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
Aug 6, 2015	2015_256517_0019	010590-15, 011192-15	Critical Incident System

Licensee/Titulaire de permis

THE CORPORATION OF THE COUNTY OF ESSEX
360 Fairview Ave West ESSEX ON N8M 1Y6

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

SUN PARLOR HOME FOR SENIOR CITIZENS
175 TALBOT STREET EAST LEAMINGTON ON N8H 1L9

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

PATRICIA VENTURA (517)

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): June 24 & 25, 2015

During this inspection the inspector completed:
Log#010590-15/M579-000022-15/M579-000020-15
Log#011192-15/M579-000023-15
M579-000009-15

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, one Registered Nurse, one Registered Nurse & Internal BSO lead, one Registered Practical Nurse, two Housekeepers, three Personal Support Workers and the interim Manager of Health & Safety and Staff Development. The inspector also observed Resident to Resident and Resident to staff interaction, reviewed the home's polices and protocols for Falls prevention, Prevention of Abuse and Neglect, Responsive Behaviours, workplace violence and Internal Reporting of Resident Incidents. The inspector also reviewed training records and education initiatives for responsive behaviours and abuse & neglect.

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

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **2 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. 76. Training

Specifically failed to comply with the following:

s. 76. (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. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
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. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff who provide direct care to residents, as a condition of continuing to have contact with residents, receive training in behaviour management.

Record review and Interview with the Administrator revealed that 30 per cent of the staff who provide direct care to residents had been trained in behaviour management within the previous year. The Administrator reported training in responsive behaviours was currently being offered to staff as part of a plan to have 100 per cent of the staff who provide direct care to residents trained in responsive behaviours.

The Administrator confirmed the expectation that all staff who provide direct care to residents, as a condition of continuing to have contact with residents, receive training in behaviour management. [s. 76. (7) 3.]

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 all staff who provide direct care to residents, as a condition of continuing to have contact with residents, receive training in behaviour management, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force 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. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee failed to ensure that the appropriate police force was 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.

Health record review and staff interviews revealed the home did not notify police of three resident incidents that caused injury to the residents.

The home's policy titled: "Zero Tolerance of Abuse and Neglect" Policy #0104-08 revised August 21, 2013, indicates: "The home staff will notify police if it suspects that an alleged, suspected or witnessed incident of abuse or neglect of a resident may constitute a criminal offence (LTCHA Reg 79/10 s. 98). All incidents of physical abuse that cause physical injury, and nonconsensual sexual behaviour must be reported to the police and/or MOHLTC."

Interviews with the Director of Care and the Administrator revealed the staff were expected to notify police immediately of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspected may constitute a criminal offence and that this was not done for the identified incidents. [s. 98.]

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 appropriate police force 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, to be implemented voluntarily.

WN #3: 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

Health record review revealed that Registered Staff did not notify the Physician and there was no collaboration with the Physician in the assessment of the Residents so that their assessments were integrated, consistent and complemented each other following two resident incidents that caused injury to the residents.

Interview with the Director of Care revealed the expectation was for Registered staff to notify the Physician and for the Physician to collaborate in the assessment of these residents following the identified incidents. The Director of Care further reported this expectation was reinforced with all Registered staff at the home following these incidents. [s. 6. (4) (a)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The home's policy titled: "Responsive Behaviours" Policy #0104-17 revised Jan 20, 1994, indicated: "Behaviour mapping is to be completed for at least one week and preferably two weeks for residents who have responsive behaviours that do not respond to non-drug interventions" Interview with the Administrator revealed that as part of completing Behaviour mapping, the staff were expected to monitor resident behaviours hourly and document these actions or observed resident behaviours on a flow sheet.

Health record review revealed that a resident had six incidents of Responsive Behaviours. Behaviour mapping documentation was not completed for five out of the six incidents.

Interviews with staff and observations revealed staff were completing frequent safety checks of this resident but were not documenting these actions on a behaviour mapping flow sheet. The inspector was not able to find completed Behaviour mapping flowsheets for the one week periods following the identified incidents of responsive behaviours.

Interview with the Administrator revealed the home's expectation that Behaviour mapping flowsheets be completed for at least one week following the identified incidents of responsive behaviours. The Administrator verified the expectation that any actions taken with respect to a resident under a program, including assessments, reassesments, interventions and the resident's responses to interventions are documented. [s. 30. (2)]

Issued on this 6th day of August, 2015

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

Original report signed by the inspector.