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 8, 2019	2019_771609_0015	013971-19, 014855-19	Critical Incident System

Licensee/Titulaire de permis

Board of Management for the District of Nipissing West
100 Michaud Street STURGEON FALLS ON P2B 2Z4

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

Au Chateau
100 Michaud Street STURGEON FALLS ON P2B 2Z4

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

CHAD CAMPS (609)

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): July 29-31 and August 1-2, 2019.

The following intakes were inspected during the course of this Critical Incident System (CIS) inspection:

One intake related to allegations of improper care of a resident; and
One intake related to allegations of staff to resident abuse.

A Follow Up inspection #2019_771609_0014 was conducted concurrently with this CIS inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Chief Financial Officer, Administrative Assistant, Director of Care (DOC), Environmental Services Manager, Physiotherapist, Registered Nurses (RNs), Physiotherapy Assistant (PTA), Personal Support Workers (PSWs), Housekeeping Staff, family members of residents and residents.

During the course of the inspection, the inspector(s) also conducted a daily tour of the resident care areas, observed staff to resident interactions and the provisions of care, reviewed relevant resident health care records, policies, procedures and internal investigation reports.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **1 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. 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:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #008, #009 and #010's responsive behaviour plans of care were based on an interdisciplinary assessment of the residents that included any identified responsive behaviours and any potential behavioural triggers.

A Critical Incident (CI) report was submitted by the home to the Director which outlined allegations of staff to resident abuse, when Registered Practical Nurse (RPN) #113 reported that they observed an incident between staff member #112 and resident #008. The report indicated that the resident sustained an injury.

1. Inspector #609 conducted a review of the home's internal investigation of the incident with the Director of Care (DOC). The investigation found that staff member #112 did not abuse resident #008, rather the resident exhibited specific responsive behaviours, towards the staff member which caused an injury to themselves.

RPN #113 and staff member #112 were unavailable for an interview during the course of the inspection.

During an interview with PSW #114, they described how resident #008 was known to be responsive in the specified manner, toward staff and had a specific known trigger for their responsive behaviours.

During an interview with Registered Nurse (RN) #108, they indicated that they were aware of resident #008's previous specified responsive behaviours.

A review of resident #008's plan of care found that the resident was at a specific risk for behaviours. The plan of care and the care plan failed to identify that the resident could exhibit the specified responsive behaviors, nor identify that the resident's specified known trigger to the responsive behaviours.

A review of the home's policy titled "Responsive Behaviour Management and Abuse/Neglect Prevention Program" last revised April 5, 2019, outlined how a key aspect of resident care was to prevent or minimize the situations in which a resident exhibited responsive behaviours. The staff of the home could achieve this preventative approach by integrating the most effective strategies for individual residents into their plans of care.

During an interview with the DOC, resident #008's plan of care was reviewed. The DOC verified that the resident's specified responsive behaviours and known trigger to the specified responsive behaviours should have been outlined in the resident's plan of care.

2. During an interview with PSW #114, they indicated that resident #009 exhibited specific responsive behaviours.

A review of the last 30 days of resident #009's electronic progress notes described various types of specified responsive behaviours on three different dates.

A review of resident #009's plan of care found that the resident was at a specified risk for behaviours. The plan of care and the care plan failed to identify that the resident could exhibit the specified responsive behaviors.

During an interview with RN #108, they denied any awareness of resident #009's specified responsive behaviours. A review of the resident's last 30 days of electronic progress notes and their plan of care were conducted with the RN, who acknowledged that the resident's specified responsive behaviours should have been in the resident's plan of care.

3. During an interview with PSW #114, they indicated that resident #010 exhibited specific responsive behaviours.

A review of resident #010's most recent Minimum Data Set (MDS) indicated that the resident exhibited the specified responsive behaviours between one and three times within the review time frame.

During an interview with RN #108, they described resident #010's specified responsive behaviours. There were two incidents that the RN was aware of where the resident demonstrated the specified responsive behaviours towards staff. The resident was known to have a specific trigger for the specified responsive behaviours.

A review of resident #010's plan of care found that the resident was at a specified risk for behaviours. The plan of care and the care plan failed to identify that the resident could exhibit the specified responsive behaviors, nor identify the specified known trigger for the resident's specified responsive behaviours.

During an interview with the DOC, they verified that neither resident #009 or #010's plans of care outlined their known specified responsive behaviours or specified triggers. [s. 26. (3) 5.]

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 resident #008, #009 and #010 as well as all other residents of the home with the specified responsive behaviours have plans of care that are based on an interdisciplinary assessment of the residents that include: Any identified responsive behaviours; and any potential behavioural triggers, to be implemented voluntarily.

Issued on this 16th day of August, 2019

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

Original report signed by the inspector.