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
Nov 23, 2016	2016_507627_0025	030641-16	Resident Quality Inspection

Licensee/Titulaire de permis

SMOOTH ROCK FALLS HOSPITAL
107 KELLY ROAD P.O. BOX219 SMOOTH ROCK FALLS ON P0L 2B0

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

SMOOTH ROCK FALLS HOSPITAL
107 KELLY ROAD P.O. BOX219 SMOOTH ROCK FALLS ON P0L 2B0

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

SYLVIE BYRNES (627), LINDSAY DYRDA (575)

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): November 14-17, 2016.

During the course of the inspection, the inspector(s) spoke with the Unit Coordinator, Resident Assessment Instrument (RAI) /Activity Coordinator, Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and their families.

The Inspector(s) conducted a daily walk through of resident care areas, observed the provision of care towards the residents, observed staff to resident interactions, reviewed resident's health records, staff training records, policies and programs.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Residents' Council

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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(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 has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents included:
(g) the matters provided for in clauses (a) through (f) that were provided for in the regulations, and
(h) any additional matters as provided for in the regulations.

During stage one of the inspection, an identified resident reported to Inspector #575 that staff had been rough when assisting the resident to bed.

The home's policy titled, "Abuse Prevention Policy", last reviewed January 2015, was reviewed by Inspector #575 for the requirements as set out under section 20 (2) of the Long-Term Care Homes Act (LTCHA), 2007, and regulation 96 of Ontario Regulation (O. Reg.) 79/10. Inspector #575 found that the policy had not included:

1) Procedures and interventions required under O. Reg. 96 (a) to assist and support residents who had been abused or neglected or allegedly abused or neglected.

The Inspector noted that the policy indicated that the Manager or delegate should have ensured that the physically or sexually abused resident was examined by a physician. No other interventions were indicated.

2) Procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents as required under LTCHA section 20 (2) (e).

The Inspector noted that the policy outlined that "the Manager or delegate shall notify the Ministry of Health and Long Term Care (MOHLTC) Regional office by telephone within 24 hours of having determined that abuse has taken place or is likely to have taken place. The Manager or the Chief Nursing Officer (CNO) or the Activity Coordinator will report the abuse to the Director of Long Term Care Facilities Branch by completing a critical incident report within five business days of the Smooth Rock Falls Hospital determining that abuse has taken place." Upon completion of the investigation, the supervisor was to notify the "Ministry's Regional Office". The policy had not outlined the correct timelines for reporting to the Director as indicated under subsection s. 24 (1) of the Act.

3) Identified the training and retraining requirements for all staff as required under O. Reg. 96 (e).

The Inspector noted that the policy indicated that staff were to sign the abuse policy yearly, sign a declaration every November indicating that they had not been involved in criminal activity over the past 12 months, and were to comply with all aspects of the abuse policy. The policy had not outlined training requirements as indicated under O. Reg. 96 (e).

4) Notification of incidents, pursuant to O. Reg. 97, every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(i) were notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that resulted in physical injury or pain to the resident or that caused distress to the resident and that was potentially detrimental to the resident's health or well-being; and
(ii) were notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident, and
(iii) the resident and the resident's substitute decision-maker, if any, were notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon

the completion of the investigation.

The Inspector noted that the policy indicated that the "Manager or delegate would notify the resident's family members, Substitute Decision Maker (SDM) or others specified in the resident's plan of care, when the abuse of that resident has, or is suspected to have occurred." Timelines for notifying the SDM were not indicated.

The policy further referenced the Nursing Home Act, which was repealed when the LTCHA came into effect on July 1, 2010, and that the MOHLTC shall investigate all allegations of abuse received through the Action Line.

During an interview with Inspector #575, the Unit Coordinator confirmed that the policy did not identify procedures and interventions to support residents who were emotionally, verbally, or financially abused, or neglected. They further confirmed that the policy did not outline the timelines notifying the SDM of any alleged, suspected, or actual abuse. As well, the Unit Manager confirmed that the training consisted of a review of the homes policy and did not include the requirements as set out under O. Reg. 96 (e) and that the policy was not up to date with the reporting requirement [s. 20. (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 the home's policy to promote zero tolerance of abuse and neglect of residents include the matters provided for in the clauses (a) through (f) of section 20 (2) of the LTCHA, 2007, and any additional matters provided for in the regulation of the Ontario Regulation 79/10, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 59. Family Council

Specifically failed to comply with the following:

s. 59. (7) If there is no Family Council, the licensee shall,
(a) on an ongoing basis advise residents' families and persons of importance to residents of the right to establish a Family Council; and 2007, c. 8, s. 59. (7).
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council. 2007, c. 8, s. 59. (7).

Findings/Faits saillants :

1. The licensee has failed to convene semi-annual meetings to advise resident's families and persons of importance to residents of their right to establish a Family Council.

On November 14, 2016, Inspector #627 was made aware by the Unit Coordinator that the home did not have a Family Council. The Unit Coordinator further stated that they had not convened semi-annual meetings with family members to make the residents' family members aware of their right to establish a Family Council. [s. 59. (7) (b)]

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 licensee convenes semi-annual meetings to advise the residents' families and persons of importance to resident of their right to establish a Family Council, 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. (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. (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; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on an assessment of the resident and the residents' needs and preferences.

During stage one of the inspection, a family member of an identified resident reported to Inspector #575 that the resident had not received a specific type of personal care they required.

The Inspector observed the identified resident on a certain day and noted that the resident had not received the specific type of personal care the required. A specific type of equipment was observed at the resident's bedside.

The Inspector reviewed the identified resident's care plan and noted interventions which indicated that the staff were to provide one person assistance; however, there was no intervention regarding the resident's preference for a specific type of personal care.

The Inspector interviewed two RPNs, regarding the identified resident's care requirements. One RPN stated that the resident's specific care was provided at a specific time and as needed; if they refused, it would have been charted in the progress notes. A second RPN stated that the resident should have been provided with the specific type of personal care at a certain time but had declined. The second RPN indicated that when they had worked on a certain day, the resident had refused the specific type of personal care.

The Inspector reviewed the progress notes over a three day period and noted one progress note which indicated that the resident had refused the specific type of personal care. There were no further progress notes to indicate that the resident had refused the specific type of personal care at any other time during the specific period of time.

The Inspector interviewed the Unit Manager regarding the care requirements for this resident. The Unit Manager stated that usually they would discuss the resident's preferences with the family during the six week and annual care conference. The Unit Manager indicated that the preference for the specific type of personal care was written on the bottom of the care conference form, and included in the resident's care plan under a certain focus. The Unit Manager was not able to locate the care conference form; however, they reviewed the resident's care plan, and confirmed to the Inspector that the resident's preference for a specific type of personal care was not included in the care plan. [s. 6. (2)]

2. The licensee shall ensure that the resident was reassessed and the plan of care reviewed and revised when the resident’s care needs changed.

During stage one of the inspection, Inspector #575 observed an identified resident in bed with the bed rails in the guard position.

During an interview with Inspector #627, a particular RPN stated that the identified resident had bed rails in the down position (guard). This was documented in the care plan. The RPN further explained that the care plan indicated up or down for bed rails use: “up” meaning that the bed rails were in a 90 degree position to assist with transfers (assist position) and that "down" meant that they were fully raised and engaged (guard).

The particular RPN and Inspector #627 reviewed the care plan, which was in effect at the time of the inspection for the identified resident. Under the focus of transferring, an intervention indicated “ bed rails up in bed”. The particular RPN confirmed that the care plan had not been updated when the resident's care needs had changed to indicate that the bed rails were to be in the "down" position. [s. 6. (10) (b)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(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. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee has failed to ensure that a written record of everything provided for in the annual evaluation of the policy to promote zero tolerance of abuse and neglect of residents, including the date, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented, was promptly prepared.

During stage one of the inspection, an identified resident reported to Inspector #575 that staff were rough when assisting the resident to bed.

Inspector #575 reviewed the home's policy titled, "Abuse Prevention Policy", last reviewed January 2015.

During an interview with the Unit Manager, they indicated to the Inspector that they did not have a written record of everything provided for in the annual evaluation of the policy to promote zero tolerance of abuse and neglect of residents. The Unit Manager confirmed that the home did not have a separate document outlining who was at the review and what changes were made. They stated that if the policy was reviewed or revised, it was indicated on the policy; however, no other record was available. [s. 99. (e)]

Issued on this 25th day of November, 2016

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

Original report signed by the inspector.