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 # / Registre no	Type of Inspection / Genre d'inspection
Oct 17, 2016	2016_195166_0029	032081-15, 027370-16	Critical Incident System

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

WINBOURNE PARK
1020 Westney Road North AJAX ON L1T 4K6

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

CAROLINE TOMPKINS (166)

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): September 29 and 30, 2016

Critical Incident logs 032081-16, related to allegations of resident to resident physical abuse and log 027370-15 related to allegations of staff to resident emotional abuse.

During the course of the inspection, the inspector(s) spoke with Residents, Family members, Director of Care(DOC), Administrator, Registered Nurse(RN), Registered Practical Nurse(RPN) and Personal Support Workers(PSW).
During the course of this inspection, the inspector, reviewed clinical records and the licensee's investigation documentation.

The following Inspection Protocols were used during this inspection:
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **1 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 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:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. related to log 032081-15

The licensee has failed to ensure that a responsive behaviour plan of care based on an interdisciplinary assessment for resident #002 included:
any mood and behaviour patterns, including wandering
any identified responsive behaviours
any potential behavioural triggers and variations in resident functioning at different times of the day.

A Critical Incident Report(CIR) was received reporting an incident of resident to resident physical abuse. Review of documentation indicated, a PSW heard a loud noise coming from a residents' room. Staff responded and found resident #003 laying on the floor and had sustained an injury. Resident #002 was observed standing over resident#003. Resident #003 indicated to staff, that resident #002 had pushed resident #003. Resident #003 was transferred to the hospital for further assessment and treatment Resident #002 was administered medication to mitigate the agitation.

Review of clinical documentation indicated that Resident #002, since admission had demonstrated responsive behaviours.
On a specific date, resident #002 was transferred to the hospital due to ongoing responsive and unpredictable behaviour.
The resident returned to the home the same day. The following day, resident #002 was transferred back to hospital due to ongoing responsive behaviours.

There is no documented evidence of a responsive behaviour plan of care that identified any aggressive tendencies, no interventions or triggers addressed related to responsive behaviours and no interventions in place to protect other resident and/or staff from resident #002's ongoing unpredictable responsive behaviours. [s. 26. (3) 5.]

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 plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. related to log 027370-16

The licensee has failed to ensure that any, policy, protocol, procedure put in place is complied with
8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with all applicable requirements under the Act; and
(b) is complied with.
The licensee's Medication Administration Policy CARE13-O10.01
Medication Management directs staff to:
-Medication must be observed for ingestion, otherwise it will not be considered administered
-Medication will not be left unattended for the Resident to self administer unless the Resident performs self administration in adherence to the Self -Medication of Medication procedure.

Review of medication administration records for one month, interview with resident #001 and interview with the Director of Care indicated that the P.M. medication(as required)(PRN) was left at resident #001's bedside for the resident to self administer on nine separate occasions .

Review of clinical documentation and interview with the Director of Care indicated, resident#001 had not been assessed in adherence with the licensee's Self -Medication procedure, in order to determine if the resident could self administer medication safely. [s. 8. (1) (a)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. related to log 032081-15

The licensee has failed to ensure that the report to the Director included the following analysis and follow-up actions:
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence

A Critical Incident Report was received reporting and incident of resident to resident physical abuse.
Review of clinical documentation indicated, a PSW staff heard a loud noise, responded and found resident #003 laying on the floor and had sustained an injury . Resident #002 was observed standing and watching resident #003.
Resident #003 indicated that resident #002 had pushed resident #003
Review of clinical documentation, including the amended version of the Critical Incident Report did not provide the Director with analysis and follow-up action related to this specific incident, including, i. the immediate actions that have been taken to prevent recurrence, and ii. the long-term actions planned to correct the situation and prevent recurrence. [s. 104. (1) 4.]

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. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. related to log 027370-16

The licensee has failed to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident.

A Critical Incident Report(CIR) was received reporting an allegation of staff to resident emotional abuse.
Review of the licensee's investigation, interview with resident #001 and the Director of Care indicated that resident #001 expressed concern that the (as required) PRN medication was left at the bedside for the resident to take independently.
Interview with resident #001, indicated it was very difficult for the resident to handle the medication cups that contained the medication and due to the physician's directions for PRN administration, which included a specific dosage at specific times, the resident indicated not being able to determine what was the correct time and dosage.

Resident#001 had not been assessed for safety related to self administration and there was no approval from the prescriber for the resident to self administer the medication. [s. 131. (5)]

Issued on this 17th day of October, 2016

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

Original report signed by the inspector.