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 # / No de registre	Type of Inspection / Genre d'inspection
Feb 22, 2018	2018_624196_0001	026714-17	Complaint

Licensee/Titulaire de permis

Anson General Hospital
58 Anson Drive IROQUOIS FALLS ON P0K 1E0

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

South Centennial Manor
240 Fyfe Street IROQUOIS FALLS ON P0K 1E0

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

LAUREN TENHUNEN (196)

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): January 23 - 26, 2018.

The following intake was inspected:
- a complaint regarding an incident of resident to resident abuse with injury.

During the inspection, the Inspector conducted a walk through of resident care areas, observed staff to resident, and resident to resident interactions, observed the provision of care and services to residents, reviewed various home policies, procedures and training records, and reviewed resident health care records.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), the Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), 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.
- **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 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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 set out, clear directions to staff and others who provided direct care to the resident.

A complaint was received by the Director with concerns regarding an incident of resident to resident abuse which resulted in injury to resident #001.

In addition, a Critical Incident System (CIS) report was submitted to the Director for this same incident of resident to resident abuse. The report indicated that resident #002 had caused a physical injury to resident #001.

The current care plan for resident #001 was reviewed by the Inspector. The plan identified staff were to have a plan to ensure the resident felt safe.

During an interview, RPN #107 reviewed the care plan with the Inspector and stated they were unsure of what the plan was to ensure that resident #001 felt safe.

During an interview, RPN #109 reported to the Inspector that the care plan was vague in reference to a specific concern and not clear regarding the plan in place to continue to ensure the resident felt safe.

During an interview with the DOC, they reported to the Inspector that the plan to keep resident #001 feeling safe included specific interventions which were not listed. The DOC confirmed to the Inspector that the care plan did not provided clear directions to staff regarding what steps were to be taken to address the safety of resident #001. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

During the inspection, Inspector #196 reviewed resident #002's current care plan for responsive behaviour information. The care plan included a specific monitoring intervention.

The specific monitoring intervention record was reviewed by the Inspector, for a particular date, at a particular time. Documentation of the half hour interval behaviours were missing from a two and a half hour period.

The Inspector reviewed the licensee's policy titled, "Responsive Behaviours Program - LTC-006", last reviewed February 16, 2017. The policy indicated that the "Personal Support Worker (PSW)", was to, "Participate in behaviour mapping" and "Follow the interventions as outlined in the plan of care."

During an interview, PSW #108 reported to the Inspector that they had been assigned to resident #002 that specific shift. When questioned regarding the completion of the specific monitoring intervention, they stated they were not aware that it needed to be done that day, and did not know who had completed the documentation up until a particular time.

When questioned regarding who had completed the specific monitoring intervention charting until a specific time on a date during the inspection, RN #111 reported to the Inspector that there was an extra staff member that worked for four hours that shift and they may have completed the documentation.

During an interview with RPN #106, they told the Inspector that the PSW was to have

completed the specific monitoring intervention charting for resident #002, as instructed in the shift report.

During an interview, the DOC reported to the Inspector that staff were to be aware of what was in the care plan and the plan of care for resident #002. They also confirmed that the specific monitoring intervention charting was ongoing, and at report, the RN would instruct the PSWs to complete this charting. [s. 6. (7)]

3. The licensee has 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 resident's care needs changed or care set out in the plan was no longer necessary.

The CIS report had indicated the use of a specific type of monitoring device for resident #002.

The progress notes for resident #002, from a specific date and onward, identified particular responsive behaviours.

The Inspector reviewed resident #002's current care plan, which included a focus initiated the day following the incident of resident to resident physical abuse and included several different types of interventions.

During the inspection, at two different times, Inspector #196 observed resident #002 with an intervention in place not listed in the care plan.

During observations on the following date, resident #002 had several different types of devices in place which were not identified in the care plan.

The licensee's policy, "Responsive Behaviours Program - LTC-006" last reviewed on February 16, 2017, indicated, "Other RN Responsibilities" included "Monitor and update the care plan at least quarterly in collaboration with the interdisciplinary team. If the interventions have not been effective to prevent, reduce or support resident, initiate alternative approaches and update as necessary".

During an interview, RPN #109 reported to the Inspector that resident #002 had different types of devices and strategies in place, different from what was listed in the care plan, to minimize and monitor responsive behaviours, and some devices that were to be used at a specific time of day. RPN #109 confirmed to the Inspector that the care plan should

have reflected the current care needs of resident #002.

During an interview, the DOC reported that care plans should be updated on an ongoing basis, when there was a change in a residents' status, quarterly with the Resident Assessment Instrument (RAI) schedule, by the RNs, RPNs and the RAI coordinator. They further reported to the Inspector that resident #002 was to have specific types of devices but was not reflected in the care plan. The DOC confirmed to the Inspector that the current care plan and the care plan that was implemented after the incident, did not identify the needs of the resident. The DOC confirmed to the Inspector that the care plan, had not been updated with what was currently being done for the resident. [s. 6. (10) (b)]

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 that ensures that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan is no longer necessary, 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 has failed to ensure that there was in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy was complied with.

Please refer to WN #1, finding #1 paragraph 3 for further information.

The CIS report was submitted to the Director on a particular date at a specific time for an incident of resident to resident abuse which had occurred approximately three and a half hours earlier. The report indicated that resident #002 had caused injury to resident #001, as result of a certain action.

The licensee's policy titled, "Zero Tolerance of Abuse and Neglect - LTC-630 - last reviewed December 16, 2015", indicated that the "Director of Care/delegate or Charge Nurse (after hours)", will "Notify the admin on call after hours". In addition, the policy indicated, "Registered Staff Responding for Care of the Resident(s) harmed by the abuse or neglect" were to, "Conduct head-to-toe physical assessment on the alleged victim and document findings if physical abuse is alleged." The policy also read that the, "Chief Executive Officer (CEO), Director of Care (DOC)/delegate" - "is responsible for ensuring all of the appropriate steps have been taken by the appropriate parties according to this policy. Upon receiving notification of abuse allegation, ensure an investigation and reporting process is underway by the staff person to whom the alleged abuse or neglect was reported."

Inspector #196 reviewed resident #001's plan of care and the internal incident report and did not locate information regarding the notification of the administration staff member on call at the time of the incident and there was no documentation of the head to toe physical assessment of the resident.

During an interview, RN #101, who was the Charge Nurse on the shift of the abuse incident, reported to the Inspector that they had not notified the on call Administration staff member that night. They added that they had not conducted a head to toe assessment on resident #001 after the incident.

During an interview, RN #102, the Charge Nurse who started the next shift after the incident, reported to the Inspector that they had not notified the on call Administration staff member. They went on to report that this would have been the responsibility of the RN on duty at the time of the incident and they could not recall if they had conducted a head to toe assessment on resident #001.

During an interview, the DOC reported to the Inspector, that Administration staff member #105, on call at the time of the incident, had not been notified of the resident to resident abuse incident. In addition, the DOC was unable to locate documentation that would have indicated a, "head-to-toe assessment" was conducted for resident #001 who had

sustained an injury from the abuse incident. The DOC confirmed that the home's policy to promote zero tolerance of abuse and neglect of residents was not complied with. [s. 20. (1)]

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 a person who had reasonable grounds to suspect that any of the following had occurred or may occur shall immediately report the suspicion and the information upon which it was based to the Director: 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.

Please refer to WN #1, finding #1 paragraph 3 for further information.

The CIS report was submitted to the Director on a particular date at a specific time for an incident of resident to resident abuse which had occurred approximately three and a half hours earlier. The report indicated that resident #002 had caused injury to resident #001, as result of a certain action.

The licensee's policy titled "Zero Tolerance of Abuse and Neglect - last reviewed December 16, 2015" was reviewed by Inspector #196. On page 7 of the policy, the policy read "....the Director of Care/delegate or Charge Nurse (after hours) will notify the Director by completing the Mandatory Critical Incident System (MCIS) report on-line or after hours calling the Ministry after-hours pager as per the Staff Reporting and Whistle Blowing Policy".

During an interview with RN #101, who was the Charge Nurse on the shift of the abuse incident, reported that they had not contacted the after hours pager for the Ministry of Health and Long-Term Care (MOHLTC). They added that they were aware of the MOHLTC mandatory reporting and stated they should have called the after hours pager number for the Director.

During an interview with the DOC, they confirmed to the Inspector that a call had not been made through the after hours pager number for the MOHLTC Director, at the time of the incident. [s. 24. (1)]

WN #4: 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:
2. A description of the individuals involved in the incident, including,
i. names of all 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. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that, 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: A description of the individuals involved in the incident, including, names of all residents involved in the incident, names of any staff members or other persons who were present at or discovered the incident, and names of staff members who responded or were responding to the incident.

Please refer to WN #1, finding #1 paragraph 3 for further information.

Inspector #196 reviewed the CIS report which indicated that two residents, resident #001 and #002 were involved in the incident. In addition, RN #101, the Charge Nurse on the shift of the abuse incident, was noted to have responded to the incident.

The Inspector reviewed the progress notes for resident #002, which included, "late entry" notes documented by PSWs #103 and #104. The notes identified that three residents were present when the discovery of the resident to resident abuse had occurred.

During an interview with the DOC, they reported to the Inspector that they were unaware of a third resident that had been present at the time of the incident. They went on to report that they were also unaware of the "late entry" progress notes that stated there were three residents in the room when the incident had occurred. In addition, the DOC confirmed to the Inspector that RN #102 was not identified in the CIS report, although they had also responded to the incident upon the start of their shift on the date of the occurrence. [s. 104. (1) 2.]

Issued on this 22nd day of February, 2018

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

Original report signed by the inspector.