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
Aug 12, 2016	2016_260521_0028	020222-16	Resident Quality Inspection

Licensee/Titulaire de permis

THE CORPORATION OF THE CITY OF LONDON
c/o Dearness Home for Senior Citizens 710 Southdale Road East LONDON ON N6E 1R8

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

DEARNESS HOME FOR SENIOR CITIZENS
710 SOUTHDALE ROAD EAST LONDON ON N6E 1R8

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

REBECCA DEWITTE (521), ADAM CANN (634), DONNA TIERNEY (569), NATALIE MORONEY (610)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 12,13,14,15,18,19, 20, 22, 25, 26, 27 and 28, 2016.

The following intakes were completed within the RQI:

013806-15 Critical Incident #M514-000024-15 related to alleged resident to resident

abuse
034052-15 Complaint #IL41885-LO related to a resident discharge
034805-15 Critical Incident #M514-000052-15 related to reporting and complaints
001580-16 Critical Incident #M514-000051-15 related to falls prevention and management
001753-16 Critical Incident #M514-000002-16 related to alleged resident to resident abuse
002096-16 Critical Incident # M514-000007-16 related to alleged staff to resident abuse
003377-16 Critical Incident #M514-000010-16 related to transfers
004246-16 Critical Incident #M514-000013-16 related to reporting to the director
004824-16 Critical Incident #M514000015-16 related to alleged resident to resident abuse
007893-16 Critical Incident #M514-000018-16 related to nursing care
008446-16 Critical Incident #M514-000020-16 related to alleged resident to resident abuse
008880-16 Critical Incident #M514-000058-16 related to alleged staff to resident abuse
008942-16 Critical Incident #M514-000022-16 related to alleged resident to resident abuse
010120-16 Critical Incident #M514-000012-16 related to resident care
012668-16 Critical Incident #M514-000027-16 related to alleged resident to resident abuse
013227-16 Critical Incident #M514-000001-16 related to falls prevention and management
013419-16 Critical Incident #M514-000055-15 related to falls prevention and management
016412-16 Critical Incident #M514-000031-16 related to alleged staff to resident neglect
016439-16 Critical Incident #M514-000032-16 related to an incident
016301-16 Critical Incident #M514-000030-16 related to a resident transferring to hospital
019193-16 Critical Incident #M514-000019-16 related to a resident transferring to hospital
020430-16 Critical Incident #M514-000057-15 related to alleged resident to resident abuse
020427-16 Critical Incident #M514-000060-15 related to falls prevention and management

021530-16 Critical Incident #M514-000034-16 related to alleged staff to resident abuse
035392-15 Follow Up #2015_277538_0033 Log#026856-15 related to bed entrapment

The following intakes were inspected at the same time as the RQI and can be found in a separate report(s):

020793-16 Complaint #IL-45642-LO related to resident records
033266-15 Complaint #IL41820-LO related to internal transfers
033515-15 Complaint #IL-41885-LO related to resident care

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, two Assistant Directors of Care, two RAI-Coordinators, four Managers, two Registered Nurses, seventeen Registered Practical Nurses, fourteen Personal Support Workers, one Physiotherapist, two Physiotherapy Assistants, one Dietitian, one Social Worker, one Dietary Aide and approximately 60 residents and some family members.

The inspector(s) completed a facility tour, a dining observation, interviews, reviewed health care records, observed residents and their care, reviewed relevant policies and other reports as needed.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

- **7 WN(s)**
- **4 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 15. (1)	CO #901	2015_277538_0033	521
O.Reg 79/10 s. 15. (1)	CO #902	2015_277538_0033	521

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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure the resident's right to be cared for in a manner consistent with his or her needs was fully respected and promoted.

Review of the clinical record showed that a resident sustained an injury. The Doctor ordered a test.
The resident did not get the test immediately.

The ADOC agreed that resident should have received the test immediately after the original physician's order.
The home did not promote and respect the resident's right to be cared for in a manner consistent with her needs when they allowed 43 days to pass before the test was provided. [s. 3. (1) 4.]

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 every resident has the right to be cared for in a manner consistent with his or her needs, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

Included in the critical incident system report regarding a resident was a description that a member of staff allegedly crossed a therapeutic boundary.

Review of the homes Resident Abuse Policy Staff to Resident; Revised March 2013:

"Any action not in keeping with the client-caregiver therapeutic relationship is inappropriate or not in keeping with care provision or assistance with activities of daily living".

All staff immediately reports any suspected or witnessed abuse to the Administrator, Director of Care or their designate.

An email sent to the Administrator showed that the resident had notified the staff of a alleged crossed boundary.

The staff directed the resident to report the alleged abuse to another staff member.

The staff did not report the incident immediately to the Administrator, the Director of Care or their designate.

An interview with management said that the staff should have reported the incident immediately to the Administrator, or the Director of Care or their designate as per the policy and that the policy had not been complied with. [s. 20. (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 there was a written policy that promotes zero tolerance of abuse and neglect of residents and that it is complied with,, 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 :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that the following has occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director regarding improper or incompetent treatment or care of a resident that resulted in risk of harm.

Review of the critical incident system report regarding a resident showed that a staff member was allegedly providing rough care and was disrespectful to a resident.

Review of the home's Resident Abuse Policy, Staff to Resident; revealed;

All staff immediately reports any suspected or witnessed abuse to the Ministry of Health and Long Term Care (MOHLTC) through the Critical Incident Reporting System or the after hours pager.

Review of the homes internal investigation notes showed that the staff had notified management when made aware of alleged abuse. The critical incident system report was submitted by management a day later.

During a telephone interview with the staff, the staff explained she reported the allegations to the management immediately.

Interview with management said that a voice message was received from staff regarding the allegation of abuse but management did not report to the Director until a day later and should have been reported immediately. [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 any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director regarding improper or incompetent treatment of care of a resident that resulted in risk of harm, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. Every licensee of a long-term care home shall ensure that, procedures and interventions were developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

Review of the critical incident system report showed a resident became aggressive during the time of care.

The homes policy Responsive Behaviours # 09-05-01 September 2010:

"All staff are responsible for completing accurate documentation in the resident's health record or on the Responsive Behavioural Record when behaviours are observed. Documentation should clearly describe:

Any identified triggers to the behaviour

How the behaviour was displayed

Any negative experience or outcome for the resident or another person/resident

All staff providing care to the resident are required to be familiar with the plan of care…..and the implementation of these interventions in place for behaviours and that staff are to reapproach the resident".

The care plan for the resident showed that staff were to accommodate resident's resistive to care behaviour and reapproach the resident in five minutes.

Review of the internal investigation notes showed that the resident became resistive to care but the staff did not reapproach the resident and continued the care.

A staff member said in an interview with an inspector that the resident had been resistive to care and the staff had not reapproached the resident as per the plan of care interventions.

Review documentation showed that on that specific shift there was no documented behaviours.

Interview with management said that staff are to document any behaviours for residents and that this had not been done when the resident was demonstrating behaviours. The management also said that the interventions had been in place to reapproach the resident when the resident was resistive to care and that the interventions had not been implemented with this incident. [s. 55. (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that, procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents, to be implemented voluntarily.

WN #5: 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).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that sets out the planned care for the resident.

During stage one and two of the resident quality inspection an inspector observed a couple of residents sitting in specific chairs.

Record review was completed of the resident's care plans. The care plans did not indicate that the resident's were to be in these specific chairs.

Record review was completed of policy - Care Planning, September 2010, with no current revision date. Policy Number 03-01-02 Care Plan requirements which revealed the residents care plan is to be kept current and reflective of the current care needs of the resident.

During an interview with a staff member said that they do place these residents in these chairs for comfort.

The management said the plan of care did not include direction regarding the chair and the residents had not been assessed.

The licensee failed to set out the planned care for the residents with respect to the use of the chairs. There was no direction regarding how and when to use the chairs to promote comfort. [s. 6. (1) (a)]

2. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the care set out in the plan was no longer necessary.

A record review of a resident plan of care identified the resident at high risk for falls. The resident was to have the bed in a low position and a logo in the resident room.

It was observed that the bed was not in the low position and the logo was missing from the resident room.

Interviews with staff agreed that there was no logo in the resident room when the care plan identified the logo should be present and the resident's bed was at the regular height while the resident was in the bed. The staff both confirmed the resident needs had changed.

An interview with management identified the plan of care for the resident had not been updated to reflect the residents care needs and it was the homes expectation that the plan of care should be reviewed and revised when the resident's care set out in the plan is no longer necessary. [s. 6. (10) (b)]

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

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. A licensee failed to report to the Director the results of every investigation.

A critical incident system report was submitted to the Director related to a past alleged incident of staff to resident verbal abuse. This report did not include the results of the home's investigation.

The management was interviewed. Management said the investigation into the alleged incident was completed with no findings of abuse.

The interview with management asked if an amendment was forwarded to the Director that identified the results of the investigation and they said there was not. [s. 23. (2)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident had fallen, a post-fall assessment was conducted using a clinically appropriate assessment instrument.

Record review was completed of the critical incident system report submitted to the Director. The incident report said that a resident sustained an injury.

Record review was completed of the assessment. The assessment was blank where answers were required and had been signed off by the staff.

Interview was conducted with management who said that it was the expectation of the home that an assessment should be completed after every incident. The management confirmed that the assessment was blank and had not been completed but had been signed off by staff.

The licensee failed to ensure that a post fall assessment was completed after the resident's fall. [s. 49. (2)]

Issued on this 15th day of August, 2016

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

Original report signed by the inspector.