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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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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
Dec 24, 2014	2014_380593_0015	S-005345-14	Complaint

Licensee/Titulaire de permis

THE ONTARIO-FINNISH RESTHOME ASSOCIATION
725 North Street Sault Ste Marie ON P6B 5Z3

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

MAUNO KAIHLA KOTI
723 North Street Sault Ste Marie ON P6B 6G8

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

GILLIAN CHAMBERLIN (593)

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): November 03rd - 04th, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nursing Staff, Personal Support Worker's (PSW), Dietary Staff, Recreation Staff, Administration Staff and residents and family members.

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

During the course of this inspection, Non-Compliances were issued.
- **2 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 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).

Findings/Faits saillants :

1. This non-compliance is supported by the following findings:

A complaint was received by the Ministry of Health and Long-Term Care regarding an incident of alleged abuse by Resident #002 toward Resident #001 occurring in the home. As a result of this incident, an interdisciplinary team meeting was held by the home regarding Resident #002's behaviours and numerous interventions were implemented to prevent this incident or a similar incident from re-occurring including:

• At shift change one staff member will always be on the floor during report. If said resident is up
they will be with them

• BSO PSW will work 1:1 with resident

• Activity staff will encourage participation in small group activities

• A deterrent sign will be applied to residents, doorways to deter Resident #002 from entering their rooms

• All members of the care team will work together to monitor location on unit and redirect when
venturing near alternate residents and their rooms

During an interview with Inspector #593 November 04, 2014, staff member #105 advised that part of the plan to manage Resident #002's behaviours included; a PSW is to sit with the resident in the morning, the resident is to be monitored during shift changeover, staff are to be on high alert as to Resident #002's whereabouts within the home and a deterrant sign is placed over residents' doors that are bothered by Resident #002. In addition, the staff member advised that there is an intervention in place so that night shift staff are aware if the resident leaves their bed during the night.

During an interview with inspector #593 November 04, 2014, staff member #106 advised that Resident #002 has an intervention in place so that staff are aware when the resident leaves their bed. In addition, a PSW from the assisted living side watches Resident #002 during the PSW night rounds to ensure that the resident does not wander into other resident's rooms.

During an interview with Inspector #593 November 04, 2014, DOC staff member #107 advised that since the incident occurred between Residents #001 and #002, an action plan has been put into place with the BSO team and an interdisciplinary team meeting was held to discuss Resident #002's behaviours. DOC staff member advised that this plan was added to the resident's plan of care.

A review of Resident #002's plan of care found that the resident has a bed feature as a PASD which is an intervention to prevent falls as the resident can be unsteady on their feet when getting out of bed. It is not documented in the plan of care that the bed feature is in place to alert staff that the resident is out of bed during the night with the potential to wander into other resident's rooms.

A review of Resident #002's plan of care, in place at the time of the incident, found an added hand written note "keep separated from Resident #001. Physical altercation". A review of Resident #002's current plan of care found no mention of the altercation with Resident #001 or instructions to keep Resident #002 away from Resident #001. In addition, the previous interventions implemented were not documented in relation to the incident occurring between the two residents, in Resident #002's current plan of care.

As such, the licensee has failed to ensure that there is a written plan of care for Resident #002 that sets out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

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 Resident #002's plan of care is kept current with all care and interventions and that all staff have access to all relevant information regarding Resident #002, to be implemented voluntarily.

WN #2: 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. This non-compliance is supported by the following findings:

A review of the home's policy: Abuse of Residents, Preventing, Reporting and Eliminating dated May 2014 found that all employees and volunteers at the home who witness or suspect the abuse of a resident are to report the matter immediately to their direct supervisor and that a person who has reasonable grounds to suspect that abuse of a resident has occurred, or may occur, shall immediately report the suspicion and the information upon which it is based to the Director of the Ministry of Health and Long-Term Care. In addition, failure to report suspected or witnessed abuse is deemed to be neglect.

A review of the home's training program found that the annual mandatory education for all staff indicates that a person who has reasonable grounds to suspect that abuse of a resident by anyone has occurred, or may occur, shall immediately report the suspicion and the information upon which it is based to the Director and that staff are to report witnessed or suspected abuse or received complaints of abuse, immediately to their direct supervisor.

During an interview with Inspector #593 November 03, 2014, staff member #100 advised that on an afternoon in March, 2014 both staff member #100 and staff member #101 witnessed rough wound care towards Resident #003 by staff member #102 resulting in pain and distress to Resident #003. After the incident occurred, the two staff members discussed the incident and together they decided to report this to their supervisor five days after the incident occurred. Staff member #100 advised that they were aware that abuse had to be reported immediately however they were unsure at the time whether this incident was considered abuse.

The licensee of Mauno Kaihla Koti submitted a Critical Incident report to the Ministry of Health and Long-Term Care in relation to the physical abuse from staff member #102 toward Resident #003. The Critical Incident report was submitted five days after the incident was reported to have happened. As such, the licensee has failed to immediately report the abuse or suspicions of abuse to the Director. [s. 24. (1)]

Issued on this 6th day of February, 2015

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

Original report signed by the inspector.