taken to assess the resident's health as a result of not receiving their scheduled medications. The DOC stated they could not recall whether the resident was harmed as a result of this incident.

A second medication incident report documented that a resident was found to have received a double dosage of their medication. The report stated that vital signs were obtained and the severity of the incident required monitoring. A clinical record review was

conducted and there was no documentation to support that actions were taken to re-assess and maintain the resident's health. The home was unable to provide documented evidence to demonstrate that the resident was re-assessed and monitored after receiving a double dosage of their medication. The DOC stated they could not recall whether the resident was harmed as a result of this incident.

The home's policy titled "LTC – Medication Incidents" last reviewed on August 31, 2016, stated that a brief actual description of the medication incident, treatment, and intervention was to be included in the interdisciplinary progress notes. It also stipulated that the resident's condition be monitored and documented for 24 hours or as per physician's order. The DOC acknowledged that they did not have any records to demonstrate that immediate actions were taken to assess the identified residents after the medication incidents occurred.

The home's policy related to medication incidents also specified that the residents' SDM be informed of all resident-related incidents. The DOC stated that the expectation was for nurses to notify the SDM immediately after the incident occurred and that notification would be documented in the progress notes on Point Click Care (PCC). The DOC acknowledged that the medication incidents involving the identified residents were not reported to their SDMs.

The licensee failed to ensure that every medication incident involving a resident was documented together with a record of the immediate actions taken to assess and maintain the resident's health and that the medication incidents were reported to the residents' SDM. [s. 135. (1)]

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

Three medication incident reports were reviewed, each one separately involving different residents. There was no documentation in any of the reports to demonstrate that an analysis was completed for the medication incidents.

The medication incidents involving two of the residents, documented that education was provided as a corrective measure to prevent a recurrence of the incident. However, the DOC stated that they could not recall the staff members involved in any of the incidents and acknowledged that they had no records to demonstrate that a root-cause analysis

was completed.

The medication incident report involving the third resident showed blank documentation related to corrective actions taken to prevent a recurrence of the incident. The DOC acknowledged that they did not have documented evidence to support that actions were taken to prevent a recurrence of the incident.

During an interview with the DOC and Pharmacist they said they did not have a written record of the analysis and corrective actions taken for the three medication incidents that were reviewed.

The licensee failed to ensure that the medication incidents involving three residents were analyzed with corrective actions taken and that a written record was kept of these requirements. [s. 135. (2)]

Additional Required Actions:

CO # - 002, 003 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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 failed to ensure that the care set out in the plan of care was provided to

the resident as specified in the plan.

During three observations of an identified resident, the resident was seated in a tilt positioned wheelchair.

A record review of the identified resident's care plan under the "Mobility" section showed that they used a wheelchair. The Safe Ambulating Lifting and Transferring (SALT) assessment documented that the resident utilized a reclining wheelchair. There was no documentation in the resident's plan of care to demonstrate the purpose of utilizing the tilt function on the device.

During staff interviews with two PSW's, one RPN, and the Physiotherapist (PT) they stated that to their knowledge the identified resident was to be tilted in their wheelchair. A PSW and RPN stated that the resident was tilted for comfort measures. Another PSW stated that the resident was tilted for pain relief and considered the application of the tilt function a personal judgement call. The RPN and DOC acknowledged that there was no documentation in the plan of care that directed staff to utilize the tilt function on the resident's wheelchair.

During an interview with a Registered Nurse (RN) they said that there was no direction provided to staff related to the application of the tilt function on the resident's wheelchair. The RN clarified that the resident's wheelchair was not to be tilted and that it was being used as a temporary device until they could get another chair. The DOC stated that the plan of care identified that the resident was in a wheelchair but there was no direction to tilt the wheelchair.

The licensee failed to ensure that the care set out in the plan of care was provided to the identified resident as specified in the plan. [s. 6. (7)]

2. The licensee has failed to ensure that the 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 change or care set out in the plan was no longer necessary.

During the inspection an identified resident was observed sitting in a wheelchair which was tilted approximately 45 degrees.

There was no documentation in the identified resident's plan of care which stated that the resident was to use a tilt wheelchair.

During an interview with a PSW they shared that the resident's health status had changed recently and they were now spending most of their time in a wheelchair. Staff would tilt the wheelchair for comfort and positioning.

A RN stated that the identified resident's condition had changed and the tilt wheelchair was something new to accommodate changes in health status. When asked how staff would be made aware of the use of the tilt wheelchair, the RN said that it would be communicated at shift report and in the resident's plan of care. The RN acknowledged that the identified resident's plan of care had not been revised to reflect the resident's change in care needs specific to the use of a tilt wheelchair.

The licensee failed to ensure that when a resident's care needs changed, the resident was assessed and the plan of care reviewed and revised. [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 care set out in the plan of care is provided to the resident as specified in the plan; and the plan of care is reviewed and revised when the resident's care needs change, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that all doors leading to stairways or doors that residents do not have access to must be kept closed, locked, and equipped with a door access control system that was kept on at all times.

A Critical Incident System (CIS) report submitted to the MOHLTC documented that a resident sustained an injury when found in an unsecured area of the home. At the time of the incident the home's door access control system was not activated.

A record review of the identified resident’s plan of care showed that they were considered to be at risk for falls.

An observation of the doorway located on the North wing showed two doors that were equipped with magnetic locks that required security pass code access for entry. Two sets of staircases was located on the other side of these doors where another non-secured door was present. The DOC stated that the door access control system was not activated to these doors at the time of the incident.

In an interview with the Environmental Manager (EM) they explained that the door access control system was disabled to the identified doors following alarm testing. This allowed the resident access to an unsecured area of the home.

In an interview with the DOC they acknowledged that two staff members became aware of the failure in the door access control system but failed to report it to the management. The DOC stated that the expectation was for staff members to remain in the area until assistance arrived to repair the system.

The EM and DOC acknowledged that the unsecured area was a significant risk and contributed to the incident involving the identified resident and their subsequent injury. Following the incident, the home implemented a new system to monitor and audit the door access control system in place in the home to prevent recurrence of this type of incident. The DOC stated that since they implemented this new system there had not been an incident of a similar nature.

The licensee failed to ensure that the doors leading to the stairways or doors residents do not have access to were kept closed, locked, and equipped with a door access control system that was kept on at all times. [s. 9. (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 all doors leading to stairways or doors that residents do not have access to must be kept closed, locked, and equipped with a door access control system that is kept on at all times, to be implemented voluntarily.

WN #5: 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 failed to ensure that the person who had reasonable grounds to suspect that the following had occurred or may have occurred, immediately reported the suspicion and the information upon which it was based to the Director.
2. Abuse of a resident by anyone that resulted in harm or risk of harm.

a) A CIS report was submitted to the MOHLTC two days after an incident which was identified as "unlawful conduct that resulted in harm/risk of harm to resident". The incident description stated that a resident had been injured by another resident during an

altercation.

b) A CIS report was submitted to the MOHLTC two days after an incident that was identified on the report as "Abuse/Neglect". The incident description stated that there was an altercation between two residents resulting in harm to one of the residents.

c) During a review of an identified resident's progress notes there was an entry which stated that the resident had been physically harmed by another resident using a device. The resident was injured as a result of the altercation and their SDM was notified of the incident.

In an interview with a RPN they stated that the home provided education annually regarding the prevention of abuse. This education included the duty to report and the process to be followed by staff. The RPN said that if they were to witness or suspect abuse of a resident by anyone, or if a staff member reported a situation of witnessed or alleged abuse to them, they were responsible for immediately reporting the incident to management. If it was a weekend or evening there was always a manager on call who they could contact.

During an interview with the DOC they said they did not recall being notified of the incident documented in the progress notes where a resident was injured by another resident during an altercation. It was possible that the registered staff did not report the incident to them and it was not picked up in the progress notes. The DOC said that this should have been reported to management who would then have notified the MOHLTC. With respect to the incidents described in the two CIS reports, the DOC acknowledged that in both cases the Director was not notified immediately of the suspected / witnessed abuse of a resident by a co-resident.

The licensee failed to ensure the the person who had reasonable grounds to suspect that a resident had been abused by another resident immediately the reported the incidents and the information upon which it was based to the Director. [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 the person who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or risk of harm, immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions.

A CIS report was submitted to the MOHLTC in relation to an altercation between resident #033 and resident #008, in which resident #008 was injured.

A second CIS report submitted to the MOHLTC involved an altercation between the same two residents. Staff intervened but not before resident #008 was injured.

Review of resident #033's plan of care identified that the resident exhibited responsive behaviours. Progress notes showed that the resident had a history of of responsive behaviours directed toward the same resident. Triggers for the resident's behaviours had

been identified and the home had established early interventions to address the behaviours. It was not until the resident's behaviours escalated and after the second incident that the home implemented additional interventions to mitigate the risk of altercations and potentially harmful interactions between residents.

During an interview with a PSW they told inspector #568 that they recalled an incident involving the two identified residents, in which resident #008 was injured. The PSW said they had to intervene to prevent escalation of the incident.

In interviews with a RPN and PSW they shared that resident #033 had a history of similar behaviours directed at resident #008. Initial interventions had not been successful in managing resident #033's behaviours and mitigating the risk of further altercations.

The Resident Care Manager (RCM) and Behavioural Supports Ontario (BSO) lead stated that resident #033 had not been followed actively by the home's BSO. The RCM and DOC stated that the Executive Director had taken the lead with these incidents. The DOC said they were not aware of the documented altercation that took place before these two incidents and agreed there was a pattern of escalating behaviours directed towards resident #008. In terms of implementing specific strategies / interventions to mitigate the risk of altercations between these residents, the DOC said they had initiated some temporary interventions but these had not remained in place. The DOC acknowledged that resident #033's responsive behaviours directed towards resident #008 had escalated and that BSO should have been actively involved with the resident to develop and implement strategies to prevent further altercations.

The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between resident #033 and resident #008, including identifying and implementing interventions. [s. 54. (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 steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that they seek advice from the Residents' Council in the development and carrying out of the satisfaction survey, and in acting on its results.

During an interview with a representative from Residents' Council they could not recall the Residents Council having been consulted regarding the development and carrying out of the satisfaction survey. The representative from Residents' Council stated that been attending RC meetings on a regular basis for a number of years.

There was no documentation in the Residents Council meeting minutes from February through October 2017, to indicate that the licensee had sought input from the RC related to the development and carrying out of the satisfaction survey.

During interviews with the Residents' Council Assistant / Programs Manager and the Acting Executive Director, they both agreed that the licensee had not asked the RC for input into the development and carrying out of the home's satisfaction survey. [s. 85. (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 they seek advice from the Residents' Couincil in the development and carrying out of the satisfaction survey and in acting on its results, to be implemented voluntarily.

Issued on this 25th day of January, 2018

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

Original report signed by the inspector.

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DOROTHY GINTHER (568), APRIL TOLENTINO (218)
Inspection No. / No de l'inspection :	2017_580568_0026
Log No. / No de registre :	025548-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jan 7, 2018
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 5015 Spectrum Way, Suite 600, MISSISSAUGA, ON, 000-000
LTC Home / Foyer de SLD :	SUMMIT PLACE 850-4TH STREET EAST, OWEN SOUND, ON, N4K-6A3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Cindie Holm

To REVERA LONG TERM CARE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall protect residents from abuse by anyone, and ensure that when there is an altercation between residents that results in abuse, that the residents' behaviours are assessed and interventions identified and implemented in order to minimize the risk of altercations and potentially harmful interactions.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were protected from abuse by anyone.

A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long Term Care (MOHLTC) in relation to an incident identified on the CIS report as "unlawful conduct that resulted in harm/risk of harm to resident". The incident description stated that there was an altercation between resident #033 and resident #008 resulting in harm to resident #008.

A second CIS report submitted to the MOHLTC involved an altercation between the same two residents, which resulted in harm to resident #008.

During a review of resident #008's clinical record, the Resident Assessment Protocol (RAP) for cognition identified that the resident had severe cognitive impairment.

The plan of care for resident #033 stated that the resident exhibited responsive behaviours. Progress notes showed that resident #033's history of responsive behaviours and altercations with resident #008 commenced several months before the two reported incidents.

During an interview with a Personal Support Worker (PSW) they told the Inspector that they recalled an incident involving resident #033 and resident #008 in which there was an altercation that resulted in injury to resident #008. The PSW said they had to intervene to prevent escalation of the incident.

In interviews with a Registered Practical Nurse (RPN) and PSW they shared that resident #033 had a history of responsive behaviours directed towards resident #008.

During an interview with the Director of Care (DOC) they acknowledged that resident #033's behaviours towards resident #008 had escalated over time and that the home had not been able to protect resident #008 from abuse by resident #033.

The severity of this noncompliance was determined to be a level three as there was actual harm to the resident; and the scope of this issue was identified as being a pattern. The home does not have a history of noncompliance in this subsection of the Long Term Care Homes Act and Regulations. (568)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2018

Order # / Ordre no : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Order / Ordre :

The licensee shall ensure that every medication incident involving a resident is:
a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and
b) reported to the resident and their substitute decision maker (SDM), if any.

Grounds / Motifs :

1. The licensee failed to ensure that every medication incident involving a resident was: (a) documented together with a record of the immediate actions taken to assess and maintain the resident's health, and (b) reported to the resident and their substitute decision maker (SDM), if any.

A medication incident report documented that a resident did not receive their scheduled medications the previous night which consisted of seven different drugs. A clinical record review was conducted and there was no documentation to support that any immediate actions were taken to assess and maintain the resident's health. The home was unable to provide documented evidence to demonstrate that any actions were taken to assess the resident's health as a result of not receiving their scheduled medications. The DOC stated they could not recall whether the resident was harmed as a result of this incident.

A second medication incident report documented that a resident was found to have received a double dosage of their medication. The report stated that vital signs were obtained and the severity of the incident required monitoring. A clinical record review was conducted and there was no documentation to support that actions were taken to reassess and maintain the resident's health. The home was unable to provide documented evidence to demonstrate that the resident was re-assessed and monitored after receiving a double dosage of their medication. The DOC stated they could not recall whether the resident was harmed as a result of this incident.

The home's policy titled "LTC - Medication Incidents" last reviewed on August 31, 2016, stated that a brief actual description of the medication incident, treatment, and intervention was to be included in the interdisciplinary progress notes. It also stipulated that the resident's condition be monitored and documented for 24 hours or as per
Physician's order. The DOC acknowledged that they did not have any records to demonstrate that immediate actions were taken to assess the identified residents after the medication incidents occurred.

The home's policy related to medication incidents also specified that the resident's SDM be informed of all resident-related incidents. The DOC stated that the expectation was for nurses to notify the SDM immediately after the incident occurred and that notification would be documented in the progress notes on Point Click Care (PCC). The DOC acknowledged that the medication incidents involving the identified residents were not
reported to their SDMs.

The licensee failed to ensure that every medication incident involving a resident was documented together with a record of the immediate actions taken to assess and maintain the resident's health and that the medication incidents were reported to the resident's SDM.

The severity of this noncompliance was determined to be a level two with potential for harm; and the scope of this issue was identified as being a widespread. The home does not have a history of noncompliance in this subsection of the Long Term Care Homes Act and Regulations.
(218)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2018

Order # / Ordre no : 003 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed;
(b) corrective action is taken as necessary; and
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Order / Ordre :

The licensee shall ensure that:
i) All medication incidents and adverse drug reactions are documented, analyzed, and corrective actions taken as necessary.
ii) There is a written record kept of these requirements.

Grounds / Motifs :

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

Three medication incident reports were reviewed, each one separately involving different residents. There was no documentation in any of the reports to demonstrate that an analysis was completed for the medication incidents.

The medication incidents involving two of the residents, documented that education was provided as a corrective measure to prevent a recurrence of the incident. However, the DOC stated that they could not recall the staff members involved in any of the incidents and acknowledged that they had no records to demonstrate that a root-cause analysis was completed.

The medication incident report involving the third resident showed blank documentation related to corrective actions taken to prevent a recurrence of the incident. The DOC acknowledged that they did not have documented evidence to support that actions were taken to prevent a recurrence of the incident.

During an interview with the DOC and Pharmacist they said they did not have a written record of the analysis and corrective actions taken for the three medication incidents that were reviewed.

The licensee failed to ensure that the medication incidents involving three residents were analyzed with corrective actions taken and that a written record was kept of these requirements.

The severity of this noncompliance was determined to be a level two with potential for harm; and the scope of this issue was identified as being a widespread. The home does not have a history of noncompliance in this subsection of the Long Term Care Homes Act and Regulations.
(218)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2018

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 Health and 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:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and 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 de la Santé et 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) 151, rue Bloor Ouest, 9e étage Toronto ON M5S 2T5	Directeur a/s du coordonnateur/de la coordonnatrice en matière d’appels Direction de l’inspection des foyers de soins de longue durée Ministère de la Santé et 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 7th day of January, 2018

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector / Nom de l'inspecteur : Dorothy Ginther

Service Area Office / Bureau régional de services : London Service Area Office