Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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
Aug 20, 2019	2019_655679_0022	007135-19	Critical Incident System

Licensee/Titulaire de permis

Algonquin Nursing Home of Mattawa
231 Tenth Street P.O. Box270 MATTAWA ON P0H 1V0

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

Algonquin Nursing Home
231 Tenth Street P.O. Box270 MATTAWA ON P0H 1V0

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

MICHELLE BERARDI (679)

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): August 12-15, 2019.

Please Note: The Long-Term Care Home address is 207 Turcotte Park Road, Mattawa ON, P0H 1V0.

The following intake was inspected upon during this Critical Incident System (CIS) inspection:
- One intake submitted to the Director for resident to resident physical abuse.

Other Inspection #2019_655679_0021 was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Food Services Manager, Office Manager, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Behavioural Supports Ontario (BSO) RPN, Personal Support Workers (PSWs), Dietary Aides and residents.

The Inspector also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, and reviewed relevant health care records, policies and procedures.

The following Inspection Protocols were used during this inspection:
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 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. 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).

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 the following was developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessments, reassessment, and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other;
3. Resident monitoring and internal reporting protocols; and,
4. Protocols for the referral of residents to specialized resources where required.

A Critical Incident (CI) report was submitted to the Director for an incident of resident to resident physical abuse. The CI report identified that on a specified date, residents #001 and #002 got into an altercation resulting in injury.

Inspector #679 requested a copy of the home's responsive behaviour policy and program from the DOC.

In an interview with the DOC, they identified that the home did not have a responsive behaviour policy or program.

Inspector #679 was later provided with a policy titled "BSO/Responsive Behaviour (NM-E-26)" date issued August 14, 2019. The policy identified written approaches to care; however, the policy did not identify screening protocols, assessments, reassessments, resident monitoring, or protocols for the referral of residents to specialized resources where required. [s. 53. (1)]

2. The licensee has failed to ensure that for each resident demonstrating responsive behaviours, that the behavioural triggers for the resident was identified, where possible.

A CI report was submitted to the Director for an incident of resident to resident physical abuse. The CI report identified that on a specified date, residents #001 and #002 got into an altercation resulting in injury.

Inspector #679 reviewed the electronic progress notes for residents #001 and #002 and identified that the residents had been in multiple previous altercations.

In separate interviews with PSWs #104 and #109, they identified that they would reference a resident's care plan to determine if a resident had responsive behaviours, their triggers, and any interventions in place to manage their behaviours. PSW #109 further identified specified triggers for resident #002.

Inspector #679 reviewed resident #002's electronic care plan and did not identify that the specified trigger was outlined in the care plan.

In an interview with RPN #110, they identified a specified trigger for resident #002. RPN #110 further identified that all the interventions and triggers for the resident's responsive behaviours should be outlined in the resident's care plan.

In an interview with RN #105, they identified a specific trigger for resident #002. RN #105 identified that they would reference a resident's care plan to determine if a resident had responsive behaviours, their triggers, and any interventions in place to manage their behaviours. Together, Inspector#679 and RN #105 reviewed resident #002's electronic

care plan. RN #105 identified they did not observe the specified trigger listed in resident #002's care plan.

In an interview with the DOC, they identified that staff would reference a resident's care plan to determine if a resident had responsive behaviours, their triggers, and any interventions in place to manage their behaviours. When asked if resident #002 had any specific behavioural triggers, the DOC identified a specified trigger. Together, Inspector #679 and the DOC reviewed the resident's electronic care plan. The DOC identified they did not observe any interventions related to the residents specified trigger. [s. 53. (4) (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 the following is developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessments, reassessment, and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other;
3. Resident monitoring and internal reporting protocols; and,
4. Protocols for the referral of residents to specialized resources where required., to be implemented voluntarily.

WN #2: 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 had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director.

A CI report was submitted to the Director for an incident of resident to resident physical abuse. The CI report identified that on a specified date, residents #001 and #002 got into an altercation resulting in injury.

Inspector #679 reviewed resident #002's electronic progress notes and identified a specified number of altercations between resident #002 and co-residents, which resulted in injury.

Inspector #679 reviewed the Ministry of Long-Term Care's online reporting portal and was unable to locate a CIS report for either of the incidents.

A review of the policy titled "Mandatory Reporting & Whistle-Blowing Protection (NM-L-01)" last reviewed January 2019, identified that 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 was based to the Director: 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.

A review of the Ministry of Long-Term Care's "Licensee Reporting of Physical Abuse" decision tree identified that if physical force was applied by a resident, and it caused physical injury to another resident, then the licensee was to immediately report the suspicion and the information to the Director.

In an interview with RN #117, they identified that they would report incidents of resident to resident abuse to the Director, if there was an injury.

In an interview with the DOC, they identified that the home follows the Ministry of Long-Term Care's abuse decision tree to determine if an incident was to be reported to the Director. Together, Inspector#679 and the DOC reviewed the specified incidents. The DOC then reviewed their CIS file, and identified they did not have copies of these incidents, and that they didn't think that there was a CIS report submitted. The DOC further identified that the incidents should have been reported. [s. 24. (1) 2.]

Issued on this 20th day of August, 2019

[redacted]

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

Original report signed by the inspector.