Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

North District
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Sudbury, ON, P3E 6A5
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Original Public Report

Report Issue Date: January 25, 2024	
Inspection Number: 2023-1522-0005	
Inspection Type: Critical Incident	
Licensee: Anson General Hospital	
Long Term Care Home and City: South Centennial Manor, Iroquois Falls	
Lead Inspector Karen Hill (704609)	**Inspector Digital Signature** Karen L Hill Digitally signed by Karen L Hill Date: 2024.02.06 13:06:11 -05'00'

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: January 2-5, 2024

The following intakes were inspected:

- Two intakes regarding allegations of resident to resident abuse.

The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect - Policy to Promote Zero Tolerance

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, 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.

1) Specifically, the licensee failed to notify a resident's substitute decision maker (SDM)/Power of Attorney (POA) of an incident that occurred.

Rationale and Summary
A resident was physically expressive towards another resident, causing injury to that resident.

The POA of one of the residents was not immediately notified when the incident occurred.

The licensee's policy, titled "Zero Tolerance of Abuse and Neglect," stated that in all cases of alleged or witnessed abuse, the SDM was to be notified immediately if a resident was harmed, and within 12 hours in all other situations.

The Director of Care (DOC) acknowledged that the POA for one of the residents was not notified as required.

Failure to notify the resident's POA as required may have prevented the POA from becoming aware of the situation and participating in decisions about the resident's care related to the incident.

Sources: A resident's clinical health record, internal communication logs, and the licensee's policy, titled "Zero Tolerance of Abuse and Neglect"; and an interview with the DOC.

2) Specifically, the licensee has failed to ensure that the DOC/Administration on call (AOC) was notified immediately of the alleged abuse.

Rationale and Summary
An allegation of abuse was reported to the Director.

The licensee's policy, titled "Zero Tolerance of Abuse and Neglect," stated that all alleged abuse should be reported to the DOC immediately; and after hours, the AOC should be notified.

The DOC stated they were not immediately notified of the incident, nor did they know if the AOC was; they stated they were made aware of the incident when they returned to the long-term care home (LTCH) two days later.

Failure to notify the DOC/AOC immediately of the allegations of abuse, placed other residents in the home at risk of harm.

Sources: Report submissions, a resident's clinical health record, and the licensee's policy, titled "Zero Tolerance of Abuse and Neglect"; and interviews with a registered staff member and the DOC.

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WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
Reporting certain matters to Director
s. 28 (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:
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.

The licensee has failed to ensure that allegations of abuse directed toward two residents, were immediately reported to the Director.

Rationale and Summary
A review of two residents' progress notes revealed allegations of abuse directed at them. One incident led to an injury.

There were no records indicating that the Director had been notified of the incidents.

The DOC acknowledged that although the home was required to submit Critical Incident (CI) reports to the Director regarding the incidents, they had not done so.

Failure to report to the Director as required, placed residents in the home at risk of harm of not receiving adequate regulatory resources to support their safety.

Sources: Two resident's clinical health records, the licensee's policies, titled "Zero Tolerance of Abuse and Neglect" and "Responsive Behaviours"; and interviews with the DOC and other staff.

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WRITTEN NOTIFICATION: Policy to minimize restraining of residents

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 33 (1) (b)
Policy to minimize restraining of residents, etc.
Policy to minimize restraining of residents, etc.
s. 33 (1) Every licensee of a long-term care home,
(b) shall ensure that the policy is complied with.

The licensee has failed to ensure that the licensee's policy to minimize restraining of residents was complied with.

1) Specifically, consent for the use of restraint with a resident.

Rationale and Summary
A resident's clinical health record showed that a specific staff member obtained consent from the resident's POA for the use of two restraints. Only one of the restraints was listed on the consent for treatment form.

The licensee's policy, titled "Restraints and PASDs", identified that only a physician or Registered Nurse in the Extended Class (RNEC) could obtain consent from the POA to use a restraint, and that consent had to be in writing.

The DOC acknowledged that the process as outlined in the policy should have been followed, and was not.

Failure to ensure that the consent for restraint use was obtained as outlined in the licensee's policy, may have put the resident at risk for improper restraint use.

Sources: A resident's clinical health record, the licensee's policy, titled "Restraints and PASDs", and the home's consent to treatment form; and interviews with the DOC and other relevant staff.

2) Specifically, the care plan requirements for the use of restraints.

Rationale and Summary
An intervention regarding restraint use was added to a resident's care plan, instructing staff to follow the licensee's restraint policy.

The licensee's policy, titled "Restraints and PASDs," stated that registered nursing staff were responsible for documenting specific directions for the use of restraints on the resident's care plan, as well as the monitoring and evaluation required while the restraint was in use.

The DOC acknowledged that, despite having reviewed the restraints policy and documentation requirements with staff, the policy was not followed in terms of the care plan.

The resident was placed at risk of harm when the staff failed to follow the licensee's policy regarding care plan requirements, when using restraints on a resident.

Sources: A resident's care plan, and the licensee's policy, titled "Restraints and

PASDs; and interviews with the DOC and other staff members.

3) Specifically, following certain requirements when restraints are in use.

Rationale and Summary
On a specific date, a restraint was initiated for a resident. The resident's care plan stated to follow the protocol in the licensee's policy when using the restraint.

The licensee's policy, titled "Restraint and PASDs", outlined specific requirements for restraint use and identified specific intervals for implementing those requirements.

There was no documentation in the resident's clinical health record to show that these requirements were complied with, while the restraint was in use for ten days.

The DOC acknowledged that the home did not do what was required.

The home's failure to ensure that all the requirements were met with respect to the restraining of a resident, may have impacted the resident's safety and need for ongoing use of the restraint.

Sources: A resident's clinical health record, internal communication logs; and the licensee's policy, titled "Restraints and PASDs"; and interviews with the DOC and other staff members.

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WRITTEN NOTIFICATION: Training

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 82 (4)
Training
Retraining
s. 82 (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations.

The licensee has failed to ensure that staff received retraining in the LTCH's policy to promote zero tolerance of abuse and neglect of residents.

Rationale and Summary
A review of the home's Surge Learning Education (SLE) records revealed that not all staff had completed the required review of the home's zero tolerance policy for abuse and neglect policy, in 2023.

The DOC confirmed that while all staff were required to receive yearly re-education regarding the home's zero tolerance policy for abuse and neglect, not all staff had completed the training as scheduled.

There was moderate risk to all residents in the home when the staff did not complete the annual mandatory re-training.

Sources: The home's policy, titled "Zero Tolerance of Abuse and Neglect", and SEL records dated January, 2023, to January, 2024, for Zero Tolerance of Abuse and Neglect policy; and an interview with the DOC.

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WRITTEN NOTIFICATION: Training

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 82 (7)

Training

Additional training — direct care staff

s. 82 (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:

1. Abuse recognition and prevention.
2. Mental health issues, including caring for persons with dementia.
3. Behaviour management.
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations.
5. Palliative care.
6. Any other areas provided for in the regulations.

The licensee has failed to ensure that all staff who provided direct care to residents received annual training as required.

1) Specifically, in caring for persons with dementia.

Rationale and Summary

According to the home's SEL records not all staff who were assigned to the training modules on Delirium, Dementia and Depression (DDD), had completed the required training in 2023.

The DOC confirmed that annual training was required, but that not all staff assigned to the training had completed it.

Failure to train staff in caring for persons with dementia, on an annual basis, put residents at risk of not receiving the most current and relevant approaches to care.

Sources: The licensee's program, titled "Responsive Behaviours", SEL record, dated January, 2023, to January, 2024, for RNAO Education modules (i.e., DDD); and an interview the DOC.

2) Specifically, in behaviour management.

Rationale and Summary
A registered staff member stated that they had not received training in behaviour management.

The home's SEL record confirmed that the staff member had not received behaviour management training. Furthermore, not all staff assigned to the training had completed the training in 2023.

The DOC confirmed that annual training was required, but that not all staff assigned to the training had completed it.

Failure to train staff in behaviour management, on an annual basis, put residents at risk of not receiving the most up-to-date and relevant approaches to behaviour management.

Sources: Review of the licensee program, titled "Responsive Behaviours", SEL records dated January 2023, to January 2024, for responsive behaviours; and interviews with the DOC and other staff members.

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WRITTEN NOTIFICATION: Responsive Behaviours

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (3) (c)
Responsive behaviours
s. 58 (3) The licensee shall ensure that,
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The licensee has failed to keep a written record that included the date of the evaluation, the names of the persons who participated, and the dates that the changes and improvements were implemented for the Responsive Behaviours Program.

Rationale and Summary
The most recent version of the licensee's responsive behaviours program was provided by the home. The date on the policy indicated that it had not been reviewed within the previous calendar year.

The DOC acknowledged that the current policy was out of date; that the required annual review had been completed, but provided no documentation.

When the licensee failed to keep a written record of the responsive behaviours program evaluation, residents were placed at risk of not receiving care based on any updates or modifications to responsive behaviour management found during the evaluation.

Sources: The licensee's program, titled "Responsive Behaviours"; and an interview with the DOC and other staff members.

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WRITTEN NOTIFICATION: Police Notification

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 105
Police notification
s. 105. Every licensee of a long-term care home shall ensure that the appropriate police service is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 246/22, s. 105, 390 (2).

The licensee has failed to ensure that the appropriate police force was immediately notified for the allegation of abuse by a resident, that may have constituted a criminal offence.

Rationale and Summary
A resident was transferred to hospital following an incident involving another resident.

The home submitted an amendment to the Director stating the police were notified of the incident several days after it occurred.

The DOC confirmed that police were not immediately notified of the incident as they should have been.

Failure to notify the appropriate police service of the alleged abuse of a resident resulted in a delay in the police investigation, potentially increasing the risk of a reoccurrence at the home.

Sources: CI submissions, and the licensee's policy, "Zero Tolerance of Abuse and Neglect"; and an interview with the DOC.

[704609]

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect - Evaluation

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 106 (e)
Evaluation
s. 106 (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.

The licensee has failed to keep a written record that included the date of the evaluation, the names of the persons who participated, and the dates that the changes and improvements were implemented for the Abuse Prevention Program.

Rationale and Summary
The DOC provided the most recent version of the licensee's policy, titled "Zero Tolerance of Abuse and Neglect"; the date on the document indicated it had not been reviewed within the previous calendar year.

The DOC acknowledged that the current policy was out of date; that the required annual review had been completed, but provided no documentation of the review.

There was minimal risk to the residents when the licensee failed to ensure that a written record of the evaluation of the Abuse Prevention Program was kept.

Sources: The licensee's policy, titled "Zero Tolerance of Abuse and Neglect, and an interview with the DOC.

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WRITTEN NOTIFICATION: Minimizing of Restraints - Evaluation

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 122 (e)
Evaluation
s. 122 (e) that a written record of everything provided for in clauses (a), (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 were implemented is promptly prepared.

The licensee has failed to keep a written record of the effectiveness of the licensee's policy to minimize restraining of residents, that included the date of the evaluation, the names of the persons who participated, and the dates that the changes and improvements were implemented.

Rationale and Summary
The home provided the most recent version of the licensee's policy, titled "Restraints and Personal Assistive Devices (PASDs)"; the date on the document indicated it had not been reviewed within the previous calendar year.

The DOC acknowledged that the current policy was outdated; that the home completed the yearly review that was required, but they did not offer any supporting documents.

When the licensee failed to keep a written record of the restraint and PASDs policy evaluation, residents were placed at risk of not receiving care based on any updates or modifications to the use of restraints and PASDs with residents that were identified during the evaluation.

Sources: The licensee's policy, titled "Restraints and PASDs"; and interviews with the DOC and other staff members.

[704609]

COMPLIANCE ORDER CO #001 Responsive behaviours

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 58 (4)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The inspector is ordering the licensee to comply with a Compliance Order

[FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

a) Review and revise a specified resident's care plan, ensuring that the behavioural triggers for that resident are clearly identified. Strategies, techniques, and interventions to prevent, minimize, or respond to the identified behaviours, must also be clearly identified;

b) Review and update the licensee's policy on responsive behaviours, in accordance with evidence-based practices, and/or with prevailing practices. A record must be kept of the names of the persons who participated in the review and the date that any changes made were implemented;

c) Develop a process and strategies within the home to manage resident to resident altercations, including minimizing the risk of potentially harmful interactions between residents;

d) Provide education for all Registered Nursing staff and Personal Support Workers on:

- the specified resident's triggers to their responsive behaviours and the strategies and interventions in place to manage the behaviours;
- the importance of ensuring all responsive behaviours, triggers, and strategies specific to those triggers, are identified in the written plan of care for any resident who exhibits responsive behaviours;
- the Responsive Behaviours policy referenced in b);
- the process and strategies developed by the home to manage resident to resident altercations, including minimizing the risk of potentially harmful interactions between residents; and

e) Keep record of the education, including the dates the education was provided, the names of the staff members who attended the education and signatures that

they understood the education, and the name/s of the staff member/s who provided the education.

Grounds
The licensee has failed to ensure that when a resident demonstrated specific responsive behaviours, that the triggers were identified; strategies were developed and implemented to respond to the behaviours; and that actions were taken to respond to the needs of the resident, including assessments and reassessments.

Rationale and Summary
Staff reported that a specified resident was known to exhibit certain behaviours, which caused other residents in the home to become upset with the resident.

a) On a specified date, the resident demonstrated the specific behaviours, which resulted in an altercation with another resident in the home.

Following the incident, the resident remained in the vicinity of other residents, unsupervised by staff, and continued to exhibit the specific behaviours.

There were no interventions or strategies implemented for the resident, to manage the behaviours or prevent recurrence.

b) Two days later, the same resident exhibited specific behaviours towards multiple residents.

The resident was moved away from the other residents.

There were no other interventions or strategies used to manage the resident's behaviours or prevent recurrence.

c) Two days later, staff observed the resident exhibiting the specific behaviours again, resulting in several altercations with other residents in the home.

Following the incidents, and four days after the first incident occurred, a specific intervention was implemented. The resident's care plan stated that the intervention was to address the resident's behaviours; however, the resident's behavioural triggers were not identified.

Several staff members acknowledged that the resident's care plan did not include any strategies or interventions to help the staff manage resident-to-resident altercations; particularly those related to the resident's known specific behaviours.

The staff members and the DOC all acknowledged that after the first incident with the resident, specific strategies should have been implemented immediately.

d) Four days after the initial incident in which the resident demonstrated specific behaviours toward another resident in the home, behaviour monitoring was initiated for the resident.

A review of the behaviour monitoring documentation over a five-day period revealed that on two of those days, documentation was missing.

The Behaviour Supports of Ontario (BSO) lead indicated that behaviour charting was part of a resident's assessment and reassessment following a recent altercation, and that assessments of the resident's behaviours and behaviour monitoring should have begun immediately after the initial incident. They confirmed that when behaviour monitoring was implemented, staff members were required to complete all documentation in order to provide accurate information.

When the home failed to ensure that triggers were identified, and strategies developed and implemented to address a resident's known responsive behaviours , there was actual harm. Furthermore, there was actual risk of harm to all residents in

the home when action was not taken to assess and reassess the resident, as information was not available to the staff on the triggers or trends in the resident's behaviours, which they could have used to assist in responding to the resident's needs.

Sources: A resident's clinical health record, the home's video footage for a specified timeline, behaviour charting for a specified timeline, and BSO behaviour monitoring resource manual; and interviews with a resident, the BSO lead, the DOC, and other staff members.

[704609]

This order must be complied with by

March 1, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.