Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
May 4, 2021	2021_853692_0008	000415-21, 000910-21	Critical Incident System

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

SHANNON RUSSELL (692), AMANDA BELANGER (736)

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): April 20-22, 2021.

The following intake(s) were inspected upon during this Critical Incident System inspection:
-One log, which was related to a critical incident that the home submitted to the Director related to abuse of a resident by anyone that resulted in harm or a risk of harm to the resident;

-One log, which was related to a critical incident that the home submitted to the Director related to Improper/incompetent treatment of a resident that resulted in harm or a risk of harm to the resident; and,

-One log, which was related to a critical incident that the home submitted to the Director related to an incident that caused an injury to a resident for which the resident was transferred to the hospital and resulted in a significant change in the residents status.

A Complaint inspection #2021_853692_0005 and a Follow Up inspection #2021_853692_0006 were conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Resident Assessment Instrument Coordinator (RAI-C), Behavioural Support Ontario (BSO) Recreation Therapist, Executive Assistant to the DOC, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and residents.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident and resident to resident interactions, observed infection control practices, reviewed relevant health care records, internal investigation notes, as well as licensee policies, procedures and programs.

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.

- **5 WN(s)**
- **3 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 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 sustained a fall, that a post fall assessment was completed.

A resident had sustained a fall, in which Inspector #736 was unable to locate a completed post fall assessment. In separate interviews with a Registered Practical Nurse (RPN) and a Registered Nurse (RN), they indicated that a post fall assessment was to be completed after a resident sustained a fall; and both staff, identified that there was not an assessment completed after the resident sustained a fall.

Sources: Critical Incident System (CIS) report; a resident's progress notes and assessments; policy titled Fall Prevention and Management Program (#LTC-001, last revised September 30, 2020); interviews with a RPN and a RN, as well as other staff. [s. 49. (2)]

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 ensuring 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, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the substitute decision maker (SDM) of a resident was notified of an allegation of abuse within 12 hours of the incident occurring.

A resident's progress notes indicated that the resident told staff that a co-resident had exhibited an inappropriate behaviour towards them. The resident's SDM was made aware of the concern 23 hours after the resident reported the incident.

Sources: A resident's progress notes; policy titled Zero Tolerance of Abuse and Neglect (#LTC-105, last revised December 1, 2020); interview with the Director of Care (DOC). [s. 97. (1) (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 ensuring that the resident's substitute decision maker (SDM) is notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee has failed to ensure that results of the analysis undertaken of every incident of abuse or neglect of a resident at the home were considered in the annual evaluation of the program, and that a written record was kept of the annual review of the zero tolerance of abuse and neglect policy.

In an interview with the DOC, they indicated to Inspector #736 that the home had not reviewed incidents of abuse or neglect of residents during the annual program evaluation, and had not kept a written record of the annual review of the zero tolerance of abuse and neglect policy.

Sources: Agenda of annual evaluation of the zero tolerance of abuse and neglect program; policy titled Zero Tolerance of Abuse and Neglect (#LTC-105, last revised December 1, 2020); and interview with DOC. [s. 99.]

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 ensuring that every incident of abuse or neglect of a resident at the home are considered in the annual evaluation and that a written record is kept of the annual review of the zero tolerance of abuse and neglect policy, to be implemented voluntarily.

WN #4: 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 the policy to promote zero tolerance of abuse and neglect was complied with, related to investigation procedures.

A resident had indicated to staff that a co-resident had exhibited an inappropriate behaviour towards them; a CIS report was submitted by the home on the following day.

During an interview with the DOC, they indicated that the home had investigated the allegation of abuse and that they had spoken with two different staff members related to the incident. The DOC indicated that they had not kept notes of the discussions, and therefore the abuse policy was not complied with, related to the investigation.

Sources: CIS report; policy titled Zero Tolerance of Abuse and Neglect (#LTC-105, last revised December 1, 2020); interview with DOC. [s. 20. (1)]

WN #5: 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 when an allegation of resident abuse had taken place, that the Director was notified immediately.

A resident had indicated to staff that a co-resident had exhibited an inappropriate behaviour towards them; the CIS report was not submitted to the Director until the following day. The CIS report also indicated that the After-Hours Pager had not been contacted to report the allegation of resident abuse.

In an interview with the DOC, they indicated that the allegation of resident to resident abuse was not immediately reported to the Director, and it should have been.

Sources: CIS report; a resident's progress notes; policy titled Duty to Report (#LTC-109, last reviewed September 17, 2020); and interview with the DOC. [s. 24. (1)]

Issued on this 6th day of May, 2021

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

Original report signed by the inspector.