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 # / No de registre	Type of Inspection / Genre d'inspection
Oct 1, 2018	2018_605213_0003	003873-18, 004699-18, 005989-18	Complaint

Licensee/Titulaire de permis

Ritz Lutheran Villa
16 Lot Road 164 5# R.R. #5 MITCHELL ON N0K 1N0

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

Mitchell Nursing Home
184 Napier Street, S.S. #1 MITCHELL ON N0K 1N0

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

RHONDA KUKOLY (213)

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): September 26, 27, 28, 2018

This inspection was completed related to:
Critical Incident (CI) log # 003873-18, CI #2689-000003-18 related to alleged staff to resident physical abuse.
Complaint log #004699-18, Infoline #IL-48986-LO related to care concerns.
Complaint log #005989-18, Infoline #IL-46865-LO related to maintenance concerns.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Assistant Director of Care, the Environmental Services Manager, a Registered Nurse, Registered Practical Nurses, Personal Support Workers, residents and family members.

The Inspector also made observations and reviewed health records, internal investigation records, education records, policies and procedures and other relevant documentation.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **2 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. (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 written policy to promote zero tolerance of

abuse and neglect of residents was complied with.

The home reported critical incident #2689-00003-18 to the Ministry of Health and Long Term Care (MOHLTC) on an identified date. The report described an incident of alleged staff to resident physical abuse that occurred on four days prior to the date of the report, whereby Personal Support Worker (PSW) #108 used excessive force during care for resident #001 causing minor injury. PSW #107, who witnessed the incident, reported the incident to Registered Nurse (RN) #105 two days after the incident, who in turn sent an email to the Assistant Director of Care (ADOC). The ADOC received the email upon returning to work four days following the incident and reported the incident to the MOHLTC on that day.

The home's "Zero Tolerance – Abuse and Neglect" #A-100-01 with a review date of August 2018 was reviewed and stated: "All staff will:
1. Protect, detect and immediately respond to any alleged, suspected or witnessed incidents of resident abuse or neglect, causing harm or risk of harm to a resident.
2. Ensure the safety and comfort of the victim.
3. Contact the Charge Nurse/manager or delegate immediately.
4. Provide an apology following the incident as appropriate.
5. Participate in the open disclosure and Critical Incident reporting process, as required."

The health care record for resident #001 was reviewed and no progress notes or assessments were found for the date of the incident or the following three days, related to the incident or an assessment of the resident. Notes dated four days after the incident indicated that the resident's family and physician were notified of the incident on that date and that the doctor examined the resident. There was no documentation indicating the findings of the examination from the physician and there was no documentation of a nursing assessment of the resident's physical or emotional status on that date.

In an interview with RN #105, the RN said that they could not recall if they had assessed resident #001 when they were notified of the incident two days after it occurred and after reviewing the health record for resident #001, said that they did not document any assessment and therefore concluded that they had not. The RN said that they emailed the ADOC during their night shift that date, regarding the incident that was reported to them. The Inspector and the RN looked at a calendar together and noted that the incident occurred on the Friday of a long weekend with this, the ADOC did not receive the email until four days after it occurred. When the inspector asked RN #105 what the expectation was for an RN when notified of an incident of alleged staff to resident abuse,

they said that they needed to assess the resident, provide treatment as needed for the resident, document assessment and the report, and call the manager on call, not email them.

In an interview with the current ADOC, the Inspector and the ADOC reviewed the health record for resident #001 and the ADOC agreed that there was no documentation of an assessment of the resident. The ADOC said that the expectation was that registered staff assess the resident when an incident of alleged staff to resident abuse was reported to them, document the results of the assessment and meet the needs of the resident at that time. The ADOC also said that the registered staff should notify the manager on call immediately, calling if they are not in the building at the time of the report, not send an email.

The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with. Resident #001 was not assessed for four days following an incident of staff to resident physical abuse, the RN was not immediately notified with the incident was witnessed, the manager was not notified when the RN became aware of the incident and the MOHLTC was not notified until four days following 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 to ensure that the written policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that for each resident demonstrating responsive behaviours, the behavioural triggers for the resident were identified, strategies were developed and implemented to respond to these behaviours, and actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions documented.

The home reported critical incident #2689-00003-18 to the Ministry of Health and Long Term Care (MOHLTC) on February 20, 2018. The report described an incident of alleged staff to resident physical abuse that occurred on February 16, 2018 whereby Personal Support Worker (PSW) #108 used excessive force during care for resident #001 causing minor injury.

The home's internal investigation records were reviewed including an interview with PSW #107 who witnessed the abuse. PSW #107 said during the interview that they requested help from PSW #108 with resident #001's care as they wouldn't let the PSW finish the care. PSW #107 described resident #001 was lying in bed and flailing/waving their hands, so they backed off. PSW #108 restrained the resident forcefully.

In an interview with PSW #110 on September 27, 2018, the PSW said that resident #001 was resistive to care and would strike out at staff. The PSW said that this usually occurred when the resident was really tired and wanted to be left alone. The PSW said that staff need to just leave the resident when they are resistive and try again at another time. When asked how staff know what the resident's triggers were and how to respond, the PSW said that it should be in the resident's kardex in PCC.

In an interview with Personal Support Worker (PSW) #109 on September 28, 2018, the PSW said that resident #001 was resistive to care, hated a particular part of care and would strike out at staff. The PSW said that staff need to just leave the resident when they are resistive, saying no and trying to stop staff from providing care, and try again at another time. When asked how staff know what the resident's triggers were and how to respond, the PSW said that it should be in the resident's kardex in PCC.

The current plan of care for resident #001 was reviewed in Point Click Care (PCC) and there were no responsive behaviours, triggers, or interventions identified related to resisting care or not wanting their face washed.

In an interview with Registered Practical Nurse (RPN) #111, who was also the Behaviour Supports Ontario (BSO) lead for the home, on September 28, 2018, the RPN said that the expectation was that when a resident demonstrated responsive behaviours such as resisting care and/or physical aggression, staff were to submit a BSO referral so that they could complete an assessment of the behaviour and develop interventions when applicable. The RPN and the Inspector reviewed progress notes for resident #001 together and the RPN agreed that resident #001 was exhibiting responsive behaviours and should have the behaviours, triggers and interventions identified to direct staff. The RPN also said that there had not been a BSO referral for resident #001.

The home's policy "Responsive Behaviours" # RC-201-87 review date of October 2018 was reviewed and stated: "Procedure:
All members of the interdisciplinary team will:
1. Work together to identify possible triggers of responsive behaviours;
2. Develop and implement strategies individualized to the resident into the care plan;
3. Evaluate the effectiveness of the plan and revise if needed;
The RN/RPN will:
1. Assess the resident exhibiting responsive behaviours and determine if the responsive behaviour is endangering others;
2. Strategize with other members of the interdisciplinary team to identify the causes and triggers;
3. Refer to available resources in the health care community such as, Behavioural Support Team (BSO), Behavioural Intervention Response Team/or Psychogeriatric Resource Consultant;
4. Coach front line staff about interventions identified on the care plan and strategize them on additional interventions required."

The licensee has failed to ensure that for resident #001, who demonstrated responsive behaviours of resisting care and striking out at staff, the behavioural triggers for the resident were identified, strategies were developed and implemented to respond to these behaviours, and actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions documented. [s. 53. (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 to ensure that for each resident demonstrating responsive behaviours, the behavioural triggers for the resident are identified, strategies are developed and implemented to respond to these behaviours, and actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions documented, to be implemented voluntarily.

Issued on this 1st day of October, 2018

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

Original report signed by the inspector.