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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 2, 2019	2018_570528_0009	021305-17, 026531-17, 000688-18	Complaint

Licensee/Titulaire de permis

Corporation of the City of Brantford and the Corporation of the County of Brant
97 Mount Pleasant Street BRANTFORD ON N3T 1T5

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

John Noble Home
97 Mount Pleasant Street BRANTFORD ON N3T 1T5

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

CYNTHIA DITOMASSO (528)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): December 18, 19, 20, 2018

This complaint inspection included:
i. Complaint log # 021305-17, #026531-17 and #000688-18 related to resident to resident altercation, bowel management, food quality, and plan of care

During the course of the inspection, the inspector(s) spoke with the Administrator, the Resident Assessment Instrument (RAI) Coordinator, the Nutrition Services Supervisor, cooks, registered nurses, registered practical nurses, personal support workers, dietary aides, and residents.

During the course if the inspection, the inspector(s) also observed the provision of care and services, reviewed documents, including but not limited to: clinical health records, menus, recipes, production sheets, complaint logs, investigation notes, policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Food Quality
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **5 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	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. 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 failed to ensure that residents were protected from abuse by anyone.

Critical Incident #M544-000014-17, log # 021305-17, submitted in 2017, described resident to resident altercation, resulting in harm to resident #003.

i. Review of the Critical Incident System (CIS) Report, from September 2017, revealed that concerns related to ongoing behaviours of resident #001 were submitted to the Director of Care (DOC), identifying an alleged negative outcome to resident #003.
ii. Review of the plan of care for resident #001 identified that the resident had multiple diagnosis. Several months before the CIS, resident #001 was not cooperating with their treatment plan resulting in worsening behaviours. The physician noted at that time that the resident was having altercations with residents and staff.
iii. Review of the complaints log revealed one complaint related to the residents ongoing behaviours, negatively impacting resident #003. Resident #001 was sent for assessment; however, upon readmission, the progress notes for resident #001 documented that the resident was demonstrating behavious the day they returned to the home. From June to August 2017, progress notes for resident #001 documented the resident continued to have demonstrated behaviours with staff and co-residents.
iv. In August 2017, an altercation occurred between two residents, with no harm identified. The following day, resident #003 was documented as having negative outcomes because of the incident and notified staff. Several days later, concerns were brought forward related to resident #001, at which time, a specified intervention was started with resident #001 and the residents were separated.
v. Review of CIS, interview with the Administrator and with PSW #105 confirmed that resident #003 was negatively impacted by the interaction with resident #001.
vi. For the purposes of the definition of "abuse" in the Act,
"emotional abuse" means any threatening or intimidating gestures, actions, behaviour or remarks by a resident that causes alarm or fear to another resident where the resident performing the gestures actions, behaviour or remarks understands and appreciates their consequences.
"verbal abuse" means any form of verbal communication of a threatening or intimidating nature made by a resident that leads another resident to fear for his or her safety where the resident making the communication understands and appreciates its consequences.
vii. Interview with RPN #110 confirmed that resident #001 was capable of their own decision making.
Resident #001's responsive behaviours directed towards resident #003 documented negative outcomes for resident #003 and they were therefore, not protected from abuse. [s. 19. (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 residents are protected from abuse by anyone, to be implemented voluntarily.

WN #2: 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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 staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

Complaint log #000688-18, submitted in January 2018, identified concerns that resident #001 reported related to a change in bowel continence.

Review of the Minimum Data Set (MDS) Assessment from June 2018, identified that resident #001 was continent of bowels. Review of the Quarterly Bladder/Bowel Continence Assessment from June 2018, revealed that the resident was not continent of bowels. Interview with RAI Coordinator confirmed that although there was no negative outcome to the resident, the Quarterly MDS Assessment and Bladder/Bowel Continence Assessment were not consistent with each other. (528) [s. 6. (4) (a)]

2. The licensee 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 residents care needs change or care set out in the plan was no longer necessary.

Complaints log # 026531-17, submitted in November 2017, and # 000688-17, submitted in January 2018, identified concerns related to the plan of care. In a follow up interview with resident #001 in December 2018, the resident revealed that they did not always get their bath.

Review of the plan of care for resident #001, identified a specific bathing preference on two identified evenings of the week. Alternatively, review of the point of care documentation for bathing for December 2018, revealed that the resident received a bath or shower on all scheduled shifts, and had refused more than once that month. Interview with PSW #107 and #111 identified that the resident did not have a specific preference but would depend on the day, that they received their scheduled bathing on day shift, and that the resident often refused. Interview with RPN #110 and review of the bath schedule confirmed that the written care plan was not updated to include the resident's current preference and scheduled bathing times.

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 failed to ensure that the person who had 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 risk of harm had occurred or may have occur, immediately report the suspicion and the information upon which it was based to the Director.

Critical Incident #M544-000014-17, log # 021305-17, submitted in 2017, described resident to resident altercation resulting in harm to resident #003.

i. Review of the Critical Incident System (CIS) report, revealed that in 2017, ongoing altercations occurred between resident #001 and #003.
ii. Review of the 2017 Complaints and Concerns Log, revealed that several months before the CIS, a complaint was submitted to the Director of Care outlining concerns and allegations of abuse towards resident #003. The complaint, which was written, was not submitted to the Director.
iii. Interview with the Administrator confirmed that the incident had not been reported to the Director. The Director of Care responded to the families concerns; however, the home was unable to find documentation to support why the allegations were not reported to the Director.
iv. Review of the home's policy 'Prevention of Abuse and Neglect: 3-A-60', revised February 2018, directed the home to notify the Ministry of Health and Long Term Care by completing a Critical Incident Report.
v. Review of the plan of care for resident #001, identified that they had multiple diagnosis and was not cooperative with their treatment plan, resulting in worsening behaviours. Furthermore, progress notes for resident #001, documented ongoing incidents of altercations with coresidents, at which time, their treatment needs were reassessed.
vi. Interview with the Administrator in December 2018, confirmed that at the time of the initial written complaint, resident #001, had a change in their health and had worsening behaviours, resulting in transfer to the hospital. The Administrator also confirmed that several months later, an investigation revealed that resident #003 had been harmed as a result of resident #001, according to definition of abuse as outlined in the Act; however this was not reported to the Director.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a documented record was kept in the home that included every date on which any response was provided to the complainant and a description of the response.

Critical Incident #M544-000014-17, log # 021305-17, submitted in 2017, described resident to resident altercation resulting in harm to resident #003.

Review of the '2017 Complaint and Concern Log', revealed that in May 2017, a written complain was submitted to the DOC related to multiple issues including but not limited to, alleged abuse to resident #003 by resident #001.
Four days later, a complaint and concern form was initiated and action taken was documented; however, the dates in which the complainant was provided a response was not included as part of the documented complaint record. Interview with the Administrator confirmed that the responses to the complainant, which were documented in resident #003's progress notes, were not documented on the Complaint and Concern Log. (528) [s. 101. (2) (e)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 103. Complaints — reporting certain matters to Director

Specifically failed to comply with the following:

s. 103. (1) Every licensee of a long-term care home who receives a written complaint with respect to a matter that the licensee reports or reported to the Director under section 24 of the Act shall submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 101 (1). O. Reg. 79/10, s. 103 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that when a written complaint was received with respect to a matter that the licensee reports or reported to the Director under section 24 of the Act shall submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 1.

Review of the 2017 and 2018 Complaint and Concern Log, identified the following written complaints:

i. In May 2017, a written complaint was submitted to the DOC that outlined concerns including but not limited to, allegations of abuse.
ii. In August 2018, a complaint was submitted to the DOC that outlined multiple care and environmental concerns.

Interview with the Administrator and RAI Coordinator in December, 2018, confirmed that the DOC at the time of the written complaints could not be interviewed. They confirmed that the items were actioned and resolved; however, a copy of the written complaints were not forwarded to the Director. [s. 103. (1)]

Issued on this 11th day of January, 2019

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

Original report signed by the inspector.