Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 28, 2013	2013_138151_0029	S-000316,000406,000432-13	Critical Incident System

Licensee/Titulaire de permis

ANSON GENERAL HOSPITAL
58 Anson Dr., IROQUOIS FALLS, ON, P0K-1E0

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

SOUTH CENTENNIAL MANOR
240 FYFE STREET, IROQUOIS FALLS, ON, P0K-1E0

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

MONIQUE BERGER (151)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 15,16,17,18, 2013

Relates to the following:
S-000316-13 and related CI:C599-000011-13
S-000406-13 and related CI:C599-000014-13
S-000432-13 and related CI:C599-000016-13

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Assistant Director of Care, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), residents

During the course of the inspection, the inspector(s)
- observed care and service delivery to residents
- toured the home several times per day
- reviewed residents health care records
- reviewed the home's policies, procedures, protocols and programs in relation to the management and prevention of resident falls
- reviewed the home's policies, procedures, protocols and programs in relation to the management of resident responsive behaviours,
- reviewed incident reports of falls and demonstrated responsive behaviour related to this inspection,
- reviewed the home's education initiatives in the last 12 months in relation to the prevention and management of falls and management of responsive behaviour
- reviewed policies, procedures and protocols related to resident capacity for decision-making and consent.

The following Inspection Protocols were used during this inspection:
Falls Prevention

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:

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. Inspector noted that resident #002 had an incident of responsive behaviour. Inspector reviewed resident #002's most recent plan of care, resident health care records and interviewed the resident and staff. Inspector observed that in this instance, the plan of care that references similar behaviours was not followed. The resident situation escalated and remained unresolved for several days.

The home did not 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 ensuring the care set out in the plan of care for resident #002 is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: 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:
6. Psychological well-being. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. Inspector noted resident #002 had an incident of responsive behaviour. Inspector reviewed resident #002's most recent plan of care, resident health care records and interviewed the resident and staff. Staff interviews and review of the resident's health care records confirmed that key management personnel of the home were unaware of the on-going issues and that front-line staff did not see a role for the home's established Responsive Behaviour Program, therefore, did not initiate the program's responsive behaviour protocols. Inspector interviewed the resident 4 days post-incident and noted the resident remained in an agitated state over the same issues that initiated the responsive behaviours. In review of the resident's plan of care, Inspector noted the responsive behaviour plan of care was not revised to address the new issues affecting the resident's state of psychological well-being

The licensee did not ensure that the responsive behaviour plan of care for resident #002 was based on a timely interdisciplinary assessment of the resident that included psychological well-being. [s. 26. (3) 6.]

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 responsive behaviour plan of care for resident #002 is timely and based on an interdisciplinary assessment of the resident that includes psychological well-being, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

Findings/Faits saillants :

1.Inspector noted resident #002 had an incident of responsive behaviour. Inspector reviewed resident #002's most recent plan of care, reviewed the resident's health care records and interviewed the resident and staff.

In addition, Inspector reviewed the home's program for the management of responsive behaviours titled: "All Behaviours Have Meaning", date of inception June 5, 2012. The program directs staff as follows:
- diffuse the situation
- complete "Post Responsive Behaviour Huddle Worksheet within 4 hours: charting the incident, identifying possible triggers, and updating care plan"
- complete incident report
- make referrals as needed: PIECES trained staff, Senior's Mental Health, psychiatrist
- if the behaviour is known and predictable - inter-disciplinary conference within 24 hours
- re-evaluate new/revised interventions within 2 weeks or sooner if not effective.
Also, the policy directs staff that when there is a change or concern in the resident's typical behavioural profile, staff are to use DOS/ABC observations to track and trend behaviours over time.

Inspector could find no evidence in the resident's health care records that showed the home had employed it's Responsive Behaviour program in consideration of the incident. The Administrator reviewed the resident's health care records and confirmed the Inspector's observation that, in regards to this incident of responsive behaviour, the staff had not implemented the home's Responsive Behaviour Program. Administrator confirmed that the program should have been applied and that the procedures indicated in the program policies and procedures had not been followed.

The licensee does have an established responsive behaviour program. In relation to the resident's latest responsive behaviour incident, the licensee did not ensure that the resident monitoring and internal reporting protocols of this program were used to meet the needs of the resident. [s. 53. (1) 3.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensure that resident #002's needs are met by implementing monitoring and internal reporting protocols for all responsive behaviours demonstrated, to be implemented voluntarily.

WN #4: 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:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. Inspector toured the home and observed a resident being bathed with the tub room door open and the curtain drawn but gaping approximately 2 feet on the left. Inspector was able to look into the room. From the corridor, through the curtain, Inspector could see silhouette shadows of the staff giving care to the resident, could hear all conversation and noted that there was an odor of feaces in and about the room. Inspector interviewed 3 Personal Support Workers (PSW) who all confirmed that sometimes they close the door to the tub room, but often do not because "it gets too hot in there for us". These Staff confirmed that most of their tub rooms do have a toilet in them and often the resident is toileted before bathing.

The licensee did not ensure that every resident is afforded privacy in treatment in caring for his or her personal needs. [s. 3. (1) 8.]

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Issued on this 29th day of October, 2013

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

Monique G. Berger (151)