Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

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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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
May 11, 14, 15, 16, Jun 26, 27, 28, Jul 19, 20, Aug 7, 9, 14, 2012 June 13, 19, 15, 19, 20, 21, 22 May 31/M	2012_070141_0009	Critical Incident

Licensee/Titulaire de permis

HOLLAND CHRISTIAN HOMES INC
7900 MCLAUGHLIN ROAD SOUTH, BRAMPTON, ON, L6Y-5A7

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

FAITH MANOR NURSING HOME
7900 MCLAUGHLIN ROAD SOUTH, BRAMPTON, ON, L6Y-5A7

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

SHARLEE MCNALLY (141)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with residents, the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Behaviour Support Nurse, Resident Assessment Instrument Minimum Data Set (RAI MDS) staff, Registered Nurses (RN), Registered Practical Nurses (RPN), and Personal Support Workers (PSWs)

During the course of the inspection, the inspector(s) observed residents during activities of daily living, reviewed resident records, home's investigation notes and incident reports, and the home's policy and procedures.

Log # H-0000202-12, H-000220-12, H-000708-12, H-001010-12

PLEASE NOTE: One non-compliance was found related to the licensee's failure to ensure residents are protected from abuse by anyone. This non-compliance (LTCHA s.19.(1)) was issued in Inspection # 2012-070141-0007, conducted on May 11, 2012 and is contained in the Report of that inspection.
One non-compliance was found related to the licensee not ensuring the policy for zero tolerance of abuse and neglect of residents is complied with. This non-compliance (LTCHA s.20(1)) was issued in Inspection # 2012-070141-0007, conducted on May 11, 2012 and is contained in the Report of that inspection.

The following Inspection Protocols were used during this inspection:

Critical Incident Response

Falls Prevention

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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 subsections:

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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee did not ensure that the care set out in the the plan of care was provided to an identified resident as specified in the plan. In 2012 the resident was in a common room being monitored by staff. The identified resident demonstrated responsive behaviour toward a second resident. Another staff member directed staff person completing the monitoring to take the identified resident from the room but the staff refused. Later on the same day the identified resident wandered into an other common area and demonstrated responsive behaviour toward a third resident. The identified resident then proceeded to another common room, with the staff providing monitoring, and demonstrated responsive behaviour to a fourth resident. The resident's plan of care initiated in 2012 prior to the incidents included the strategy for staff to redirect the identified resident from common areas. The staff completing the monitoring at the time of the responsive behaviours confirmed that resident had not been redirected from the common areas. The Behaviour Support Nurse confirmed nursing staff responsible for monitoring the resident were informed to keep the resident away from common areas. s.6(7)
2. The licensee did not ensure that care set out in the plan of care was provided to an identified resident as specified in the plan. The resident was assessed in 2012 by an outside resource after incidents of responsive behaviour toward other residents. The resource recommended they be notified if there was a deterioration in the resident's responsive behaviour. The identified resident had further incidents of responsive behaviours. The outside resource was not contacted and no reassessments were completed. The DOC confirmed that the outside resource had not been contacted to reassess the resident related to their exhibited responsive behaviours. s.6(7)
3. The licensee did not ensure that the plan of care was revised when the resident's care needs changed. An identified resident had safety needs due to responsive behaviour exhibited towards her by another resident and actions were implemented. The plan of care did not include the action. s.6(10)(b)
4. The licensee did not ensure that the plan of care was revised when the resident's care needs changed. An identified resident was assessed as needing physical restraining for safety and actions were implemented. The resident written plan of care did not include the use of the physical restraints or interventions related to their use. s.6(10)(b)
5. The licensee did not ensure the identified resident was reassessed and the plan of care reviewed and revised when the care set out in the plan had not been effective. The identified resident's written plan of care related to responsive behaviours was initiated in 2012 after incidents of responsive behaviours toward other residents. The identified resident had ongoing incidents of responsive behaviour and identified changes in the behaviours. The written plan of care related to the identified behaviours had not been revised since initiation of the plan. s.6(10)(c)

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 the written plan of care for each resident sets out clear directions to staff and others who provide direct care to the resident, and the resident is reassessed and the plan of care reviewed and revised when the resident's care needs change or have not been effective, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following subsections:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee did not ensure where the Act or Regulation requires the long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system is complied with. The home's policy "Resident Fall with No or Minor Injury" (30.06.11) stated that if head injury possible begin Head Injury Routine as per policy. "Head Injury Routine" (30-04-03) stipulates that head injury routine is to be initiated when head injury is observed and blood pressure, pulse, respiration, pupils and hand grips must be monitored every 15 minutes for 1 hour, if stable hourly for 3 hours, and if stable every 4 hours for following 24 hours. An identified resident had an unobserved fall in 2012. The next day the identified resident was noted to have an injury and was transferred to hospital. Initial head injury routine was completed at the time the injury was identified and documented in the progress notes. There was inconsistent documentation of the resident's blood pressure, pulse and respirations for the next 24 hours and there was no further assessment documented of the resident's pupils or hand grip. A Head Injury Routine assessment form was not completed. On one shift there was no documented assessment of the resident. The Director of Care confirmed that the documentation did not occur and assessments had not been completed consistently. s.8(1)(b)

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following subsections:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:

1. Customary routines.
2. Cognition ability.
3. Communication abilities, including hearing and language.
4. Vision.
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.
6. Psychological well-being.
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.
8. Continence, including bladder and bowel elimination.
9. Disease diagnosis.
10. Health conditions, including allergies, pain, risk of falls and other special needs.
11. Seasonal risk relating to hot weather.
12. Dental and oral status, including oral hygiene.
13. Nutritional status, including height, weight and any risks relating to nutrition care.
14. Hydration status and any risks relating to hydration.
15. Skin condition, including altered skin integrity and foot conditions.
16. Activity patterns and pursuits.
17. Drugs and treatments.
18. Special treatments and interventions.
19. Safety risks.
20. Nausea and vomiting.
21. Sleep patterns and preferences.
22. Cultural, spiritual and religious preferences and age-related needs and preferences.
23. Potential for discharge. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee did not ensure that an identified resident's plan of care was based on assessment of the resident's mood and behaviour patterns. The identified resident exhibited a responsive behaviour toward another resident in 2012. The progress notes indicated the resident had ongoing responsive behaviours related to a perceived belief. This belief as a trigger to the resident's responsive behaviour was not identified in the written plan of care, or were strategies documented to address the behaviour. s.26(3)5.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following subsections:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.
3. Resident monitoring and internal reporting protocols.
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

Findings/Faits saillants :

1. The licensee did not ensure written approaches to care were developed to meet the needs of an identified resident who exhibited responsive behaviour towards multiple residents. Behaviour was first identified in 2011. The resident's written plan of care did not include this responsive behaviour until 2012. The home confirmed that the plan of care was not revised at the time the behaviour was initially identified and there was no written approaches to care developed until 2012. s.53.(1)1
2. The licensee did not ensure the written approaches to care were developed to include reassessment of all triggers and strategies for an identified resident's responsive behaviours, upon return from hospital in 2012. The resident continued to exhibit responsive behaviour toward other residents. The resident's current written plan of care did not include all identified triggers for the responsive behaviour. Not all strategies had been identified on the written plan of care. The Behaviour Support Nurse confirmed that not all triggers and strategies had been entered into the resident's written plan of care. s.53.(1)1

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following subsections:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.
2. An environmental hazard, including a breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety, security or well-being of residents for a period greater than six hours.
3. A missing or unaccounted for controlled substance.
4. An injury in respect of which a person is taken to hospital.
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee did not inform the Director no later than one business day after incidents of injury from falls that resulted in an identified resident being transferred to hospital. The resident had two falls in 2012 and was transferred to hospital due change in medical status. The resident had expressed pain. The identified resident had another fall and was transferred to hospital again due to injuries observed. Both transfers to the hospital were not reported to the Director. The Director of Care confirmed the critical incident reports had not been completed for either incident. s.107.(3)

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following subsections:

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 did not ensure that actions taken with respect to an identified resident for interventions related to exhibited responsive behaviours were documented. Safety checks were initiated for the resident in 2011. The Director of Care confirmed safety checks were initiated for this resident. Documentation of the safety checks being completed was inconsistent on the resident's progress notes and only 4 days were completed for a 2 month period on the home's template for documentation of checks. s.30(2)
2. The licensee did not ensure incidents of exhibited responsive behaviours towards an identified resident by a second resident were documented. The identified resident was the recipient of multiple incidents of responsive behaviour by a second resident in 2011 and 2012. Not all the incidents were recorded in the identified resident's written records. Incidents were confirmed in the second resident's written records. The Director of Care confirmed that all incidents had not been documented in the identified resident's records. s.30(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 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, to be implemented voluntarily.

WN #7: 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 subsections:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated;
(b) shall clearly set out what constitutes abuse and neglect;
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect;
(d) shall contain an explanation of the duty under section 24 to make mandatory reports;
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents;
(f) shall set out the consequences for those who abuse or neglect residents;
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the policy to promote zero tolerance of abuse and neglect of residents clearly set out what constitutes abuse and neglect. The home policy "Resident Abuse (60-18-04) stated that sexual assault and molestation are an example of physical abuse but does not define what constitutes sexual assault and molestation. The Director of Care confirmed the policy also does not clearly define what constitutes sexual abuse. s.20(2)

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Issued on this 18th day of October, 2012

[redacted]

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