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 31, 2019	2019_778563_0004	004539-18, 008619-18, 014844-18, 026755-18, 001020-19	Critical Incident System

Licensee/Titulaire de permis

Sharon Farms & Enterprises Limited
108 Jensen Road LONDON ON N5V 5A4

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

Kensington Village
1340 Huron Street LONDON ON N5V 3R3

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

MELANIE NORTHEY (563), KRISTEN MURRAY (731)

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): January 22, 23, 24 and 25, 2019

The following Critical Incident (CI) intakes were completed within this inspection:

Related to Fall Prevention
Log #004539-18 / CI #2729-000006-18
Log #008619-18 / CI #2729-000010-18
Log #014844-18 / CI #2729-000015-18
Log #026755-18 / CI #2729-000022-18

Related to the Prevention of Abuse and Neglect
Log #001020-19 / CI #2729-000001-19

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Clinical Best Practice Manager, the Resident Assessment Instrument Coordinator, the Director of Operations, Registered Practical Nurses, Personal Support Workers and residents.

The inspector also made observations of residents and care provided. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed.

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

During the course of this inspection, Non-Compliances were issued.
- **3 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. 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 has failed to ensure that the written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

Section 2(1) of THE Ontario Regulation 79/10 defines physical abuse as "the use of physical force by a resident that causes physical injury to another resident" and defines verbal abuse as "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".

A) The home submitted a Critical Incident System report to the Ministry of Health and Long-Term Care (MOHLTC) related to a specific incident involving two residents.

A review of both residents progress notes in Point Click Care stated that the above incident had occurred on a specific date and there was no documented evidence that the registered staff reported the abuse to the home's management on that date.

The Director of Operations stated that they reported the incident three days later when they found out about the incident, and that they would have expected the Registered Nurse (RN) to notify management immediately following the incident.

B) The home submitted Critical Incident System report to the MOHLTC related to a specific incident involving two residents.

Section 2(1) of Ontario Regulation 79/10 defines physical abuse as "the use of physical force by a resident that causes physical injury to another resident".

A review of one resident's progress notes in Point Click Care stated that the above incident had occurred on a specific date, and there was no documented evidence that

the registered staff reported the abuse to the home's management on that date.

The Director of Operations stated that they do not believe the RN in charge of the home called the manager on call to report the incident and that staff may not have been clear on the policy to contact the management after-hours.

The Director of Care (DOC) stated that the home did not call the after-hours action line and did not meet the reporting requirements for contacting the MOHLTC. The DOC stated that the home's expectation was that staff would immediately report any allegations of abuse or neglect to management in the home and the manager on-call during after-hours.

The home's policy "Zero Tolerance of Abuse and Neglect (HR-J-15)" stated that "The Charge Nurse/RPN will: 3. Immediately Notify Administrator/DOC/ADOC/designate. After hours the RN in charge of the Home must immediately report to the manager on Call".

The licensee failed to ensure that the written policy that promoted zero tolerance of abuse and neglect of residents was 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 the written policy that promoted zero tolerance of abuse and neglect of residents is complied with., 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. (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 the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed.

A Critical Incident System report submitted to the Ministry of Health and Long Term Care documented that a resident sustained a fall and suspected injury.

The resident was observed lying in bed with multiple fall prevention strategies in place. The resident also has a specific device in use for their wheelchair. The Resident Assessment Instrument Coordinator (RAI-C) entered the room and stated that the resident had a specific device on their wheelchair to reduce fall risk.

The current plan of care in Point Click Care (PCC) documented all observed fall interventions with exception to the wheelchair device. The Point of Care (POC) tasks in PCC listed other devices and interventions for monitoring related to falls and safety, but not the specific device noted on the resident's wheelchair.

The Health Status progress note in PCC documented that the resident has been using the device for several months.

The Director of Care and Clinical Best Practice Manager (CBPM) acknowledged that the resident's plan of care was not revised to include the use of the device when the resident's fall prevention strategies changed. The CBPM also stated that the use of the device should have been added to the POC task list for Personal Support Worker documentation.

The licensee has failed to ensure that the resident's plan of care was revised to include the use of a specific device in the prevention of falls. The progress notes documented the use of the chair alarm as early as six months ago and the device was never added to the plan of care or tasks list in PCC when the resident's strategies to reduce falls changed. [s. 6. (10) (b)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee failed to report in writing to the Director setting out the following with respect to the incident: names of any residents involved in the incident.

A Critical Incident (CI) System report documented a fall. The incident category documented, "Incident that causes an injury to a resident for which the resident is taken to hospital and which results in a significant change in the resident's health status [107(3)(4)]". The resident's name was not was documented as part of the report to the Director.

The Director of Operations acknowledged that the resident's name was absent from the CI report and shared that the CI should have been amended to include all mandatory reporting information.

The licensee failed to report in writing to the Director the name of the resident involved in the incident that caused an injury for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. [s. 107. (4) 2. i.]

Issued on this 6th day of February, 2019

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

Original report signed by the inspector.