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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 28, 2019	2019_760527_0002	011368-18, 027904-18	Complaint

Licensee/Titulaire de permis

Corporation of the County of Simcoe
1110 Highway 26 Midhurst ON L9X 1N6

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

Sunset Manor Home for Senior Citizens
49 Raglan Street COLLINGWOOD ON L9Y 4X1

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

KATHLEEN MILLAR (527)

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): January 10, 11, 14, 16, 18, 21, 22 and 23, 2019.

The following Complaints were inspected:

Log #011368-18, related to responsive behaviours; and
Log #027904-18, related to privacy, diet and falls.

The Complaint Inspection was conducted concurrently with the Critical Incident System (CIS) and Follow-Up Inspection, Inspection Report #2019_760527_0001.

Rhonda Ridgeway, LTCH Inspector #737 attended this inspection and conducted the Complaint Inspection Log #027904-18.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Associate Director of Care (ADOC), registered nurses (RNs), registered practical nurses (RPNs), Personal Support Workers (PSWs), Activation Aides, Responsive Behaviour Nurse, Program Support Services Manager, the Professional Standards Supervisor, residents and families.

During the course of the inspection, the inspectors toured the home, reviewed the licensee's compliance plan, reviewed clinical records, reviewed investigation notes, reviewed the licensee's information and policies and procedures, interviewed staff, residents and families, and observed the provision of care.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Falls Prevention
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours

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

- **3 WN(s)**
- **1 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	Légende 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 O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee failed to ensure that procedures and interventions were developed and implemented to assist residents who were at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

Resident #001 was assessed for responsive behaviours and interventions were developed and implemented. Resident #001 was in their room on a specific date, when another resident came into the room and was threatening resident #001. The home implemented a specific safety intervention.

The clinical record was reviewed, which identified that for the resident's safety, they had a safety intervention in place to alert staff that one of their co-residents may have entered resident #001's room and staff were expected to respond.

Resident #001 was observed on five separate dates and times. On a specific date and time, LTCH Inspector #527 entered the resident's room and the safety intervention activated; however no staff responded. The inspector then entered and exited the room five more times over a twenty minute period and still no staff responded.

Registered Practical Nurse (RPN) #105 and Personal Support Workers (PSWs) #106 and #114 were interviewed individually. Each of the staff acknowledged the resident's responsive behaviours, the altercation between the two resident's and the development and implementation of the safety intervention. The staff also acknowledged that when the safety intervention was activated, they were expected to respond as soon as possible, just in case another resident was in resident #001's room.

The ADOC #102 was interviewed and acknowledged that the safety intervention was implemented after a previous incident in 2018 and the purpose was to alert staff if a co-resident entered resident #001's room. The ADOC acknowledged that the staff were expected to respond to the activation of the safety intervention, as soon as possible in order to prevent any altercations.

The licensee failed to ensure that procedures and interventions were developed and implemented to assist resident #001, who was at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

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 procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents, to be implemented voluntarily.

WN #2: 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:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every resident had the right to have their personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

Resident #005 was transferred to hospital on a specific date in 2018. Two visitors arrived at the hospital to visit prior to the substitute decision makers (SDM) notification.

Resident #005's SDM said that two visitors came to the hospital to visit the resident, as they were told by a staff member at the home, that the resident was in the hospital and some additional personal health information. The SDM also stated the home had posted the resident's birthday in the elevator and they had signed a form stating not to post photographs or make public the resident's information.

The clinical record review was completed, which identified that on a specific date and time, the resident's SDM had reported concerns related to confidentiality. The SDM also reported their concerns to the RPN #118 and RN #121.

The policy related to resident confidentiality, directed staff to maintain resident confidentiality from all sources at all times.

PSW #115 was interviewed and said that staff were not to give out any personal information about a resident to, except for the SDM.

RPN #116 and #119 were interviewed and also said that no personal information was to be shared with anyone unless they were the Power of Attorney (POA) or SDM.

The licensee failed to ensure that resident #005, had the right to have their personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a documented record was kept in the home that included, (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant.

Resident #005's SDM reported concerns to the home related to the resident's care and a breach of confidentiality on a specific date in 2018. The family called the Ministry of Health and Long Term Care Action Line on the same date to report their concerns.

Resident #005's clinical record was reviewed and confirmed the SDM's complaints to RPN #118, related to care and a breach of confidentiality.

The home's Complaint Logs for 2018 were reviewed and there were no complaints by the SDM initiated, investigated, actions taken, time frames with follow-up responses, the final resolution and responses provided to the complainant related to resident #005.

The licensee's Complaint policy identified that all complaints received shall be acted upon immediately, which included written or verbal complaints.

RPN #118 was interviewed and confirmed that the SDM had reported their concerns related to resident #005's care and the breach in confidentiality on the specific date in 2018. The RPN reported the concerns to RN #121 and they acknowledged that they had notified the nurse manager who advised them to give the SDM a complaint form to complete.

The DOC acknowledged that based on their complaint policies and procedures and the legislative requirements, there should have been a formal complaint initiated and immediately investigated, as a result of the SDM concerns.

The licensee failed to ensure that a documented record of the complaint for resident #005, was kept in the home that included, (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant.

Issued on this 28th day of January, 2019

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

Original report signed by the inspector.