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
Feb 10, 2017	2016_336620_0024	022139-16	Resident Quality Inspection

Licensee/Titulaire de permis

The Board of Management for the District of Manitoulin
70 Robinson Street Postal Bag 460 LITTLE CURRENT ON P0P 1K0

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

MANITOULIN CENTENNIAL MANOR HOME FOR THE AGED
70 ROBINSON STREET POSTAL BAG 460 LITTLE CURRENT ON P0P 1K0

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

ALAIN PLANTE (620), TIFFANY BOUCHER (543)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): September 06-09, and September 12-15, 2016.

The inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, and reviewed numerous licensee policies, procedures and programs.

As part of this inspeciton two critical incidents related to resident to resident sexual abuse, one critical incident related to resident to resident verbal abuse, one critical incident related to staff to resident verbal abuse, two critical incidents related to resident falls resulting in a significant change, and one complaint related to staff to resident abuse/neglect were inspected.

During the course of the inspection, the inspector(s) spoke with the Administrator, Directors of Nursing and Personal Care (DOC), Manager of Infection Control (MIC), Resident Assessment Instrument (RAI) Co-ordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Dietary Aides, Activity Aids, Housekeeping staff, Behavioural Supports Ontario (BSO) staff, family members, and residents.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

5 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure rights of residents were fully respected and promoted; specifically, failed to ensure every resident had the right to be properly clothed, groomed and cared for in a manner consistent with his or her needs.

Inspector #620 reviewed a complaint submitted to the Director which related to a staff member being removed from providing care to residents due to an allegation of abuse. The complainant alleged that they were aware of ongoing neglect and abuse that was occurring in the home. They identified that PSW #106, had been abusive with residents. They also indicated that PSW #107 and #108 had neglected residents.

Inspector #620 interviewed the complainant. During the interview, the complainant described that three residents were being neglected by staff during the night shift. They identified that resident #019, #021, and #022 were neglected and that they had reported the neglect to staff and that the home did not respond appropriately to their allegation.

Inspector #620 reviewed a complaint investigation which indicated that PSW #111 reported that resident #019 was received in the morning in the same clothes as the day previous and that they were malodorous. The form also indicated that PSW #107 falsely documented that the care had been provided.

Inspector #620 reviewed the documented narrative of a meeting to discuss, "some complaints received regarding resident care." The meeting was attended by the Administrator, the DOC, PSW #108, and PSW #108's union representative. The documented interview identified that resident #019 was found in a state of dress not indicated in their plan of care. Resident #021 was identified as wearing the same clothes as the day previous; resident #022 was found to be fully dressed from the day previous.

Inspector #620 reviewed a progress note documented by RN #110 which indicated that resident #022 had been found in bed in an unclean state. The note also identified that the resident was in the same clothes as the day previous. Under the heading of, "Action" RN #110 indicated the evening PSW was reminded to do proper evening care including dressing the residents in proper sleep clothes.

Inspector#620 interviewed RN #103 who stated that they were approached by PSW #111 who told them that resident #019, #021, and #022 did not receive evening care. They stated that they observed each resident and that from their observation that they had concluded that the residents had not been dressed for bed, had not received brief changes, sheets were found to be urine stained, and one resident was found sleeping on top of their covers. They stated that there were a few occasions where there was a lack of care received by resident #019, #021, and #022. They stated that as a result of numerous incidences they decided to document the lack of care in a more formal manner on a compliant investigation form.

Inspector #620 discovered a second complaint investigation form which indicated that PSW #111 reported that PSW #107 had documented that they provided mouth care to resident #020 but the mouth care was not provided. The form detailed that the DOC counseled PSW #107 regarding the home's expectations.

Inspector #620 interviewed the DOC who confirmed that resident #020 had not received oral care as specified in their plan of care. They stated that they counseled PSW #107 as a result of the incident. They stated that they could not recall when the allegations related to resident #019, #021, and #022 had been brought forward.

Inspector #620 interviewed the Administrator who verified that care had not been provided to resident #019, #020, #021, and #022 as necessary. [s. 3. (1) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs, to be implemented voluntarily.

WN #2: 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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 care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

Inspector #543 reviewed a critical incident report that was submitted to the Director. The CI report indicated that resident #012 had a fall and sustained an injury.

A review of resident #012's health care record identified that the resident had experienced 11 falls in a five month period.

A review of the resident #012's care plan in place at the time of the incident indicated that resident #012 was at high risk for falls. Interventions within the care plan advised staff to, "Check q (specify) minutes for safety…" and, "Individualized routines geared to fall prevention e.g. toileting naps (specify)" and, "identify root cause of falls (specify)." It was unclear from the care plan what the term specify indicated.

In an interview with the RAI coordinator, they stated that resident #012's care plan was not specific to their needs. The RAI coordinator concluded that staff had altered the interventions in the care plan but neglected select individualized interventions based on assessment. They stated that the appearance of the notation, "(specify)" within the care plan indicated that staff were expected select an intervention based on the most recent assessment but staff had not done so.

In an interview with the DOC, they reviewed resident #012's care plan with Inspectors #543 and #620. The DOC verified that this resident's care plan, specifically related to falls, had no interventions in place to meet the individual needs of resident #012. The DOC stated that the resident's interventions were not specific, and the care plan should have evolved to reflect the resident's assessed needs. [s. 6. (2)]

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.

Inspector #620 reviewed a complaint submitted to the Director. The complaint was related to a staff member who was removed from providing care to residents due to an allegation of abuse. The complainant alleged that they were aware of ongoing neglect and abuse that was occurring in the home. They identified that PSW #106, had been abusive with residents. The also indicated that PSW #107 and #108 had been neglectful in their care of residents.

Inspector #620 reviewed a complaint investigation form which noted that PSW #111 reported that PSW #107 had documented that they provided mouth care to resident #020 but the mouth care was not provided. PSW #111 described that they received resident #020 in the morning and that mouth care had not been received by the resident.

Under the heading of, "Summary of Investigation" the complaint investigation form indicated that PSW #107 was unaware that resident #020 needed a specific type of mouth care. The form also noted that it was the expectation that PSW #107 should have known the plan of care for each resident including their specific care needs. The form detailed that the DOC counseled PSW #107 regarding the home's expectations.

Inspector #620 reviewed resident #020's care plan that was current at the time of the incident. The inspector identified a focus specific to the resident`s dental care needs. The goal indicated the nature of the resident`s need for the specified dental care, as well as, the manner in which it was to be provided. An intervention in the care plan advised staff

to, provide the particular dental care with a defined frequency.

Inspector #620 interviewed the DOC who confirmed that resident #020 had not received oral care as specified in the plan of care. They stated that they counseled PSW #107 as a result of the incident; they advised PSW #107 that it was the home's expectation that care was to be provided as specified in the plan of care. The DOC stated that staff providing resident care were to ensure that they reviewed the resident's plan of care to ensure that care was being provided 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 ensuring that the plan of care is based on an assessment of the resident and the resident's needs and preferences, and 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 #3: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails were used, that the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident.

As a result of an observation by Inspector #543, a potential restraint device was identified when resident #006 and #002 were observed with two bed rails in a certain position. Inspector #620 also observed a potential restraint device when they documented that resident #007 had two bed rails in a specific position.

A memo from the Ministry of Health and Long-Term Care (MOHLTC) dated August 21, 2012, was sent to all Long-Term Care (LTC) Home Administrators indicating that all LTC homes should use the Health Canada guidance document 'Adult Hospital beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards' as a best practice document in their homes. This document referenced the 'Clinical Guidance for the Assessment and implementation of Bed Rails in Hospitals, Long Term Care Facilities, and Home Care Settings' (CGA), as a prevailing practice for assessing the use of bed rails.

Inspector #543 conducted a review of resident #006, #007, and #002's health care record which failed to identify that any assessment had occurred indicating a need for bed rails.

Inspector #620 and #543 interviewed the DOC who verified that there was no bed rail assessment completed for resident #006, #007, and #002. They stated that beds and mattresses had been assessed for entrapment; however, the residents of the home who utilized bed rails had not been assessed for the use or need for bed rails. [s. 15. (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 ensuring that where bed rails are used, that the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents, was complied with.

The Long-Term Care Health Act, 2007, (LTCHA) describes emotional abuse as, "any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident, or any threatening or intimidating gestures, actions, behaviour or remarks by a resident that causes alarm or fear to another resident where the resident performing the gestures, actions, behaviour or remarks understands and appreciates their consequences..."

Inspector #620 reviewed a complaint submitted to the Director. The complaint related to a staff member being removed from providing care to residents due to an allegation of abuse. The complainant alleged that they were aware of ongoing neglect and abuse that was occurring in the home. They identified that PSW #106, had been abusive with residents. The also indicated that PSW #107 and #108 had been neglectful in their care

of residents.

Inspector #620 interviewed the complainant who described that PSW #109 had inappropriately grabbed resident #023. They stated that the incident was witnessed by RN #110.

In an interview with Inspector #620, RN #110 stated that they witnessed PSW #109 inappropriately touch resident #023. They stated that they notified the On-Call Manager right away, who in turn, called The DOC and the Administrator. The stated that they had also sent an email to the DOC that outlined the occurrence.

Inspector #620 reviewed an email sent by RN #110 to the DOC dated March 20, 2016. Under the subject of, "Incident" RN #110 described that they witnessed PSW #109, inappropriately touch resident #023. RN #110 described the resident's affect appeared anxious and embarrassed. In a second email RN #110 advised the DOC that they had instructed the evening and night shift PSWs that they did not want PSW #109 providing resident #023's care without other staff present.

Inspector #620 reviewed documentation related to the incident between resident #023 and PSW #109. A transcribed interview between PSW #109 and the home's Administrator and the DOC was documented on a specific date. The document noted that the DOC had read a statement regarding the incident and that PSW #109 had responded by saying they knew, "wouldn't be appropriate behaviour."

Inspector #620 reviewed the home's policy titled, "Zero Tolerance of Resident Abuse and Neglect: RC-02-01-01" with an effective date of April 2016. The policy defined emotional abuse verbatim as described in the LTCHA.

Inspector #620 interviewed the DOC who confirmed that they were made aware that resident #023 had been inappropriately touched by PSW #109. They were unaware of whether PSW #109 had been reprimanded as a result of the incident. [s. 20. (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 ensuring that the home's written policy to promote zero tolerance of abuse and neglect of residents, is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or a risk of harm immediately reported the suspicion and the information upon which it was based to the Director.

Inspector #620 reviewed a complaint submitted to the Director. The complaint related to a staff member being removed from providing care to residents due to an allegation of abuse. Please refer to Written Notice #4 for additional details.

Inspector #620 interviewed RN #110 who stated that they witnessed PSW #109 inappropriately touch resident #023. They stated that they advised the On-Call Manager right away, who in turn, called The DOC and the Administrator. The stated that they had also sent an email to the DOC that outlined the event.

Inspector #620 conducted a review of the home's submission of critical incidences reported to the Director and was unable to identify a submission related the described incident of abuse.

Inspector #620 reviewed the home's policy titled, "Zero Tolerance of Resident Abuse and Neglect: RC-02-01-01" with an effective date of April 2016. The policy defined emotional abuse verbatim as described in the LTCHA. The policy also detailed that the Administrator or designate was responsible for, "Ensuring that reporting requirements to provincial/regulatory bodies have been completed as required."

Inspector #620 interviewed the Administrator who stated that they had conducted a full investigation including interviews as a result of the allegation of abuse. They confirmed that they had not submitted a report to the Director and that it was the home's policy that these types of allegation were to be reported. [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 ensuring that a person who has reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or a risk of harm immediately reported the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

Issued on this 13th day of February, 2017

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

Original report signed by the inspector.