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 # / Registre no	Type of Inspection / Genre d'inspection
Apr 6, 2017	2017_542511_0007	004053-17, 005446-17	Complaint

Licensee/Titulaire de permis

MENNONITE BRETHREN SENIOR CITIZENS HOME
1 Tabor Drive St. Catharines ON L2N 1V9

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

MENNONITE BRETHREN SENIOR CITIZENS HOME
1 Tabor Drive St Catharines ON L2N 1V9

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

ROBIN MACKIE (511)

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): March 13, 14, 15, 16, 20, 21, 22, 23, 27, 28, 2017.

This Inspection included complaint # 004053-17 (Prevention of Abuse, Transferring and Positioning) and 005446-17 (Reporting and Dealing with Complaints).

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurse (RNs) and Registered Practical Nurse (RPNs), Personal Support Workers, (PSWs), Therapeutic Recreation Supervisor, Recreation Therapist, Resident Assessment Instrument (RAI) co-ordinator, Dietary Manager, Dietary staff, staff scheduler, residents and family members.

During the course of the inspection the Inspector observed the provision of resident care, reviewed applicable policies, practices and resident clinical records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **8 WN(s)**
- **5 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. (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).

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, (a) in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other; and (b) in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

A review of the clinical record identified resident #002 had been previously referred to Behavioural Supports Ontario (BSO) for responisve behaviours. Resident #002 was identified as cognitive.

The BSO had seen the resident for five consecutive months in 2016 through 2017, with multiple strategies described to address the triggers for their responsive behaviours. A review of the DOS charting confirmed the resident had responsive behaviours during an identified observation time. On a specified date, in 2017, a discharge note from the BSO, indicated the staff had managed the resident's behaviours and reported that the behaviours had decreased.

After discharge from the BSO in 2017, a new focus had been documented in the resident's plan of care by RN # 211. The plan of care identified resident #002 had further responsive behaviours.

Interview with RN #202, stated they were familiar with resident #002 and confirmed the

resident previously had behaviours. RN #202 confirmed the resident had been identified. They stated they had a physical condition that had been treated and had not observed a reoccurrence of this behaviour, on their shift, in the previous months and felt the behaviour had been related to the resident's physical condition.

Interview with the Therapeutic Recreation Supervisor (TRS) stated they were familiar with resident #002's behaviours and that the resident was pleasant, cooperative and engaged with appropriate interactions with co-residents and identified staff. The TRS stated they would be kept up to date, weekly, on any changes with resident behaviours through the home's multidisciplinary meetings and the monthly SOS meetings. Both meetings were held with resources that included Psychogeriatric Outreach consultants, BSO and other disciplines, such as: nursing, PSW, dietary and the home's chaplain, if needed. The TRS stated resident #002's behaviours had not been discussed at any of these meetings in the previous three months and not been referred as having a reoccurence of their behaviour.

Interview with resident #002 in 2017 confirmed the resident was pleased with the care provided by the staff but identified a concern related to one identified staff member.

A review of resident #002's clinical record, which included behavioural progress notes, point of care behavioural symptoms and resident response rate reports, indicated the resident had improved and demonstrated a continued decline in identified behaviours.

Interview with RN #211 confirmed they had updated the plan of care, with the new focus in 2017, as described above. RN #211 confirmed they had not collaborated with other members of the multidisciplinary team in the assessment of the resident when they created the focus in the plan of care and had not reviewed documentation in the clinical record from other departments that included, but was not limited to, the behavioural notes, behavioural symptom, resident response rate reports and recreational participation, in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other. [s. 6. (4) (a)]

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.

A review of the clinical record for resident #003 described the resident to be cognitively impaired and required assistance for their activities of daily living. Resident #003

required the assistance of a mechanical lift in order to be transferred from one position to another.

On a specific date in 2017, a PSW was identified to have transferred resident #003, without the use of a mechanical lift or another staff member. The resident was not injured by the transfer. A review of the home's internal investigation confirmed the PSW was aware of resident #003's transfer status, as outlined in the plan of care, and had proceeded to lift and transfer resident #003 without the use of a mechanical lift.

Interview with the DOC confirmed the licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan. [s. 6. (7)]

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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was protected from verbal abuse by anyone.

A complaint was received by the Ministry of Health and Long Term Care in 2017. The complainant alleged that resident #002 had told them that a PSW had used profanity when speaking to them.

A review of the clinical record identified resident #002 was discharged from Behavioural Supports Ontario in a specific month in 2017, for identified of behaviours. Resident #002's recent quarterly Minimum Data Set (MDS) assessment indicated the resident required assistance with all activities of daily living (ADLs). Resident #002 had physical limitations, and it was documented that the staff believed the resident was capable of increased independence in at least some of their ADLs. The most recent Resident Assessment Protocol (RAP) identified the resident had behaviours up to five days week.

An interview with resident #002, identified the resident to be pleasant, cooperative and oriented to person, place and time. The resident repeated and confirmed the profanity alleged by the complainant. The resident stated they were upset when PSW #205 made the comment to them and stated they felt humiliated and degraded by the comment. Resident #002 stated they felt PSW #205 became frustrated with them. They stated they reported the comment to another staff member and a registered staff member the next day. Resident #002 stated they did not want to be alone with PSW #205 during any further care and confirmed a second staff had been present during all other care episodes after the incident.

Interview with resident #002's family member stated, approximately one week after the alleged incident, that the resident described the profanity made by PSW #205 towards them. The family member stated this language was not language the resident was known to use.

RN #202 and RPN #200 confirmed, during an interview, that they had been notified of the allegation as indicated in the complaint report and confirmed the comment would be considered to be degrading and humiliating to resident #002. RN #202 stated they had spoken to resident #002 and the resident had reiterated to them the comments made by PSW #205. RN #202 stated the resident was cognitive and, although could become frustrated with the staff, had not made allegations or used this language in the past. They confirmed they believed the resident to be truthful in their comments. RN #202 and RPN #200 stated they notified the DOC immediately of the incident.

Interview with the DOC identified the allegation of verbal abuse had not been investigated by the home. The DOC confirmed the identified comment would be considered to be humiliating or degrading in nature, which diminished the resident's sense of well-being, dignity or self worth, and a form of verbal abuse. [s. 19. (1)]

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 residents are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that (a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, was immediately investigated: (i) abuse of a resident by anyone.

A) A review of the clinical record identified resident #002 was identified as being cognitive and continued to establish their own goals by being independent in their leisure choices and pursuits. Resident #002 required extensive physical assistance with all activities of daily living.

On an unidentified date in January 2017, PSW #201 received a verbal complaint from

resident #002 that alleged an inappropriate comment was made to the resident from PSW #205. PSW #201 immediately reported the comment to RPN #200. Interview with RPN #200 confirmed the comment would be considered a form of verbal abuse to resident #002. RPN #200 immediately reported the comment to the Director of Care. Interview with the family member, of resident #002, confirmed the resident had told them about the comment and that they had spoken to RPN #200, approximately one week later and were told that the incident was being investigated. The family member confirmed they had not heard anything from the licensee on the outcome of the investigation, as of March 2017.

A review of the resident's clinical record and the home's complaint documentation, did not identify any investigation regarding the above allegation of the emotional abuse.

B) A review of the clinical record identified resident #001 required extensive assistance from one staff for transferring and was usually understood but had some difficulty finding words or finishing thoughts.

On a specified date in February 2017, PSW #201 reported a verbal complaint from resident #001 to RPN #203. Interview with PSW #201 stated they observed resident #001 visibly upset, when being brought from their room by another unidentified PSW. PSW #201 stated when they approached the resident, they had complained that the care was "rough". During an interview, RPN #203 confirmed they received the complaint from PSW #201 when resident #001 had complained that an identified part of their body was hurt during personal care from a PSW. Progress notes for a specified date in February 2017, completed by RPN #203, described the resident's body part was assessed and they had not observed any injury. The following day, the resident was noted to have an injury to the same identified body part. The POA was notified and a progress note, completed by a different RPN, stated the injury was from an unknown cause and that the POA was concerned regarding the rough handling of resident #001. RPN #203 stated the verbal complaint of rough care should have been investigated.

A review of the resident's clinical record, home's complaint documentation, did not identify any investigation regarding the above allegation of rough care.

The DOC confirmed the licensee failed to ensure, as described above, that every alleged, suspected or witnessed incident that the licensee knew of, or that was reported to the licensee, was immediately investigated. [s. 23. (1) (a)]

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 ensure that (a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated: (i) abuse of a resident by anyone, to be implemented voluntarily.

WN #4: 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 have occurred shall immediately report the suspicion and the information upon which it was 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.

A complaint was received by the Ministry of Health and Long term Care (MOHLTC) for an allegation of abuse, towards resident #001 and verbal abuse towards resident #002,

in 2017. The complainant alleged they heard resident #001 complain of rough handling by a PSW during care and a verbal complaint from resident #002 of a PSW comment that was considered humiliating and degrading to the resident.

1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

A review of the clinical record indicated resident #001's plan of care indicated the resident required assistance by one staff for transfers. The resident had cognitive impairment and was usually understood but had some difficulty finding words or finishing thoughts. The resident usually understood but may have missed some part or intent of the message.

Interview with PSW #201 stated resident #001 was observed to be visibly upset when they had been brought to the lounge by another PSW. PSW #201 asked the resident what happened and the resident had questioned why the care had to be so rough and was touching an identified part of their body. PSW #201 stated they immediately reported their concern to RPN #203, who was the nurse in charge.

Interview with staff #213 confirmed they observed resident #001 upset and complaining of being sore on an identified date and time in 2017.

Interview with RPN #203, confirmed PSW #201 had reported to them, that resident #001 had complained of an injury to their body part during care on an identified date and time in 2017. RPN #203 stated they assessed the resident's body part approximately one hour later and had not identified any injury. RPN #203 stated the resident had not complained of pain at the time of their assessment. RPN # 203 stated they had not reported the incident.

A review of resident #001's clinical record identified documentation on an identified date in 2017, that confirmed a PSW had reported to RPN #203 that resident #001 was complaining of an injury to a specific part of their body. Resident #001 had an injury documented to the identified part of their body the following day. Further documentation identified a family contact note that described that resident #001's Substitute Decision Maker (SDM) asked the RPN how the injury occurred and alleged a PSW caused the injury from rough handling. There was no documentation indicating the allegation of rough care was reported to the Director.

Interview with the DOC confirmed the licensee had reasonable grounds to suspect that improper or incompetent treatment or care had occurred that resulted in harm or a risk of harm to resident #001 and that the licensee failed to immediately report the suspicion and the information upon which it was based to the Director.

2. Abuse (verbal) of a resident by anyone that resulted in harm or a risk of harm to the resident.

Resident #002 was described as being cognitive with an ability to establish their own goals and being independent in their choices. Interview with resident #002 demonstrated the resident remembered an incident, during their personal care, when PSW #205 directed a profanity towards them. The resident stated they felt humiliated and degraded by the comment and had not wanted to receive further care, alone, by PSW #205. Interview with PSW #201, confirmed resident #002 had alleged to them, on an unidentified date in January 2017, a comment that they felt was humiliating and degrading. PSW #201 stated they had immediately reported the incident to RN #202, who had been the nurse in charge. Interview with RN #202, confirmed the allegation was reported to them by PSW # 201 and it was considered to be verbal abuse, as the comment was humiliating and degrading to the resident. RN #202 stated they reported the allegation to the DOC immediately.

Interview with the Administrator confirmed the previous DOC, that had been working at the time of the allegation, was no longer working at the home and was unavailable for interview. The home's current DOC, confirmed after a review of the home's records, the licensee had reasonable grounds to suspect that verbal abuse occurred or may have occurred and failed to immediately report the suspicion and the information upon which it was based to the Director. [s. 24. (1)]

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 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. 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, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A complaint was received by the Ministry of Health and Long term Care (MOHLTC) for an allegation of abuse in 2017 towards resident #001. The complainant alleged they heard resident #001 complain of rough handling by a PSW during care.

Resident #001 had sustained an injury to an identified body part on a specific date in 2017. The resident had been observed by staff #201 and #214, visibly upset and touching a part of their body, after they had been brought to the lounge area by an unidentified PSW.
Staff #201 stated they heard the resident complain that the injury occurred during the care from an unidentified PSW. On a specific date in 2017, documentation indicated the resident had an injury noted to their identified body part . Resident #001's plan of care identified resident #001 required extensive assistance, from one staff, for transferring.
The DOC acknowledged, after a review of the clinical record, that resident #001 had sustained an injury, of unknown origin, on an identified date in 2017.

A review of the PSW staff schedule identified PSW #212 had provided and signed for the care, to resident #001, on the identified date in 2017. PSW #212 accessed the resident's plan of care and confirmed the transfer status as described above. PSW #212 confirmed they would have transferred resident #001 with a one person, pivot transfer. PSW #212 agreed to an observation of their one person, pivot transfer technique.

Resident #001 was unavailable for the transfer observation and PSW #212 identified resident #005 had the same transfer status. A review of resident #005's plan of care confirmed the resident's required extensive assistance from one person. Resident #005 provided consent for the observation of their transfer with assistance from PSW #212.

An observation was completed in March 2017, of PSW #212 transferring resident #005, using a one person, pivot transfer technique from their chair to their bed and from their bed back to their chair. Safety concerns related to perpendicular placement of the chair to the bed, were observed when the staff completed the transfer. The placement of the chair required a 180 degree pivot verses a 90 degree pivot of the resident due to the placement of the chair in relation to the bed. The PSW was unable to provide a safe and secure centre of gravity, for the resident, when they had to lean over the wheelchair in order to support the resident during the transfer. The one quarter bed side rails where left in the raised position, during the transfer to the bed, which caused the resident to be seated closer to the foot of the bed. The chair was left in the same position for the transfer back to the chair from the bed. Due to the previous placement of the resident in the bed they were unable to access the bed side rail to assist and support themselves to a sitting position prior to their transfer back to the chair. The return transfer to the chair demonstrated the PSW was unable to provide a stable centre of gravity to safely support the transfer as they had to lean over the chair during the transfer. Resident #005 voiced no complaint of pain or evidence of injury during the transfer.

Interview with PSW #214, who was identified by the licensee as a PSW coach for safe lift and transfers, was described and shown diagrams of the extensive assistance, from one person, pivot transfer technique used by PSW #212 for resident #005. PSW #214 confirmed the perpendicular positioning of the chair to the bed was not a safe transferring and positioning technique used to assist residents. [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: 5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.

A review of resident #002's plan of care, updated in March 2017, identified the resident had behaviours that required interventions.

A review of the clinical record's behavioural progress notes and Point of Care (POC) PSW documentation of behaviour symptoms for a three month period in 2017, indicated potential triggers and variations in resident functioning at different times of the day. Interview with staff member #211, #205, #203 and #200 confirmed resident #002's identified responsive behaviour occurred more frequently on an identified shift and rarely occurred on another shift.

A review of the plan of care, dated in March 2017 and an interview with RN #211, confirmed the plan of care focus for mood and behaviours patterns, had not identified any responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day . [s. 26. (3) 5.]

WN #7: 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 were documented.

A review of the Licensee's Complaints policy identified the procedure for addressing verbal complaints. The policy described that the staff member with whom the concern is shared with will ensure a Verbal Complaint form is completed, and will record the concern in the progress notes (PN) in Point Click Care (PCC) where the concern involves a resident in the long term care home.

Interview with RPN #200 confirmed a verbal complaint was brought to their attention in early January 2017, for resident #002. The RPN stated they spoke with resident #002 about the verbal complaint and then reported the complaint to the DOC immediately. Approximately two weeks later, RPN #200 confirmed they spoke with resident #002's family member regarding the verbal complaint. Interview with resident #002's family member confirmed the communication with RPN #200.

A review of the clinical record from January 2017 to March 15, 2017, did not identify any documentation in the PN or in PCC regarding the above conversations.

Interview with RPN #200 stated the information of the verbal complaint should have been documented and was not.

The DOC confirmed the licensee failed to ensure that any actions taken with respect to a resident under the home's Complaint program, including assessments, reassessments, interventions and the resident's responses to interventions were documented. [s. 30. (2)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(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. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that for each resident demonstrating responsive behaviours, (c) actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

Interview with staff member #200 stated resident #002 had an identified responsive behaviour and was to have a weekly custom behaviour note documented in the clinical record that included the resident's behaviour, intervention, time spent and effectiveness/evaluation. A review of the clinical record for resident #002 identified 40 behavioural notes for a time period that included four consecutive months in 2016-2017. There were inconsistent completions of the behaviour notes during this time period. On multiple occasions the intervention and the effectiveness of the intervention had not been documented.

The DOC confirmed the licensee failed to ensure that actions taken to respond to the responsive behaviours of resident #002 had been documented to include the intervention and the resident's responses to the intervention for 20 of the 40 documentation notes. [s. 53. (4) (c)]

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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

Issued on this 3rd day of May, 2017

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

Original report signed by the inspector.